tology and Blood Transfusion of the I.M.L.T., and also for the practical aspect of the same subjects relating to the senior medical student. This second edition includes a number of additional techniques, e.g. the investigation of the haemorrhagic disorders, the electrophoresis of haemoglobins and the Rose-Waaler test. Sections on blood bank organisation and parasitology present in the first edition have been omitted, but there are four new chapters on blood groups, serological and cross-matching work and blood transfusion reactions.

The text is clear and precise, and the great asset of the book is the collection and presentation, in a single volume of reasonable size, of much haemtological data and techniques available otherwise only in more specialised manuals. At the close of many of the chapters are helpful brief lists of references, and there is also a glossary of terms at the end of the book. Constructive criticism is the absence of reference to the photo-electric cell for haemoglobin estimation, now the method of choice and certainly the most accurate. Other omissions are directions for preparing Coombs' reagent and also some general information and points on the significance of vitamin B_{12} serum estimations and absorption tests.

The book undoubtedly fulfils the function which the authors had in mind, and its practical value as a bench book in the subject is established.

H.F.B.

BOOKS RECEIVED

Textbook of Gaenecology, by J. H. Peel. Published by Heinemann. Price 30s.

Childbirth Without Fear, by Grantley Dick-Reed. Published by Heinemann. Price 12s. 6d.

Medical Terminology for Radiographers, by P. M. Davies. Published by Heinemann. Price 15s.

Principles of Pharmacology, by J. J. Lewis. Published by Livingstone. Price 55s.

Diagnosis in Locomotor Disorders, by K. Stone. Published by O.U.P. Price 25s.

Roy. Nat. Hosp. for Rheumatic Diseases, Bath. Reports. Volume 10, 1958-59.

Varicose Veins, by T. Cleave. Published by John Wright & Sons. Price 7s. 6d.

Clinical Physiology, by E. J. M. Campbell and C. J. Dickinson. Published by Blackwell. Price 50s.

Body Fluids in Surgery, by A. W. Wilkinson Published by Livingstone. Price 21s.

A Final Study in the Nature of Disease, by J. E. R. McDonagh. Published by Heinemann. Price 30s.

An Introduction to Congenital Heart Disease, by L. Schamroth and F. Segal. Published by Blackwell. Price 22s. 6d.

Acknowledgement in this column does not preclude a review.

ST. BARTHOLOMEW'S HOSPITAL JOURNAL

Vol. LXIV, No. 5 MAY, 1960

EDITORIAL

Medicine at the beginning of the present century was still a relatively simple and uncomplicated art. The previous one hundred and fifty years, it is true, had seen spectacular advances; vaccination had done much to remove the scourge of smallpox, and the advances in anaesthetics and bacteriology had broadened the scope of surgery. Through the concepts first of anti-sepsis, and then asepsis, the patients prospects of recovery had been much improved. X-rays, too, were being developed as a valuable aid to diagnosis. Nevertheless, it was still possible for an individual to be well versed in most of the branches of medicine. Specialisation in medicine, surgery or obstetrics was well established, but it was not uncommon for one or more of these specialities to be combined with general practice. Nor were the specialities as closely associated with hospitals as is the case today. It was by no means uncommon for major surgery to be undertaken in the patient's own home, with his own doctor as anaesthetist. Domiciliary visits by Consultants were far commoner than today, and it was only among the poorer classes that hospitalisation was really necessary.

Under this system the General Practitioner was the prop and stay of his patient in time of crisis. He alone knew the patient's full history and background, and though Consultant opinion might be sought, the G.P. still remained visibly in charge of his patient's health and well-being. Professor T. F. Rodger* has called attention to the fact that the General Practitioner has traditionally been something more than a diagnostician—he is a unique type of psychotherapist. In primitive societies the medicine man, invested with strong magic powers, is enabled to exert powerful therapeutic effects through suggestion. In the rôle of the priest-physician he was likewise able to help his patients through the power of prayer and the exorcism of evil. "The doctor still retains much of his traditional status, but in his newer more competent technical rôle he sometimes finds it irksome to be regarded irrationally as a purveyor of magic or to be burdened with confidences and intimacies which often seem irrelevant to his task and which he would gladly see his patients take elsewhere."

In recent years the glamour of medicine has, as far as the public is concerned, shifted to the hospital. It is here that the modern dramas are played out, and it is here that the full battery of investigations can be trained on the patient. The Consultant has at his command vast technical resources, and the G.P., once his patient has been warded, has to await the progress reports which will be sent to him in due course. Inevitably it would seem, the General Practitioner's prestige has taken a knock.

* Textbook of Medical Treatment ed. Dunlop, Davidson and Alstead Livingstone

The advent of the N.H.S. has, according to some authorities, struck a further blow at the status of the G.P. The capitation fee has meant that the practitioner is under permanent contract to treat the majority of his patients, and in some circles this has led to a notion of a master-servant relationship. Certainly the rôle of unpaid tax-collector, collecting prescription fees, is not becoming.

Be that as it may, the practitioner himself has recently done his best to shed many of the symbols of his traditional rôle. Gone are the top hat and professional dress, his surgery is businesslike and often his manner is brisk, discouraging superfluities of conversation. Yet, in spite of this, his prestige persists, shared now by his auxiliaries—nurses, social workers, physiotherapists, and the like—is still as powerful as ever to sway the emotions of his patients.

The doctor-patient relationship is an essential tool of psychotherapy which Freud showed was as important as the uncovering of repressed material. In psychoanalysis this relationship is known as the *transference situation* because in the course of treatment emotions formerly attached to other people are transferred to the doctor, who becomes the object of fluctuating emotions, both positive and negative. This situation is not confined to psychoanalysis, something similar plays a part in all therapeutic relationships. "All sick patients need psychotherapy in the sense that the emotional significance of the doctor-patient relationship can never be neglected."

In times of stress an individual leans on another individual, not on a team, though this team may be essential for the proper diagnosis and treatment of his disease. The Consultant is unable to spare the time or devote the necessary interest to individual patients to fulfil this need. At the other extreme, the young houseman is scarcely in a position to undertake this function. Who, then, is to lead the team? The answer every time must be the General Practitioner, he alone has a full knowledge of the patient in his own environment, and if the whole patient is to be treated instead of only his disease it is essential that the consultant shall look to the G.P. as leader and co-ordinator of the team.

The general practitioner must also remain the friendly healer of all the quasi and para-medical ills which his patients may lay before him. The patient must have one person in whom he can confide and on whom he can unburden himself of difficulties which may affect his health. The G.P. must be his guide, mentor and friend. It follows from this that he must have a broad understanding of social needs and perhaps more training in social case work. In this way he will not be competing at their level with his consultant colleagues.

The G.P. must take more interest in mental health (surely one of the most pressing problems of our day) as his intimate knowledge of the patient and his background allow prompt treatment of minor problems and shed valuable light on cases which may have to be passed on for specialist opinion and treatment.

Preventive medicine and Public Health are also important fields for the G.P., but it is in the realms of psychiatric and social medicine that he may use, consolidate and maintain his prestige and influence to best advantage.

To this end it is to be hoped that much greater emphasis will be placed on the teaching of these subjects in our medical schools.

The Medical College prospectus for the academic year 1959-60 lists, among the recreational facilities offered to the students, squash courts and tennis courts at Charterhouse and Chislehurst. At the meeting of the Students' Union Council, held on April 13th, the Secretary of the Squash Club called the attention of the Council to the steadily decreasing revenues from booking fees for the squash courts, and asked the Council to approve a plan to fix special locks to the doors of the courts which could only be opened by the insertion of a sixpence. The Secretary attributed the declining revenues to the current tendency to play "on spec" as opposed to booking the court well in advance. A similar trend has been noted in the booking of the Charterhouse tennis courts. The Secretary went on to say that although the Squash Club was not financially embarrassed by the fall in income, a steady flow of booking fees had, in the past, enabled them to manage on a correspondingly reduced grant from the Students' Union.

It was pointed out that there is no booking fee for the tennis courts at Chislehurst, and it was asked if some sort of parking meter would, in future, be attached to the goal posts used for soccer, rugger and hockey. These points were countered by the President in a ruling, the rationale of which is more than obscure, namely that the pitches and courts at Chislehurst are "part of the amenities," whereas the tennis and squash courts at Charterhouse are not!

Now no-one can reasonably object to paying sixpence for the privilege of booking a court for squash or tennis, but surely there can be no justification for exacting a capitation fee of sixpence only from those people who want to play squash. All those who enjoy the sporting facilities provided by the Medical College should object to this anomaly.

Christmas and Easter are both national holidays, at which time the domestic staff might reasonably expect some easing of the duties which they perform throughout the year. At Christmas the refectory in College Hall is closed and meals are provided in the Hospital, but this Easter both refectories were shut on Good Friday and on Easter Monday.

It is to be hoped that next year arrangements will be made which will allow more adequately for the nutrition of those people who stay on to work.

Abernethian Society

On April 21st, Mr. D. M. Jackson, M.D., F.R.C.S., Director of the Burns Unit at the Birmingham Accident Hospital, addressed the Society on the "Present Treatment of Burns."

From the medical point of view, a burn is an incident that is followed by a disease with complications. The complications are shock, sepsis and scarring. The treatment of shock is often carried out on the basis of a formula, which he deplored, and he emphasised that every case should be treated on a rational basis. There are five guides to a rational treatment of shock which are reliable when regarded as a whole, but which can be unreliable if used as isolated criteria. The physical signs can be regarded as the first guide. The patient will be cold, pale, restless and with a low blood pressure, but these signs will not have developed if the patient is observed within half an hour of the burn. This is because loss of fluid from the vascular system takes place slowly into a damaged tissue after a burn. As a general guide, a child with 10 per cent of the body burnt, or an adult with 15 per cent, will probably develop clinical shock. The second guide is the haematocrit from which the loss of vascular fluid can be calculated unless there was extensive red cell destruction also as a result of the burn. Thirdly, the urine output should be observed. This should not be allowed to fall beneath 20 ml/hour for a child or 35 ml/hour for an adult. The plasma volume itself can be measured and the fluid lost calculated, and finally the blood volume can be measured using red cells labelled with radioactive phosphate or chromium.

After an extensive burn there are two periods of haemoglobinuria. This may be sufficiently serious to cause a severe anaemia if more than 40 per cent of the body surface is burnt. The first occurs in the first and second hours after the burn and represents haemoglobin from the direct destruction of red cells. The second occurs 24 hours later and may be the most serious. The cause of the red cell destruction at this time is not known but auto-immunity has been invoked as an explanation.

Considering the treatment of the burn itself, Mr. Jackson emphasised that a "new burn is a clean wound" but that, at present, more patients die from subsequent infection than any other cause. Burns can either be treated by complete coverage of the area with infrequent changes of dressing under sterile conditions, or by the "exposure technique," in which the burnt area is kept dry. It is then a poor medium for bacterial growth. Both methods are very successful if used in the appropriate circumstances. In either case the burnt area is treated with penicillin cream, but systemic antibiotics are not employed. The penicillin inhibits the growth of haemolytic streptococci which interfere with the subsequent grafting, but straphylococcal and pyocyaneus infections are still troublesome. The best treatment is excision of the burnt area followed by repair with split skin grafts on the same day, if possible,

but there are various contra-indications to this. If complete coverage of the area with autografts is not possible, the grafting can be done in thin strips with the autografts interspersed with homografts. The latter will come off after 14 days, but the autografts spread and often unite with each other as the homografts come off.

It is obviously important to know whether full skin destruction has occurred before the area is grafted. The appearance of whiteness or blanching on pressure are poor guides, but sensitivity to sharp pin-prick is better. If the grafting operation is carried out in an ischaemic field such as could be obtained in an arm or a leg, the appearance of the subcutaneous fat is important. If this remains pink it means stasis has occurred in the vascular bed, and such fat should be excised. Mr. Jackson then discussed in more detail the techniques of grafting. He illustrated his talk with coloured slides and answered numerous questions. In regard to prognosis, he said this was directly related to the person's age and that though the cure of those who survived was more complete than previously, the mortality of burns had not decreased in the last ten years.

Lt.-Colonel Groves

We learn, with deep regret, of the death of Lt.-Col. J. N. Groves, D.S.O., who was better known to many of his friends as "Bash." Speaking at the funeral service, held at St. Luke's Church, Chelsea, the Revd. Ross Hook mentioned Colonel Groves' athletic prowess, which led him to box for both Cambridge and Bart's.

Colonel Groves had, however, a much more gentle side to his nature, and a deep love of his fellow men, which inspired much of his work as a doctor ; he was more than a physician to his patients, he was their friend.

Colonel Groves had a particular fondness for children, and it is related that when the advancing Allied armies occupied any town or village, having attended to his military duties, he was next to be seen wandering down the streets distributing sweets to the children.

The Colonel's interest in children and their welfare led to the very considerable work that he undertook on behalf of St. Mary's Childrens' Home at Eastnor, which was formerly a Church of England Home for Waifs and Strays. There he made persistent efforts to bring about the closer integration of the Children's Home and the village.

A memorial fund has been opened which already totals £209. This is to be used to provide a hut where the older children can enjoy their hobbies without interference from the younger ones.

A Tribute to Sir Geoffrey Keynes

To celebrate his seventieth birthday, Sir Geoffrey Keynes' friends and colleagues at St. Bartholomew's Hospital and the Osler Club held two meetings, where tribute was paid to his many-sided genius. These tributes together with the minutes of the Osler Club meeting and a complete bibliography of Sir Geoffrey's writings, have now been collected and are to be printed for the Osler Club. The book will contain the speech made by Sir Russell Brain in the Great Hall of St. Bartholomew's Hospital, with the tributes which were then presented to Sir Geoffrey in the form of a privately printed leaflet, and the speeches made by the President and Sir Gordon Gordon-Taylor at the Osler Club meeting. The Librarian of the Royal College of Surgeons, Mr. W. R. Le Fanu, has prepared the bibliography, which lists all Sir Geoffrey's books and articles in periodicals, medical and literary, arranged in chronological order under subject-headings. The book will be illustrated with a portrait of Sir Geoffrey and a facsimile of the manuscript of his *Religio Bibliographici*, and will be bound in half-cloth with decorated paper boards ; the price will be 15s.

The book will be distributed by Messrs. Rupert Hart-Davis Ltd., 36 Soho Square, London, W.1, and those wishing to subscribe to the volume should communicate with them before June 30th. A full list of subscribers will be printed in the volume.

Sir Joseph Henry Pierre

A recent issue of *Spotlight*, a monthly newsmagazine published in the Caribbean area, carries a feature account of the life and work of Sir Joseph Henry Pierre.

Sir Henry was born on October 28th, 1904, in a settlement some fifteen miles from Port of Spain. His father, the Hon. C. Henry Pierre, was a highly popular member of the City and Legislative Councils.

At an early age, young Henry became interested, through the good offices of the family doctor, in how medical men went about their work and, from this, his interest developed naturally to the very substance of medicine.

After completing his secondary education at Queen's Royal College, Henry Pierre came to Bart's, where he fell under the influence of Sir Girling Ball, who was then Dean of the Medical College. At Bart's he also met a group of young men who worked hard and played hard, and this, says *Spotlight*, is still one of the most notable features of his way of life today.

Having qualified, Henry Pierre turned down offers of work in this country in order to return to Trinidad and the type of practice which over here was contemptuously termed "colonial medicine." It was a name he hated, and he burned with a desire to bring West Indian medicine up to world standard. His twenty-four year progress from a junior appointment to a knighthood in 1957 and an Honorary Fellowship of the Royal College of Surgeons, has been studded with pioneer operations in all fields of surgery, but especially in chest surgery. His ambition to remove the "colonial" handle from West Indian surgery has been achieved for all time through his skill, personality and capacity for almost non-stop work.

Hospitals' Symphony Orchestra

The concert on April 1st was attended by rather fewer people than usual, and it is certainly true to say that those who were not there missed a most enjoyable evening. The major work performed was Beethoven's 6th Symphony, which was probably aiming rather high, and the result was very mixed : there were times when the second violins hardly seemed to have the stamina to maintain pages of semi-quavers, and tension rose as the uncertainty increased. On the other hand, the *tutti* were almost always excellent, the intonation of the orchestra good, and the playing controlled and sensitive.

The outstanding performance of the evening was unquestionably Holst's Ballet Music from "The Perfect Fool." Although at times of considerable technical difficulty, the orchestra clearly enjoyed itself and succeeded in overcoming the effort of invoking the Spirits of Earth, Water and Fire, while the audience found themselves relaxed and at ease, yet certainly moved by this work.

The Trumpet Concerto of Haydn (played by Philip Jones) was delightful and played with an ease and confidence which further emphasises the fact that both orchestra and audience enjoy a work which they can master readily much more than one which is stifled with numerous technical difficulties. Rossini's Overture to Simiramide was rather shaky—but one must make an allowance for the first work of the evening. Christopher Finzi, the conductor, should be congratulated on the standard of this concert. Talent from Bart's is responsible for seven and a half per cent of the orchestra strength !

P.J.W.

"Great Expectations"

This is the third time in as many months that the Mermaid Theatre has attempted to "bring the classics to the masses." In "Great Expectations" they have a play which, although at times is slow, holds the attention throughout, for so skilful is the production that at the very moment one begins to drift, a twist of humour is introduced and the mind is back to the play.

Again clever lighting and a simple but functional set give atmosphere to a play set in early Victorian times. With little imagination you find yourself on the marshes, remote and desolate, only to find, minutes later, that you are in the heart of London ; and with all this to help them an excellent cast fit themselves into character extremely well.

With what many of us found in our youth to be a long and tedious book, the Mermaid has produced in "Great Expectations" an adaptation which should appeal even to those who are sceptical of Dickens being "potted."

From now on I'll prefer it that way.

J.W.

Drugs are Not Enough

Addressing the Congress of the Royal Society of Health, Dr. C. A. H. Watts, of the Standing Health Advisory Committee, said that drugs alone are not enough in the treatment of a patient's disease. The patient needs and relies upon the personality of his doctor.

"Never in the history of medicine has the family doctor had such useful weapons with which to fight disease and suffering. But," Dr. Watts went on, "our prestige is not nearly so high. Our status has fallen because we have been misled by the power of our new tools . . . . . We have largely forgotten and ignored the ancient sources of our power. Besides the drug, the patient needs the personality of the doctor behind it."

Commenting on the need for a wider understanding of the psychiatric aspects of medicine, Dr. Watts said, "Progress in general medicine must go on side by side with progress in the understanding of human behaviour. The doctor who studies his patient's fears and phobias not only helps the patient, but he also enriches his own clinical acumen."

Rheumatism

It has been announced that the Empire Rheumatism Council is to finance an investigation into the effects of rheumatism on industrial workers and their output. It is estimated that 27 million working days per year are lost to the nation through the effects of rheumatic disease.

The investigation, which will be directed by Dr. J. J. R. Duthie, Director of the Rheumatic Unit at Edinburgh, will seek to gain a more accurate picture of the incidence of rheumatic complaints in specific industries. The survey will estimate the financial implications of rheumatic disease, both for sufferer and employer, and will seek to elucidate the importance of working conditions in aggravating rheumatic disorders.

In the light of its findings, it is hoped that it may be possible to advise employees of ways in which the incidence of such diseases may be reduced, and to designate occupations suitable for workers already partially disabled by rheumatism.

News in Brief

The Revd. D. Neill, M.A., who was a student at Bart's from 1928-1930 has recently been appointed Chaplain-General to H.M. Forces.

Dr. C. F. Harris has been appointed for a further year as Vice-Chancellor of the University of London.

Mr. G. J. Hadfield has been appointed Surgeon to the Aylesbury Group of Hospitals.

Mr. E. A. J. Alment has been appointed consultant obstetrician and gynaecologist to the Northampton and Kettering Group of Hospitals.

Mr. I. McColl has been appointed Junior Registrar to the Surgical Professorial Unit as from May 1st, 1960.

Mr. P. Bliss has been appointed Junior Registrar to Mr. Hosford's Firm as from May 1st, 1960.

Dr. C. S. Nicol appeared in the I.T.V. programme "The Shadow of Ignorance" on March 30th. The programme, introduced by Jo Grimond, discussed some of the medical and social problems encountered in venereology and called attention to the current increase in the incidence of venereal disease. This programme was a fine example of the proper use of television as a medium for educating the public in medical problems. The factual presentation can have done nothing but good, and the over-dramatisation of hospital practice, which is such a conspicuous feature of another weekly programme, was scrupulously avoided.

Dr. A. K. Thould was successful in the University of London examination for the degree of M.D. held in April.

The Soccer Club Dinner will be held on Thursday, June 16th, at the Talbot Restaurant, London Wall. Mr. Alan Hunt will preside. Any past members of the Club who would like to attend are asked to write to the Hon. Secretary, B. D. Hore, College Hall, Charter-House Square, E.C.1. The cost of the dinner is 15s.

Suture Packs

The use of catgut tube breakers has been rendered unnecessary by a new type of package introduced by Ethicon Limited, of Edinburgh. Sutures are now available in five-foot lengths in aluminium foil packs. These packs are readily torn open leaving the suture ready for use, and the risk of damage to gloves or suture from broken glass is obviated.

The packs are presented in a jar of disinfecting fluid containing formalin. This preserves the packs in antiseptic conditions and, it is claimed, ensures their complete sterilisation should they be returned to the jar unused after the operation.

Fifty Years Ago

Thomas Horder read a paper to the Abernethian Society in 1910 on "Fever Without Other Physical Signs." He defines physical signs as those signs "which can be appreciated by the unaided senses of the observer. The author excludes from his heading "cases in which there are physical signs but . . . signs inadequate for diagnosis." "The cases (of fever) may be divided into two groups according as the physical signs are latent or difficult to find or are altogether absent."

In the first group in which the physical signs are overlooked or latent, Horder includes seven conditions. "*Cholecystitis*—the patients are usually the subjects of gallstones . . . often they are stout . . . pain is generally present . . . flatulent distention of the bowels is almost constant. *Pyelocystitis*—the amount of pus in the urine may be quite small . . . the commonest microorganism at work is *B. coli*. *Pyorrhoea alveolaris*—long-continued and marked pyrexia may certainly own no other cause than oral sepsis. The form of fever is apt to be periodic, with intermissions lasting from one to several days. *Perigastritis and subphrenic abscess*—when signs do appear, pleural friction is apt to be the first. *Acute rheumatism*—may give rise to bouts of fever with little or nothing manifest in the way of physical signs . . . sodium salicylate may have no effect upon the fever. It is highly probable that some serous membrane is in a state of smouldering inflammation. *Localised tuberculosis*—is probably the commonest cause of fever with latent physical signs. *Fever following surigcal operation* A physician is not infrequently called upon to discover the cause of pyrexia arising in a patient shortly after an operation has been performed. Painful experience has at length taught the modern surgeon to treat with due respect the subtle possibilities of the pyogenetic coccus. *But* might he not now with advantage turn his attention to greater care for the integrity of the tissues through which he passes during the steps of his operation? That is to say might he not be repaid for showing more respect to the soil, as he has been repaid for showing more respect to the microbe?"

In the second group, entirely lacking physical signs, ten conditions are included. "*Influenza*—is probably the commonest cause of pyrexia without other physical signs. Indeed, most cases of influenza run their course without other signs than that recorded by the thermometer. *Typhoid fever*—is the most frequent and most important cause of fever of longer duration than five days in Great Britain, physical signs being absent. Neither a sudden form of onset, nor absence of headache, nor form of temperature chart must be allowed to interfere with a consideration of this infection as a possible cause of pyrexia. *Septicaemia*—especially following the puerperium may lead to marked fever without other signs. The presence of a bone injury in a child suffering from sudden fever must always receive the most critical examination. *Malta fever*—the patient may come under observation for general weakness, for neuralgic joint pain or for fever . . . the most careful clinical examination may fail to demonstrate any possible focus. *Malaria*—the diagnosis rests upon the discovery of the parasite in the blood . . . a leucopenia ("relative lymphocytosis") is almost invariable. *Cerebro-spinal fever*—occasionally there may be an absence of the diagnostic clinical signs for some days or even weeks. *General tuberculosis*—a rare cause of fever in patients who show no other physical signs of disease. *Intestinal intoxication*—obscure fever which seems to depend for its cause upon the absorption of poisons generated in the intestine. *Rat-bite fever*—there is a disease having the following characters: The patient is bitten by a rat. After an incubation period of three to four weeks fever appears, accompanied by an erythema and much constitutional disturbance. A high leucocytosis is present. *Nervous fever*—in a case of fever . . . the question of nervous influence must be considered."

Although the author has "only dealt with matters of personal experience" and this paper was read fifty years ago, a more recent classification could differ little from this list which Horder prepared for the Abernethian Society.

Six of One, Half a Dozen of the Other

Queen Farah of Persia is expecting a baby, and everything possible is being done to ensure the birth of an heir to the Peacock Throne. An Associated Press message quotes a royal court source as saying that the queen is following a careful regimen. "This regimen was advised by experienced specialists, and is believed to give at least a 50 per cent assurance for the birth of a boy"!

MR. NASH
AT BLACK SEA RESORT

—The Guardian

Mr. Nash meets Kruhschev

—Daily Express

Well, well!

CALENDAR

JUNE

Wed. 1—L.T.C. *v* Royal Free (A)
Sat. 4—On duty : Dr. R. Bodley Scott
Mr. A. H. Hunt
Mr. F. T. Evans
Cricket *v* Queen's College, Cantab. (H)
L.T.C. *v* King's College Hospital (H)
Cricket Club Dance
Sun. 5—Cricket *v* Parkfield (H)
Wed. 8—L.T.C. *v* Royal Holloway (A)
Fri. 10 } OPEN DAYS
Sat. 11 }
On duty : Dr. A. W. Spence
Mr. C. Naunton Morgan
Mr. R. A. Bowen
Cricket *v* Wimbledon (H)
Sun. 12—Cricket *v* Horlicks (A)
Wed. 15—L.T.C. *v* Westminster (H)
Thur. 16—Abernethian Society :
Dr. Phillip Addison, M.R.C.S., L.R.C.P.
Sat. 18—On duty : Dr. G. W. Hayward
Mr. A. W. Badenoch
Mr. R. W. Ballantine
Cricket *v* Charing Cross Hospital (A)
Cricket Club Dance
Sun. 19—Cricket *v* O. Cholmondelians
Shooting ; U.H. Championships
Mon. 20—Film Society : " Passport to Pimlico "
Wed. 22—L.T.C. *v* St. Mary's Hospital (A)
Thur. 23—Abernethian Society :
Sir Roy Cameron, F.R.S.
Sat. 25—On duty : Dr. E. R. Cullinan
Mr. J. P. Hosford
Mr. C. Langton Hewer
Cricket *v* Jesters (H)
Sun. 26—Cricket *v* O. Roans (H)
Shooting : Staff *v* Students
Hospital Championships
Wed. 29—L.T.C. *v* Bedford College (H)
Henley Royal Regatta opens

ANNOUNCEMENTS

Engagements

HADFIELD—SLEIGH.—The engagement is announced between Geoffrey John Hadfield, F.R.C.S., and Beryl Sleigh. The marriage will take place at St. Bartholomew-the-Great on May 21st.

SPENCER—BACON.—The engagement is announced between Dr. A. George Spencer and Pamela Bacon.

Births

ARDEN.—On April 5th, at Cape Town, to Ann, wife of Surgeon Commander L. D. Arden, R.N., twins, a son and a daughter.

BUNJE.—On January 28th, to Elizabeth and Dr. Henry Bunjé, a son (Richard Henry).

CHURCH.—On March 8th, to Rhoda, wife of Dr. John C. T. Church, a son (Jonathan Christian Martin).

CLARKE-WILLIAMS.—On March 15th, to Shirley, wife of Dr. Michael Clarke-Williams, a son (Jeremy), brother for Marion and Adam.

GREY-TURNER.—On March 20th, to Lilias, wife of Dr. Elston Grey-Turner, a daughter.

HANS.—On March 14th, to Nora Frances, wife of Stanley Hans, F.R.C.S., a daughter.

RICE.—On March 20th, to Brita, wife of Dr. N. S. C. Rice, a daughter (Karin Elisabeth), a sister for Andrew.

ROBINS.—On February 23rd, to Shirley and Robert Robins, a third child (James Edward).

SKEGGS.—On March 24th, to Anne and David Skeggs, a daughter.

VERNEY.—(Adoption.) By Dorothy and Dr. Geoffrey (Bob) Verney, a daughter (Nicola Jane), sister for Timothy.

Deaths

COUCHMAN.—On March 18th, Dr. Hugh John Couchman, aged 73. Qualified 1912.

DICKIE.—On March 20th, William Stewart Dickie, O.B.E., F.R.C.S., aged 87. Qualified 1900.

ETHERINGTON-WILSON.—On April 4th, William Etherington-Wilson, F.R.C.S., aged 66. Qualified 1916.

FORRESTER-WOOD.—On April 6th, William Rodney Forrester-Wood, F.R.C.S. Qualified 1929.

Radiology in the Investigation of Abdominal Tumours

by R. A. KEMP HARPER

Over the years, Radiology has become increasingly essential to the physician and surgeon in the investigation of abdominal disease, and is now a fundamental part of the investigation of abdominal tumours. It is seldom that a patient is operated on nowadays without an accurate pre-operative diagnosis having been made when a tumour mass is present, but if one examines the operation lists of 25 or more years ago, the word " laparotomy " was very frequently used. The credit for the improvement in diagnosis is largely due to the advances which have taken place in Radiology.

How does one set about investigating a mass found in the abdomen ? As most radiologists do not see the patient before the clinician, consultation with the radiologist as to the best means of approach is valuable and often time-saving, whereas failure to do so may result in a blunderbuss attack by requests for a series of investigations, the sequence of which may not and often does not lead to the greatest economy in time and expense.

Gastro-Intestinal Tract

Naturally, if the mass is thought to be in the gastro-intestinal tract, a barium meal for stomach examination, or a barium enema for colon examination, is essential, but it is not fully appreciated how necessary it is to have full preparation of the colon before x-ray examination and we frequently see how " a palpable mass in the colon " proves merely to be a hard scybalous mass which disappears with adequate preparation or during the post-evacuation phase of the barium enema examination.

The evidence of an intrinsic mass in the gastro-intestinal tract consists of narrowing of lumen, rigidity of the outline, often the presence of ulceration and sometimes a large intra-luminal mass. The presence or absence of peristalsis and mobility of the viscus is also important. Some tumours, however, mostly benign, arise deep to the mucosa and may only show a filling defect without ulceration. Then there are tumours which deform the gastro-intestinal tract but lie outside the tract. Many of these displace and deform the tract by pressure in medial or lateral, anterior or posterior directions, or a combination of these. This applies mainly to retro-peritoneal tumours which are the most difficult to localise and especially to diagnose with accuracy.

A barium meal examination is usually successful in determining whether the mass is intragastric or lies outside the stomach. If it lies outside the stomach it often deforms the stomach by pressure and the site of the pressure defect and the direction of the deformity may indicate the position and often the origin of the mass. The origin may, however, on occasion, be very difficult to determine, as in the case of a patient with an actinomycotic mass deep to the anterior abdominal wall which deformed and was adherent to the anterior surface of the stomach.

Doubt sometimes arises as to whether a left upper abdominal mass arises from the stomach or spleen and in such a patient radiology very seldom fails to give an accurate diagnosis. In this type of patient a plain film of the upper abdomen can give the answer without further investigation, as the spleen can usually be identified and the outline seen clearly.

Case 1. W.B. Age 29. Male. Retro-peritoneal neurilemmoma.

Symptoms :

Increasing size of abdomen for 2 years.

Clinical Findings :

Mass in left abdomen. ? spleen.

Radiological Investigation :

Plain abdomen—Spleen thought to be grossly enlarged.

Barium Swallow—No varices. Displacement of stomach to right.

I.V.P.—Left hydronephrosis due to displacement by " grossly enlarged spleen."

Operation Findings :

18/10/57. Massive retroperitoneal tumour which had pushed left kidney down into the pelvis. Splayed out adrenal tissue at superior medial aspect of mass. Highly vascular. Spleen enlarged × 2.

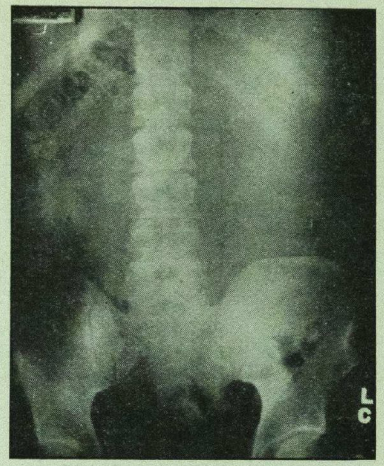


Fig. 1. Case 1. W.B.
Uniform opacity on the left side of the abdomen which also extends into the right side, displacing all the bowel gas shadows on the right and towards the pelvis. Absence of psoas shadows. Exceedingly large retroperitoneal neurilemmoma.

14/3/58. Removal of remainder of tumour.

Pathology :

Coarsely lobulated mass weighing 4,310 grms. "world's record" in neurilemmoma, arising in nerves adjacent to adrenal gland, which is closely adherent to capsule of tumour, but not involved.

Comment :

This illustrates the difficulty of differentiating the spleen from a retroperitoneal tumour in certain instances.

Difficulty arises only when the mass may be a splenic cyst or sarcoma in which case the outline is not typically spleniform or when the spleen is involved by a malignant tumour arising in the region of the suprarenal or tail of the pancreas. Most pancreatic masses deform the stomach on the posterior surface or deform the duodenum or sometimes both. A tumour in the body or tail of the pancreas tends to cause localised deformity of the posterior gastric surface and may actually invade it. A tumour in the head of the pancreas tends to deform and widen the duodenal loop and may also invade it. Sometimes the pyloric end of the stomach is also deformed by pressure and we have seen two instances of pancreatic carcinoma invading and causing ulceration of the first part of the duodenum, the ulcers being malignant and not benign. Malignant ulceration of the first part of the duodenum is always due to invasion.

We have been fortunate to discover quite a number of tumours of the duodenum in various sites and of varied pathology by paying rather more attention to examining the duodenum in its whole length than may be the custom in the course of a barium meal examination. The tendency to neglect the duodenum distal to the first part and also the proximal jejunum arises from the pressure of work and time involved in carrying out vast numbers of barium meals which occupy such a large part of a radiologist's time. This applies to an even greater extent to radiologists working in non-teaching hospitals. In the department in this hospital there are approximately 75-80 gastro-intestinal examinations carried out each week. The work, therefore, has to be shared by all the radiologists to minimise the strain, both mental and visual, of working in the dark for long periods. It is seldom that tumours are found in the small intestine and examination of the small intestine which is tedious and time-consuming, should not be requested unless there seems to be a definite reason for doing so, such as diarrhoea, colic of an apparently small intestinal type, obscure abdominal masses, symptoms suggestive of regional enteritis and haemorrhage or iron-deficiency anaemia of obscure origin. Some masses cause displacement of coils of small intestine and retroperitoneal tumours may first be suspected by finding some displaced coils of jejunum or ileum. The extent of these tumours is often indicated by the degree and direction of displacement of such coils. Crohn's disease or regional ileitis often produces an inflammatory mass, and it can usually be located and defined by deformity of the ileum in the form of narrowing, rigidity, ulceration and often some degree of obstruction. In the earlier stage of the disease, irritability and a variable degree of narrowing may be seen without complete rigidity. The mass may also include several adherent and inflamed coils of intestine sometimes with fistulous communication between them, and these may be outlined by barium or a fistula between small and large intestine may be seen. An appendix abscess deforms the medial wall of the caecum and often displaces loops of ileum, which may be adherent to the mass. A mass of glands in the ileo-caecal angle may also produce displacement and cause obstruction of the terminal ileum.

If a tumour or any type of pathological change is suspected in the colon, barium enema examination is the most satisfactory method, and is very much more accurate than waiting until barium outlines the colon after a barium meal. For the detection of any lesion the colon should be practically empty before the examination, and this is absolutely essential if small polypi are to be looked for. These are shown best after the patient has evacuated the barium and the colon has been redistended with air. The thin layer of barium remaining on the mucosa plus the contrast of air in the lumen shows up even quite small polypi in the colon.

Carcinoma and diverticulitis of the pelvic colon may be impossible to differentiate clinically, but the difference is obvious radiologically when the diverticula are outlined and the deformity of the lumen resulting from inflammatory changes is demonstrated. Difficulty only arises when carcinoma and diverticulitis co-exist. The mucosal pattern has to be carefully studied to see if it is still intact or whether it is ulcerated, as this commonly denotes the presence of carcinoma. In addition, a pericolic abscess may be diagnosed by the existence of a smooth pressure defect on one aspect of the colon in the region of the diverticulitis. Sometimes barium leaks from a diverticulum into an abscess or through a fistulous track into a loop of small intestine, the bladder or the vagina.

The pelvic colon may also be displaced by a mass arising in the pelvic cavity, most of which tumours are of uterine or adnexal origin. Much rarer tumours arise behind the peritoneum or from the bony wall of the pelvis, but these also frequently cause pressure deformity of the rectum or pelvic colon.

Urinary Tract

Plain films of the renal tract are essential to the exclusion of opaque calculi, but in addition the outlines of the kidneys are usually well seen and an opinion can be given regarding the shape, size and position of the kidneys. Enlargement of the whole renal outline usually denotes the presence of a marked degree of hydronephrosis or less commonly of a widely infiltrating renal carcinoma or more rarely still of a kidney infiltrated with Hodgkin's disease or amyloid disease. The left kidney is often deformed by pressure from the spleen, but carcinoma or cyst mostly produce more localised deformity and also deformity of pelvis or calyces, or both, a feature which is not seen when the deformity is due to splenic pressure. A tumour may arise in the renal pelvis or ureter and cause gross hydronephrosis, which renders the kidney palpable. It may be very difficult in certain instances to differentiate a cyst from a carcinoma in the kidney, as each may produce local enlargement and smooth deformity of the calyces. In such a case, the injection of an opaque medium into the renal artery followed by serial x-ray films almost always shows the difference in the circulation and position of the blood vessels in the two conditions. There is usually an increased and very irregular vascular pattern in the pathological area when neoplasm is present and displaced and sparce vessels when a cyst is present.

The mass may, however, prove to be outside the kidney, in which case the kidney is frequently displaced. Renal displacement mostly in a distal direction, is caused especially by enlargement of the liver, spleen, pancreas, suprarenal and by retroperitoneal masses above the renal level. It is not generally realised that a huge spleen or tumour can displace a kidney into the opposite side of the abdomen and gross displacement often produces distortion of the renal pedicle with consequent interference with function and development of hydronephrosis.

It is important to differentiate between a renal and a suprarenal mass, and this can usually be done by studying the renal outline. Difficulty arises when the mass is adherent to the upper pole of the kidney and obscures the outline but, in general, the absence of deformity of the superior calyces of the kidney helps to exclude a renal tumour and, if doubt still exists, oxygen introduced into the perirenal space or opaque medium into the renal and suprarenal arteries, commonly enables differentiation to be made.

The ureters may be displaced by a tumour and several examples of this have been seen in patients with retroperitoneal masses.

The bladder also gives useful evidence of the presence of tumours, and intrinsic carcinomas are often shown by an irregular margin and a filling defect in the bladder

outline, but the commonest defect is that at the base of the bladder produced by an enlarged prostate. A film taken after micturition, when the bladder has been outlined by an opaque substance gives a satisfactory measure of the residue of urine which remains in the bladder in cases of obstruction. Sometimes the first indication of the existence of a fibroid of the uterus is pressure deformity of one side of the bladder fundus. Rather exceptionally a carcinoma of the bladder is diagnosed from a plain film of the urinary tract owing to the deposition of calcified debris on the surface of the bladder tumour, but confirmation by intravenous urography is usually essential. The only other condition likely to produce bladder calcification is Schistosomiasis which is so prevalant in Egypt, but seldom seen in this country. Calculi not uncommonly seen in the bladder present a different appearance. Tumours of the uterus or rectum may spread in the pelvic tissues so that the lower end of one or other ureter may be involved. Intravenous urography enables local extension of the tumour to this degree to be confirmed or excluded. If a tumour obstructs a ureter it may be necessary to examine the ureter or kidney by retrograde means, i.e., the passage of a catheter through a cystoscope into the ureter and thus outlining the ureter below the obstruction with an opaque medium, or the ureter, renal pelvis and calyces if the obstruction is incomplete.

Tumours which originate outside the biliary, gastro-entestinal or renal tracts are the most difficult to localise, and these are the tumours which may require multiple examinations before their origin can be determined. Examination of all these systems may be necessary before the site of the tumour is accurately located, and this is likely to be so with tumours in the right upper quadrant of the abdomen. Displacement of the gall bladder medially usually denotes a tumour arising from the liver or in the porta hepatis lateral to the gall bladder. Lateral displacement of the gall bladder but medial displacement of the duodenum can occur with a renal or suprarenal mass. Lateral displacement of the second part of the duodenum localises the tumour to the region of the head of the pancreas, and distal displacement of the third and fourth parts of the duodenum indicates a mass in front of or within the head or body of the pancreas. In a patient recently seen, most of the features indicated a mass of pancreatic origin, but the third and fourth parts of the duodenum moved over the surface of the mass and could be made to lie on its upper surface. This tended to exclude a pancreatic lesion and the mass proved to be a retroperitoneal sarcoma.

Retroperitoneal tumours can displace viscera in any direction except posteriorly, but an assessment of the features seen on urinary and gastro-intestinal examination can usually localise the mass fairly accurately.

Case 2. M.G. Age 58. Female. Retroperitoneal Sarcoma.

Symptoms :
Left upper abdominal pain.

Clinical Findings :
Left hypochondrial mass.

Radiological Investigation :
Barium Meal Calcification in left renal area. Enlarged kidney. Displacement of stomach to right.
I.V.P.—Large soft tissue mass in left abdomen. Left kidney functioning.

Operation Findings :
Retroperitoneal mass adherent to spleen, diaphragm, stomach and colon. Left kidney embedded in the mass.

Pathology :
Fibro-sarcoma well differentiated.

Comment :
Difficult differential diagnosis in view of poor renal function and outline, but the calcification seemed to extend beyond the limits usually found in a kidney with relatively normal calyces.

Careful scrutiny of the plain film is often of great value to the radiologist, not only in studying the renal and psoas outlines (one or both of which may be obscured by a retroperitoneal tumour) but also for the presence of odd flakes of calcification which may be found in a haemorrhagic or necrotizing tumour and for the presence of an area of increased translucency such as occurs in tumours containing an excess of adipose tissue, e.g. lipoma.

It is often helpful to carry out retroperitoneal pneumography by injecting 1,000 ml. of oxygen or carbon dioxide behind the rectum and allowing it to ascend into the upper abdomen in the renal and suprarenal areas by which means the size of the tumour and its exact situation is usually ascertained. In these cases the gas always escapes in some degree into the mediastinum. This method is sometimes used in France and Italy to

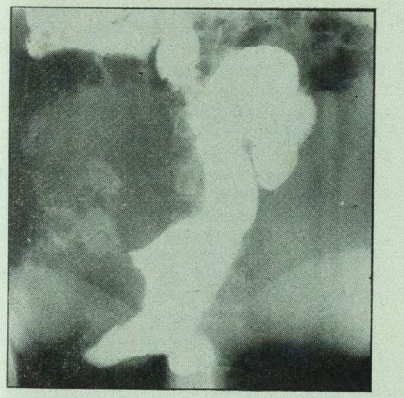


Fig. 2. Case 2. M.G.
Displacement of the stomach to the right. Deformity of the greater curvature by very large mass in the left side of the abdomen in which there is extensive calcification. Very large retroperitoneal fibro-sarcoma.

produce a pneumo-medisatinum in cases of mediastinal tumour.

Case 3. R.L. Age 35. Male. Renal cyst.

Symptoms :
Peripheral neuritis for six weeks.

Clinical Findings :
Mass in left side of abdomen. ? Spleen. Was seen by surgeon and queried as pancreatic cyst in view of previous history of trauma.

Radiological Investigation :
Plain films—Large mass obscuring kidney and spleen. Urography necessary.
Urography-intravenous—Marked proximal displacement of pelvis and calyces ; mass almost certainly renal in origin—probably cyst. Right kidney normal.
Barium Meal—Stomach displaced to the right and anteriorly.
Retroperitoneal Pneumography (as surgeon still considered it to be pancreatic in origin)—Tomography and urography were also employed and confirmed the renal origin of the mass.

Operation Findings :
Cyst measuring 7 cms. in diameter removed from the lower pole of the left kidney.

Post-Operative Intravenous Urography :
Both kidneys normal.

Comment :
The diagnosis was apparent after intravenous urography but the clinician was swayed by the history of trauma to the left upper abdomen and required further persuasion.

Fig. 3. Case 3. R.L.
Combined urography, retroperitoneal pneumography and tomography reveal a much enlarged left kidney, calyces displaced proximally. Enlarged renal outline is due to a very large cyst of the lower pole.

In certain instances, if the tumour infiltrates widely the gas is prevented from extending in the area of infiltration and this is sufficient to indicate the invasive nature of the tumour and the extent to which it has spread. This method is also used to demonstrate the presence and size of para-aortic glands in Hodgkin's disease as such glands are not easily palpable unless they are of considerable size. The radiotherapist is also enabled to limit the field of radiation to the area of the mass. By this examination also, a mass associated with the kidney can be well demonstrated, and this procedure is very useful where cysts of the kidney may be attached to the kidney only by a pedicle.

In some countries in Scandinavia and on the Continent, air is at the same time introduced into the stomach and tomographic cross sections taken of the patient to show the relationships in transverse section. This procedure is clearly useful in the chest as well

as the abdomen and the installation of such x-ray equipment must be given serious consideration.

Lastly, the vascular supply in the region of the tumour can be outlined by introducing a catheter through a needle inserted into the femoral artery and by pushing the catheter as far up the aorta as the level of the tumour. The arterial system at this level is outlined by the injection of an opaque medium through the catheter so that the circulation may be seen on serial x-ray films. This serves to outline the normal and abnormal arterial supply and vascular pattern and enables the size and location of the tumour to be assessed. It is a very popular method of investigation in Sweden. In certain patients more extensive filling of the aorta with opaque medium is useful if there is doubt as to the origin of the tumour and occasionally the inferior vena cava has been similarly outlined by catheterising through the femoral vein.

How then does one plan an investigation of an abdominal tumour? If it is thought to arise from one of the tracts, the most likely tract should be examined first, but if both urinary and gastro-intestinal tracts are to be examined, as usually has to be done, especially if the tumour is thought to be outside both, the urinary tract should be examined first as the plain film may give a lead to its location and thus to whether a barium meal or enema will be the next step. Also time is saved as it takes several days before barium can be completely eliminated, whereas a barium meal or enema can follow quickly after intravenous urography. Failing sufficient information from these examinations, the more specialised examinations, i.e. retroperitoneal pneumography and aortography or arteriography may have to be carried out in addition before the tumour is defined and some idea of its origin and nature discovered.

Thus radiology is essential and is often the most important method of examination in the discovery, location and assessment of the nature of an abdominal tumour. The precise histological nature of the tumour must naturally await the observation of a section under microscope.

It is only when the closest co-operation exists between the physician or surgeon and the radiologist that the fullest assistance from radiological investigation may be gained in the many difficult clinical problems which so often arise.

LUMBAGO

When a man has got Lumbago
He hopes to hell it may go,
With mind and body on the rack,
His thoughts are centred on his back,
It has his sole attention.
He uses language too perforce
His dearest friends forgive of course,
Though scarcely fit to mention.

Much sympathy he gets for sure
From menfolks, maids and madams,
But sympathy alas won't cure
Or mitigate his spasms.
A prisoner he is forced to be,
The movies now he cannot see,
He cannot to the play go,
But in his bed must rest his head
And feed on milk and sago.

"God bless you merry gentlemen, may
nothing you dismay":
This used to be a greeting in the olden time
of day.
I would suggest that it were best to alter this
and say,
My blessings on you gentlemen as through the
world you go
May all the Gods and all the Saints protect
you from Lumbago.

J.P.J.

This poem was sent in by a correspondent to whom it was given by an octogenarian patient.

The Pathologist and the Patient*

by PROFESSOR J. W. S. BLACKLOCK

With the advances in scientific knowledge, due to the discovery of new technical methods in all branches of science, including Medicine, more and more reliance has been placed on scientific methods in the diagnosis, prognosis and the treatment of disease, and less on clinical impression and experience. Some long-cherished clinical beliefs have been rudely shattered as the result of laboratory tests and experiment. The pathologist is no longer just master of the dead-house, but is now a specialised clinician who must have a wide knowledge of disease and its treatment. He is no hand-maiden and has an ever-increasing interest in the patient. In any well-ordered hospital, consultation between physicians, surgeons and pathologists results in benefit for all concerned. When I was a young pathologist it used to be said with some truth that the physicians knew everything but did nothing, the surgeons knew nothing but did everything, and the pathologists knew everything, did everything, but all too late. But all this has changed.

Trends in Pathology

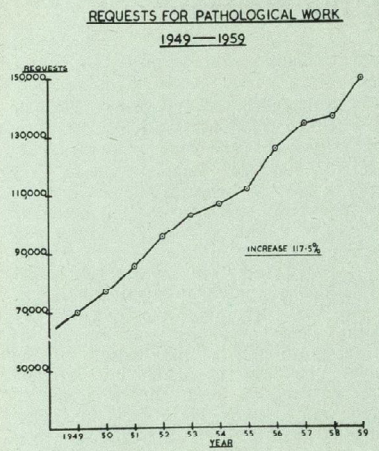
For 40 years I have been associated, in one way or another, with Pathology in all its branches. At the beginning of this period, the pathologist was almost completely divorced from the patient, except for the occasional examination of a swab or a blood examination. His principal duty was to conduct the autopsy and reconstruct from observation of the ashes of the dead fire the cause of disease, and with his clinical colleagues to correlate the symptoms suffered by the patient with the morbid changes, much as Morgani had done in the late eighteenth century. Undoubtedly many valuable lessons were learnt, but it was too late to benefit the patient, though some still living may have profited. Morbid Anatomy and Histology was not the end: it was a step forward in the final discovery of the cause of disease and its cure. There is still a place for the clinico-pathological conference in the post-mortem room, and many a young physician or surgeon may yet learn a salutory lesson of his errors in diagnosis and treatment. Even in this scientific age some patients die as a result of treatment and some for the lack of it.

But it is the early stages of disease that matter if cure or arrest is to be achieved. With the advent of Bacteriology and the marriage of Pathology with Physiology and Biochemistry early in this century, a great step forward had been made. No longer was Pathology a purely observational science. It was fast becoming experimental and clinical. The pathologist was out of his charnel-house and at the bedside of the patient. He was now able to correlate disturbed function during life with morbid change and to study the progress of disease and often help to direct its treatment. Our sole duty as medical men is no longer to alleviate the patient's symptoms but, as the result of scientific advances many of which have been discovered in the last decade by the experimental method in the laboratory, we have now the power to cure many diseases. In those early days many pathologists, like myself, apart from a sound clinical training, embarked on their career very inadequately equipped, particularly in the field of chemistry. The tests then in use were crude compared with the modern micro-analytical methods which have made so many advances possible. But it was a beginning, and the flood tide of advance led to further experiment and to the discovery of more scientific tests and thus the early signs of many a disease gradually became unravelled.

The Increase in Pathological Investigations

The amount of pathological work at St. Bartholomew's is based on the number of requests made for laboratory examinations from the wards or out-patient department and, over 11 years (1949-59), there has been an increase from 69,134 to 150,505—117.5 per cent (Graph 1). The average number of pathological examinations, which, in 1949, was 6.2 per in-patient, showed a steady rise to 11.1 in 1959 (Table I). Thus, in 11 years, the pathologists have almost doubled their services to each in-patient. The same was found for the out-patients, though the average number of laboratory examinations per patient in their case was less.

* A synopsis of a paper read at a Joint Meeting of the Sections of Medicine and of Pathology of the Royal Society of Medicine on February 2nd, 1960.



Graph 1

In considering the increases in examinations over the same period in the different branches of Pathology, the mother-subject, Morbid Anatomy and Histology, will be taken first. Here the number of examinations has risen from 2,073 to 5,745—176.6 per cent—due to the taking of more biopsies, chiefly in relation to advances in radiotherapy, to liver and kidney punctures, to cytodiagnosis and to an increase of about 10 per cent in major operations. The yearly number of autopsies has, however, remained much the same during the whole period (Graph 2).

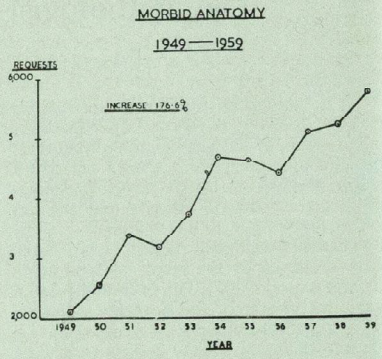
PATHOLOGICAL WORK PER IN-PATIENT

1949——1959

YEAR	REQUESTS PER PATIENT	YEAR	REQUESTS PER PATIENT
1949	6·2	1955	8·9
50	6·2	56	9·1
51	6·7	57	10·2
52	7·6	58	10·1
53	8·2	59	11·1
54	8·1		

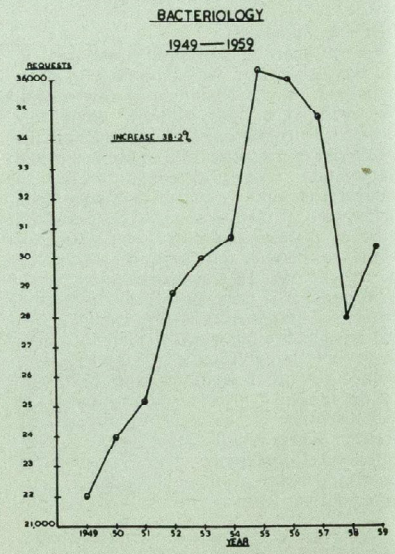
INCREASE
INPATIENTS - 30·2 %
OUTPATIENTS - 14·0 %
PATH WORK -117·5 %

Table 1



Graph 2

In Bacteriology there was a steady rise in examinations from 22,002 in 1949 to 36,379 in 1955—65.3 per cent—and thereafter a fall with a second increase in 1959 to 30,423—38.3 per cent—over the 1949 figure (Graph 3). Both increases have been largely due to



Graph 3

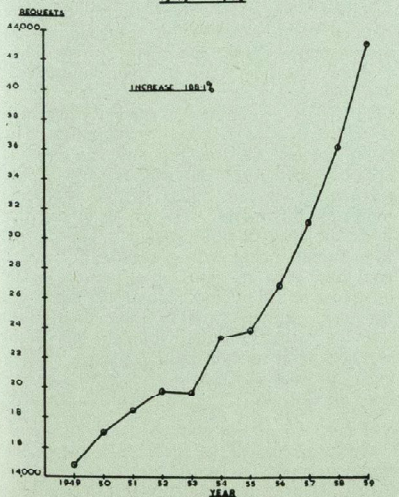
requests for sensitivity tests in connection with antibiotic therapy. The first was also due to the extensive use of this therapy resulting in resistant strains which caused much cross-infection, necessitating a large number of bacteriological examinations. Once this had been overcome the number of investigations fell slightly.

In Chemical Pathology there has been a steady increase from 14,890 to 42,901—188.1 per cent—due to more requests for tests for hormonal dysfunction, electrolyte balance, liver function and insulin therapy (Graph 4).

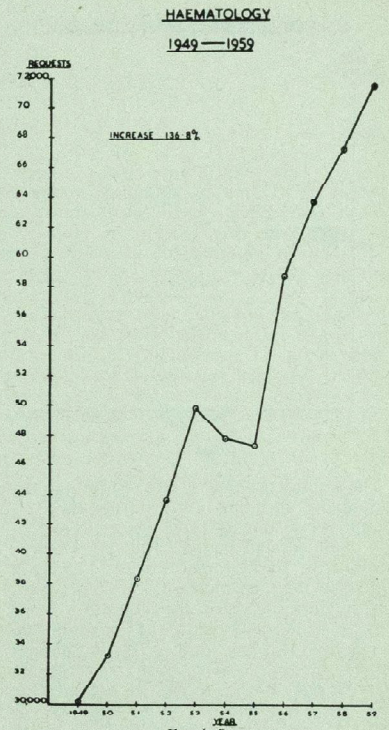
In Haematology there has been a rise from 30,169 to 71,436—136.8 per cent—due to more requests for tests connected with anticoagulant therapy, blood transfusions and to the more recent therapies of the anaemias and the leukaemias (Graph 5).

The Problems Involved in this Increase

The greatest difficulty is the shortage of trained technicians. Indeed, most laboratories are working under their normal establishment of trained personnel, and have had to make good with young student technicians or technicians who have come from overseas for training for short periods.



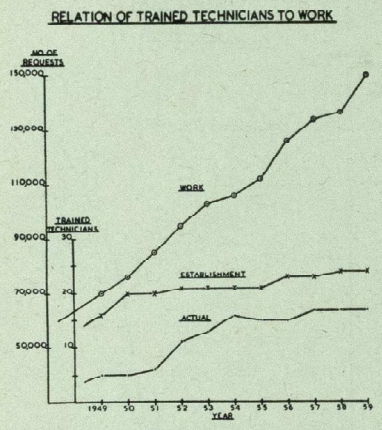
Graph 4



Graph 5

The relationship of trained technicians to the work over the years 1949 to 1959 in St. Bartholomew's is shown in Graph 6 which demonstrates that the increase of available trained technicians has not kept pace with the increase in the work. Indeed, we never have had our full establishment of trained technicians throughout this period, as they were just unobtainable. The main cause of this shortage, which is most serious, is the inadequate remuneration for technical staff and the shortage of suitable recruits who are attracted to industry where the financial awards and conditions of service are better than in the Health Service.

Many laboratories, too, are experiencing difficulties in recruiting suitable young medical graduates, due, I think, to the better chance of promotion in other spheres of Medicine. For the most part, however, this does not apply to the large teaching hospitals.



Graph 6

The staffing problem is fast resulting in the pathologist spending most of his time on routine work and less and less on research. The qualified staff in the Pathology Department at St. Bartholomew's was 17 in 1949 and 20 in 1959, an increase of 17.6 per cent. Yet, in these 11 years, the laboratory work directly connected with the patient had increased 117.5 per cent. To the present patient the pathologist does his duty by carrying out the tests requested, but with the ever-increasing load of routine work he has not the time for experimental work so necessary for the advance of his subject and which may result in benefit to future patients. In this physicians and surgeons could help materially by limiting their requests to examinations that are really necessary, particularly for the more complicated investigations. But even if this is successful, there is still a pressing need for an increase in academically qualified staff in Pathology.

With the rapid advance of the subject and the progressive increase in the volume of work, laboratory accommodation has become hopelessly inadequate and unsuitable. Indeed, in some places work is still being carried out in departments designed 40 to 50 years ago when Pathology was almost a pure observational science. All too often the beds in a hospital or in a Region have increased, and the appropriate increase in staff and accommodation of the various ancillary services, including Pathology, have been completely neglected. This results in over-crowding in laboratories and unsatisfactory working conditions which the Factories' Act would not permit in industry.

Results and Dangers of Increase in Laboratory Tests

In the past Medicine was an art and a science, an art in that the clinician, whatever his speciality, learned at the bedside to diagnose, to relieve the suffering of and to understand his patient. Now Medicine has become more of a science than an art. It can be argued that the art of Medicine never cured anyone but it often did relieve physical suffering and gave peace to a troubled mind and so allowed the bodily defences to cure the disease or to adjust the physiological functions to compensate for the pathological changes.

This is a scientific decade, not of Chemistry, nor of Physics, but of Biology, when at last the cell, the final unit, is gradually yielding its secrets to our scientific probing. Thus our methods of investigating disease are bound to become more scientific and more complex. There is a real danger that the patient may come to be regarded as an interesting scientific specimen. Great clinicians of the past were all great humanists, who, without the patient being aware, could lift an anxious mind out of the rut into which it had fallen as a result of disease. The doctor-patient relationship now, as then, is still of paramount importance, and is the feature which has made British Medicine unique in this world. Do not let us sacrifice it on the altar of pure science. The patient is a human being with a personality and a soul and even in spite of all the scientific advances in Medicine, most patients still have an implicit trust in their doctors to alleviate their suffering, whether mental or physical, and to cure their diseases. Whatever our speciality we must not betray this trust in this age of rapid scientific advance.

Influences on the Progress of Physiology in the Seventeenth Century

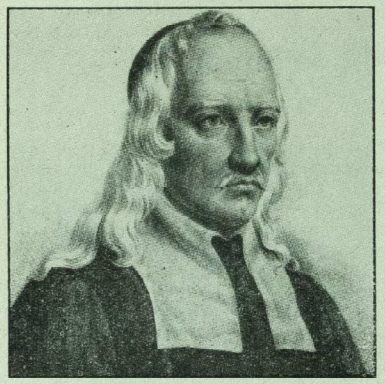
by B. D. HORE

The seventeenth century was one of considerable progress in the science of physiology. It was, as Franklin has stated, a century in which one feels as having stepped out of the ancient world of science into the modern. At the beginning of the century the Galenic view of the circulation was rigidly held; many physiological processes were explained in terms of spirits (these were a considerable time in dying), and little was known of the minute structure of the body. At the end of the century the way in which the blood circulated had been discovered; spirits had been largely replaced by physical processes and chemical reactions, and the histological structure of skeletal muscle and numerous organs, including the liver, kidney and spleen had been established. The factors which brought about these advances were fourfold. Firstly, the work of Harvey; besides his description of the circulation of the blood (perhaps the greatest single contribution made to science by any man), he gave men an idea of arriving at an understanding of physiological processes by the means of deducing hypotheses from anatomical structure and testing these hypotheses by carefully controlled experiments. Here we shall not consider his work any further as his contribution has been dealt with so often in numerous books and papers, and indeed has been described fully in past numbers of this journal. It is with the other factors that this paper is concerned. These were the introduction of physics and chemistry into physiological research, and the invention of the microscope.

The Influence of Physics on Physiological Research:

The first of these influences we shall consider is that of physics. The work of Galileo and others early on in this century gave considerable impetus to the study of this subject, and during the seventeenth century physical ideas began to be used to explain the physiology of living organisms. The greatest contribution in this field was made by Giovanni Borelli (1608-1679). Primarily he was a mathematician and physicist, but he used a knowledge of these subjects to explain the workings of the animal body. His work included expositions on the physiology of muscle, the mechanism of gastric digestion, the formation of urine, the workings of the circulatory system and the physiology of nerves.

In 1680 there was published the first, and in 1681 the second volume of his treatise on the movements of animals. The problems involved here, he divided into two groups. Firstly, the actual mechanical problems involved in these movements, and secondly the problems regarding the actual mechanism of muscular contraction. He attempted to solve the first group in a manner similar to that he had used in solving the problems concerning the workings of inanimate machines, calling to his aid mathematical figures and calculations. As regards the second problem, he was considerably helped by knowing some of the microscopic details of muscle, as these had been previously established by Stensen. From his work it became clear that each muscle fibre was made up of a group of fibrils. These fibrils were differentiated into a central portion and two terminal portions, the fibrils being bound together to form a fibre by means of transverse fibrils originating in the muscle sheath. Both Stensen and Borelli believed that during muscular contraction it was the central portion of the fibrils that actually contracted rather than the terminal portions which were joined to the tendon of the muscle. Stensen described the central and terminal portions of each fibre as being of different geometrical shapes and discussed at length the consequences of this arrangement. Borelli strove hard to reach a definite mechanical understanding of the processes of muscular contraction. He considered that during contraction the muscle increased in bulk (an idea which remained until the eighteenth century, when technical methods for measuring the volume of a muscle during contraction were available), and that the tension in a muscle when it contracts was due to two factors. Firstly some agency residing and passing down the nerves to the muscle, which acted upon the second factor, some



Giovanni Borelli (1608-1679) *From a lithograph by Vigneron. Impression in the Wellcome Historical Museum*

material in the fibres themselves, such that on the arrival of the nervous influence there occurred something resembling the chemical processes of fermentation or boiling. It was this process that caused the sudden inflation of the muscle to occur.

The physiology of gastric digestion during this century was explained in two different ways by two different schools. As we shall see later, the Iatrochemical school explained it largely as a process of fermentation, whilst the Borelli school considered it to be mainly a mechanical process in which the ingested food underwent a mechanical grinding by the movement of the stomach musclature. Into the stomach of turkeys, Borelli introduced glass balls and wooden cubes, and the next day on inspection of the stomach contents found that the balls had been pulverised and the cubes crushed. He was not satisfied with a qualitative approach and obtained quantative figures for the force of this stomach contraction. By hanging weights on to a human jaw he was able to get an idea of the maximal force that the human jaw muscles were able to exert. He was aware that this force was not, or only just enough, to crack glass " vesicles " when introduced into the mouth. Introducing identical " vesicles " into a turkey's stomach resulted in them being crushed ; he concluded, therefore, that the force of contraction of the turkey's stomach muscles to be not less than that of the human jaw (1,350 lb.). Although he was the leader of the Iatromathematical school, unlike many of his pupils he believed that chemical processes played a part in gastric digestion for in some species, notably fishes, where the stomach was of a " membranous " nature, he stated that flesh and bones were digested by a corrosive fluid poured forth by small glands present in the stomach.

To the Borelli school the formation of urine was primarily a mechanical filtration of blood. Borelli was very much aware of the idea of membranes having pores of a certain size, and only allowing particles of a size smaller than this to pass through them. He envisaged the kidney as containing two kinds of orifices in the manner of sieves. One of these, the venous one, was of a suitable size to allow blood particles to pass through, whilst the other allowed water particles to pass but not blood particles. Borelli accepted Harvey's description of the circulation, but went further and mathematically worked out the force needed by the heart to propel blood through the body. His view on the nature of the steady flow of blood within the arteries is similar to that held today. He quite clearly understood that during systole the arteries were injected with blood from the heart ; the entrance of this blood caused a stretching of the arterial wall, which resulted during diastole in a contraction of the arterial wall, expelling blood contained within it. His contribution to nervous physiology was not great, but it emphasises how he always approached physiological problems from a physical angle. He considered the nerves to be hollow tubes containing fluid. This fluid was subject to physical laws of flow and he developed theories as to the mechanical arrangements which determined this flow. He compared a nerve to a rod of Elder pith filled with fluid and so through the fluid capable of transmitting oscillations.

In this section we have not exhausted Borelli's contribution to physiological progress during his time, but we have seen some idea of his approach to physiology. It is worth noting that Borelli in his description of muscle contraction and gastric digestion called to his aid in explaining these processes the new science of chemistry. From this we can see he did not believe that all physiological problems could be solved by a physical approached as was believed later by many of his pupils.

The Influence of Chemistry on Physiological Research :

It was also during this century that the concept that chemical reactions were part of the normal physiological mechanisms of the body was developed. By the end of the century a school of thought akin to the Borelli school had developed. The views of this school, the Iatrochemical school, are discussed below.

The three great names of chemical physiology of this century were Van Helmont (1577-1644), Sylvius (1614-1672) and Stahl (1670-1734). Van Helmont has been called the father of chemical physiology. His views were a mixture of both rational and mystical thought. It was the former which principally aided physiological progress during this time. After studying the process of fermentation of grapes and hops he considered that some, at least of the physiological processes of the body, were dependent upon a similar mechanism. In all he considered that there were six fermentations in the body following food ingestion. Fermentation occurred in the stomach and duodenum and the chyle after entering the mesenteric veins was subjected to a third fermentation, whilst in these veins and in the adjacent liver and vena cava. This resulted in the chyle being converted into a crude form of blood. This crude blood was further purified by another fermentation in the heart and arteries, in which the crude blood became lighter and " volatile." He seems to be meaning here the change from venous to arterial blood, but did not clearly distinguish between this fermentation and the next. This next fermentation occured in the left ventricle and endowed the blood with vital spirits. As will be realised from this description the Harvcian doctrines had not made themselves fully felt in Van Helmont's mind. He taught that there was one more fermentation. Each tissue of the body, according to him, had its own store of ferments which acted on substances brought to that tissue by the blood, and so the nutrition of the tissue was maintained. These fermentative processes were the means by which a series of spirits governed the workings of the body. Here we note the mystical quality of his thought.

It is important to note that whilst he considered these fermentations to resemble those occurring outside the body, he did not consider that they were identical in nature. Sylvius, who succeeded Van Helmont as leader of this school, was familiar with many chemical processes. His expositions on physiology resembled generally that of Van Helmont, but differed from him in two important aspects. Firstly, he removed the idea of spirits from the scheme and, secondly, he considered there was no essential difference between vinous fermentation and the fermentation occurring in the body. He had studied chemical processes other than fermentation, and he thought that the solution to physiological problems lay entirely in a chemical approach. He thus made the mistake that the pupils of Borelli often made in considering that the new science (chemistry in his case) was the " answer to all ills." On the other hand, he made the positive contribution of removing spirits from Van Helmont's scheme, which aided the progress of physiology in the sense that many people had been sceptical of the work of Van Helmont and others because of their associated mystical quality. He also brought into recognition the fact that physiological problems were as much chemical problems as mechanical or physical. His confidence in his methods is illustrated by his theory of urine formation. He considered that prior to the secretion of urine the heart altered the blood in such a way as to render it suitable for the kidney to secrete. He thought, therefore, that it was the completion only of this secretory process which occurred in the kidney. He went on to state (and here I am quoting from Foster) " that although I cannot as yet fully follow out this process of urine secretion, nevertheless I hope to arrive at it by the process of precipitation ! " The Borellian view on gastric digestion has been given. To Sylvius and his pupils this digestion was a process of fermentation ; opinions differed as to what exactly was the cause of this fermentation, i.e., whether it was juice from the stomach itself or from another secretion such as the saliva.

The idea of an extra-corporeal agency in influencing living processes was revived by Stahl. He believed that although chemical processes carried out in the laboratory might seem similar to those occuring in the body, this was only a superficial resemblence ; those occurring in the body being governed by a sensitive " soul." He stands forth at the end of this century as the founder of animism whose doctrines later lead on to the idea of a " vital principle " which maintained itself in men's minds through succeeding centuries.

The Influence of the Microscope on Physiological Research :

Undoubtedly the greatest single technical advance of this century was the invention of the compound microscope. The workers of previous centuries had proceeded considerably in their understanding of the anatomical structure of the body, but had always been limited by the small range of their visual sense. The microscope in this century in the hands of Malpighi and others, clarified the minute structure of several organs and allowed an understanding of the functions of these organs. Malpighi was a man of many talents. He made considerable contributions to embryology, botany and pathology, but it is with his contribution to histology and physiology that we shall deal here.

Marcell Malpighi (1628-1694). *From the line engraving by Isabella Piccini after a medal of* 1691 *by Ferdinand de Saint - Urbain*

Firstly, let us deal with his work on the lungs. Prior to this work, it had been considered that the lungs contained numerous spaces and into these spaces the blood from the pulmonary artery was poured, whence it passed into the pulmonary vein. Further the relation between the lung substance and the trachaca was not understood. In his observations on the frog's lungs Malpighi was able to show firstly that the final bifurcation of the trachaea ended in small air sacs deep within the lung substance, and secondly that the fine divisions of the pulmonary artery did not end in spaces, but continued into very fine tubes which when traced were found to join the small branches of the pulmonary vein. This was the first description of the capillaries and the realisation that the circulation in the lungs was a closed one came into being. The fuller description of capillaries in numerous species by Anton van Leeuwenock established this as a general principle throughout the body tissues, and the missing link in Harvey's chain had been found. It will also be appreciated that with his description of a respiratory tree beginning at the trachaea, and going through smaller and smaller branches, and ending finally with the air sacs deep in the lung substance in close relation to the lung capillaries that Malpighi had laid the anatomical basis from which an understanding of the true nature of respiration could be made. This understanding was considerably aided by the use of other technical advances. Robert Boyle, in 1660, using an air pump was able to show that in a partial vacuum brought about by this pump, life could not continue for long and a flame was soon extinguished. In a complete vacuum these phenomena occurred earlier. This was perhaps the fundamental experiment on respiration, since it showed firstly that it was the entry of air into the lungs that was the prime function of respiration, and secondly that the change occurring in breathing was a similar process to that involved in the burning of a candle. At this time some people considered that the movement of the lungs in breathing was an essential part of the respiratory process.

Robert Hooke, in 1667, was able to show that the essential feature of respiration was the entry of fresh air into the lungs, whether this was brought about by normal lung movement or as in his experiment by artificially ventilating a stationary lung. In his experiment air was driven into the lungs by bellows joined to the trachaea and left through holes pricked in the lung substance. This technique of artificially ventilating the lungs was used by Richard Lower when, in 1669, he showed that in an open-chested animal undergoing artificial ventilation, the blood in the pulmonary vein was bright red, whilst that in the pulmonary artery was a much darker red. If the ventilation was stopped the blood in the pulmonary vein resembled that in the pulmonary artery. He further showed that blood drawn from the inferior vena cava, when circulated through the lungs, became red in the pulmonary artery providing artificial ventilation was maintained. From these and similar experiments he concluded that this change in colour as blood went through the lungs was due to the uptake of air. It will be appreciated that the close anatomical relationship between the capillaries and the air sacs as described by Malpighi enabled scientists in this period to understand more clearly how this could occur.

It is perhaps for his work on the structure of the liver, spleen and kidney that Malpighi is most famous. Current views prior to his work on the liver and spleen were somewhat as follows—crude blood was carried to the liver via the portal vein, here some kind of fermentation occurred in which from the blood two impurities were removed, the lighter of these escaped as yellow bile into the biliary duct, the darker went to the spleen and from here was passed into the stomach to serve some useful but undefined purpose. The purified blood entered the vena cava and then the heart.

Malpighi through his careful microscopic observations of these two organs was able to get an insight into their function. He described the liver as being lobular in nature, the lobules being composed of glandular acini, and to each lobule there being carried numerous vessels, the branches of the bile duct, vena cava and portal vein. The glandular structure so resembled that of the pancreas and other known secretory glands that Malpighi considered that the liver was in fact a glandular organ, the product of the gland being the bile and its excretory duct being the bile duct. This was, as will be realised, a great step forward in understanding hepatic function. In his description of the spleen he described the muscle capsule, the trabeculae and splenic pulp and traced the course of the arteries and nerves through the organ. He is remembered today in his description of the lymphoid tissue surrounding the arteries, which still retain the name Malpighian bodies. From his understanding of the structure of the spleen he declared that it was a contractile vascular organ and likened it to the auricles.

Finally, we shall consider his description of the kidney. Bellini, a pupil of Borelli, had previously described the kidney as consisting of a series of tubules opening into the renal pelvis, and thought that the blood of the renal artery on entering the renal parenchyma passed through pores of a suitable configuration to enter the tubules and thus the renal pelvis. Malpighi took this description further, he described the kidney substance as being composed of pyramidal masses, these masses consisting of tubules and the tubules he observed opened into the renal pelvis at the apices of the pyramid. He also showed that at one end of the tubule, the end away from the apex of the pyramid, there was a knot of capillaries which were joined to branches of the renal artery. Little of fundamental importance was added to this description of the kidney until the work of Bowman in the nineteenth century. Malpighi, despite his genius, made some mistakes, e.g., he observed the red blood cells but thought them to be fat globules, and he described the grey matter of the central nervous system as being of a glandular nature. However, when we realise that little was added to this description of the liver, kidney and spleen for well over a century, and the importance of his work on the lungs, we realise how great a figure in the history of science this man was and how important the invention of the compound microscope.

In conclusion, it must be apparent that great progress in certain fields of physiology were made in this century, and this progress was largely brought about by the work of Harvey and the three influences we have considered here. We have seen that physics and chemistry, when used wisely, were a considerable help to the understanding of physiological processes, but were a hindrance to progress in the hands of those men who considered their particular science to provide the answer to all problems.

Acknowledgment

The author is indebted to Dr. D. A. McDonald for his advice regarding the preparation of this article.

References :

1. "Lectures on the History of Physiology." Sir Michael Foster, 1901. C.U.P., London.
2. "A Short History of Physiology." Kenneth J. Franklin, 1949. Staples, London.
3. "A History of Biology." Charles Singer, 1950. H. K. Lewis, London.

Photographs by courtesy of the Wellcome Historical Museum

Two Poems

These two poems, submitted by Dr. Louis Rose, were written by a patient of his—a woman of 38, during a schizophrenically-coloured hypomanic episode—not her first. It is perhaps worth mentioning that there was very little alteration or correction of the original drafts. At the time she was having moderate doses of Fentazin and, although electroplexy was considered, her response was good enough without it: (it had been necessary on a previous occasion.) The episode subsided within three weeks, and the patient is now well and looking after her home and children.

To Two Friends, 1960

He has much to give
This old man with veins resting on his hands
and forms blurring in his eyes.
Now, in Spring, he sees only the budding
Japonica.

He knows Self and his hope does not die.
He knows the method and the diamond
Moment.
He knows the Word but he is cautious.
He is human and he knows to hold his
Wisdom deep.

He listens only with his memories, well
chosen, for he has tasted our foolishness
and is tired of the repetition.

Can nothing be imparted?
Must we stand forever at the precipice?

J.M.R.

Ode to the E.C.T.
or
"Pin a Rose on You, Jay-Bird"

It seems a pity
It is a shame
You can't speak words
When you say my name.
You must leave me in "quiet"
Hope for the "best"
Pray the sudden flash will do the rest.

Why, why am I feeling so "early-Eliotesque"?
You can't quite answer.
Is everyone thinking "It's all grotesque?"
But yes, that Current will do its level best
We'll have you down to earth again using
your common sense.

It's done now, fine!
You have had your time
And so, Mr. Sweeney, continue once again.

Jay M.R.

Historical Diagnosis

From the LIFE and ADVENTURES
of JOHN NICOL, Mariner

Sent in by the late Philip Gosse

We set sail for St. Helena, where we made a present to the Governor of a number of empty bottles; he, in return, gave us a present of potatoes, a valuable gift to us. While here, I and a number of the crew were nearly poisoned by eating albicores and bonettos. We split and hung them in the rigging to dry; the noon's rays have the effect of making them poisonous. My face turned red, and swelled; but the others were far worse; their heads were swelled twice the ordinary size, but we all recovered.

In a few days we set sail for England, having circum-navigated the globe. We came into the river in the month of September, 1788.

A Squared Circle

by Ray Windsor

Abernethy Ward

These are not the Halcyon days. The spring is too young, too green. In the Square there are clusters of soot-specked daffodils round the bare trees, whose arms are raised in comical embarrassment at their own nudity. The round-shouldered cherubs crouch under the fountain, making believe that their ridiculous indefatigability supports its grey-green weight. An endearing delusion which the rising fish ignore. The tableaux of students, anonymous in their white coats, come in between the newsreels of scurrying people in scurrying showers. When the sun is turned on they blossom untidily, occasionally narcissusistically, frequently precariously, round the fountain's rim. And I am the visible invisible, the blind man on the corner selling matches B.C.—Before Christie.

The Square is austerely beautiful, an urban mandala symbol, but not completely enclosed. Within it the raw, soot laden wind of outside realities enters via the archway and side alleys to mingle with the inner realities. We are all very aware of inner realities here.

Perhaps this is why the gaiety of the students is subdued, for all its noise. They do not tick with the monotonous precision of the pure scientist, nor have they the desperate joy of the arts man, as self-consciously irrelevant as this year's Budget. They lack the gloomy sophistication of the quasi-social scientist, everlastingly defining life as a long illness with a fatal prognosis. I find them as refreshing, raw and shocking as the spring wind.

They swirl around me as I lie prone on my Stryker frame, augmented by a few nurses who have not quite forgotten that the Vivandière preceeded Florence Nightingale in the history of their profession. And now the occasional houseman joins the melange . . . the blancmange pink of a Vicarage Club tie rents the air.

There is an earnest group of young men discussing Apartheid and its consequences. They are calm and moderate in their views. A demure nurse listens impassively, poised on the brink of the fountain. Suddenly she rises from her pedestal with an expression of deep suffering. The conversation changes to a clinical exchange on haemorrhoids. I reflect with a finalist on life after death. The finalist is told not to be morbid; a mocking cry of "morbid" echoes through the crowd. The sun gets brassier and the maids come out, chattering to each other in continental English. Matron crosses the Square and a nurse whispers to me excitedly, "You have just seen a living legend."

"Sobranie tobacco is very good," says one student, puffing his pipe reflectively.

"The best I had was some flavoured with plum brandy . . . bought it in Cambridge," replies his companion.

"I say! How much does it cost to get your shoes repaired?"

"Try stick-a-soles, it's cheaper" (puff, puff).

"We've got a ward round this afternoon, our first on your old firm. What'll he ask us?"

"He'll catch you out on something simple you never bothered to check up on, like the composition of small-pox vaccine . . . ."

"Made a complete fool of myself the other day. Tried to remove a large thoracic bruise with ether . . . thought it was flavin . . . ."

"How are your SOPs?"

"As good as your MOPs."

"Well we do cure somebody occasionally . . . beginners luck I'm afraid."

"Man with three stab wounds in the Accident Box!"

The sun retires behind the clouds and I sense a Grey Imminence. A well-wisher hides my gallipot of fag ends in the fountain so I know, without interrupting my examination of Rufus, the fag-end eating fish, that the Dean has arrived and the hospital cat and I will be left to huddle together for warmth round a deserted fountain.

Off they all go . . . coats flying, notes flapping.

"Cheerio! Must go an' look at the meat!" Poor sons of rich men, com-

paratively rich, grant-earning sons of poor men. Cambridge and Shoreditch . . . but mainly Cambridge. The blasé, the nervous, the earnest, the flippant, the eager and the reluctant, the maculate and the immaculate.

At times they make me feel like an aged D.P. None of them want to reform the world in an excess of political zeal. They do not bowl religious arguments at each other and stonewall them the the retort " linguistic claptrap." They have neither the time nor the inclination to appreciate the ironies of their own situation, perhaps they think that to do so is a luxury.

I lie prone, being whilst they do and it is my job to interpret them. For me they represent yet another piece in a bewildering jigsaw, an important piece round which all the rest fits. The perils of the body and the perils of the soul are a basic human experience, men's ageless enemies. Their individual and social survival depend on their skill in combating them, their other activities are derivatives.

As I think this, the world's politicians, philosophers and creative artists seem to me to be like the little cherubs, naïvely imitating Atlas under the fountain. It is all summed up so well by the Bart's crest. A nurse told me that it represents an equal chance of life or death. It is a contract which is made for all of us when we are born. It has never been so collectively true as it is today.

Do the student nurses and doctors who have come here for many different reasons, ever think, I wonder, that they have taken sides in the only battle which ultimately matters. It is fortunate that they are busy, too busy to think of all the implications of such an idea or they might run away and do something else for a living. These are not the Halcyon days.

It begins to rain and I hope there will be doughnuts for tea. They said the meat I had for lunch would be tender and it was about as tender as old boots. Soon they will come to take me back to the warmth of the ward where I have hibernated all winter. Perhaps they let me out too early. I diagnose my condition as spring on the brain.

The Medicine Bottle

by G. FAGG

Many voices have been raised in condemnation of the bottle of medicine, of those who prescribe it, and of the patients who need such assistance for recovery. Economy being the order of the day, such voices are loudly applauded by the gods of Whitehall. May I, at peril of bringing down the wrath of these same gods upon my head, put in a plea for this humble form of treatment?

My first introduction to the art of dispensing came when acting as a locum for a country G.P. I was shown the " dispensary," a large bare room with bottles standing all over the rough wooden floor, by the doctor who was waiting to leave as soon as I arrived. The first surgery, and many subsequent ones were run on lines very different from those used by the doctor himself. He used to disappear into the vastness of his dispensary and emerge with the appropriate bottle for the patient to carry triumphantly away. This was impossible for me to do as I first needed assistance in deciphering the writing on the panel cards and then the mixing up was a lengthy business. The only possible solution to the problem was to make up the bottles after the surgery and take them round the countryside on my daily rounds. At long last the art was mastered, the only error—an expensive one—being the making up of the mixtures according to the pharmacopoea. The patients remarked on the strength of the medicines, and the doctor on his return was dismayed at the quantities of valuable drugs which had been used.

Having, by my own efforts, overcome this deficiency in my training, I became an ardent devotee to the art of dispensing. Later, when in the Air Force, many happy hours were spent mixing my own concoctions, the worst tragedy being the explosion of a bottle and the smothering of my " best blue " with a syrupy mixture.

Thus was born an affection for the bottle which has stayed with me ever since, and may my critical scientific colleagues bear with me in such sentimentality. Anyway, if I were to admit that medicines were useless, then my personal triumph in mastering the art of dispensing would be an empty victory, and a justification for this form of treatment is therefore necessary.

No physician can be a good physician until he has a reputation, and in paediatrics the bottle is the easiest way by far to its attainment. Also, it forms the essential part of the process known as " stealing the Lord's thunder." The orthopaedic surgeon has his wedged heels and night splints to perform the same process, and the dermatologist uses snow to cure naevi, which will surely disappear if left alone. The crux of the matter is that one must treat with something tangible, the conditions which are going to get better on their own. How often in the past has a mother returned to hospital to hear the results of investigations, only to enter the room with face wreathed in the smiles which tell that recovery has taken place. With pride I used to beam back at her but then to discover to my discomfiture that no treatment had been ordered. I could not, therefore, bask in the glory of success, the credit for recovery going to the next door neighbour who had recommended aspirin. Not so nowadays; the prescription is the vital part of the first interview, and only rarely does one find that the mother has failed to use it.

Next comes the case which is cured by one's advice, or maybe merely by entering the sacred precincts of the hospital. I remember a harrassed mother bringing her healthy two-year-old daughter, complaining that she would not eat a thing. The mother related, with tears in her eyes, that the only square meal her daughter had had for months was when she settled down to eat the cat's meat with great relish off the kitchen floor. Advice, and very sound advice, was given, but alas no bottle. This child on return was completely cured, probably because she herself was listening to the advice. The mother was many degrees more sane and the father also had recovered from his chronic pain in the knee. This was related to me by the mother, but no credit was given where it was due, either to myself or to the Lord. Rather, was she inclined to attribute the results to the supernatural.

Parents do not like admitting that their management has been faulty; they will accept advice and often act on it, but they like a back door through which to escape, rather than admitting the trouble was their own fault. What serves better than a bottle medicine? Here is a simple and understandable reason for recovery and the fact that the doctor thought it was necessary confirms that they were right in suspecting that something was wrong!

" Do not fool your patients or you will eventually fool yourself." This is oft-proffered advice. Yet how often do the scientists fool themselves into thinking that it is what they put in the bottle and not the bottle itself which does the good. It is certainly advisable for the young practitioner to use drugs which have some demonstrable action, either on the bowels or some other organ. Perhaps later coloured water will do, and later still, when his reputation as a healer is well established, the laying on of hands will suffice. At present I use phenobarb. sol., with tinct. nux vom., the one to make sure that the other has no effect.

Finally, to propitiate the gods of Whitehall so wantonly roused to anger, may I put in a plea for cheap medicines. The expensive ones can better be replaced by advice. Brown bread is better than Beplex, exercise than evacuants, Horlicks than hypnotics, care than chloromycetin; and in the case of children M & F are far more important than M & B.

Make the medicine cheap and nasty for adults, and cheap but not too nasty for children. Remember, if it is not taken one cannot claim credit for the cure.

Letters to the Editor

HOUSE JOBS

Dear Sir,

In your March number you say the time spent in holding a first and second House job "often seems to be regarded as a year of pre-registration drudgery". I write hoping that some young man (or men) may either convincingly contradict you or, alternatively, explain this lamentable and astonishing state of affairs, for astonishing it must be to anyone of my own or earlier generations and to some at least of our successors.

To us 1919 and the early '20's do not seem all that long ago and in some respects history has played a repeat. In those years the survivors of the batch qualified in 1914-16 came back from service in Flanders, Gallipoli, Mesopotamia or the High Seas to pick up threads, become fit for civilian doctoring and, perhaps, work for a degree and we asked the hospital to help us. It did. It gave us House jobs and we were profoundly grateful. Our age was about 30; some of us had, rashly, married; some knew what they meant to do but others were mere adventurers, trusting that "a doctor need never starve"; the N.I.H. capitation fee was, probably 9s. 6d. (possibly 11s.). Never, I think, has the practice of medicine seemed so enthralling as in those brief six months—for applicants were so many that we could not be given longer; life was uncomplicated and satisfying, we served the hospital and practised the Art; we felt like little gods and on pay at the rate of £60 a year we also felt rich. After all, our fathers had done the same job for no pay at all.

This is all plain truth, Sir; any Bart's man of my year will confirm it. What calamity has happened and why does no one cry out about it or attempt to put it right? £750 p.a. to "dispel the sense of injustice"! O tempora!

Yours faithfully,
Lindsey W. Batten

The Editor was thinking not of those lucky enough to get House jobs at Bart's but of the many less fortunate people who spend their preregistration year in the provinces.

ANAESTHESIA AT ST. BART'S

Dear Sir,

Until recently it has generally been supposed that chloroform was first administered by inhalation to a human-being for a surgical operation by Dr. (later Sir James) Young Simpson in Edinburgh early in November 1847 on the suggestion of David Wadie, a Liverpool chemist.

Dr. Stanley Sykes,* a Leeds anaesthetist and a Bart's man, has delved into this question and has produced strong evidence to show that "chloric ether" (chloroform with spirits of wine) was first used as an inhalation anaesthetic at St. Bartholomew's Hospital by Mr. Holmes Coote on a patient of Mr. (later Sir William) Lawrence in the *Spring* of 1847. Actually this fact was suggested in Dr. Barbara Duncum's admirable book "The Development of Inhalation Anaesthesia" published in 1947.

As a general rule the establishment of historical precedents is a profitless exercise but this event has proved to have such far reaching consequences that the truth as far as we know it should be appreciated more widely, especially amongst Bart's men "whom one can always tell, but not much".

Yours faithfully,
C. Langton Hewer

*Sykes, W. Stanley. "Essays on the first hundred years of Anaesthesia", 1960. E. & S. Livingstone.

INACCURATE !

Dear Sir,

I am very distressed that our Sixth Floor ladies should think me so unrealistic, not to say naïve, as to associate them with the "notion of apathy". The occasion to which they refer was not of course the Council Meeting but the Annual General Meeting; some of them were presumably present and will recall that I did nothing but sing their praises.

It is even more distressing, however, to reflect that they do not seem fully to appreciate the delicate art of journalism which we find practised with such mastery in your monthly editions. Some of the principal and most delectable features of this are the almost inextricable intermingling of report and comment (the case in point), a predilection for fantasy rather than fact (particularly in the September and October editions of last year), a taste for original syntax (does one "do" a loss, even of £150?), and a deliciously uninhibited approach to punctuation (of which there are three glaring examples in the January report).

These techniques, whilst adding greatly to the charm of our Journal, tend to exercise the gullibility of the reader.

Yours faithfully,
David Julier

Sports News

VIEWPOINT

The season of winter sports is over, and the summer activities have now been in progress for some time.

It is now possible to sum up the statistical results of the Clubs concerned, and it can be said that they are hardly exciting. In fact, the Rugger Club has had one of its worse seasons for years. The Hockey Club's results are no better than last year, and the Soccer Club has no outstanding record. In fact, the only Hospital Club which has had a successful season is the Ladies' Hockey Club. For many years now, its record has been superb, and on the whole has been carrying all opposition before it. The United Hospitals' Cup has been won again this year; this cup has been won by Bart's for so many years now that one tends to take the fact for granted. But all credit must go to the ladies for the way in which they keep their standard so uniformly high.

It is too early to tell what sort of season the summer clubs will have. The Cricket Club has not lost many players since last season and, indeed, appears to have more talent than usual from the new intake. Perhaps it will be able to win the U.H. Cup this year, after its failure in the final last year. The Ladies' Tennis Club is holder of the U.H. Cup at present, and will no doubt do their utmost to retain it. In fact, let's face it, the women have the men beaten at sport.

RUGGER

1st XV v. O. Paulines (A) Saturday February 13th.

The conditions on this very wet February morning were far from ideal for playing rugby, and throughout the game neither side ever mastered the greasy ball. Play was even for the early part of the game, but a very bad offside mistake by one of the Bart's forwards gave the Paulines a 3-0 lead at the interval. In the second half the Bart's forwards pressed very strongly and some good running by the centres nearly produced scores on several occasions. However, the Paulines defended steadily and the game ended 3-0 for the opposition.

Team: P. Niven, J. Stevens, C. Frears, A. Letchworth, S. Harris, J. Bamford, I. Peek, J. Harvey, M. Jennings, A. Knox, J. Pennington, M. Orr, P. Moynagh, R. Jones, G. Halls.

1st XV v. Saracens, at Chislehurst, Saturday February 20th.

On a sunny day, with the ground in beautiful condition, the heavier Saracens side playing very open football were soon on the attack. Their first score came from a well-manoeuvred pushover beneath the posts. The Hospital were always on the defensive after this, but they could not prevent the Saracens from scoring two further tries and a penalty goal. At the interval the opposition had built up a 14 points lead. From the kick-off in the second half the Bart's team began to attack a little more often, and Pennington reduced the arrears with two very good penalties so making the score 14-6. Almost immediately Stevens following up a long kick scored a try in the corner. For a short time it looked as if Bart's might well save the game, but a very good Saracens movement led to another goal and the game ended Saracens 19, Bart's 9.

Team: P. Niven, J. Stevens, J. Bamford, A. Letchworth, S. Harris, R. R. Davies, I. Peek, J. Harvey, M. Jennings, A. Knox, J. Pennington, M. Orr, D. Goodall, P. Moynagh, G. Halls.

1st XV v. Treorchy (A). Saturday, February 27th.

On a fine sunny day, but with the pitch very wet from heavy rain on the previous day, Bart's kicked off and were soon attacking in the Treorchy 25. The backs handled and ran well with the ball, but could never quite create a sufficient opening for a try. The heavier Treorchy forwards after a slow start gradually pushed the Hospital on to the defensive, and from a five-yard scrum, scored a good try from a blind side movement. The try was duly converted and the teams changed over, Bart's 0, Treorchy 5.

In the second half Bart's played very good open football, and several times were all but over the line for a score, but the Treorchy defence was too strong. Towards the close of the game, following some very slack tackling, Treorchy scored another goal, making the final score Bart's 0, Treorchy 10.

Team: P. Niven, J. Stevens, J. Bamford, A. Letchworth, N. Burbridge, R. R. Davies, A. P. Ross, B. O. Thomas, M. Revill, A. Knox, R. Jones, M. Orr, H. Jones, D. Richards, D. Goodall.

1st XV v. Aldershot Services, at Chislehurst, Saturday, March 12th.

The hospital started the game as usual on the defensive, and the large Services pack soon forced play into the Bart's 25. However, it was soon found that the Aldershot weaknesses lay in their backs, and the Bart's three-quarters took play into their opponents half. J. Bamford made a fine run to score under the posts, with J. Stevens converting. The Bart's forwards were winning the ball from the line outs and from the tight lead and the first half ended with the Hospital attacking strongly.

In the second half the handling by Bart's was even more impressive and Burbridge on the left wing got very close to the line on several occasions, and finally, after a very good threequarter movement, he scored in the corner, the try was unconverted. From the kick-off the Bart's forwards im-

mediately ran through the defence with a very good passing movement and P. Moynagh was well up to take the final pass for a good try which Stevens duly converted. The Aldershot defence had no answer to the open Hospital play and two more tries resulted from Letchworth and Burbridge, the extra points being added to one by Stevens. The game ended with a good win for the Hospital 21-0.

1st XV v. Streatham, Saturday, March 19th.

After the fine performance of the previous week this game was a disappointment. With only 14 men Bart's were early on the defensive and after about 15 minutes were 3 points down as a result of a good Streatham try. Whilst scoring this try the Hospital's lock forward R. Jones sustained a knee injury so reducing the pack to 6 men. The Bart's side fell back completely on the defensive and Streatham scored three more tries and a penalty goal and at half time were leading 17-0.

At this point the missing member of the Bart's side appeared, and the play became somewhat more vigorous. The Hospital were now holding their own, but towards the end of the game were having some difficulty in maintaining the pace, and it was through this that Streatham scored a final goal.

1st XV v. Harlequin Wanderers, Saturday, March 26th.

On a day that was ideal for good open rugby, Bart's started very well indeed, and were soon 3 points ahead from a penalty by J. Pennington. The Harlequins soon recovered, and their very much heavier forwards brought the play into the Bart's half and went ahead with a very nice try which was converted. From the kick-off the Harlequins mounted a strong attack, and were now showing complete supremacy in all departments over the Hospital side. Just before half time they scored an unconverted try and the teams changed over Bart's 3 Harlequins 8.

In the second half Bart's opened the game up more, and began to press the opposition into numerous mistakes, but full advantage was not taken of them and no score resulted. The Harlequins still playing some quite attractive football scored 3 more unconverted tries, but Bart's were not deterred, and just before time Bamford ran right through the defence to score a very good try. The final result was Bart's 6 Harlequins 17.

INTER-FIRM SEVENS

The annual Seven-a-Side competition was held at Chislehurst on Saturday, 2nd April, and with a very good entry from both the Pre-clinical and Clinical sides, together with unusually fine weather, the whole afternoon was a great success.

As in past years three types of sevens team could be recognised, one made up of 7 rugby players, another made of seven non-rugby players, and a third a mixture of the two. However, whatever the constitution of the team some very good sevens play was seen during the afternoon.

In the first round the only upset to expected form was the defeat of the second time Clerks I by the Mops and Sops who, however, were quickly disposed of in the second round by a very strong first time Clerks team, who subsequently reached the final.

In the second semi-final the second year Pre-clinicals reached the final by beating the Finalists.

Before the final the annual demonstration match between the Housemen and Registrars took place. Some very fine, and some very unusual rugby was seen, and after some 20 to 30 minutes play the match ended with a win for the housemen by some unknown score.

In the final of the sevens tournament the second year Pre-clinicals who had had the more difficult run to the final were beaten by a very proficient first time Clerks team.

In the evening an enjoyable dance was held in the pavilion.

SOCCER CLUB

The Soccer Club has had a poor season winning only 4 of its 30 matches, while 4 others were drawn. In the United Hospital League we didn't win a match, but 2 were drawn and 3 matches were cancelled. We went out to University College Hospital in the first round of the Hospital's cup and reached the second round of the AFA Junior cup. The Oxford and Cambridge tours were successful apart from the football, the hospitality shown us in both towns being a feature of the season. Lack of new blood and a certain apathy among regular members necessitated frequent changes in the team throughout the season and probably explains the poor results. With more training around a nucleus of keen players next season we hope to obtain better results.

LADIES' SQUASH CLUB

This season the Ladies' Squash Club has sprung into existence. It has, so far, been entirely unconstitutional, unofficial and unsubsidised, but nevertheless very active. We have played ten matches, against the Royal Free, the London, St. Mary's, Guys, Middlesex and Kings College Hospitals. We refrain from boring readers with details of our defeats, but we did finish the season by winning a return match against Guys, which restored morale. The standard of play improved as the season wore on and we are looking forward to more frequent successes next year. The following people have played for the team.

P. Aldis, J. Clarke, S. Cotton, J. Hartley, D. Layton, T. Lopez, V. Nash, K. Robinson, J. Sutcliffe, J. Sykes, A. Vartan, S. Whitaker (Capt.).

Book Reviews

ISOTOPIC TRACERS by G. E. Francis, W. Mulligan and A. Wormall. **Published by the Athlone Press, 1959.** Second edition. Pp. 524. Price 52s. 6d.

The second edition of this book is considerably larger than the original and, in printing and binding, it would compare favourably with any transatlantic publication. The original aim of the authors was to explain the basic principles and techniques in the use of isotopic tracers in a way that could be easily understood by advanced students of medicine and biology who had no previous experience in the field. In the five years since the original edition was produced many fundamental advances have been made and the present edition contains descriptions of recent scintillation and gas-counting techniques and radio-autography. The chapter on the hazards and precautions in the use of radio-isotopes has been revised. The second part of the book contains the details of representative experiments employed in the special course in isotopic techniques run by the Medical College of this Hospital. The additional information has not at all interfered with the clarity of the presentation, and this book will be of value to established workers in the field as well as an introduction for students.

J.C.C.

NOTABLE NAMES IN MEDICINE AND SURGERY by Hamilton Bailey and W. J. Bishop. **Published by H. K. Lewis & Co. Ltd.** Third edition. Price £1 15s.

The third edition of this book has been revised and reset in a more readable type on better paper of more pleasing format (the previous edition of 1946 having been hampered by wartime restrictions). It is now a book which is aesthetically most satisfying. According to the policy of the authors, eponyms which have become more fashionable have been added, while others now less familiar have been rejected. De Graaf, Corrigan, Gram, Babinski and Reiter are a few of the twelve new names included, while Fowler, Unna and Böhler are some of the fourteen which have been omitted. It is difficult to know where the line should be drawn, and one awaits with interest the publication of "More Notable Names in Medicine and Surgery," which is in preparation. Names such as Crohn, Kernig and Fröhlich spring to mind as possible candidates for inclusion.

The inclusion of footnotes giving a description of almost every name which appears in the book is according to the tradition of some of the other books of Hamilton Bailey, and is most welcome. The comments are brief and very much to the point, for example :—

Caleb Hillier Parry, 1755-1822. M.D. Edin., F.R.S. Physician, the General Hospital, Bath. In addition to describing Hirschprung's disease before Hirschprung, Parry described Graves' disease before Graves.

or :—

Tobias Smollett, 1721-1771. British novelist whose main themes are the depiction of wandering rogues and low life in London.

Almost seven pages of biographies for further reading have been added towards the end of the book, and are a welcome addition. Some of the pictures are new and improved ; if a comment is to be made on the illustrations it is that it would be interesting to know the origin of some of the older prints. The excellent index in which reference is made to the footnotes and illustrations as well as the main text, must also receive comment.

Unfortunately, one must pay dearly for this book, and its price will probably succeed in keeping it off the shelves of most students, for whom, after all, it was primarily intended. On one of the earliest pages the authors have quoted from a review of the first edition (in the *British Journal of Surgery*) : "Medical History should be a discipline for the mind, and inculcate into the student a habit whereby in later life he is able to implement the advice of St. Paul to the Thessalonians, 'Prove all things, hold fast to that which is good'."

P.J.W.

A SHORT HISTORY OF NURSING by W. R. Bett, M.R.C.S., L.R.C.P., F.S.A.(Scot.). **Published by Faber.** Price 12s. 6d.

A sixth-form girl who was going to be a nurse would like to read this little book. No time is spent on those vague pre-Christian women and early saints whom historians wishfully class as nurses. The story progresses from medieval times to the nurse in war, the nurse's uniform through the ages, the origins of some nursing equipment and district nursing to an appendix on the nurses portrayed (unflatteringly) in literature. Student nurses of this hospital will find much about our own medieval history to interest them.

W. E. Hector.

BIOCHEMICAL VALUES IN CLINICAL MEDICINE by R. D. Eastham. **Published by John Wright & Sons Ltd., 1960.** Pp. 141. Price 15s.

This is a small handbook summarising the results of about 200 different chemical pathological investigations. The author indicates the physiological values normally obtained and gives extensive lists of the pathological conditions under which they may be raised or lowered. A reference to the original literature is given after most of the tests. This book does not replace the larger text books of chemical pathology for those wishing to have an understanding of the subject, but would be useful for reference for those engaged in active ward work.

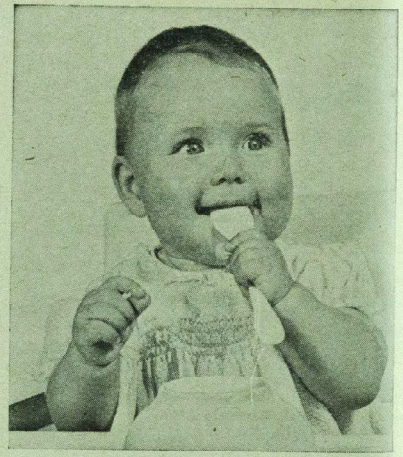
A SHORT TEXTBOOK OF SURGERY by Illingworth. **Published by J. and A. Churchill Ltd., 1959.** Seventh edition. Price 45s.

Congratulations ! Professor Illingworth's Shorter Textbook of Surgery has become of age. The radical changes which have occurred in surgical opinion and technique during the past 21 years—and, indeed, though to a less extent since the last edition four years ago—have presented a great challenge to an author whose aim has been to produce a textbook "avoiding on the one hand the imperfections of the smaller handbooks and, on the other, the encyclo-

paedic unwieldiness of compilations." Today, more than ever, there is no doubt at all that the medical student requires such a book. How successful has Professor Illingworth been?

The book is well set out, easy to read and understand, and the diagrams, photographs and in particular X-rays, are very good. All the essential facts are presented, and it is instructive to note the economy of word and space compared with some of the larger textbooks. The chapters on aspects of general surgery are brief and to the point; those on orthopaedics excellent. In those on regional surgery only a brief account of the pathology is given, but the symptoms and signs are dealt with fully. Operative techniques are described succinctly—but are these not better learned in theatre? On some occasions the specific post-operative complications are omitted—e.g. no mention is made of the treatment of reactionary haemorrhage causing tracheal compression after thyroidectomy.—The policy of jettisoning obsolete material has been rigidly maintained and been extended to discontinuing the chapter on the female genital tract—a subject probably better considered in the gynaecological textbooks. The section on peripheral vascular disease has been brought up to date and a brief section on blood vessel grafts added.

This book will be a great help to those starting surgery, but those who require more detailed knowledge must study the larger books—this is surely the author's intention. The student must not strive to learn minutiae, but to get a good basic understanding of general surgery. Professor Illingworth's book will help him to do just this.



ST. BARTHOLOMEW'S HOSPITAL JOURNAL

Vol. LXIV, No. 6 JUNE, 1960

EDITORIAL

Traditions which are not actively kept alive become vestigial and finally extinct, and yet tradition and convention are powerful forces in the lives of every man no matter to what race or creed he may belong. The British, it is popularly supposed, are more bound by tradition and convention than any other western race and certainly our delight in ceremonial, if nothing else, does much to foster this belief.

Some people find it either fashionable or amusing to be cynical about the value of tradition, but those people whose national or institutional traditions are yet young are often heard to bewail the fact. What is it that such people feel they would gain from a greater weight of tradition?

The values of tradition are intangible in the extreme. Tradition engenders a pride in the Establishment, an *esprit de corps*, and a sense of institutional solidarity and maturity. It also provides a standard for men to live-up-to and so helps them to give of their best.

Bart's, after eight hundred years of service to the sick poor, is endowed with a great weight of tradition and it is pleasant to think that in observing some of them we are paying tribute to the great men of the past to whom the hospital owes so much. The prime example of such tribute is surely View Day—the main social event of the hospital's year. This ancient ceremony, so the Journal informs us (July 1959), dates back to 1586 when the Governors were summoned to attend a View Day which started with a service held at seven o'clock in the morning.

View Day was held this year on Wednesday, May 11th, but, *O tempora, O mores*, where were the hospital Governors? The procession of our new Treasurer, Mr. M. W. Perrin, was sadly depleted. However, it was heartening to see so many of the staff, especially members of the House, in morning dress, and *some* of the ladies put on their garden-party hats despite the uncertainty of the weather.

Those who had come expecting to enjoy the usual hospitality of the wards were to be disappointed. Tea was served in the nurses dining room which, though it was convenient, scarcely matched the elegance of some of the visitors. In consequence the wards received somewhat fewer visitors than usual, and those who ventured past the doors without that cup of tea to convey a sense of security were seen to make a rapid and somewhat embarrassed circuit of the ward, trying hard not to convey to the patients the impression that they resembled animals in a menagerie.

The various official exhibitions, such as medical photography, surgical instruments and hospital archives, were as successful and well-attended as ever, but the student photographic exhibition nearly perished when, with two days to go, there were only four exhibitors and some very large exhibition frames to be filled!

View Day is over for another year. Was it a fitting tribute to the past, or does it need a shot in the arm?

The members of the Abernethian Society enjoyed a rare privilege on Thursday, May 26th, when they gathered in the Great Hall to hear Sir Derrick Dunlop speak on "Changing Fashions in Therapeutics". Of all the hospital buildings the Great Hall is surely the place *par excellance* for fine oratory: Sir Derrick Dunlop more than did it justice.

In the course of his stimulating address Sir Derrick traced the development of several aspects of therapeutics from the time when the physician had only simples culled from the hedgerow to help him in his treatment to the present emergence of a precise science of therapeutics.

Professor Groen, in this month's edition of *The Practitioner* discusses the current situation in respect of the development and usage of psychotherapeutic drugs. "The medical world", he says, "is still not scientifically prepared for the clearly indicated use of tranquilizers, and there is a great discrepancy between the haste and waste with which the chemical industry has put them at our disposal and our understanding of their specific indications and mechanism of action." There is a very real risk in the use of these drugs to palliate symptoms if a thorough search for their underlying causes is omitted.

Lysergic acid diethylamide and mescalin, on the one hand, and the tranquilizers on the other, have opened up the whole concept of a biochemical approach to mental disorders. It is fascinating to speculate on what further advances may stem from this approach both in the fields of psychopathology and the development of other potent psychotherapeutic substances.

Commenting on the responsibilities of doctors who administer drugs that produce marked personality changes, Sir Derrick said that the moral problems to be faced were as great as those involved in the use of atomic energy. Here indeed is food for thought.

This journal like many others has had, in the past, editors who have been driven to speculate in print on the precise functions which they fulfil. Such reflections are not usually the product of an earnest desire to analyse the current situation, but represent, rather, the last-ditch refuge of an editor who approaches his publication date with nothing to say. It was, therefore, with considerable apprehension that the representatives of the Bart's journal attended the conference of journal Editors organised by the B.M.S.J. under the aegis of the B.M.J.

The morning session was devoted to a series of most interesting and stimulating paper speeches. Mr. Percy Cudlipp spoke on the aims of *The New Scientist*, Mr. Charles Macmillan, of E. & S. Livingstone, talked about publishing for the medical profession, and Dr. Hugh Clegg (the Editor of the B.M.J., and a Bart's man) described the history and workings of his journal.

The first afternoon session was devoted to a discussion of "The Functions of the Medical Student Journal". After a couple of somewhat hysterical speeches from the representatives of Belfast and Sheffield, the conference came within an ace of concluding that the journals which it edited were in fact functionless! It is not proposed here to defend Medical Student or even Hospital journals. We conclude from our continued existence that we serve *some* function. If our readers disagree strongly let them write and tell us. We are always open to suggestion!

The last session of the conference was devoted to journal finances. By comparison with other journals of comparable size which come out only four or six times a year, the Bart's Journal, with production costs in the neighbourhood of £2,250 per annum for twelve issues, seemed to be very reasonably priced. As every student in the hospital receives, or should receive, his or her monthly copy of the journal entirely free (there is no subsidy from the Students' Union) we hope that more Bart's men will, in future, repay the compliment when they leave by becoming regular subscribers. The journal is the best way of keeping in touch with the hospital.

The conference concluded with a most successful dinner given by the B.M.J. to whom we are most grateful, not only for the dinner but for organising such an interesting and enjoyable function.

Rifle Club

The Hospital Rifle Club, it has been announced, is to lose the use of its indoor range below the Medical Records Department. The range, opened in 1908 by Lord Ludlow, has been of inestimable value to the club and an article elsewhere in this issue details the many successes of the club which must be ascribed largely to the enthusiasm engendered by the possession of this unique facility.

It is sad to reflect how tenuous is the hold of the Medical College on its amenities within the hospital, but a programme of expansion within the somewhat rigid confines of the hospital site necessitates the uttermost economy of space. It is understood that the reorganisation of the Records Department will effect a considerable saving of time and effort and the needs of the hospital must of course have priority.

The Rifle Club is trying to find temporary accommodation with one of our neighbouring clubs in the City, and doubtless the members will do their best to ensure that this upheaval does not cause a lowering of their standards. In the meantime it is to be hoped that developments on the Medical College site at Charterhouse Square will soon allow the Club to return from exile.

View Day Ball

The View Day Ball was held on Thursday, May 12th in Quaglino's Ballroom. The Ball Committee's new policy, designed to avoid the financial losses of last year was, as far as the customer was concerned, very successful. It remains to be seen if the books will balance!

Dancing to Bill Savill and his band was from 9 p.m. to 3 a.m., and during the first part of the evening, while supper sittings were in progress, there was plenty of room on the floor for all who wished to dance. Later, however, the floor became more crowded, and the closure of the bar at 2 a.m. led to an uncomfortable jostle.

The Ball, however, had much to recommend it. The venue was pleasant, the band excellent and the food good. The revised hours of dancing may have been one factor which induced some of the senior staff to come—we hope there will be even more next year—and it was pleasant to see so many of the gentlemen in tails. Let's hope it will be as good next time.

News in Brief

It is with deep regret that we record the death of C. M. Hinds-Howell, D.M., F.R.C.P. A Memorial Service was held in the Church of St. Bartholomew-the-Less at 12.30 p.m. on May 26th. Obituary notices of Dr. Hinds-Howell and of the late Sir Archibald McIndo will appear in due course.

The collection in aid of World Refugee Year which was organised by the B.M.S.A. representative has now passed the target of £100. Our thanks are due to all those who contributed so generously.

Professor H. Marvin Pollard of Ann Arbor, Michigan, U.S.A., who is President of the American Gastro-enterological Society gave a lecture entitled "Developments in Problems of Malabsorption" before a large audience in the clinical lecture theatre on May 18th.

Professor Sir James Patterson Ross gave his last lecture to the Medical College on Wednesday, May 25th; his subject was "Tuberculous Lymphadenitis".

Dr. E. F. Scowen and Dr. Frankis T. Evans have been elected Fellows of the Royal College of Surgeons without examination.

Mr. A. H. Hunt has been nominated as a candidate for election to the Council of the Royal College of Surgeons.

Dr. E. B. Strauss spoke to the United Hospitals Catholic Society on the subject of Magic and Scruple on Monday, May 16th. Mr. J. E. A. O'Connell addressed the Society on Moral decisions in Neuro-Surgery on Monday, May 30th.

The University Grants Commission visited the Hospital and Medical College on Tuesday, 24th May.

Miss A. M. Alderson has been appointed Junior Lecturer in Physiology as from 19th April.

Dr. A. J. H. Ellison and Dr. A. Whitworth have been appointed General Practice Clinical Assistants as from July 1st, 1960.

Press Relations

In a recent article in *The Lancet*, Dr. A. W. Franklin discusses the relationship between the Press, the Patient and the Hospital Doctor. Drawing on his recent experiences in the case of the Siamese Twins Dr. Franklin comes to the following conclusions: "It is of the first importance in these days that such an unusual case should be recognised as of legitimate public interest. Preparation must therefore be made as to how the Press is to be handled. A consistent, agreed, and co-operative policy can lead to the establishment of confidence and mutual respect between all parties concerned. Information should be available to reporters to the limit of what is seemly. Professional anonymity cannot be maintained unless the whole of the Press agrees to such a policy.

Without this agreement members of the staff concerned are best safeguarded by the release of some information about what part they play, and availability of photographs would save them from being hunted."

B.M.S.A. Notice Board

On Tuesday, May 3rd, Mr. J. H. Bootes of this hospital, Vice-President of the B.M.S.A. and Chairman of the London Region, received from Mr. Reginald George, Managing Director of Ortho Pharmaceutical Ltd., a token presentation of one of the notice boards which Ortho are donating to 28 member schools of the B.M.S.A.

Mr. George spoke of his firm's interest in the welfare of the medical student and expressed the opinion that future developments in therapeutics will necessitate the closest possible co-operation between the medical profession and the pharmaceutical firms in order that the fullest benefit may be derived from research programmes.

Catholic Society

On Thursday, April 18th, a talk was given by Father Gerrard Rathe of the White Fathers. His subject was the work of the missionaries and doctor in Africa.

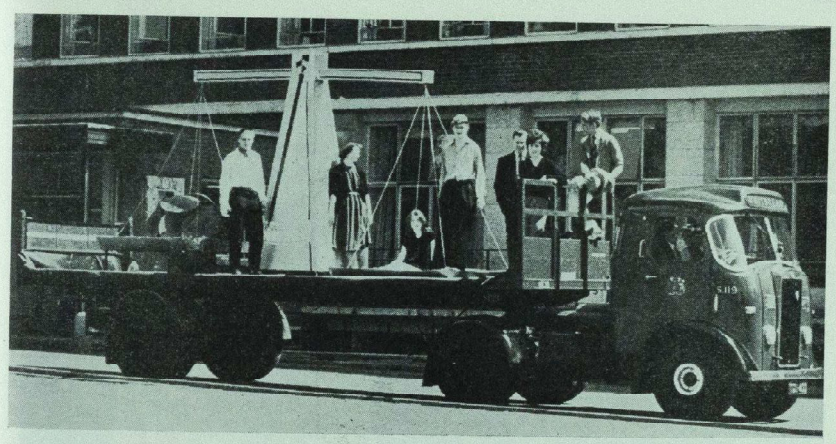
His talk was illustrated by a film "John Guarnisson w.f., Missionary and Doctor". Guarnission is one of the few White Fathers who is also a doctor. The film showed how in his part of Nigeria Guarnisson had built up his own "health service" by delegating as much of his work as possible to others, and especially to the Africans themselves. It was shown how he had taught African nurses to remove cataracts purely as a mechanical procedure. He started his own school of nursing and some of the more able men were given elementary medical instruction. Working from his own centre he established many new centres in outlying villages and staffed them. He himself cycled round from one to the next holding clinics. By his efforts he had ensured that his work would not die with him but rather would flourish.

Father Rathe discussed the qualities required for the Mission fields. He emphasised that much experience was essential as in Africa the doctor might have to make do with just what he could take with him having no hospital or laboratory facilities. It was essential that no one go unprepared to this work.

We were most grateful to Father Rathe for talking to us and showing us such an interesting film.

On Thursday, May 17, we were invited to join the Nurses Catholic Society at a Brains Trust. The distinguished panel was Lord and Lady Pakenham and Mr. and Mrs. Douglas Woodruff. The Chair was taken by Dr. Lawther. The evening was a most stimulating one and we were indeed privileged to hear such brilliant conversation.

E.K.



Float for University Carnival

University Carnival

This year Bart's entered a float for the University Carnival procession for the first time. As the proceeds were for World Refugee Year the theme of the float was "A Penny for Them", and depicted a large pair of scales with pennies in one pan and "refugees" in the other. The Carnival Committee would like to thank all those who helped in any way, especially the firms who gave the materials: Johnstone's Wood Mills, Bowaters, The Daily Express, Whitbreads and Freemans (paint).

London to Brighton Stroll

"I do not regret this journey for it has shown that Englishmen have strength courage and fortitude." (Scott's Diary.)

The London to Brighton Stroll, sponsored by Guiness, is now an annual event, but this was the first year that Bart's had been invited to send representatives. Eighty people from the College left the Tower on the evening of May 21st bound for Brighton. The object of the walk is to get to Brighton within twenty-two hours, thus qualifying for a special necktie (headscarf for the ladies) presented by Guiness. There is no prize for the first man home as this is a purely "social" stroll, the Toucan Trophy is, however, awarded to the hospital which gets the largest percentage of its student population to Brighton. This year Ovaltine presented a cup for the ladies to be awarded on a similar basis.

The stroll was started by H. M. Governor of the Tower of London at 5.55 p.m., the route being over Tower Bridge to the Elephant and Castle, and then along the A23 to Brighton.

By the time the leaders had reached Coulsden the field was spread over seven miles (due largely to the Junior Secretary of the Students' Union who, starting late, was well in the rear) and the Bart's party was doing well, a large number of them marching as a platoon and entertaining the natives with song. With darkness came the rain and the first blisters which were treated at the check point just beyond Coulsden where a van organised by Bart's was feeding our own walkers and any others who needed sustenance.

Midnight found the leaders passing through Redhill and nearing Gatwick—the halfway checkpoint. Here warmth and food dispensed by an all-night cafe proved too much for many and they withdrew from the struggle.

Feeding and looking after the "comfort" of the walkers was now a major problem as the length of the column imposed great strain on our small mobile support team. The food van made three main stops and dispensed hot dogs, drinks and words of comfort to almost the entire field on each

Leaving the Tower of London

occasion, while cars ferried refreshment to Bart's men who were near the head of the column which at one time stretched twenty-eight miles. During the hours of darkness the cars covered nearly 1,500 miles between them and the help and encouragement of their crews and of those who did the catering were invaluable to the walkers. Without such help and inspiration many of them might not have arrived.

The dawn came in a grey mist of rain which obscured the beauties of the South Downs—not that many had any attention to spare from the struggle to finish the course. Blisters and cramp were now taking their toll and one Bart's man who reached the Brighton Gates, only five miles from the finish, with nine hours to go, had to give up on account of cramp.

At 5.45 a.m. M. Bascombe, accompanied by two walkers from Guy's strode up to the finishing line eleven hours and forty minutes after leaving London.

Some walkers nearing the finish were waylaid and interviewed for television. One well-known member of the Rugger Club was seen a few nights later explaining that the condition of his feet would not interfere with his future career!

Bart's did not win the trophy, but they did get the highest percentage of their starters to Brighton. All those who qualified will receive their ties in due course and will also be entertained to dinner by Guiness later in the year.

J. W.

Results:

	Arrivals	Percentage
1. The London Hospital	68	12.6
2. St. Mary's	44	9.8
3. Guy's	93	9.2
4. Bart's	42	8.0
5. St. Thomas's	23	6.0

The Ladies' Trophy was won by St. Mary's.

Marching Song

(with apologies to G. K. Chesterton)

At six o'clock one chill May night from out the Tower strode
Through streets and suburbs, on and on, to reach the open road
Five hundred students, some in strange and singular attire
Bedaubed with woad like ancient Britons. On through mud and mire
They walked. At first they talked and sang—the air was full of sounds
The night they went to Brighton Pier across the rolling Downs.

"On such a night as this"—so Shakespeare fancifully told.
But that was warm and full of stars; this was wet and cold.
"My friends we will not go again next year", so rang the cry,
As grey succeeded blackness in the eastern morning sky.
And still they marched with blistered feet as the early cockerel's crowed,
The night they went to Brighton Pier along the Brighton Road.

But memories of aching legs and painful feet will fade.
This time next week they will be glad that the attempt was made.
And though they swear they'll go no more whatever might forbode
And curse the English drunkard for his rolling English road,
They'll leave again though rain pour down and clouds of thunder lower
One night to go to Brighton Pier from London's ancient Tower.

Fifty Years Ago

Mrs. A. E-, act. 38 years, was admitted to Paget Ward on February 26th, 1909, complaining of a faecal discharge from an opening in the right groin.

She was a healthy-looking woman, and except for the sinus in the right groin, no abnormalities in any of her "systems" could be discovered.

The following history was obtained: She noticed a "rupture" on the right side in May 1908, and this became painful in June. She was advised to wear a truss by her doctor, and wore one for two months. Towards the end of this time the lump which she had noticed in May became red, hot, painful, and swollen, and was opened by her doctor as an abscess. The cavity contained foul-smelling pus, and in a few days faecal matter was discharged from the opening, and it was the constant escape of this material which brought her to Hospital.

On admission, a small opening, with the usual pouting edges, and admitting a No. 12 catheter, was found in the right groin at the situation of the external abdominal ring.

On March 1st of that year Mr. Power decided to dissect out, and, if possible, close the sinus. An oval incision was made round the opening, but no trace of the loop of intestine which was expected could be found; the sinus led into the external abdominal ring, and the tubular structure was found to be attached to the caecum, and near it a definite mesentery was discovered. The inguinal canal was opened up freely, the caecum drawn down as far as possible, and the tube which was evidently the appendix, removed in the usual way.

What had happened was, apparently, this: The patient had a hernia sac, which she noticed first in May; the appendix had prolapsed into it, and probably from the pressure of the truss, had acquired an attachment to the wall of the sac. Later, from the same cause, it became inflamed, and an abscess formed in the sac. This was opened by the doctor, and faeces continued to be discharged from an opening in the appendix.

After the operation the patient made an uninterrupted recovery, and was discharged cured on March 28th, 1909.

The interest of the case lies, I think, in two points: first, the presence of the appendix in the hernial sac, and, secondly, the formation of a natural appendicostomy which in this case, at any rate, performed no useful function.

Overheard

In the square:

. . . "Yes, Prof. Garrod put two female goldfish in the Fountain to encourage them to breed."

"That's no good—you need a gravel bottom for breeding."

"Have you got a gravel bottom?"

"No, I manage allright without."

On View Day:

E. G. T. to ex-Pink—"I never recognise nurses without their clothes."

CALENDAR

JULY

Sat. 2—On duty: Medical and Surgical Units
Mr. G. H. Ellis
Cricket v. U.C.S. Old Boys (H) 2.30.
Tennis v. London (H)
Cricket Club Dance
Henley Royal Regatta, Finals
Sun. 3—Cricket v. The Past (H) 11.30
Mon. 4—National Rifle Association Imperial Meeting
Fri. 8—U.H. Rifle Club competition
Sat. 9—On Duty: Dr. R. Bodley Scott
Mr. A. H. Hunt
Mr. F. T. Evans
Cricket v. Incogniti (H) 11.30
Sun. 10 Cricket v. Hampstead (H) 11.30
Tues. 12—National Clinical Conference B.M.S.A.
Wed. 13—Students' Union Meeting
N.C.C. (Mr. Tubbs lecturing)
Fri. 15—N.C.C. Dinner
Sat. 16—On duty: Dr. A. W. Spence
Mr. C. Naunton Morgan
Mr. R. A. Bowen
Cricket v. Nomads (H) 2.30
Association Football Club Dinner
N.C.C. closes
Sun. 17—Cricket v. Dartford (H) 11.30
Sat. 23—On duty: Dr. G. W. Hayward
Mr. A. W. Badenoch
Mr. R. W. Ballantine
Cricket, inter-firm 6-a-side and Dance at Chislehurst
Sun. 24—Cricket v. R.N.V.R. (H) 11.30
Sat. 30—On duty: Dr. E. R. Cullinan
Mr. J. P. Hosford
Mr. C. Langton Hewer
Sun. 31—Cricket Club Tour begins

Changes of Address

DR. I. I. M. CASTLEDEN, 43 Parkside, Mill Hill, N.W.7. Tel: MIL 1797.

DR. DOUGLAS S. PRACY, 36 Birchington Road, London, N.8.

DR. MICHAEL E. GLANVILLE, Jocelyn House, 18 High Street, Chard, Somerset. Tel: 3380.

DR. JOHN SPENCER, Glentarras, Nursery Road, Loughton, Essex.

ANNOUNCEMENTS

Engagements

ANDREWES—WOODD.—The engagement is announced between Dr. David Anthony Andrewes and Katharine Woodd.

CHURCH—BEE.—The engagement is announced between Dr. Robin Birdwood Church and Joan Mary Bee.

COLLIER—JOSEPH.—The engagement is announced between Leonard Joseph Collier and Marilyn Jeanette Joseph.

PRICE—COVERDALE.—The engagement is announced between Dr. John Scott Price and Clare E. M. Coverdale.

WALLER—BRODRIBB.—The engagement is announced between James O. Waller and Anne S. Brobribb.

Marriage

HADFIELD—SLEIGH.—On May 21st, at St. Bartholomew-the-Great, Geoffrey John Hadfield, F.R.C.S., to Beryl Sleigh.

Births

BENCH.—On April 27th, to Jacqueline, wife of Surg-Lieut. John Bench, R.N., a son.

COOLE.—On May 15th, to Prilla and Dr. Colin W. Coole, a daughter (Helen Elizabeth).

GRAY.—On April 11th, to Rosemary June, wife of Dr. Anthony J. Gray, a daughter.

LAMMIMAN.—On April 26th, at David Bruce Hospital, Malta, to Sheila and Surg-Lieut. David Lammiman, R.N., a son (Robert Nicholas Anthony) brother for Christopher.

MILLARD.—On May 2, to Rosemary, wife of Capt. John Millard, R.A.M.C., a daughter.

MORLEY.—On May 3, to Elisabeth and Dr. David Morley, a son (Peter Thomas).

ROGERS.—On May 6, to Pamela, wife of Lieut. Col. N. C. Rogers, R.A.M.C., a son.

Deaths

FRIEND.—On April 24th, Dr. Francis Friend. Qualified at Bart's 1941.

HINDS-HOWELL.—On May 9, Dr. Conrad Meredyth Hinds-Howell, aged 83. Qualified 1903.

LONG.—On May 1st, Dr. William Christopher Long. Qualified 1889.

ROWDEN.—On March 28th, Grace Emily Rowden, aged 90. One-time Sister at Bart's.

WATERFIELD.—On April 27th, Noel Everard Waterfield, O.B.E., M.B., F.R.C.S., aged 80. Qualified 1902

Research at Bart's

DEPARTMENT OF SURGERY

Research in the Department of Surgery may be divided into the investigations in which clinical methods alone are employed, and those in which the somewhat more exact techniques of basic medical science are used. The former may be styled "Clinical Research", and the latter "Surgical Science" which can again be subdivided into experimental surgery on animals, and the use of laboratory methods to examine patients before and after operation. It may be said that many surgical operations, particularly those undertaken to rectify disorders of function, are experiments in human physiology; and if the function of the affected organ is carefully studied before and after operation this kind of surgery can rightly be regarded as research. The claim made long ago by Sir James Paget still holds true —"within our range of study, that alone is true which is proved clinically, and that which is clinically proved needs no other evidence".

1. CLINICAL RESEARCH

(*a*) *Investigation*

Clinical investigation includes radiography when it is employed to elucidate a rare or obscure disease. A good example is Mr. Hunt's investigation of the portal circulation using either portal or splenic venography, which can be of vital importance in deciding what to do for portal hypertension and in demonstrating thrombosis of the portal vein. Mr. Hunt has now done about 290 portal venograms and 140 splenic venograms.

Angiography is being employed by Mr. Birnstingl on selected patients with the most peripheral form of obliterative arteritis affecting the digital vessels in the hands. Such patients are commonly sent to Hospital for "Raynaud's disease", and the clinical or radiographic appearances are being correlated with the histology of the small arteries in the hope of discovering what the nature of the disease may be and so enabling us to recognize it on clinical criteria alone.

Mr. Naunton Morgan is undertaking a diagnostic study of Crohn's disease affecting the colon, the aim being to differentiate it from ulcerative colitis before operation. In the same Unit Mr. Keynes is collaborating with Dr. Trapnell of the X-ray Department in seeking for examples of hypertrophic pyloric stenosis in adults, barium meal examinations being correlated with operative and pathological findings.

Bilateral renal calculi are being investigated by Mr. Badenoch, and a clinical study of fatal pulmonary embolism is being made by Mr. Taylor. These conditions are being approached from the same point of view, for in each an analysis is being made of the factors concerned in their production, with prophylaxis as the ultimate objective.

(*b*) *Therapeutic*

Any critical clinician must be constantly assessing the value of different methods of treatment, but when an intensive study is made by someone who is taking a special interest in treating a series of patients according to a well-defined plan the work deserves to be regarded as research.

A number of these studies are no more than a critical "follow-up" of patients suffering from a given disease treated according to an agreed system but not necessarily by the same method in every case. Such are the follow-up of carcinoma of the rectum and colon by Mr. Naunton Morgan who has been practising high litigation of the inferior mesenteric vessels in order to remove the widest possible lymphatic field—the value of the method should be assessable within the next three years; of carcinoma of the skin, and carcinoma of the upper jaw by Mr. Alan Hunt; and of carcinoma of the stomach by Mr. Robinson. This form of research yields important information about the natural history of the diseases under review, and is essential as an indicator of the value of certain forms of treatment.

In a slightly different category are the diseases each one of which is being treated by a standard method, the aim being to assess the exact value of that particular form of treatment. In this group we place Mr. Badenoch's work on the effects of indirect irradiation with the cobalt bomb upon carcinoma of the bladder, and also his assessment of the results of pyeloplasty for hydronephrosis; Mr. Keynes's trial of yet another operation for femoral hernia; and Mr. Hadfield's evaluation of primary or prophylactic

oophorectomy as an adjunct to adequate local treatment in women before the menopause who have operable but locally advanced cancer of the breast.

A third group under this main heading includes therapeutic trials, methods of treatment the results of which have to be carefully followed and assessed, sometimes with the dual purpose of elucidating the nature of the disease as well as evaluating the treatment. Mr. Alan Hunt's work on portal hypertension comes into this category for he is both treating the disease and also studying the associated disorders of the liver. We should include Mr. Nash's investigation and treatment of children suffering from urinary disorders complicating malformations of the spinal cord, and from other congenital urological lesions; Mr. Badenoch's treatment of chronic interstitial cystitis, particularly in women, using intravesical intramuscular injections of hydrocortisone followed by the administration of cortico-steroids; Mr. Taylor's enquiry into the relationship of the size of the thyroid remnant after partial thyroidectomy to the post-operative metabolic state in which he uses plastic moulds made at operation to measure the size of the remnant, and also his clinical studies of the use of by-pass grafts in severe occlusive arterial disease, and two studies of breast cancer, one by Mr. Keynes in which he is using cortico-steroids partly for the treatment of metastases, and partly as a test to determine whether endocrine surgery is indicated, and the other by Mr. Hadfield on the effects of surgical removal of the ovaries, or the adrenal glands, or the pituitary body upon patients with metastatic breast cancer, correlating the clinical course of the disease with estimations of various hormones after these operations. There is one further piece of work by Mr. Hadfield which may properly be included here, namely the effect upon the mammary gland of radical excision of the main ducts close beneath the nipple for the treatment of the complications of non-malignant obstruction of these ducts. The operation is successful because of the consequent atrophy of the secreting tissue of the gland.

II. Surgical Science

(*a*) *Animal Experiments*

A great deal of experimental work on animals has been carried out in the department of thoracic surgery and this is so important that it demands a special report and will not be included here. Almost all the rest of the animal work has been done by members of the Surgical Unit. It is unfortunate that the demands of routine duties and our limited laboratory space make it difficult for Chief Assistants on the non-professorial Units to undertake this kind of surgical research though it has long been the desire and in fact the aim of the Directors of the Units to expand the space in the Dunn Laboratories or elsewhere so as to enable any member of the Department of Surgery to have access to an experimental laboratory and the necessary technical assistance, but their efforts up to date have not met with much success, though there are some indications of better things to come.

The object of one group of experiments has been to study a certain operation in animals in order to deduce what is likely to occur when the same procedure is performed in man. Mr. Taylor has been studying the reactions in dogs to plastic protheses used to replace segments of arteries in the hope of determining the fate of such protheses when they replace diseased segments of human arteries.

Most of the animal work, however, is experimental pathology involving attempts to reproduce and study in animals certain pathological processes encountered in man. Mr. Taylor, with the help of Dr. Shooter and his assistants, has been investigating the problem of post-operative wound infection by determining the minimum dose of staphylococci which will produce a wound infection, and then varying the local conditions in the wound and the constitutional state of the animal (including alterations in diet) to study the effect of these factors upon the minimum infecting dose.

Mr. Birnstingl has been continuing the study of pancreatitis which he started several years ago in San Francisco. He has been ligating the pancreatic ducts of dogs and rabbits and using operative pancreatography and histological methods to estimate the changes in the ducts and in the gland parenchyma resulting from obstruction. He has also given rabbits large doses of calciferol thus inducing a state of hypercalcaemia, and in such animals pancreatic calculi have developed in the presence of duct obstruction. In a third group of experiments he has been studying the effects of administering the amino acid dl-ethionine to rats and rabbits: he has observed that these animals develop widespread pancreatic lesions which are fatal and show the histological appearances of a specific acinar necrosis.

Mr. Birnstingl has undertaken two other groups of experiments. In one he has been trying to reproduce hypertrophic pulmonary osteoarthropathy in dogs by constructing atrio-caval venous shunts, anastomosing the inferior or superior vena cava to the left atrium. A sufficient number of his dogs have survived this hazardous operation to enable him to study the development of the characteristic changes in the extremities. In the other experiments he has been investigating antigen-antibody reactions in the intestinal mucosa by administering extracts of intestinal mucosa mixed with an adjuvant to rats and examining their serum for precipitins and also their intestinal mucosa histologically for evidence of an antigenic response. Thus far these experiments have failed to show any evidence of such a response.

In addition to these several pathological studies Mr. Hadfield has been making an experimental study of the physiology of the mammary gland using hypophysectomized rats and intact mice. He has shown how growth of the mammary gland can be enhanced by giving human pituitary extract, oestrone or progesterone, singly or in combination. Hypophysectomy, adrenalectomy and castration have the opposite effect.

(*b*) *Clinical Science*

The methods of the laboratory can be employed in the study of patients and investigations of this kind have been collected into a fourth group.

The studies of liver function in which Dr. Lehman has collaborated with Mr. Hunt should be included by virtue of the biochemical estimations involved—the serum albumin, pseudocholinesterase and the transaminases. Mr. Hunt's measurements of the speed of flow in the portal vein using radioactive sodium provided quite useful scientific information, and can rightly be placed under this heading.

Mr. Taylor and his Research Assistants have been carrying out several investigations upon patients which have required laboratory techniques. One was designed to study the aetiology, pathology, and clinical aspects of primary lymphoedema and included lymphangiography, the study of the lymphatic circulation using radio-active plasma protein, and of the protein content of oedema fluid in lymphoedema. Attempts were made to reproduce lymphoedema in animals but in comparison with the investigation of patients these experiments were relatively unrewarding.

Another extremely interesting piece of work is concerned with the measurement of tissue oxygen availability in ischaemic skin using the microelectrode polarographic technique. The importance of these observations lies in the additional and more exact information they can provide as a guide to prognosis and treatment when gangrene appears to be imminent.

Furthermore, when peripheral vascular disease has resulted in arterial occlusion, alterations in arterial pressure in main vessels distal to the occlusion are being studied before and after operations for arterial grafting, the pressure measurements being made with a capacitance manometer.

Mr. Todd is continuing the studies of bowel physiology (in particular motility) which he started in Toronto.

Mr. Keynes is making a study of the lymphatics of the colon and rectum in which he attempts to inject the lymphatics of the portions of the bowel to be excised, and then by using microradiographic and histological techniques he is relating the topography of the lymphatic vessels to the pathological process.

Mr. Keynes is also interested in seeking for cases of hyperparathyroidism, with special reference to the diagnostic value of changes in the metabolism of phosphorus.

Before Mr. Paten Philip left for the United States he was investigating a feminizing tumour of the testis, and in the course of this study he was greatly assisted by Mrs. Robinson in the Department of Biochemistry.

Mr. Birnstingl, in addition to the animal experiments already mentioned, has been studying chronic pancreatic disease in patients and also in autopsy specimens by injection and histological methods, and has been led to make certain deductions about the importance of recognizing that some examples of "chronic pancreatitis" may be the result of cancerous obstruction of the ducts. He has also used a similar method of combining injection and microscopy to investigate the arteriographic variations and the incidence of organic occlusion of the digital arteries in 100 necropsy specimens obtained from subjects without ischaemic symptoms during life. He has used these findings as a

form of "control" in his clinical study of digital arterial disease to which reference has already been made.

Finally there are the investigations which Mr. Hadfield has been making of patients with gynaecomastia with a view to obtaining further information about the part played by hormones in the growth and function of the mammary gland.

I feel that I owe an apology to any readers of this article because it offers merely a catalogue of the many items of research being undertaken in the Department of Surgery without providing sufficient detail to indicate the real interest and importance of the work. It must be obvious, however, that the article is already very long, and to make it still longer would have made it unacceptable. It should at least indicate what is being done and it is to be hoped that if any reader of the Journal wants to know more about any particular research problem he will not hesitate to go and ask the person concerned to show him and tell him about the work.

J. P. R.

Examination Results

UNIVERSITY OF OXFORD

2nd B. M. Examination—Hilary Term 1960
Special & Clinical Pathology

Cawdery, J. E.
Waring, A. M.
Meade, T. W.

UNIVERSITY OF CAMBRIDGE

Examination in Pharmacology—Lent Term 1960
Passed:

Jailler, J. M.
Wood, E. M.

UNIVERSITY OF LONDON

Special Second Examination for Medical Degrees March 1960

Aldis, P. W.	Maw, A. R.
Bridger, C.	Phaure, T. A. J.
Clarke, J. M.	Poore, P. D.
Dudley, N. E.	Pusey, J. H.
Gleadle, R. I.	Robertson, A.
Hadley, D. A.	Salole, R. M.
Jennings, M. C.	Snow, M. G.
Latham, D.	Tam, Y. D.
Lettington, W. C.	Whyatt, N. D.
Lofti, D.	Wise, K. S.
Pain, V. M.	Austin, A. I.
Phillips, J. D.	Chant, A. D. B.
Powles, T. J.	Doran, B. R. H.
Richards, C. J.	Gardner, Z. N. C.
Rauoss, C. F.	Gurry, B. H.
Shinebonrne, E. A.	Hilton, A. M. B.
Stephens, A. D.	Lageard, V. M. E.
Ware, E. A. S.	Leaver, P. K.
Wilson, R. G.	Lopez, J. T.
Amir-Ahmadi, H.	Minns, S. A.
Caine, P. W.	Phillips, H.
Coates, O. A.	Powles, R. L.
Dupré, P. C.	Ratcliffe, R. M. H.
Glover, D. N.	Rolfe, M.
Hardy, J. D.	Scriven, P. C.
Knight, A. H.	Stanley, P.
Layton, D. C.	Waller, J. O.
Lewis, A. A. M.	Williams, C. R.

CONJOINT BOARD

First Examination—March 1960
Pharmacology—Passed:

Evison, P. R. H.
Janosi, M.
Anthony, P. P.
Welch, D. M.
Katjer, T.
Hadley, R. M.

Final Examination, April 1960
Pathology

Griffiths, C. J.	Evison, P. R. H.

Medicine

Weaver, P. C.	Pettavel, J. P.
Hadley, R. M.	Hijazi, H. K.
Pemberton, M. J.	Cassell, P. G.
Mackenzie Ross, R. K.	Musgrove, J. S.
Booth, D.	Craggs, J. C.

Surgery

Weaver, P. C.	Roles, W.
Pemberton, M. J.	Davies, R. N.
Walker, K. A.	Musgrove, J. S.
Tufft, I. J.	Bonner-Morgan, B. M.
Pettavel, J. P.	Gletsu, A.
Fasan, P. O.	

Midwifery

Weaver, P. C.	Fasan, P. O.
Mercer, J. D.	Goodchild, M. C.
Craggs, J. C.	Pettavel, J. P.
Bonner-Morgan, B. M.	Hijazi, H. K.
Cassell, P. G.	Arnold, J.
Musgrove, J. S.	Almeyda, J. J. R.

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

Weaver, P. C.	Roles, W.
Musgrove, J. S.	Davies, R. N.
Bonner-Morgan, B. M.	Pettavel, J. P.
Tufft, I. J.	Fasan, P. O.
Almeyda, J. J. R.	Gletsu, A.
Cassell, P. G.	Arnold, J.
Pemberton, M. J.	

Rupture of the Spleen

by D. A. MACFARLANE

The pathological spleen not infrequently ruptures. Splenomegaly results in loss of the normal protection afforded by the bony cage, and increased vascularity, friability and peri-splenitis allow damage from external trauma. Injury is often minimal in the enlarged spleen of malaria, leukaemia or infective mononucleosis. The normal spleen well guarded anatomically is less liable to damage which usually follows severe and crushing injuries, perhaps associated with other conditions such as fractured ribs or ruptured kidney. Less commonly the trauma is slight and even "spontaneous rupture" has been recorded. The typical case is generally obvious but the insidious onset in some may mislead patient and physician until the signs of blood loss become grossly apparent.

The incidence of ruptured spleen is low; 0.1 to 0.2 per cent in urban communities, and Sir James Learmonth (1951) stated he only had experience of one case. Several years ago the author was fortunate enough to deal personally with seven cases of ruptured spleen and had knowledge of five others, all from a medium-sized hospital of 340 beds in South Wales during a period of eight years. Although it only drained a population of approximately 120,000, the close proximity of colliery and arterial road may have account in part for the high incidence. In view of this experience it has been considered worthwhile to emphasise certain aspects of presentation and thereby facilitate early diagnosis in a lesion occasionally overlooked and yet responding well to prompt surgical attention.

Pathology :

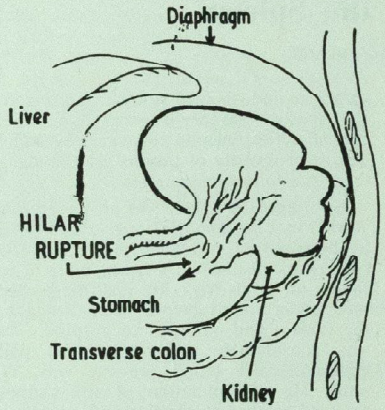
Injury to the spleen may follow a penetrating or non-penetrating wound or occur unintentionally during surgical procedures in the vicinity, e.g. partial gastrectomy. In civilian life non-penetrating violence is more often the cause than a penetrating force and was responsible for all twelve cases in the present series, where two were due to motor car accidents, two occurred underground and the remainder were from miscellaneous causes.

The type of injury is generally moderate or severe and directed towards the region of the spleen. Seventy-five per cent of the present series fell into this category and the degree of severity of trauma may be gauged from the following example.

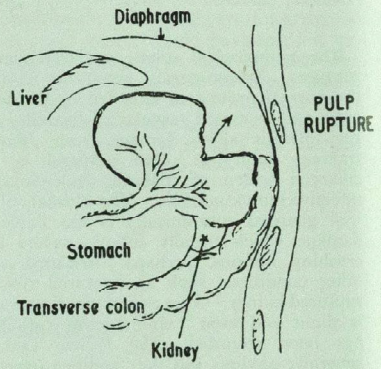
I.W., aged 50 years, was an underground worker in a neighbouring coal mine. Whilst at the coal face movement of the supporting framework resulted in a heavy mass of coal falling on to his back. He was transported a mile underground before being brought to the surface and admitted to hospital. Pain was considerable and shock and pallor apparent. The blood pressure was 90/70 mms. Hg. Examination of the abdomen revealed marked tenderness and guarding in the left hypochondrium together with tenderness in the hypogastrium. Bowel sounds were normal and there was no abnormality on rectal examination. Movements of the left leg were painful and limited with tenderness over the greater trochanter. Fracture of the neck of the left femur was confirmed by X-ray. Rapid transfusion with two pints of blood improved his general condition and laparotomy was undertaken. A ruptured normal spleen was found together with a division in the mesentery of the distal ileum. Approximately one foot of devitalised bowel was resected and splenectomy performed. Unfortunately he succumbed eight days later from a further intestinal obstruction.

On occasions the amount of trauma appears slight and yet rupture follows. The explanation may lie in an unusual degree of fixity of the organ by peri-splenic adhesions from previous inflammation or even minor injury. In other instances an excessively mobile spleen may undergo torsion as a result of congestion with final rupture when slightly injured. Such minor trauma was responsible in the following case.

A.Q., a young soldier of 18 years, whilst stacking sandbags, felt a pain in the left hypochondrium three days before admission to hospital. It was not severe and he did not report sick until six hours later when he had finished his duties. His general condition was good, but because of guarding and slight tenderness in the left hypochondrium his Medical Officer admitted him to the Sick Bay. Persistence of this sign was responsible



Hilar rupture



Pulp rupture

for sending him to hospital but during transportation by ambulance he became pale, his general condition deteriorated and there were signs of shock and exsanguination on arrival. The blood pressure could not be recorded : pulse rate was 130 beats per minute. Marked guarding and rigidity were present in the left hypochondrium and Ballance's sign was positive. Blood transfusion was commenced and because of a temporary shortage it included one pint of fresh blood volunteered by the patient's own Medical Officer. Three pints were given with improvement and at laparotomy, assisted by the same doctor, a ruptured spleen and haemoperitoneum were found. Splenectomy was performed and followed by a normal recovery.

Complete absence of trauma in rupture of a normal spleen is excessively rare and Orloff and Peskin (1958) could find only 28 cases of spontaneous rupture in the English literature. Many authors deny its existence (Wright and Prigot, 1939 ; Johnson, 1954) and maintain that a history of injury may always be obtained. Slight injury is easily overlooked, particularly when rupture is followed by delayed haemorrhage weeks or months later. Despite this, in a careful study Orloff and Peskin were convinced that spontaneous rupture occurred in their case and in 27 others from the literature ; it also appeared to be so in the following patient.

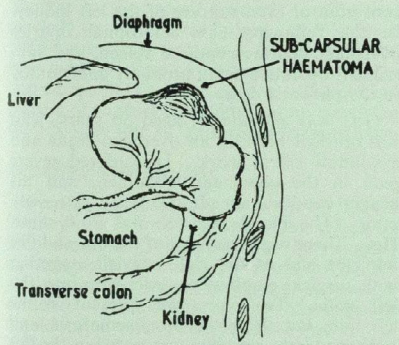
E.S., a collier of 45 years, gave a history that after working on a night shift he retired to bed for seven hours sleep. On waking he enjoyed a meal of stew but this was rapidly followed by acute abdominal pain and the desire to defaecate. During this action he collapsed and was transported to hospital. There was no history of injury that could be recalled. He was pale and shocked on arrival, with general abdominal guarding which was maximal in the left hypochondrium. A ruptured spleen was found at laparotomy and removed. Histological section confirmed normality and recovery was uneventful.

Types of Splenic Injury :

The degree of injury to the spleen may be minimal or severe but it is almost always serious. The following main types occur although various combinations are not infrequent :—

1. Hilar rupture
2. Pulp rupture
3. Fragmentation
4. Subscapular haematoma
5. Perisplenic haematoma

In hilar rupture and fragmentation haemorrhage is profuse and generally associated with severe trauma. There may not be such marked trauma in pulp rupture but haemorrhage is usually brisk. In some instances the splenic capsule exercises restraint on the underlying bleeding with the formation of a subcapsular haematoma. Occasionally there is conversion to a blood cyst or in intrasplenic haemorrhage, organisation of the



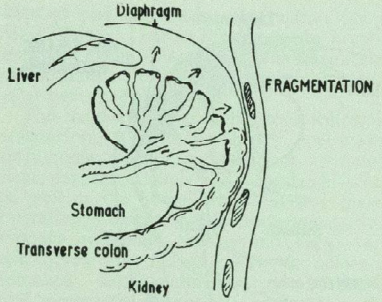
Sub-capsular haematoma

haematoma with the formation of a " fibrinous tumour," but the more usual course is eventual rupture. This is facilitated by interference with the capsular blood supply due to its elevation by the underlying clot. Minimal bleeding with an associated capsular tear may cause a perisplenic haematoma. The anatomical position of the spleen tends to localise such an effusion particularly when bleeding is slow. The diaphragm may be raised, the colon depressed and the stomach displaced, the whole collection becoming walled off by adhesions between alimentary tract and abdominal wall. This, in turn, may later rupture.

Effects of Injury :

The important sequelae are the result of blood loss. Free escape of blood into the peritoneal cavity usually accompanies hilar rupture, fragmentation and most cases of pulp rupture. Such immediate haemorrhage is more severe in the hilar type with its close proximity to large vessels than in some instances of pulp rupture where bleeding is more protracted. This is exemplified in the following cases.

A.T. was an adventurous young schoolboy of 12 years who, whilst exploring the face of a cliff, fell 50 to 60 feet to the seashore below. There was no loss of consciousness but considerable pain in the upper abdomen, particularly on the left side. He was pale and shocked on arrival in hospital with a blood pressure of 90/50 mms. Hg. and there was generalised abdominal guarding and rigidity. The 10th and 11th ribs were fractured on the left side. A diagnosis of ruptured spleen was confirmed at laparotomy,

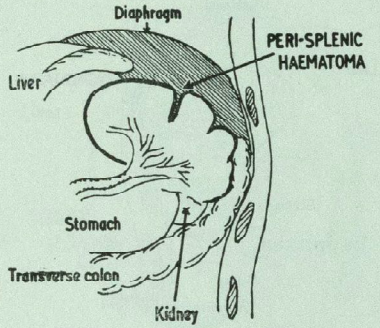


Fragmentation

when the peritoneal cavity was found to contain about two pints of fresh blood. Whilst closing the abdomen cardiac arrest occurred but sub-diaphragmatic massage was promptly instituted with success. He made a normal recovery except for a left-sided pneumothorax which did not require active treatment.

K.P. was a young boy of 15 years who, whilst climbing trees, fell about 15 feet on to his left side. He was aware of some pain in the upper and left part of his abdomen, but returned home. He carried on with his normal routine for about ten hours when, after defaecating, he felt weak and was transferred to hospital. The blood pressure on arrival was 90/65 mms. Hg. and pallor was a marked feature. Tenderness and guarding in the left hypochondrium were present together with some generalised rigidity. Splenectomy was undertaken for the rupture of a normal spleen. Convalescence was uneventful.

In subscapular and perisplenic haematomas bleeding may temporarily cease—the latent period—but later be followed by evidence of further blood loss. This delayed haemorrhage may be due to subsequent trauma disrupting the subscapular or perisplenic haematomas or unplugging a portion of omentum which had sealed the initial tear. In his classical paper on Delayed Haemorrhage following Traumatic Rupture of the Spleen in 1932, Sir Archibald McIndoe restricts this group to cases in which the latent period was at least 48 hours. In some instances the interval between trauma and obvious haemorrhage may be as long as six months, but it is commonly between the third and ninth day. Three in the present series fell into this category and the following



Peri-Splenic haematoma

case is indicative of the minor degree of trauma which may break down the tenuous adhesions engulfing the haematoma.

R.B. was a pharmacist of 25 years, who was admitted to hospital having been involved in a car accident and being concussed. He complained of no pain except from superficial lacerations of the occiput, left gluteal region and the anterior aspect of the right leg. He was conscious, his blood pressure was 110/90 mms. Hg. and there was no obvious pallor. Examination of the abdomen appeared normal. Six days later, after turning over suddenly in bed, there was a sudden onset of pallor, abdominal pain and guarding in the left hypochondrium. Immediate laparotomy for a ruptured spleen was followed by a normal post-operative recovery.

Clinical Features :

Males in general are more exposed to the risk of injury and all twelve cases occurred in this sex. Three were under 16 years of age, which suggests the recklessness of youth is a possible hazard.

The clinical features are related to the amount and rapidity of blood loss. Where the initial injury is severe, shock and exsanguination are usually apparent. A ruptured ectopic gestation is the most likely cause of sudden acute collapse and pallor in the female, but ruptured spleen should at once be considered in the male. Many of the features have already been described, but certain aspects require emphasis.

1. Associated injuries may mask a splenic rupture. The related physical signs may be attributed to fractured ribs, severe muscular contusion or even rupture of the left kidney. In the following case additional injuries overshadowed the ruptured spleen, and subsequent operative delay probably contributed to the patient's death.

G.L. was a labourer, aged 50 years, who was crushed between an overhead crane and a window sill at work. He suffered severe pain in the chest and abdomen, and his general condition on admission was extremely poor. The blood pressure was 70/0 mms. Hg. There were fractures of the 8th and 9th left ribs and of the right clavicle, together with surgical emphysema extending into the left axilla. Tenderness was present in the left loin, but there was no haematuria and only moderate guarding was noted in the left hypochondrium. Conservative treatment was adopted but, 24 hours later, further guarding and rigidity in the left hypochondrium together with abdominal distension indicated an intraperitoneal lesion. Laparotomy revealed a ruptured spleen, which was removed, but the patient died from respiratory causes 48 hours later.

2. Pain in the left hypochondrium was a constant feature in all patients. It is unfortunate that the presence of pain in the left shoulder (Kehr's sign) was not always recorded, but it is found in about 70 per cent of cases and may be produced by raising the foot of the bed for ten minutes with the patient lying supine (O'Connell, 1951).

3. Local guarding and rigidity were found in all cases and are most important physical signs. General abdominal tenderness, guarding and rigidity were found in only four cases and although a haemoperitoneum may be present it does not always progress sufficiently to produce generalised peritoneal irritation.

4. Ballance's sign of shifting dullness on the right side only due to a splenic haematoma was found in only one case. It may not have been elicited in all, but probably has only minimal value.

5. Throughout the latent period in cases of delayed rupture local tenderness and guarding persist. This is often difficult to differentiate from muscle spasm, particularly when associated with contusion or fractured ribs, but should be viewed with strong suspicion.

6. Delayed rupture may occur from extremely minor trauma. In one instance it was caused by an over-conscientious nurse who administered an enema ; in another by the patient suddenly turning over in bed six days after injury, and Stretton (1926) records a case in a female who was five months pregnant where violent coitus had occurred two hours earlier. The clinical picture of rupture then differs in no way from the classical one of immediate haemorrhage.

Accessory Investigations :

Berman et al. (1957) have shown that a leucocytosis follows rupture of the spleen by blunt trauma. Where physical signs suggest the diagnosis a white cell count of 15,000 per cmm. or more is strong supportive evidence. Estimation of the haemoglobin is seldom of value in acute blood loss.

Radiography may help the diagnosis, the more important features being (*a*) increased tissue density in the left hypochondrium, (*b*) obliteration of the renal outline and psoas shadow, (*c*) elevation of the diaphragm, (*d*) downward displacement of the splenic flexure, and (*e*) displacement of the stomach to the right. There may also be evidence of gastric dilation, ileus or free fluid or of other pathology such as fractured ribs or pulmonary damage.

Management :

The only satisfactory treatment of a ruptured spleen is its removal. Resuscitative methods with blood replacement may be required initially but should be followed by early splenectomy. As in ectopic gestation, when the source of haemorrhage is removed there is often immediate improvement. When the diagnosis is in doubt accessory investigations may help and, if supportive, exploratory laparotomy should be undertaken because of the considerable risks from insidious or delayed haemorrhage.

An upper left paramedian incision, if necessary with a transverse extension, or a left subcostal incision may be employed. The more direct approach to the spleen by the latter route made it preferable in the majority of cases. The frequent finding of greater omentum in the left hypochondrium was a valuable pointer to the original source of haemorrhage. All portions of the spleen require to be removed to avoid later splenosis, when as many as 200-300 small masses of splenic tissues have been reported (Learmonth, 1951).

McIndoe (1932) suggests all cases of suspected rupture of the spleen should be kept at rest and under observation for at least 14 days. Earlier discharge may involve delayed haemorrhage under unfavourable circumstances with fatal results. Rupture after two weeks is unusual.

The incidence of complications following splenectomy is reported as high. Atelectasis, pneumonia, mesenteric thrombosis, adynamic ileus, pancreatic fistula and wound dehiscence as well as the complications of any major operative procedure—phlebothrombosis, pulmonary embolism and wound sepsis—are considered more frequent when the spleen is removed. Both pulmonary complications and mesenteric thrombosis occurred in the present series, but were the result of the initial trauma, either fracture of the ribs or division of the mesentery, and did not follow splenectomy alone. The one case of wound disruption is not significant. Cardiac arrest successfully treated by massage occurred in one instance, but is not specifically related to splenectomy. The complications may be minimised by avoiding pancreatic damage at operation through adequate exposure and careful technique. There were two deaths in the present series but in both severe associated injuries contributed to this mortality. In uncomplicated splenic rupture all patients survived surgery.

Conclusions and Summary

Rupture of the normal spleen may be followed by immediate or delayed haemorrhage. In either instance the effects are severe and if treatment withheld the result is usually fatal. The initial trauma may be severe and the diagnosis obvious but occasionally associated injuries overshadow the splenic rupture. When in doubt exploratory laparotomy should be performed, particularly if the diagnosis is supported by a leucocytosis of 15,000 or more, as undue delay may give fatal results. Even when the original injury is appararently slight, rupture and severe bleeding may follow, and it is the most likely cause of haemoperitoneum in the male. Minor trauma may also cause delayed haemorrhage and the initial injury be forgotten, no doubt the most frequent reason for "spontaneous rupture." During the latent period persistent pain and tenderness in the left hypochondrium are important and additional information may be obtained by radiology. Splenectomy, with adequate exposure to avoid pancreatic injury, and the removal of all fragments to prevent splenosis,

are essential. A study of 12 cases with personal experience of seven has served to emphasise the importance of early diagnosis thereby allowing prompt and efficient surgery which in the uncomplicated case should be followed by a negligible mortality.

I am grateful to Mr. Evan Griffiths, F.R.C.S., for permission to include two patients who came under his care, and to Mr. N. K. Harrison, of the Photographic Department at St. Bartholomew's Hospital, for the illustrations.

REFERENCES

BERMAN, J. K., HABEGGER, E. D., FIELDS, D. C. and KILMER, W. L. (1957). J. Amer. med. Ass., 165, 1537.
JOHNSON, N. (1954). Aust. N.Z. J. Surg., 24, 112.
LEARMONTH, J. (1951). Brit. med. J., 2, 67.
MCINDOE, A. H. (1932). Brit. J. Surg., 20, 249.
O'CONNELL, T. J. C. (1951). Brit. med. J., 2, 1404.
ORLOFF, M. J. and PESKIN, G. W. (1958). Int. Abstr. Surg., 106, 1.
STRETTON, J. L. (1926). Brit. med. J., 1, 901.
WRIGHT, L. T. and PRIGOT, A. (1939). Arch. Surg. 39, 551.

SUMMARY OF TWELVE CASES OF RUPTURED SPLEEN

	Age	*Sex*	*Type of Trauma*	*Associated Injury*	*Period of Haemorrhage*	*Result*	*Complication*
Q.	18	M	Minimal	None	Delayed	Alive	Nil
P.	15	M	Moderate	None	Immediate	Alive	Nil
B.	25	M	Moderate	None	Delayed	Alive	Nil
T.	12	M	Severe	Fractured Ribs Pneumothorax	Immediate	Alive	Cardiac Arrest
L.	50	M	Severe	Fractured Ribs Surgical Emphysema	Immediate	Died	—
W.	50	M	Severe	Mesenteric Thrombosis Fractured Femur	Immediate	Died	—
B.	9	M	Minimal	None	Immediate	Alive	Nil
S.	45	M	None	None	Immediate	Alive	Nil
H.	40	M	Severe	Fractured Left Humerus	Immediate	Alive	Wound Disruption
R.	23	M	Moderate	None	Immediate	Alive	Nil
J.	38	M	Severe	Partial Rupture of Left Kidney Fractured Left Humerus	Delayed	Alive	Nil
T.	22	M	Severe	Partial Rupture of Left Kidney	Immediate	Alive	Nil

The Students' Questionnaire

by E. A. J. ALMENT

In December 1957, all students at the Hospital were invited to complete a questionnaire containing 58 questions including some 300 alternatives. The purposes of the inquiry were to discover the students' ambitions with regard to a career, their views on possible emigration, and their opinions on some teaching and Journal topics, and to relate these to detailed information about their social, domestic, economic and educational background. None of the Journal sub-committee who undertook this work had previous experience in this field and the great deal of study necessary in connection with the analysis of the results has been the chief cause of delay in publishing the findings.

The copies of the questionnaire were distributed by a team of students, each representing a firm or group, who checked carefully that every student received one. The completed questionnaires were then returned anonymously into a box in the Hospital Library so that all means of identification would be lost. It had been decided that the alternative method of identifying each individual for the purpose of a later follow-up investigation might create reticence in the subjects, especially as some of the questions were of a personal nature. It is perhaps significant that in fact these questions were answered as often as the more general ones.

The questionnaire met with a very good response: 171 out of 212 (80.7 per cent) pre-clinical and 206 out of 239 (86.1 per cent) clinical students returned their copies. This initial study deals with the answers as a whole or from the first analysis by sex and by pre-clinical and clinical groups. A more detailed analysis with all relevant correlations has been made and will be published as six further articles:

1. The social, economic and educational background of the student.
2. The student's view of General Practice.
3. The student's view of Specialist Practice.
4. The student's view of emigration.
5. The special views of the woman student.
6. The student's view of educational and Journal topics.

Finally it is proposed to collect and publish the whole, together with a copy of the questionnaire, in booklet form.

THE INITIAL STUDY

Only in certain answers was a marked difference between pre-clinical and clinical groups noticed. There was also only occasional variation between the male (317, or 84 per cent) and female (60, or 16 per cent) groups. These differences will be indicated where they are marked: otherwise the study refers to the answers as a whole, and the figures given are usually percentages. ALL PERCENTAGES GIVEN RELATE TO THE NUMBER ANSWERING THE RELEVANT QUESTION, NOT TO THE TOTAL.

Education

50 per cent first became interested in medicine as a possible career before the age of 14 (14 per cent under age 8!), and 50 per cent had decided upon medicine as a career by the age of 16. This early determination may be related to a medical family tradition, for 34 per cent had a doctor father. Amongst males there were two general practitioner fathers to one specialist, whilst the females' fathers were equally divided. (Is it possible that the luxury of entering a daughter in medicine is easier for the specialist?) 17 per cent had a mother who was a doctor or nurse, 12 per cent an elder brother or sister, and 33 per cent a grandparent, uncle or aunt in the profession.

Factors influencing the decision to become a doctor were many and varied (40 in all). A striking comparison is that humanitarian reasons were the most important for the largest number (15 per cent) and the good financial prospects of a medical career were preferred by none. Interest in science claimed second place (11 per cent), and was more important to males (13 per cent) than to females (6 per cent). Conversely, the prospect of meeting people from all walks of life was more important to

females (17 per cent) than males (7 per cent). The influence of upbringing in a medical household was acknowledged by 10 per cent. Amongst the many other prime factors given could be detected humour: "Pre-occupation with death", insight: "Power", and frankness: "Couldn't think of anything better". If they had the opportunity of choosing their career again, 87 per cent indicated that they would still choose medicine.

Schooling was for the majority, 61 per cent, at a public school, and for 31 per cent at a grammar school. Specialisation in science began before taking School Certificate or G.C.E. for 39 per cent and after leaving school for only 12 per cent. After leaving school and before starting medicine 22 per cent studied a non-medical subject for 6 months or more, took a job for the same period, or did National Service. Only males, of course (13 per cent) did the latter. The total University ratio was as follows: London 76 per cent; Cambridge 18 per cent; Oxford 5 per cent; Others 1 per cent, and London University claimed 73 per cent of males and 92 per cent of females. At university, academic science was studied for one or more years by 17 per cent, with a strong predominance of males (20 per cent) over females (5 per cent).

Entry to Bart's

Family associations with the Hospital were the most important reason for 23 per cent. This is related to the high proportion of students who had a parent or close relative who trained at Bart's or was on the staff, as a doctor (24 per cent) or a nurse (7 per cent). 16 per cent based their choice upon the teaching facilities and reputation, 15 per cent came to Bart's because it was the first hospital at which they were accepted, and 14 per cent because of the hospital's professional reputation. If entry to Bart's had not been possible, the other London teaching hospitals were indicated as second choice in the following order: St. Thomas's 27 per cent; Guy's 25 per cent; Middlesex 10 per cent; St. Mary's 8 per cent; The London 6 per cent; University College Hospital 5 per cent, etc. Perhaps it is indicative of the chivalry shown by the male medical student that only 2 females chose the Royal Free Hospital as their alternative.

Stage of training and domicile

The proportion of pre-clinical students in the survey was 46 per cent and the greatest numbers were in the 3rd pre-clinical year (19 per cent) and the 1st clinical year (21 per cent). The great majority, 91 per cent (95 per cent women and 90 per cent of men), were citizens of Great Britain and a further 6 per cent came from other parts of the Commonwealth. The majority had spent most of their lives in cities (31 per cent) or towns (42 per cent) and almost half in the south of England, with an even distribution elsewhere in England, Scotland and Wales. During their time at Bart's 30 per cent lived at home or with relatives. Comparison of the pre-clinical and clinical groups showed that whilst none of the former, of course, lived in College Hall, nearly half (46 per cent) lived at home or with relatives. Of clinical students, 40 per cent lived in College Hall and a smaller proportion of the remainder, only 18 per cent, with parents or relatives. One man and 4 women did not disclose their domestic arrangements.

Economic factors

The majority of students were aided by grant or scholarship, with a greater proportion of males (65 per cent) than females (59 per cent). The majority of aided students received under £200 per annum and only a sixth were awarded over £300 per annum. Study of the *total* annual income including grant or scholarship, other amounts for tuition and also for board and lodging, showed that just 50 per cent of students have less than £350 per annum, with the males (48 per cent under £350 presumably buying drinks for the females (59 per cent under £350). After qualifying 60 students (16 per cent) expected a private income of over £100 per annum.

Marital status

At the time of answering the questionnaire marriage had claimed 22 students (only 3 pre-clinical), of whom seven already had a family, and a further 37 (5 female) were engaged. Less than half of marriages or engagements were to medical students, doctors, or nurses. Amongst the unmarried majority 138 (39 per cent) said they were postponing marriage for financial, ambitious, or other reasons. 14 males (and no females) firmly wished to remain single; nine of these in spite of having, as clinical students, presumably encountered Bart's nurses!

Politics

Medicine is, of course, a profession above party politics. However, all but 18 per cent favoured some party and the result of the poll was as follows:

Conservatives: 213 (57 per cent);
Liberals: 42 (11 per cent);
Labour: 37 (10 per cent);
Others: 14 (4 per cent)

giving the present Government a clear majority.

Choice of career

In the broad choice between general and specialist practice 30 per cent preferred the former, with a higher proportion of females (37 per cent) than males (28 per cent). However, only 9 per cent were definitely decided at the time of answering the questionnaire with a further 43 per cent strongly inclined, the pre-clinical and clinical groups showing the same proportions. One might have expected this important decision to have been made by more of the senior group. It is clear that the undecided student continues to defer such a decision, because those who had not definitely decided between general and specialist practice were asked when they expected to have chosen. Of the pre-clinicals 79 per cent thought they would have decided by the time they had qualified, 19 per cent by the end of the pre-registration year, and 2 per cent by the end of their National Service, whilst the proportions were 25 per cent, 54 per cent, and 21 per cent respectively of the clinical group.

The factors determining the choice between general and specialist practice, and between types of specialisation, will be dealt with in detail in the articles devoted to each of these subjects. The main facts emerging can be summarised as follows:

1. 60 per cent of general practitioners' offspring would prefer general practice, compared with 30 per cent of specialists' offspring and 20 per cent of students without medical parents.

2. General medicine and psychiatry tied as the subjects most interesting to students. Geriatrics, radiology, venereology and industrial health interested no-one the most.

3. The three main reasons inclining students towards general practice were: responsibility for the health of individuals from birth onwards; the diagnosis and treatment of a greater variety of complaints, and: too much competition and uncertainty of becoming a consultant.

4. By far the most important reason inclining students towards specialist practice was that it appeared to offer more time for the diagnosis and treatment of each patient.

5. Of the different types of general practice, group practice appealed to 48 per cent, a small partnership to 39 per cent, and a single-handed practice to 13 per cent.

6. The most popular area of choice for general practice was the South (47 per cent) or West (19 per cent) of England.

7. 20 per cent of students already had an opportunity to join a particular general practice.

Emigration

One of the main purposes of the questionnaire was to discover the attitude of the student to emigration and this is also the subject of a special article. In fact no less than 240 students (66 per cent) had seriously considered this possibility. Of these 10 per cent had decided against and 11 per cent for emigrating, 55 per cent were postponing their decision and 24 per cent remained undecided. All students were asked to indicate which would be their country of choice if they were to emigrate. Canada (30 per cent) was most popular with New Zealand (16 per cent) runner-up. 8 per cent preferred the U.S.A. 13 per cent had already visited the country of their choice.

Many reasons for wishing to emigrate were suggested, and the two indicated as most important were the better financial prospects and standard of living (29 per cent) and the desire for travel and adventure (18 per cent). For one third of the students it was family ties that prevented them from emigrating or considering this possibility.

Teaching

Students were asked which subjects (of those they had studied) they considered best and worst taught in their curriculum. The analysis of their replies is presented in another article, but in general these showed wide differences of opinion and changes of opinion trends in the light of later experience. Certain subjects which lend themselves to systematic teaching and are covered in courses of tutorial lectures, such as Pharmacology and Midwifery seem to be most popular. Rightly or wrongly the stu-

dent still regards intensive and systematic teaching as good teaching.

The majority (79 per cent) favoured an individual tutorial system as part of the teaching programme and a smaller majority (61 per cent) seemed in favour of total or partial integration of the "vertical" type in their training. A very large proportion (83 per cent) felt that more instruction in general practice was needed and this strongly reinforces the impression that, while the experience of upbringing in general practice makes a student willing to enter this field of medicine, the training he and his less-informed fellows receive is inadequate to make them feel ready for the type of work which inevitably will claim a large proportion.

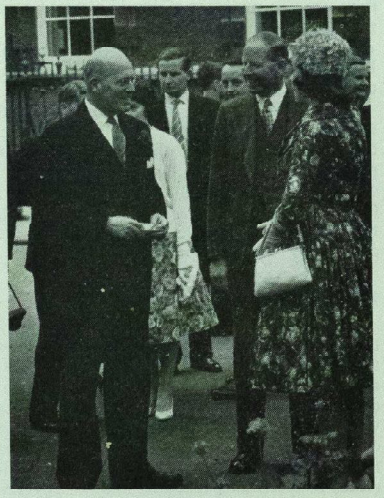
Acknowledgments

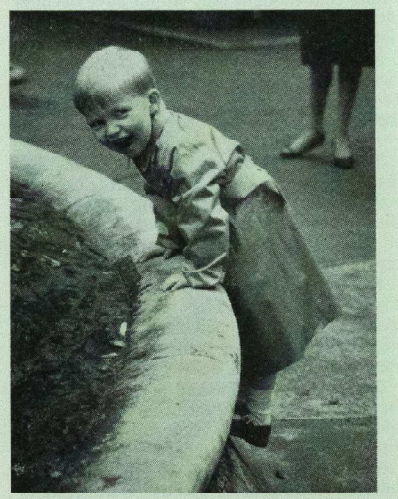
The Questionnaire Sub-committee of the Journal Publication Committee was composed originally of Mr. J. S. Price, Mr. J. T. Silverstone. Mr. G. K. Wright and Mr. E. A. J. Alment, and later included Miss A-M. E. Macdonald, Mr. J. D. Scobie and Mr. P. J. Watkins. Mr. M. P. Curwen has given a great deal of general and statistical advice at all stages and the analysis of the replies, for which punch cards were used, has been carried out by Mr. J. P. Mandeville's Tabulating Research Service. The cost of the study has been met by the generosity of the following benefactors:

A. Wander Ltd., Ciba Laboratories, Parke Davis & Co. Ltd., British Drug Houses and the Wellcome Foundation.

Finally, the outcome has depended on the willing and serious co-operation of all those students who completed a long and exacting questionnaire and so provided this anonymous corporate shadow of their living selves.

View Day 1960





Sir James Patterson-Ross talking to View Day visitors while Stephen Hobday studies the goldfish

Eighty Years of Marksmanship

by A. M. WARD

The history of the St. Bartholomew's Hospital Rifle Club is rather obscure in its early days, as most of the contemporary records have been destroyed. The Editor of the Journal, in August 1894, regretted that the rifle club was no longer active, and expressed the hope that the club would again compete at Bisley in the coming season. He also noted that the United Hospitals Rifle Cup was one that seldom, if ever, visited the Hospital. Perhaps the main reason for the abeyance of the club at this time was the absence of proficient Volunteers, a necessary qualification for all competitors at Bisley.

The National Rifle Association records enable the club to be traced back to 1881, when the United Hospitals Cup was first presented. The club seems to have had little success in this competition at Wimbledon, during which time Snider and Martini-Henry rifles were used. In 1890, however, the competition was moved to the new ranges at Bisley, and the club was placed second to St. Thomas's by the narrow margin of 3 points.

Small-bore shooting started in October 1894, when a shooting club was established at the Headquarters of the Volunteer Staff Medical Corps in Charterhouse Square. The Corps had their own range and the club was supplementary to the Amalgamated Clubs. The club remained under the auspices of the V.S.M.C. until applying to join the Amalgamated Clubs in April 1895.

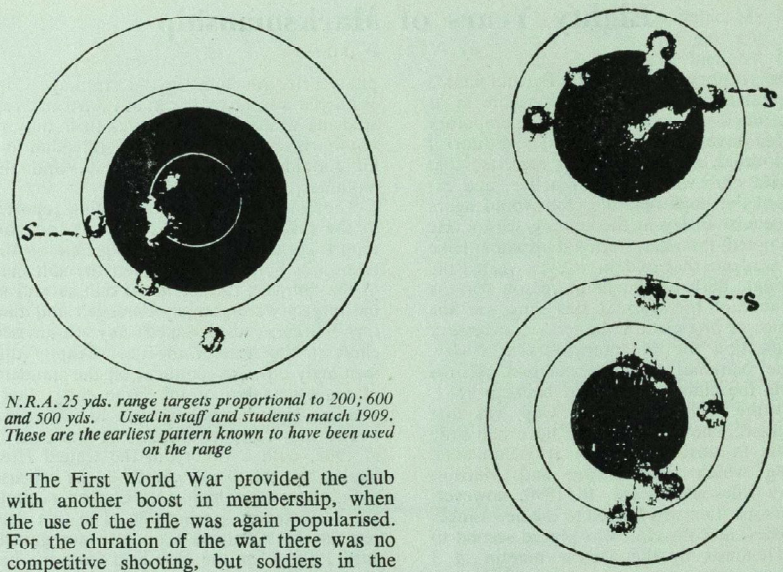
1897 saw another change in rifles, the bolt action Lee Enfield being used in competition, and with this new rifle the club was again placed second in the United Hospitals Cup, for the first time since 1890.

The objects and programme of the Club were laid down in September 1899, these being to promote marksmanship among the students of the Hospital, to shoot matches against other Hospitals, and to compete in the United Hospitals Cup at Bisley. Shooting commenced at the beginning of the summer session with practices at Runnymede range, and matches were held once or twice a week, a prize meeting being held in July. At the A.G.M. for that year Mr. H. J. Waring was elected President of the club. During the next year Silver Spoon Competitions were held at regular intervals, and the club competed in the first United Hospitals Prize Meeting for the Armitage Cup. With the advent of the South African War, students were told that it was their duty to familiarise themselves with the rifle, and that all should join the Rifle Club, and the Volunteer Corps.

The Journal sent a non-shooting reporter to the Prize Meeting in July 1901, and his report speaks of the loud squelch of the dum-dum bullet as it reached the soft clay of the butt. He further noted that several of the targets were scarcely damaged and that the markers were saved any ill-advised effort in the heat of the day! Despite this seemingly adverse comment on the standard of marksmanship of the large entry, there was one highest possible score at 600 yards.

The first recorded success of the club is in 1902, with a victory in the United Hospitals Cup, this being gained at the expense of St. Thomas's, who lost the Cup on a count-out, both teams scoring 226. The first success in the Armitage Cup was not gained until 1905, when the club lead from the beginning of the first stage, and were never displaced from their position.

The activities of the club received a boost with the opening, on May 4th, 1908, of the Miniature Rifle Range in the Hospital by Lord Ludlow, the Hospital Treasurer. After a preliminary ceremony in the Abernethian Room, Lord and Lady Ludlow, accompanied by Dr. Herrington, the President of the Students Union, Mr. Waring and various other officers adjourned to the range, where His Lordship followed Queen Victoria's example by scoring a bull with the ceremonial shot which was fired to declare the range open. On his return to the Abernethian Room, Lord Ludlow spoke of the benefits to be gained by proficiency with the rifle, and expressed a hope that good use would be made of the range. Mr. Waring, in his reply, spoke of the great advantage it would be to the resident staff and students who made up the rifle club to have a range in the hospital, and said "It teaches the medical man to be exact in all that he does". Lady Ludlow presented the club with a Challenge Trophy to be shot for on the range, this Cup is now the club's Small-bore Championship Cup. In the following year another trophy was presented to the club, for annual competition between the Staff and the Students.

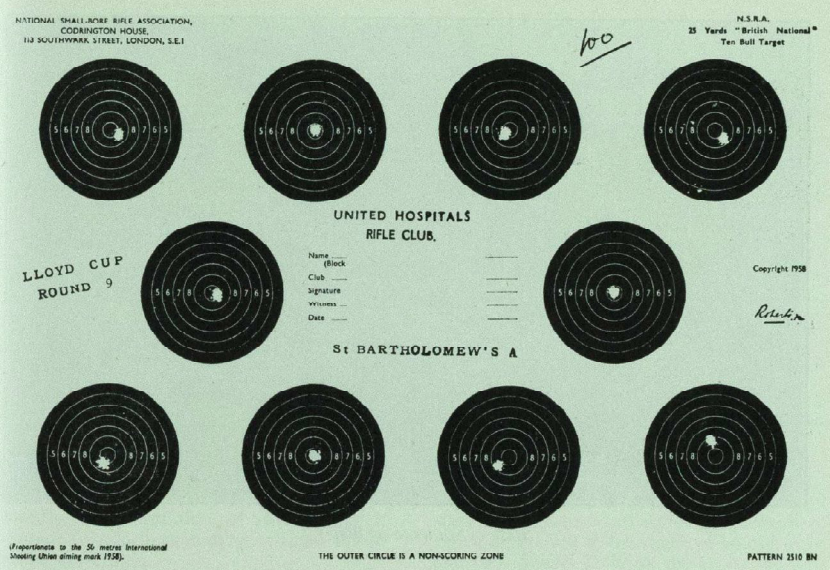


N.R.A. 25 yds. range targets proportional to 200; 600 and 500 yds. Used in staff and students match 1909. These are the earliest pattern known to have been used on the range

The First World War provided the club with another boost in membership, when the use of the rifle was again popularised. For the duration of the war there was no competitive shooting, but soldiers in the Hospital expressed their thanks to the club for being allowed the use of the range for a peaceful shoot during their convalescence. With the restart of shooting in the miniature range, ammunition was fixed at 1s. 3d. for 50 rounds, but later in 1920 this was increased to 1s. 8d., a price higher than that in force in 1937. The reason for this increase, or later decrease, is not clear unless it reflects a shortage of supply at this date.

The full-bore season of 1921 marked the beginning of an era of almost uninterrupted success for the club at Bisley, not only in team competitions, but also in individual competitions in the Imperial Meeting. Regulations were changed this year to allow the use of aperture sights and slings, and the club celebrated this with victory in the United Hospitals Cup. Mr. J. Elgood shot his way into the King's Hundred, this being the first recorded instance of a student member of the club getting into the final stage of the King's Prize. During the next twelve years, the club won the United Hospitals Cup seven times, in 1922, 1923, 1925, 1927, 1928, 1930, and 1932, and the Armitage Cup six times, in 1922, 1923, 1926, 1928, 1929, and 1930. J. Elgood was in the King's Hundred in 1922 and 1923—winning the Silver medal in the second stage; N. A. Jory in 1922; M. J. Harker in 1923, 1924, 1925 and 1927; F. T. J. Hobday in 1927, 1928, and 1929. In addition to all these successes various members of the club shot for their countries in the National Match and other Internationals almost too numerous to mention in full.

Small-bore shooting was started again in 1925, with the re-opening of the range, and in 1930 the rifles were renewed, and a number of shoulder-to-shoulder matches arranged. One of the club's Vickers Mk. III rifles was sold in 1931 and replaced by a B.S.A. pattern 15, then the latest pattern of small-bore match rifle, and still in use in the club. During the years that followed until the beginning of the Second World War, when shooting was brought to a halt, teams were entered in the City of London Leagues, University Intercollegiate Leagues, and United Hospitals Leagues. No great success was gained in the first of these leagues, but in the University and Hospitals Leagues the club was always to the fore-front. The Lloyd Cup, Inter-Hospitals, League, was won in 1933 (thus remaining in its accustomed place in the library where it had stood since last competed for in 1911) 1934, 1935, and 1937: whilst the Engineers Cup, Intercollegiate League, was won in



N.S.R.A. British Indoor Target. Introduced in 1959, this pattern is still in use

1934 and 1936. During this time the only successes at Bisley were individual ones, G. A. Owen gaining a place in the King's Hundred in 1936.

The Second World War caused the longest break in the history of the club, shooting having finished in the summer of 1939, and was not started again until the winter of 1948. At the first post-war A.G.M. of the club Mr. H. Jackson Burrows was elected President and the club has continued under his guardian eye to the present time. Some difficulty was experienced in 1948 and 1949 in getting rifles back from their war-time home with the War Office, and ammunition was always scarce. For the first year the club had to find temporary range accommodation at the Cripplegate Institute until the hospital range was repaired and returned to its proper use in the autumn of 1949. Some more new rifles were bought in 1949, and these began to pave the way to more success, the Engineers Cup being won in 1950, as also was the Armitage at Bisley. During the ensuing years successes have been scattered in time and space, being both in the small-bore and full-bore spheres. The Lloyd Cup was won in 1952 and 1959, and the Armitage Cup in 1953 and 1957. In 1957 the club also became the University Champions in the first year that full-bore championships were held. Generally during this period the club has always been to the fore in university and hospitals shooting, and at various times has provided considerable proportions of University and United Hospitals Rifle VIII's. The period has been one of almost continual expansion, and over the last five years two new forms of shooting have been introduced, namely small-bore Pistol, and Standing and Kneeling, and in both of these the club has shown itself to be more than merely proficient. With the increase in standard and numbers shooting after the war, it may seem strange that one has to come to this period to find any record of the Staff beating the Students in their Annual Challenge Match for the E.B.I' Anson Cup. This trophy was presented in 1908 and was competed for annually, apart from certain breaks in the activity of the club, but it was first won by the Staff in 1951. In 1958 this match was transferred to Bisley from the miniature range, and again

Staff v. Students at Bisley

the Staff were victorious. Further successes during this period are individual ones, D. B. Lascelles getting into the King's Hundred in 1951 and G. R. Hobday in 1959.

As to the future of the club, one can only hope for further success. The closing of the miniature range, which has served the club so well for the past fifty years, is a blow to the club in its present form, but another range will be found in the near vicinity. It is to be hoped that the move to a foreign range will only be temporary.

Was My Face Red!

by P. E. Pym

The episode certainly jolted my self-esteem badly at the time, but it is so long ago since it happened that, although the details still stand out clearly in my mind, I now feel that I can recount the story with a reminiscent smile.

The advertisement in the "Locums Wanted" column indicated that the work would be light, but with "motor-cycle provided" there would be plenty of mileage and fresh air. So, having just finished a six month's Casualty job, I seized this offer of rest and relaxation in the heart of Suffolk.

By and large the advertisement lived up to its promise, except that no mention had been made of the fact that some fourteen or fifteen confinements were due during the month I was to be in charge. It was one of these confinements which provides the centre-piece of this anecdote.

One afternoon I was called to a cottage, miles from anywhere, where lived a farm labourer whose wife, nearly a month overdue, was at last in labour. On arrival I was confronted with a large fat woman in an enormous feather bed which occupied quite half the room. Taking up a large slice of what was left of the floor space was another equally fat, and rather fearsome looking, woman who smothered the chair she sat on as she supped a mug of tea. Between sups I was given to understand that, although she was unqualified, she had been in on so many confinements that it was more than likely that my services would not be required.

Having scrubbed up in water from a kettle which had been filled from the duck pond, the sole source of supply, I went through the motions of an ante-natal examination. But the fat defeated me, and I was no wiser at the end of it all. It was, however, some comfort to discover that this was her fourth child, and that the pains were still infrequent and in front. With words of reassurance and a few sedative tablets I asked them to let me know as soon as there were signs of progress, and left them to it.

Rather to my surprise, I was not called for during the night. Had the midwife's prediction been fulfilled? Whatever hopes I may have had on that score quickly disappeared when I arrived at the cottage. My tablets had failed to give the household a restful night, and the pains were becoming more frequent and increasingly severe. By dint of some rough usage I managed to reach the cervix and was persuaded that it was still closed. A stronger dose of sedative and a promise to return at midday enabled me to escape gracefully.

After a morning round and a late lunch, I rode out once more to what was now becoming for me a scene of doubts and fears. A groan amounting to almost a bellow reached my ears as I walked up the garden path. Clinically, so far as I could make out, the situation was much the same, but domestically the atmosphere had become chill and tense. An aggressive warning from the midwife that, "after 36 hours of labour, it was high time that something was done" did nothing to help my peace of mind.

Taking a grip of myself, I tried to view the clinical picture dispassionately, to get a grasp and make up my mind what I was going to do. But the only reward for my efforts was an alarming vision of "Cross Lies." In vain I endeavoured to recall the teachings of the "Bishop" when faced with similar conditions. But again all that came to mind was his famous dictum, "Never interfere in a confinement until you think it is too late and you will just about be in time." I had little doubt that in this case that moment had now arrived, but with a cervix that refused to dilate such words of wisdom did not seem to offer much hope or scope.

An Ambulance Service or a Second Opinion would have solved the problem, but the former did not exist and the price of the latter was quite beyond the means of a farm labourer. Despite her vast experience, my helper had nothing constructive to offer.

In the midst of these cogitations there came the sound of heavy boots clumping up the wooden stairs. The husband had arrived. Under any other circumstances I would, I am sure, taken kindly to this gruff and burly son of toil. But the time was not propitious nor was the atmosphere congenial.

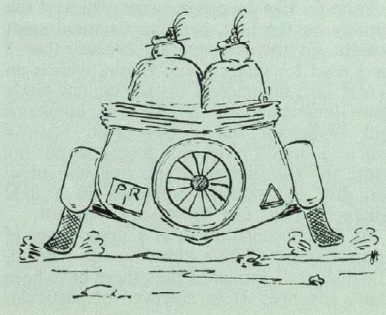
Fixing me with his eyes and without a word of greeting, he stabbed a gnarled and grubby forefinger in the direction of his wife. "If ur 'ad been a cow," he said, slowly and with emphasis, "Oi'd 'ave 'ad ur calf out on ur be now." Whereupon, perceiving that I was not disposed to argue the case, he turned on his heel and went downstairs again.

Slowly the hours dragged by, whilst from the bed came periodic sound effects which an injection of scopolamine and morphia had done little to subdue.

I was still grimly holding on, hoping against hope that at any minute something would start to happen, when suddenly promise of salvation arrived in the shape of an old worn and torn Model T. Ford, driven by the husband's boss. He had come to make enquiries.

Without stopping to consider the niceties of packing off a woman in labour on a 25 mile journey in an open car, I was down the stairs and asking him to undertake rescue operations before he had got out of his car. Certainly. He was, in fact, on his way to Norwich anyhow. With almost indecent haste we wrapped the patient in blankets, helped her downstairs and humped her into the back seat.

As I watched that Tin Lizzie, with its rear springs flattened by the combined weight of patient and midwife, disappear down the road in a cloud of dust, I heaved as big a sigh of relief as I shall ever heave.



Some hours later I was heading for an early bed when a call came through from the hospital. To my surprise I heard the voice of a friend of mine who, unbeknown to me, was doing the midder job there.

"Thought you might like to know your patient has arrived," he said.

"Everything all right? Everybody happy?" I asked, trying hard to keep any trace of anxiety out of my voice.

"Y-yes," he said, "except that they had to pull up by the roadside to mop up the mess when the baby was born."

We both laughed. But not in quite the same way.

Letters to the Editor

RHEUMATIC DISEASES

Sir,

As a Bart's man, I was delighted to read the symposium in the current number of the Journal.

As a member of "The Committee on Chronic Rheumatic Diseases", appointed by the President of the Royal College of Physicians, in 1934, and as a member of its Nomenclature Sub-Committee, I was most interested in your reference to it. I feel, as you do, that the classification that we advised at that time, does provide a basis for clinical work, and for research. Unfortunately our clinical pathological classification can only give a somewhat indistinct picture of the people who suffer from arthritis and rheumatism. Your annotation and the acceptance by the medical staff at Bart's of this subject for undergraduate teaching is a big step towards finding a solution for this big social and medical problem.

It is the medical student of today, and family doctor of tomorrow who must take a lead if those who suffer from these disorders are to be recognised and given early and proper management. Team work in the treatment of these people is essential, and I was delighted to read the article by my friend Miss Macindoe, the almoner.

At the end of August 1960, the Eighth World Congress of the International Society for the Welfare of Cripples is being held in New York City. We intend to form a Commission or Committee on Arthritis and Rheumatism, for the purpose of co-ordinating the different fields of activity, and creating a reference library. I should like to take this opportunity of extending a welcome to Dr. Balme, or to one of the physiotherapists, occupational therapists, or almoners, who work at the hospital, or to one of its senior medical students.

Yours sincerely,
FRANCIS BACH

1a Devonshire Place, W.1.

Sir,

I should like to congratulate you and the authors on the best, easily understood symposium on the Rheumatic Diseases that I have read for many years. Glynn, who is an expert on fundamental principles, has made these understandable to the less highbrow and Wykeham Balme has given you an article, I should have been happy to put my name to—the highest praise one individual can give to another—especially in a field where opinions can be so very different.

In 1952 I contributed, at a predecessor of yours request, "Some notes on the Rheumatic diseases", but since then there have been many advances. It is, however, of particular delight to have an article on this subject, which Bart's has sadly neglected, by someone on the staff of Bart's. After his recent trip to the States we shall expect to see Balme bringing Bart's into its proper place in this field, which has now become "quite respectable!" When I first interested myself in this line of country, Sir Francis Fraser, my boss on the Unit, asked me why I had decided to "prostitute my soul by associating myself with all the quacks in the universe". I must say, however, that after more consideration he gave me every support and encouragement.

I think Balme might go further than saying in gout "newer and more potent drugs

are on the way". Anturan is proved to be superior to benemid and zoxazolamine (flexin) runs it a close second in safely promoting uric acid excretion. Shortly the publication of a multi gold trial will give some further evidence to support the older clinicians that gold really does help a reasonable proportion of cases. His summing up of the steroid position is excellent prednisolone or prednisone, which can be considered as the same, should be our sheet anchor where steroids are used—the newer ones are only for the less than 5 per cent "peculiar" cases. ACTH certainly often works when steroids fail and especially in systemic lupus. Some precautions for the use of steroids are worthy of mention. Prednisolone or prednisone, incidentally the cheapest of the steroids, should be given with food and crushed to reduce their "gastric" effect, but when there is a history of serious dyspepsia or ulceration, the enteric coated tablets, costing 1s. 3d. instead of 8d. for 5 mgms., should be employed. Some extra Vitamin C and potassium and a high protein diet is also helpful. This brings one to the use of anabolic hormones—male hormones with the minimum of maleness—and where the patient is exceedingly ill and is failing to react to steroids alone they may be the turning point in the condition. Durabolin is the best of these. Occasionally, however, when they are used in large doses and when ACTH is "pushed" oestrogens may have to be added to avoid acne in males or unfortunate male attributes in females.

Again may I say how much I appreciate your lucid and common sense articles on the rheumatic diseases.

Yours sincerely,
G. D. KERSLEY

6 The Circus,
Bath.

VISITING OTHER HOSPITALS

Sir,

Reading the Editorial in your April issue, I would like to support your plea for students to broaden their clinical outlook in attending lectures at other teaching hospitals.

You may know that in the pre-war years a scheme was in operation whereby students from Bart's, Guy's and St. Thomas' could attend each others clinical lectures. This was a most excellent arrangement and I availed myself frequently of the opportunity afforded to visit Guy's and St. Thomas' to hear some of the pundits at those hospitals. I am sure such a plan could well be introduced as I felt in pre-war days it was never exploited as much as it should have been.

May I in closing join with those correspondents in your April issue in saying how much I look forward to each issue of the Journal as it appears, they are fine productions.

Yours sincerely,
J. B. GURNEY SMITH

Royal Earlswood Hospital,
Redhill, Surrey.

THE PLAGUE AT ATHENS

Sir,

The account of the plague at Athens in 430 B.C. recounted by Thucydides in his history of the Peloponesian War which was featured in the Historical Diagnosis in the February Journal—has been variously interpreted.

Noah Webster (1758-1843) is numbered among the many who have written on this subject, and his comments and interpretation are to be found in a letter written to Dr. William Currie of Philadelphia, dated October 30, 1797.

Webster, after careful correlation and consideration of the views of the medical and philosophical societies of the New England States, concluded that the plague was only the highest grade, or worst form, of Yellow Fever. After giving a translation of the account of the plague at Athens, he wrote:

"Let any man compare this account of the Athenian plague, with the symptoms of yellow fever, as described by Dr. Rush, Dr. Bailey, or Dr. Smith and deny, if he can, that the yellow fever of our country is the specific disease which Thucydides described more than 2000 years ago. Indeed, whatever small varieties the disease may exhibit in Asia, Africa, or America, it must be agreed, on all hands, that the principal symptoms of the plague and the yellow fever are the same. I shall therefore call the dis-

ease which has afflicted our sea ports the Plague—that being the technical term in common use to specify the worst form of bilious fever."

Webster wrote further on this subject in a letter dated November 2nd, 1797, also to Dr. Currie. In this he said that the account was of extreme value as the disease bore an exact resemblance to the yellow fever of the Eastern States.

It is, perhaps, relevant to point out that Webster had received no medical training. He graduated from Yale in 1778, and was admitted to the bar at Hartford in 1781. He practised law until 1793, when he took up journalism. During this later period he took it upon himself to inform the public about such facts and principles as were pertinent to the intelligent control of disease. He published "A collection of papers on the subject of Bilious Fever" in 1796, and "A brief history of Epidemic and Pestilential Diseases" in 1799.

Yours faithfully,
A. M. WARD

Abernethian Room.

HOGARTH MURALS

Sir,

Your article in the April Journal on the cleaning of the Hogarth murals, brings to our attention the grisailles below the main subjects. It is of interest to note Walter Thornbury's comment thereon in his "Old and New London" (published in the latter part of the 19th century): "There is also a picture of Rayer laying the first stone of the hospital, and a sick man being carried on a bier by monks, which is the work of some other hand." Unfortunately, he does not inform us who the artist was—perchance some other reader might know the answer?

Yours faithfully,
SYLVIA WATKINS

College Hall,
Charterhouse Square.

Sports News

VIEWPOINT

A new activity seems to have entered the sporting world of the Hospital, that of road walking. For the first time, Bart's entered a large "team", if it can be called such, for the United Hospitals London to Brighton Stroll. Whether the entrants took part for the honour of the Hospital, for something to do or merely with the thought of free Guinness at the other end, no one knows. But for some reason or other, the idea of about twenty-two hours of road slogging appealed to the imagination of well over fifty people, some athletes and many not. More than half our walkers reached Brighton, which was a very creditable effort, and although Guy's entered three times as many walkers, we were not far behind them on points. Perhaps next year even more people will take part from Bart's. This is an event for which everyone with two feet can enter, and no skill is required.

Success for the Men's Tennis Club. It has been mentioned that it has won its first U.H. Cup match since 1954. One hopes that this revival will continue.

CRICKET

1st XI v. U.C.H. Saturday April 30th. (Away). Won by 4 wkts.

U.C.H. won the toss and started to bat, but they were unable to gain the initiative from any of our bowlers and were eventually all out for 116. After tea, Pagan and Jeffreys together gave us a good start, but frivolous strokes by later batsmen enabled the opposition to capture six wickets before the game was eventually won.

U.C.H. 116 (Harvey 4-29, Harrison 3-10).
Bart's 117-6 (Pagan 34, Jeffreys 24).

1st XI v. Putney Eccentrics Sunday May 1st. At Chislehurst. Match Drawn.

After the start had been postponed until 1.30, Bart's opened their innings on a rather lively wicket, and Warr and Jeffreys did well to stay together until the worst had passed. Davies and Merry then came together and embarked on a partnership of 153 in 105 minutes, both batsmen scoring 76. After they were out Walker and Harvey kept the score moving and we were able to declare at tea with the score at 222 for 4.

Putney never looked like getting the runs, mainly due to fine bowling by Garrod and Harrison, but all chances offered were not accepted and we were not able to capture the tenth vital wicket before the close.

Bart's 222 for 4 dec. (J.D. Davies 76, R. T. G. Merry 76, H. R. J. Walker 31 not out).
Putney Eccentrics 174 for 9 (J. O. Garrod 3-24).

1st XI v. Wimbledon, Saturday May 7th (Away). Lost by 3 runs.

An exciting but rather disappointing game. Wimbledon batted first on a very humid Saturday afternoon, and were soon in trouble against Garrod's swing bowling. After a good start Bart's never relaxed their stranglehold on the batsmen and Wimbledon were eventually all out for 97 runs. However over-confidence and an experiment with the batting order precipitated the worst display of batting seen for a long time and we were finally dismissed on a perfect pitch for 94, just four runs short of victory.

Wimbledon 97 (J. A. Garrod 2-16, J. A. Harvey 4-22).
Bart's 94 (H. R. J. Walker 27).

1st XI v. Hampstead, Sunday May 8th. (Away). Match drawn.

A very strong Hampstead XI batted first and by lunch had scored 155 for 3. After lunch our bowling and fielding improved considerably, and Hampstead found it difficult to keep the scoring rate up to the desired level. They eventually declared at 243 for 9, leaving us 3 hours to get the runs. Even though Warr gave us a fine start with a delightful innings, we lost our first four batsmen in reaching 50, and so decided to give up the chase. Stoodley and Jeffreys shared in a useful partnership of 70, which enabled us to play out time.

Hampstead 243 for 9 (J. Mocatta 110, J. A. Garrod 4-74).
Bart's 152 for 7 (B. J. Stoodley 49 not out, R. V. Jeffreys 46, A. C. Warr 26).

1st XI v. Romany, Sunday May 15th. At Chistlehurst. Won by 4 wkts.

Romany won the toss and decided to bat first. Most of our bowlers bowled well and were supported by keen, efficient fielding, but Harvey and Niven found the pitch especially responsive to their seamers and these two were largely instrumental in dismissing a powerful batting side for 177. Warr and Jeffreys shared in an opening stand of 63, but at this total three wickets fell and it was left to Abell, Harvey and Walker to knock off the remaining runs. This they did with very little trouble, so giving Bart's a convincing win over a very strong Romany side.

Romany 177 (Branston 46, J. A. Harvey 4-76, P. A. R. Niven 3-24).
Bart's 178 for 6. (A. C. Warr 46, J. D. Abell 41, J. A. Harvey 37 not out. H. R. J. Walker 21).

1st XI v. King's College "Maniacs", Sunday May 22. At Chislehurst. Match drawn.

King's College were put in to bat on a pudding. Again the main brunt of the bowling was borne by Harvey and Niven, but the fielding was not up to the usual high standard and King's were able to declare at 170 for 7. In trying to get the runs at the required rate most of our batsmen got themselves out after they had played themselves in and were going well. Thus we found that the chase had to be abandoned 10 minutes from the close, a rather unsatisfactory ending to an otherwise enjoyable game.

King's College 170 for 7 dec. (J. A. Harvey 3-50, P. Niven 2-61).

Bart's 147 for 7 (A. C. Warr 35, R. T. G. Merry 27, J. A. Harvey 25, J. D. Abell 23).

TENNIS

The season started with a series of trials at Charterhouse which produced very few new faces, and it is difficult to believe that there are not more players willing to support the hospital.

1st VI v. Clare College. At Cambridge—Lost 0—9

This was our first match of the season and, since four of our experienced players were not available, we could not provide serious opposition for their practiced side.

Team: C. A. McNeill (Capt.), P. D. Poore, M. C. Jennings, S. Rohli, D. Prosser, M. Penny.

1st VI v. London House. At Chislehurst—Drawn 4½—4½

This was a very enjoyable afternoon's tennis. Our first pair and their second pair abandoned their rubber at one set all to avoid holding up everybody else, and the resulting draw was a satisfactory result.

Team: A. J. Gordon, J. H. Pennington, C. A. McNeill (Capt.), P. D. Poore, M. C. Jennings, S. Rohli

1st VI v. West Heath. At Croftway—Inconclusive.

We arrived for this evening match expecting it to rain at any minute. Their grass courts were very damp, and we used one of these and their two hard courts. We started fairly late and bad light soon stopped play, but not before Colin McNeill shattered his racket with yet another brilliant smash. We were very well entertained after the game, and look forward to our return match at Chislehurst on July 2nd.

Team: C. A. McNeill (Capt.), P. D. Poore, M. C. Jennings, K Davies, D Latham, A. J. Frank.

CUP MATCH v. LONDON HOSPITAL. At Chislehurst—won 9—0

We managed to field what was probably our strongest team, and won comfortably against a weak side. This is our first victory in a cup match since 1954 when we got as far as the semi-finals. With the exception of 1955, when we lost to Middlesex Hospital, we have drawn against Guy's, the eventual winners, every time. This year we hope to meet them in the semi-finals.

Team: D. A. Richards, J. H. Pennington, A. J. Gordon, A. T Seaton, C. A. McNeill (Capt.), M. C. Jennings.

LADIES' TENNIS

Cambridge Tour: May 27th-29th.

1st couple: P. Aldis, D. Layton.
2nd couple: E. Knight, A. Vartan (Capt.).
3rd couple: S. Cotton, J. Clarke.

On Friday two set off by train and four piled into a Morris minor with enough luggage to stock a dress shop, the team converging almost simultaneously on Newnham for the first match.

The clouds rolled away as we got on to the courts. The 3rd couple quickly defeated their opposite number and the 2nd followed suit. The 1st eventually won 6-8, 6-2, 8-6 after saving a set point, and Bart's finally won a fairly easy match 7-2.

On Saturday Homerton proved tougher oppo-

sition and each couple lost their first match in two straight sets. The 1st couple averted complete disaster by winning their next two matches, but all the others went to Homerton.

We had another sunny day for our match against Girton, which we won 6-3. The 2nd and 3rd couples defeated their opposite numbers and then rested while the 1st went to 3 sets and narrowly lost. The 3rd were playing well, defeating Girton's 2nd 6-1, and when victory had been consolidated we once more tucked into a large tea and then set off for home, feeling sunburnt and successful.

ATHLETICS

Sports Day 1960

100 *yds*: N. Burbidge, C. J. Richards, S. Harris 10.8 sec.
220 *yds*: N. Burbidge, C. Bridger, A. Knox. 24.4 sec.
440 *yds*: I. L. Macdonald, A. Knox, C. Bridger. 54.0 sec.
880 *yds*: I. L. Macdonald, P. Littlewood, A. A. Lewis. 2 min. 2.4 sec.
1 *Mile*: I. L. Macdonald, P. Littlewood, A. A. Lewis. 4 min. 31.4 sec.
3 *Miles*: P. Littlewood, A. A. Lewis. M. M. Orr, 15 min. 15.2 sec.
120 *yds. Hurdles*: M. J. G. Thomas, A. L. Houghton, M. S. Noble. 19.2sec.
Shot: J. E. Stevens, T. Herbert, C. J. Richards. 37 ft. ½ in.
Discus: T. Herbert, J. E. Stevens, C. J. Richards. 94 ft. 10 in.
Javelin: C. J. Richards, M. M. Orr, B. H. Gurry. 171 ft. 4½ in.
Long Jump: B. Marsh, N. Burbidge, D. Glover. 18 ft. 8 in.
High Jump: S. Harris, B. Marsh, B. Kasterliz. 5 ft. 2½ in.
4 x 220 *yds Relay*: Introductory Year; 2nd Year Preclinical; M.O.P.'s. and S.O.P.'s. 1 min 41.8 sec.
Housemen's 100 *yds*: Dead Heat: Dr. Lindop, Dr. Dowie, Dr. Pugh, Dr. Francis. 13.6 sec.
Egg & Spoon: J. Kirby, G. Western, M. Kirby.
Children's Race: J. Kirby, C. King, M. Kirby.
3-*Legged Race*: Miss D. Bishop and P. Littlewood.
Sack Race: J. Kirby, G. Western, M. Kirby.
Tug-of-War: Preclinicals beat Clinicals.

Inter Year Competition

Introductory Year: 80 points.
2nd Year Preclinicals: 58 points.
M.O.P.'s and S.O.P.'s: 48 points.
1st Time Clerks and Dressers: 39 points.
Dentists (one man): 21 points.
2nd Time Clerks and Dressers: 2 points.

The Kent Hughes Cross Country Cup was awarded to P. Littlewood who was the year's United Hospitals Cross Country Champion.

Chislehurst was a fine sight on Sports Day this year but there were few people present to enjoy it. Although there were only forty competitors, many events were closely contested. I. Macdonald ran extremely well, winning three races—all in good times—to win the President's Cup. N. Burbidge won two events and was second in one while C. J. Richards was placed in four events.

Nowadays forty competitors in a Hospital Sports is not a small number; with competitors entering two or three events each, the field does not seem too meagre. Six or seven years ago, however, there were many more competitors and spectators. The ever-increasing standard of athletics parallels the increasing luxury and comfort of civilisation: these two circumstances have limited athletics to a small section of the community who are either athletically talented, or prepared to endure the rigours of training.

Spectators have dwindled even more than competitors, so many now watch their Saturday sport from an armchair in front of the "box". Can we get more people to come to Sports Day? Is it possible to make it the athletic and social occasion it once was? These questions must be answered, for the money and work expended merit a better response than was seen this year.

Those who came to Chislehurst enjoyed themselves, both in the afternoon and at the dance in in the evening. The Athletics Club is very grateful to all who helped: the President of Sports Day, Dr. C. E. Francis and Mrs. Francis, the judges and time-keepers, the ladies who prepared tea, Mr. and Mrs. L. W. White and all who came down to watch or compete.

P.L.

BOAT CLUB

United Hospitals Bumping Races 1960

It is sometimes said that Bumping Races should not be held on the Thames because the river is wide enough to accommodate the more usual side-by-side rowing. This seems to disregard completely the very great pleasure that both oarsmen and spectators can derive from this peculiar form of racing. I am sure that anyone who took part in, or watched, the last two nights of the Bumps this year would agree with this and it would therefore be a great pity if they were to be discontinued on this count alone.

Bumping races cannot be rowed without some organisation, however, and the lack of this on the first night caused a certain amount of argument and ill-feeling. The second division was disrupted to such an extent that the final results do not indicate the true relative standard of any of the crews. Neither was the first division spared, since a misunderstanding about who exactly had entered necessitated a re-row of part of that division on the following night—Bart's being affected by this. By the second night all was well however, and the subsequent racing was very enjoyable.

It is, therefore, to be hoped that more people in the coming years will become interested in the Bumping races, for without support in *all* capacities, on the river and the bank, the Bumps cannot be organised efficiently and cannot therefore be expected to hold their place in the rowing calendar as the senior hospital event of the year. Bart's however, cannot be criticised in any way for we had four crews on the water—again more than any other hospital, and our support from the bank, which was very much appreciated, was constant, loud, and helpful throughout.

Results:

1st VIII: After a re-row, Bart's I technically bumped St. George's I who failed to appear at the correct time. Thereafter the crew rowed over finishing 5th.

2nd VIII: Bart's II were the victims of circumstance on the first night and were technically bumped by St. Mary's II. On the second night they were bumped by Bart's III and thereafter rowed over finishing 12th.

3rd or Gentlemen's VIII: Bart's III rowed over on the first night, bumped Bart's II on the second night and technically bumped Guy's II on the last night finishing 10th. Thus the 2nd and 3rd changed places over the course of the races.

4th or Rugger VIII: This crew was also affected by the first night and were technically and literally bumped by Westminster II. Thereafter they rowed over finishing 14th.

Crews:

	1st VIII	2nd VIII
Bow.	R. Knight	J. D. Hardy
2.	J. A. K. Bootes	P. C. Scriven
3.	A. I. Wilson	J. H. Pusey
4.	T. G. Hudson	R. G. Wilson
5.	J. J. D. Bartlett	D. D. Bodley-Scot
6.	N. E. Dudley	N. D. Whyatt
7.	D. E. L. King	R. B. Blake-James
Stroke,	W. S. Shand	K. M. Stephens
Cox.	N. D. L. Coughlan	K. Manchester

	Gentlemen's VIII	Rugger VIII
Bow.	Mr. J. K. Anderson	
2.	Mr. D. V. Jones	N. Smythe
3.	Mr. S. al-Khederi	R. Kowes
4.	Mr. R. S. Edmonson	T. Coltart
5.	Mr. R. France	M. Jennings
6.	Mr. G. M. Besser	P. Niven
7.	Mr. E. M. C. Ernst	R. Courtenay-Evans
Stroke,	Mr. J. G. Diamond	C. McNeill
		J. Morrison
Cox	Mr. G. L. Scott	G. Renn
Substitutes:	Mr. A. J. Miller	R. Merry
	Mr. B. Fisher	P. Caine
		N. Orr
		P. Bacon

Book Reviews

A GUIDE TO ORTHOPAEDICS by T. T. Stamm, M.B., B.S., F.R.C.S. **Published by Blackwell Scientific Publications, Oxford.** Pp. 115. Price 12s. 6d.

There appears to be a growing prevalance at the present time to attempt a separation of detail from generality in the specialist departments. This is partly achieved by this author who wisely states in his preface that the book has been written primarily for the orthopaedic auxiliary worker "to help the non-specialist to understand the orthopaedic wood as a whole without confusing the issues with too much detail about the individual trees." Providing the medically qualified reader bears this fact in mind, this monograph will make, by virtue of its lucidity of style and clarity of production, interesting and informative reading and serve as a most useful adjunct to the more orthodox and standard textbooks already available. Only 115 pages long, the reviewer, a notoriously slow reader, found it one long evening's easy reading.

However, on reflection, one is left with a feeling of frustration. There are many points which could be improved. So short a work might well be extended by another 50 or so pages to include more detail on the application of bandages and splints and much more than a casual paragraph should have been devoted to anti-tuberculous treatment. This latter made the more important by the excellent preceeding paragraph on the rehabilitation of these patients and the value of social medicine in this specialist field.

As regards production and planning, there is much to recommend. The graded approach from the skeleton as a whole through the joints, their infections and affections, to three chapters—one fifth of the whole—on the feet, gives not a small amount of coherence to such introductory reading.

This is a book which can be well recommended to all those beginning their out-patient appointments and also to those reading for finals or after finals, who want a brief reminder of the overall aims of orthopaedic medicine.

R.M.H.

DISEASES OF THE NOSE, THROAT AND EAR, a Handbook for Students and Practitioners, 7th edition, by I. Simson Hall, M.B.,Ch.B., F.R.C.P.E., F.R.C.S.E. Published by E. and S. Livingstone, Ltd. Price 21s.

The author introduced the first edition of this book by saying that: ". . . being designed to meet the needs of the busy practitioner and the student, it is strictly limited in its aim." In the preface to this, the 7th edition, he indicates that it is still "in proportion to the amount of time which this specialty is accorded in the medical curriculum", and this is indeed true, because it is a book quickly read, and absorbed, from cover to cover.

The book is divided into six sections which deal with the various regions which come under the headng of E.N.T. Each section is introduced by a chapter on anatomy which is far from satisfactory, because where the more complex regions (for example, middle and inner ear) are described, one is given only the vaguest impression and it is essential to consult larger textbooks if it is to be clearly understood. For this reason it would seem that the book would lose little if these chapters were omitted, and perhaps others expanded instead. One feels the same about the section on diseases of the lungs and oesophagus which is so brief that it is of very little value.

Another criticism which must be made is that in *every* section there are far too many *short* paragraphs describing, for example, tuberculosis, syphylis or neoplastic diseases. This means that there is much repetition, and also makes for unsatisfactory reading because the text changes from one subject to another in a succession which is far too rapid. It would probably have been better to cover each of these subjects in a separate chapter, which would give a much more cohesive picture of the disease process. Other subjects to which similar arguments are applicable are, for example, herpes, keratosis and atrophic diseases of mucous membranes, all of which appear several times.

Excellently covered are some of the commoner

ailments, notably otitis media, and also sinusitis and tonsilitis. Chapters describing some of the commoner operations and the various "endoscopies" are useful.

This edition is little different from the previous one, but some of the advances in steroid treatment and radiation therapy have been included.

P. J. W.

SYNOPSIS OF EAR, NOSE AND THROAT DISEASES by Ryan, Thornell and von Leden. **Published by Kimpton.** Pp. 369, 59 illustrations. Price 50s.

Faced with an ever-growing curriculum the medical student of today must welcome any book which gives a clear and concise account of diseases of the special departments. Such a work is the one under review, by three U.S.A. authors.

It does not purport to be a book of reference, and deliberately omits all descriptions of treatment and operations which should be undertaken only by a specialist.

Written somewhat on the lines of the familiar "Aids" series, it has excellent diagrams, and an ample description of the normal anatomy and physiology precedes the account of morbid conditions. The subject matter is well set out, and readable.

Of special interest to the practitioner is a chapter on headache often confused with sinusitis.

At the end of each chapter is a summary of the salient points.

Now for some criticisms. It is surprising to find no mention of calciferol or streptomycin in the treatment of lupus, and that radium therapy is still considered, albeit only as a last resort, in the treatment of recurrent nasal polypi, despite well recognised radiation hazards.

It must surely have been a proof reader's slip to pass the sentence "The discharge of allergic rhinitis is *usually always* bilateral."

But, these minor criticisms apart, this is an excellent symposium, and can be unreservedly recommended to students, nurses and general practitioners.

N.A.J.

ESSENTIALS OF ORTHOPAEDICS by Philip Wiles, F.R.C.S. 3rd Edition. J. and A. Churchill Ltd. p. 576. Illust. 417. Price 70s.

The third edition of this deservedly popular textbook has been extensively revised, and in many places re-written but it has lost nothing of its previous character which stems from the author's readable and authoritarian style.

The sections which have been re-written vary from osteoclastoma to scoliosis, from spondylolisthesis to gout. The chapter on back pain, to which one is so often referred, has new matter under the heading "low back pain", and the re-written section on the anatomy and pathology of the intervertebral disc is most useful.

The addition of lists of suitable references for further reading is most welcome and the idea of placing these at the end of the book has much to recommend it.

New printing techniques have been used to improve the reproduction of radiographs. The results with figs. 108, 109 and 110 are disappointing. Perhaps new blocks can be found for the next edition. Apart from this lapse the illustrations are excellent.

This book fully merits the popularity it enjoys and the new edition will ensure its continuing success. We look forward to Mr. Wiles' volume on fractures with keen anticipation.

A.J.B.M.

SYNOPSIS OF OPHTHALMOLOGY by W. Havener. **Published by Henry Kimpton.** Price 50s.

This is a book which is welcome because it is right in length and weight for the busy general practitioner and for the interested undergraduate. It is well written, compact without being terse, well-balanced and seemingly unhurried in its composition.

Although rather expensive for its size, the book is beautifully produced, the paper is of high quality, the printing clear and the sections well set out. It is profusely illustrated, and this is important in ophthalmology where so much depends upon inspection. But hand drawings of fundus appearances are still better than photographs, even when taken by the latest special camera. For the more superficial parts of the eye, photography has proved highly successful.

The book commences with a comprehensive system of examination of the eye, and deals with ophthalmology from the point of view of the general practitioner rather than the student. It is, however, a disappointment that the appearance of the fundus in relation to systemic disease is only briefly covered. Thus, there are only four of the rather small pages dealing with the important topic of hypertensive retinopathy, and other systemic diseases producing retinal changes are rationed to two or three lines each.

Where the eye is treated as an entity in itself, the author is on happier ground, and the chapters on glaucoma and the treatment of eye injuries are particularly good. It is perhaps indicative of the author's treatment of his subject that the final chapter is entitled "Blindness is preventable." This is the main theme of the book, and from this admirable point of view it renders a valuable service.

The book may therefore be recommended to the general practitioner for the advice on treatment which it contains, and also to the student on account of its general soundness and brevity.

LECTURE NOTES ON OPHTHALMOLOGY.—by P. D. Trevor-Roper. **Published by Blackwell.** 94 pp. 76 figs. Price 12s. 6d.

This book has been written for the student market and there it meets the opposition of the current favourite, C. R. S. Jackson's book "The Eye in General Practice". Both cover the same ground in about the same amount of detail but Mr. Trevor-Roper's new book is 8s. 6d. cheaper and has three times as many illustrations—most of them very good. The styles of the texts are quite different. Jackson is more discussive, enjoyable reading, but, if you like your facts packed close, Trevor-Roper packs them closer than most, and arranges them more logically in chapters dealing with symptoms rather than structures. In this way he leaves out less than Jackson (who does not acknowledge, for example, the existence of nystagmus), but he also orientates his reader better towards dealing with patients, and, one hopes, examiners.

This an ideal book if you're in a no nonsense pre-finals frame of mind, but at 12s. 6d. it is worth buying much earlier than that.

D. G-M.

FUNDAMENTALS OF GYNAECOLOGY Samuel J. Behrman, John R. G. Gosling. **Published by Oxford University Press** 76s.

This book can be unreservedly recommended, particularly for the Student. Its beauty lies in the fact that it had been written by real teachers of the subject who have employed every artifice in putting across their material.

The text is lucid and instructive and in my opinion easier of retention than in many contemporary volumes, this having been the guiding aim.

Thus many of the chapters are of amplified lecture format with useful headings and lists, set early in front of the reader in order to impart perspective before discussion. This logical and ordered approach will appeal to the postgraduate as a sound foundation for more detailed reading.

The contents are set out in seven parts: Anatomic considerations, Menstrual and Endocrine considerations, The Inflammations (in which section, rather oddly, are included benign neoplasms and endometriosis) Malignant Neoplasms, Conditions relating to Conception, and finally a section on lower abdominal pain and pelvic pain and the principles of radiation treatment in Gynaecology.

There are many illustrations of gynaecological histopathology, and while their reproduction is only average and therefore disappointing in such a book as this, a novel means of identifying the components has been employed which represents a real advance in the teaching of histology.

Diagrams, drawings and charts are but part of the aids to understanding and therefore learning incorporated, and as they often permit of reproduction are all the more valuable. This is an introductory book of modest size, and in consequence details of therapy, and in particular surgical technique, are restricted. This is a pity as I am sure these authors would have illustrated the broad principles of the common gynaecological operations extremely well.

The student need have no fear that the contained material would be unacceptable to a British examiner on account of its trans-Atlantic origin. Similarity in outlook and practice seems surprisingly uniform, perhaps because the book excels in putting over the basic principles.

BRIAN MEASDAY.

SYNOPSIS OF GYNAECOLOGY by R. J. Crossen, D. W. Beacham and W. D. Beacham. St. Louis: C. V. Mosby & Co., London: Henry Kimpton Ltd. 340 pp. 106 Illust. Price 48s. 6d.

This is a luxurious synopsis indeed and could, with advantage, be re-titled as an "Introduction" to, or "Outline" of gynaecology. The price, as is usually the case with American books seems excessive and may well discourage students from purchasing it. Nevertheless this is a well executed and useful volume for the use of students who are embarking on their Midder and Gynae or who are approaching finals.

In the first part of the book the anatomy and physiology of the female pelvic organs are simply described in an easily assimilated style. A good account is then given of the techniques employed in a gynaecological examination with special reference to bimanual palpation.

In the second half of the book are described the disorders of the female pelvis classified under the organ affected and the pathological process involved. Symptomatology and treatment are simply described and references are given for further reading.

This slim volume slips readily into the pocket, and as one might expect the printing, illustrations and presentation are excellent.

THE ROYAL COLLEGE OF SURGEONS OF ENGLAND : A HISTORY by Zachary Cope. **Published by Anthony Blond, 1959.** Pp. xii, 353, illus. Price 63s.

It is strange that no substantial history of the Royal College of Surgeons has previously appeared, particularly as the well-kept records and other necessary materials have been available for this purpose. Possibly it awaited a person suitably equipped with a keen interest in historical research, and with the leisure required for sifting the masses of manuscript and printed documents extant. Sir Zachary Cope was requested by the President and Council to write this book, and he has accomplished a most difficult task in an admirable manner. He was faced by a mass of factual evidence, with gaps caused by the secret deliberations of the Council not being entered in the Minutes, and has endeavoured to produce a readable history containing factual examples.

Beginning with the separation in 1745 of the Company of Surgeons from the Barber-Surgeon's Company, we are presented with a connected history of the development of the Royal College of Surgeons of London, as it is named from 1800 to 1843, when its title was altered to "of England," and we are able to envisage the development of surgery during that period. All the great names in British surgery are featured, and we recognise numerous Bart's men who served the College in one way or another. John Abernethy, who introduced Richard Owen and Robert Willis to the College; Edward Stanley, William Long, Sir William Lawrence, Thomas Wormald; Luther Holden; Sir James Paget, and a long line of distinguished surgeons, many of whom served as President. Possibly the historical interests of Sir James Paget, G. E. Gask and Sir D'Arcy Power inspired the current President of the College to encourage the publication of this study.

It is of interest to note the effect of medical legislation on the College, to recall the influence of the College on medical education, and to read of medical politics and the clashes of eminent figures so common in institutions of this nature. Most impressive is the development of the Royal College of Surgeons since the war, when the destruction of much of its property must have appalled the enthusiasts who had contributed so much to its development. Far from being disheartened, they have planned, and partially brought to fruition, extensions undreamed of in pre-war years, and the resultant College provides facilities for teaching and research inferior to none in this country.

Miss Jessie Dobson and Mr. W. R. LeFanu contribute chapters on John Hunter's Museum and the Library, respectively, and these are of particular interest and value. The College has derived great benefit from the possession of John Hunter's collection which has been extended and maintained as an invaluable teaching collection. The Library has suffered from lack of funds, insufficient staff and lack

of adequate space, yet has maintained its place as one of the outstanding medical libraries in the world. Mr. LeFanu relates its development, and provides details of its librarians, several of whom were pioneers in library administration. He does not mention his own prominent part in building up the Library under adverse conditions, and his influence on medical librarianship in general.

This well-illustrated volume will remain the standard source of information on the Royal College of Surgeons of England for many years to come, for who would face the task of repeating Sir Zachary's researches? They must form the basis for any future comprehensive study, and he is to be congratulated on the results of careful selection and condensation into a readable, authoritative history.

J.L.T.

EMERGENCIES IN MEDICAL PRACTICE

Edited by C. Allen Birch.

Published by Livingstone. 55s.

The popularity of this well-known book is demonstrated by the fact that it has reached its sixth edition since it was first published in 1948. This is due, no doubt, to the fact that it is full of practical information required almost daily by every hospital officer and active General Practitioner whether he is in one of the services or in civilian practice, at home or abroad. This edition maintains its original form and the author is to be congratulated that it has been enlarged by about sixty pages only, despite revision, re-arrangement and the addition of two new chapters and some useful appendices.

The subject matter is well set out and simply presented so that it is easy to understand at a glance. The list of chapters at the front of the book is a great help in finding information quickly, while the index which has been extended in this edition although fairly full, might be enlarged still further with advantage. The text not only includes a useful short chapter on the practioner's emergency bag, but also deals with the causes of accidents occurring as a result of medical procedure, well worth studying in view of the present tendency to litigation on medical matters. Emergencies of all kinds are covered under the appropriate headings. Looking through the new chapter on emergencies in Ear, Nose and Throat disease one is struck by the common occurrence in everyday practice of so much of the subject matter which seems to be typical of the remainder of the book. Publicity given to the risk of irradiation hazards at the present time has merited a new chapter on emergencies resulting from nuclear and allied radiations. This subject may be rather specialised in its general practical applicaton but is of obvious interest to all those in practice.

The appendices have been increased to supply additional data on administrative matters, mostly addresses of key health services centres that may be of use in emergencies—addresses usually available but not always in a place of easy reference.

This volume contains much useful information on medical problems, usually scattered through many text books, articles and pamphlets under different headings, here arranged in an easily readable book. It therefore becomes of considerable value to the final year student during his revision period. It should be read by all those going into practice as it will marshall knowledge already gained as a student and fill in numerous gaps. It should be within the reach of all those likely to encounter medical emergencies.

T. O. McKane.

SURGICAL NOTE-TAKING—a booklet for surgical dressers and clerks commencing clinical studies—by C.F.M. Sain and J. H. Louw. 5th edition. London: H. K. Lewis. 172 pp. 12s. 6d.

This book consists of a list of questions to be asked and the signs to be looked for as a guide to the student in history-taking and physical examination. The authors accentuate in their introduction that the "schemes" covered must be used only as a guide and should be modified according to the individual patient. The schemes are clearly presented.

W.M.K.

THE FINAL DIAGNOSIS

by Arthur Hailey.

Published by Michael Joseph, in association with Souvenir Press 15s.

Mr. Hailey's novel is a collection of dramas, taken from hospital and private life, carefully woven into an exciting story. His vivid characterisations—almost too real—leave little to the imagination. His style is flowing, and easy to read for those familiar with the intracies of hospital life, and with medical jargon. To others, the many detailed technicalities would prove trying in places; but perhaps this does not matter, as the chief moral of the tale is directed at members of the medical profession, to whom it is a book worth reading.

EPIDEMIC DISEASES.— by A. H. Gale, D.M., D.P.H. **Published by Penguin Books.** Price 3s. 6d.

This book throws a new light on the old subject of epidemic diseases, putting them into their true perspective on a histrocial basis, the importance of which is stressed in the introduction when the author quotes Trevelyan: "Besides the contemplation and study of the past for its own sake, there remains the second great value of history, namely the light it throws on the present." There can be few subjects to which this could better be applied, and for this reason, the book, although addressed primarily to laymen, has much to offer to medical men.

The chapters follow a general pattern in which the origins of disease are traced (a fascinating historical study), their pattern of development in subsequent years, and often the causes for their decline or disappearance are discussed. There are many mysteries connected with the disappearance of Plague, of sweating sickness (whose precise identity is not even certain) and more recently of encephalitis lethargica, to quote some examples. One of the disappointing features of the book is that too little time is devoted to these problems, and frequently one felt that the discussion had only just begun and could have been continued with profit. The chapters, on the whole, are rather too short for satisfactory continuity—but the whole book is quite short, and very quickly read. The last chapter of all is in effect a summary to the whole, and consists of a most interesting survey of the rapidly changing pattern of epidemic diseases over the years, according to the social habits and customs, to public health and treatment, or even to the whims of the organism.

The appendix contains the Bill of Mortality for the Plague Year of 1665, and is followed by a useful bibliography and a reasonably comprehensive index. The text is liberally illustrated with graphs and figures.

Following the premature death of the author, the book has been edited by E. R. Hargreaves. If it is read during the study of fevers in the medical curriculum, the subject is made infinitely more interesting.

P.J.W.

STRONG AND ELWYN'S HUMAN NEUROANATOMY.—Ed. R. C. Treux. 4th Edition. **Baillière, Tindall and Cox Ltd. pp. 485. 80s.**

This beautifully printed, and excellently illustrated volume is aimed, according to the preface, largely at the American Pre-clinical student. It is, however, far too elaborate for his British counterpart and would be more appropriate for the Primary candidate.

The first 8 chapters are devoted to the general organisation, embryology and histology of the nervous system, with some interesting comparative references. The larger portion consists of a very detailed topographical account illustrated by a wealth of colour and black and white diagrams.

The subject matter is well arranged, and apart from a very few Americanisms and a highly erroneous diagram of the cavernous sinus on p. 88, can be thoroughly recommended for reference and further studies.

L.N.D.

BOOKS RECEIVED

Aids to Biochemistry, by S. P. Datta and J. H. Ottaway. Published by Baillière, Tindall and Cox. 15s.

The final Diagnosis, by Arthur Hailey. Published by M. Joseph. 15s.

Home Guide for the Diabetic. Published by Iliffe & Sons. 3s.

Manuel of Surgery. Rose and Carless. 19th edition. Published by Baillière, Tindal and Cox. 84s.

Notes on Infant Feeding, by S. Graham and R. A. Shanks. Published by Livingstone. 4s. 6d.

Textbook of Otolaryngology, by D. D. De Weese and W. H. Saunders. Published by H. Kimpton. 65s.

A Synopsis of fevers and their Treatment, by J. H. Lawson. Published by Lloyd Luke. 10s.

Alfred Hospital Clinical Reports, Vol. 9, 1959. Published by the Alfred Hospital, Melbourne.

Principles of Bone X-ray Diagnosis, by George Simon. Published by Butterworths. 57s. 6d.

Aids to Forensic Pharmacy, by H. Fowler. Published by Baillière, Tindall and Cox. 12s. 6d.

Acknowledgement in this column does not preclude a review.

Recent Papers by Bart's Men

Aston, J. N. Locked middle finger. *J. Bone Jt. Surg.*, 42B, Feb., 1960, pp. 75-79.

*Backhouse, K. M. Testicular descent and ascent in mammals. *15th Int. Congr. Zool.*, Sect 5, Paper 15 (1959?).

*——, (with Hewer, H. R.). Field indentification of bulls and cows of the grey seal *Halichoerus grypus* Fab. *Proc. Zool. Soc. Lond.*, 132, Aug., 1959, pp. 641-645.

*Boughton, Barbara, and Wheatley, V. R. Further studies of the composition of the unsaponifiable matter of human-forearm "sebum". *Biochem. J.*, 73, No. 1, 1959, pp. 144-149.

*——, and Wheatley, V. R. The fatty acid composition of the skin surface fat ("sebum") of normal human subjects. *J. invest. Derm.*, 33, Aug., 1959, pp. 49-55.

*——, Mackenna, R. M. B., Wheatley V. R. and Wormall, A. The fatty acid composition of the surface skin fats ("sebum") in acne vulgaris and seborrheic dermatitis. *J. invest. Derm.*, 33, Aug., 1959, pp. 57-64.

*Bounden, J., and Rotblat, J. Vacuum in medicine. *Vacuum*, 9, 1959, pp. 1-16.

*Boyd, A. M. (and Bloor, K.) Results of tenotomy of the tendo achillis in intermittent claudication. *Brit med. J.*, Feb. 20, 1960, pp. 548-551.

Bradshaw, A. L. *see* Dolphin, G. W., and others.

Capener, Norman. Chiropractic. *Practitioner*, 184, March, 1960, pp. 378-382.

Christie, R. V. Chronic bronchitis and emphysema. *Trans. Stud. Coll. Phys. Philad.*, 27 July, 1959, p. 16.

Crosfill, M. L. and others. Variation of sensitivity to ionizing radiation with age. *Nature*, 183, June 20, 1959, pp. 1729-30.

*Dangerfield, W. G. and others. The investigation of lipoproteins in lymph and other body fluids by electrophoresis. *J. clin. Path.*, 13 Jan., 1960, pp. 76-81.

*Dolphin, G. W., and others. Investigations of high energy electron beams for use in therapy. *Brit. J. Radiol.*, 32 Jan., 1959, pp. 13-17.

——, *see also* Haynes, R. H., and ——.

——, *see also* Lidwell, O. M., and others.

*Dormer, A. E. The treatment of bacterial endocarditis. *Brit. med. Bull.*, 16 No. 1, 1960, pp. 61-66.

*Franklin, A. White. Respiratory diseases of the newborn. *Nursing Mirror*, Jan. 29, 1960, pp. v-vii.

Franklin, K. J. Francis Joseph Cole, 1872-1959. *Obit. Not. roy. Soc.*, 5, 1960, pp. 37-47.

——, (with others). William Harvey's debate with Caspar Hofmann on the circulation of the blood: a new documentary evidence. Translated by K. J. Franklin. *J. Hist. Med.*, 15, Jan., 1960, pp. 7-21.

Gale, N. H., *see* Dolphin, G. W., and others.

Garrod, L. P. Antibiotics in medicine: Introduction. *Brit. med. Bull.*, 16, No. 1, 1960, pp. 1-2.

*——. Relative antibacterial activity of three penicillins. *Brit. med. J.*, Feb. 20, 1960, pp. 527-529.

*——, and Scowen, E. F. The principles of therapeutic use of antibiotics. *Brit. med. Bull.* 16, No. 1, 1960, pp. 23-28.

GARROD, Oliver. Thyrotoxicosis. *Brit. med. J.*, April 9, 1960, pp. 1123-1125.

GILLETT. G. B., and KEIL, A. M. Trimeprazine tartrate in paediatric premedication: a preliminary communication. *Anaesthesia*, 15, April, 1960, pp. 158-162.

HAVARD, C. W. H., and SCOTT, R. BODLEY. Urticaria pigmentosa with visceral and skeletal lesions. *Quart. J. Med.*, N.S. 28, Oct., 1959, pp. 459-470.

HAYNES, R. H., and DOLPHIN, G. W. Calculation of linear energy transfer with special reference to a 14 MeV electron beam. *Physics Med. Biol.*, 4, 1959, p. 2.

HOWELL, Trevor. Rehabilitation after a stroke. *Chest and Heart Bull.*, 23, Feb., 1960, pp. 10-11.

HUNTER, Richard A. (and ROSS, Ian P.) Psychotherapy in migraine. *Brit. med. J.*, April 9, 1960, pp. 1084-1088.

JONES, Arthur, and WEDGWOOD, John. Effects of radiations on the heart. *Brit. J. Radiol.*, 33, March, 1960, pp. 138 158.

*KAZANTIS G. (and Bomford, R. R.). Dyspepsia due to inhalation of carbon tetrachloride vapour. *Lancet*, Feb. 13, 1960, pp. 360-362.

KEIL, A. M. *see* GILLETT G. B., and ——.

*KERSLEY, G. D. Analgesia in chronic rheumatic conditions. *Practitioner*, 184, Jan., 1960, pp. 58-61.

KEYNES Sir Geoffrey. A large thyroglossal cyst. *Brit. J. Surg.*, 47, Jan., 1960, pp. 447-449.

KINMONTH, J. B., *see* DANGERFIELD, W. G., and others.

LIDWELL O. M., and others. The use of radiation to estimate the number of micro-organisms in airborne particles. *Brit. J. Hyg.*, 3, 1959, p. 57.

*LINDOP, P. and ROTBLAT, J. Ageing effects of ionizing radiation. *Prog. Nucl. Energy*, 2, 1959, pp. 58-68.

*——, and ROTBLAT, J. Protection against acute effects of radiation by hypoxia. *Nature*. 185, Feb. 27, 1960, pp. 593-594.

*——, and ROTBLAT, J. Shortening of lifespan of mice as a function of age at irradiation. *Gerontal. Exper.* 3, 1959, pp. 122-127.

——, *see also* CROSFILL, M. L., and others.

*LUMB, George (and others). The results of varying degrees of narrowing in the left circumflex coronary artery in dogs. *Amer. J. Path.*, 36, Jan., 1960, pp. 113-123.

*MACKENNA, R. M. B. Acne vulgaris and pituitary metabolism. *Acta dermat.-venereol., Proc. 11th Internat. Congr. Dermat.*, 1957, 3, 1960, pp. 1039-1041.

——, *see also*, BOUGHTON, Barbara, and others.

*MCMENEMEY, W. H. Joseph Godwin Greenfield. 24th May, 1884-2nd March. 1958. (Obituary). *J. Path. Bact.*, 78, No. 2, 1959, pp. 577-592.

MANFIELD, Pauline A., and others. Nasal staphylococci and sepsis in newborn babies. *Brit. med. J.*, April 9, 1960, pp. 1098-9.

*MAXWELL, James. Diagnosis and the cancer patient. *Brit. J. clin. Pract.*, 14 Feb., 1960, pp. 125-126.

*——, Urine testing. *Brit. J. clin. Pract.*, 14 March, 1960, pp. 211-212, 240.

*MEDEL. Dennis. Tubular reabsorpation of protein in the rat. *J. Physiol.*, 148 No. 1, 1959, pp. 1-13.

MILLICHAP, J. Gordon. A potential new therapy for febrile seizures: preliminary report on development of *N*-phenylbarbitone. *Brit. med. J.*, April 9, 1960, pp. 1111-1112.

*MOODY, D. P. The presence of a β-substituted furan ring in marrubin. *Chemistry & Industry*, 1960, p. 75.

MORGAN, C. Naunton. The comparative results and treatment for cancer of the rectum. *Postgrad. Med.*, 26, Aug., 1959, pp. 135-141.

NOBLE, W. C., see LIDWELL, O. M., and others.

PRANKERD, T. A. J. The diagnosis and treatment of leukaemia. *Brit. J. clin. Pract.*, 14 Feb., 1960, pp. 101-105.

*ROTBLAT, J. Biological hazards of ionizing radiations. *Bull. Inst. Physics*, April, 1959, pp. 77-83.

*——, (with others). The scattering of alpha particles by helium. *Proc. roy. Soc.*, A, 251, 1959, pp. 143-155.

——, (with others). The scattering of 38 MeV a-particles by C.N.O. F and Kr. nuclei. *Proc. roy. Soc.*, A. 254, 1960, p. 395.

——, *see also* BOUNDEN, J., and ——.

——, *see also* CROSFILL, M. L., and ——.

——, *see also* LINDOP, P., and ——.

SCOTT, R. BODLEY, *see* HAVARD, C. W. H., and ——.

*SCOWEN, E. F., and others. Further observations on the genetic basis of primary hyperoxaluria. *Ann. hum. Genet.*, 23, 1959, pp. 367-381.

——, *see also* GARROD, L. P., and ——.

SEDDON, H. J. Peripheral paralysis. *Physiotherapy*, 46, Feb., 1960, pp. 34-39.

*——. The surgery of nerve injuries. *Practitioner*, 184, Feb., 1960, pp. 181-187.

SHOOTER, R. A., *see* MANFIELD, Pauline A., and others.

SMITH, Elspeth B., *see* DANGERFIELD, W. G., and others.

SPENCE, A. W. Endocrinological problems of adolescence. *Practitioner*, 184, March 1960, pp. 293-300.

*TAYLOR G. W. Preventive use of antibiotics in surgery. *Brit. med. Bull.* 16, No. 1, 1960, pp. 51-54.

——, *see also* DANGERFIELD, W. G., and others.

*THORNE, Napier. The skin clinic. Brit. J. clin. *Pract.*, 14, Feb., March, 1960, pp. 133-136, 219-222.

*TODD R. McLaren. Congenital tuberculosis: report of a case with unusual features. *Tubercle*, 41, Feb., 1960, pp. 71-74.

*——. Infant feeding—a comparison of human, evaporated and dried milk. *Practitioner*, 184, March. 1960. pp. 352-354.

*WATERWORTH, Pamela M. The antibacterial properties of leucomycin. *Antibiot. Chemother.*, 10, Feb., 1960, pp. 101-108.

WATTS, R. W. E., *see* SCOWEN, E. F., and others.

WEDGEWOOD, John, *see* JONES, Arthur and ——.

WHEATLEY, V. R., *see* BOUGHTON, Barbara, and

*WOOD, Patrick. A private practice in the welfare state. *Practitioner*, 184, Feb., 1960, pp. 216-230.

WORMALL, A., *see* BOUGHTON. Barbara, MACKENNA, R. M. B., WHEATLEY, V. R and WORMALL, *A*.

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

ST. BARTHOLOMEW'S HOSPITAL JOURNAL

Vol. LXIV, No. 7 JULY, 1960

CALENDAR

AUGUST

Wed. 3—L.T.C. v. West Heath Lawn Tennis Club (A).
Fri. 5—End of C.C. Tour.
Sat. 6—On duty: Medical and Surgical Units.
Mr. G. H. Ellis.
U.H.S.C. Inter Hospitals race.
Wed. 10—Students' Union Meeting
Sat. 13—On duty: Dr. R. Bodley Scott.
Mr. A. H. Hunt.
Mr. F. T. Evans.
Sun. 14—C. C. v. Bromley (A) Start 2.30.
Sat. 20—On duty: Dr. A. W. Spence.
Mr. C. Naunton Morgan.
Mr. R. A. Bowen.
C.C. v. Ferring Sussex (A) Start 2.30.
Sat. 27—On duty: Dr. G. W. Hayward.
Mr. A. W. Badenoch.
Mr. R. W. Ballentyne.
Mon. 29—General Assembly I.F.M.S.A. Milan.

SEPTEMBER

Sat. 3—On duty: Dr. E. R. Cullinan.
Mr. J. P. Hosford.
Mr. C. Langton Hewer.
U.H.S.C. Harvey Wright Gold Bowl (Burnham).
Sat. 10—On duty: Medical and Surgical Units.
Mr. G. H. Ellis.

EDITORIAL

ORGANISATION is something we adore. Our grandfathers might well be offended rather than frightened if they knew the extent to which we retire behind the façade of committees. Nevertheless, as the wisdom of the body ordains that the brain shall control the members, so are we wisely ruled by committees. And the Students Union must surely endow us all with a certain dignity and importance which we would lack as individuals!

A committee is supposed to have a life cycle. From this premise it is easy to deduce that a committee must be organic rather than mechanical. Further it must take root, grow and multiply. Most of this has also been stated—although it could have been deduced from the original premise.

It is easy to imagine the roots of the Students' Union and its committee (or council). The mysteries of finance which clubs provoke is sufficient *raison d'etre*. The growth, however, has not been pruned. The scope of the Students' Union is today almost as intangible as that of the Monarchy. In a reassuring way it claims to help every student, to co-ordinate clubs and finance, and make representations on academic and social matters (to other more venerable bodies). Unfortunately the multiplication has only been in the number of people who sit on the council and the business which passes through it. The growth has been so

rapid that few records have been kept and few committees are small enough to be efficient. The problems, for example, of organising Sports Day are experienced afresh each year and the same mistakes are made. The meeting each month is, by design, a congregation rather than a council.

All the real work falls on very few who receive but small rewards. It is true that often there is something we can gain from, as well as contribute towards, a committee. This, however, is a trivial compensation for manipulating a constitution that is inefficient and presiding over a council that is unwieldy.

The ease with which criticism can be made about anything is always deceptive. It is very difficult to advise or change. However, many feel that the council should be a smaller and more efficient body. A great deal of the initial work on most issues could be done before ever reaching it. Decentralisation is surely an important principle in most organisations. Efficient records—to enable routine measures to be undertaken easily each year—are at the moment of greater importance than increasing the scope of the Union. We like to be organised but efficiency seems to escape us. The necessity seems to be for a Union of restricted scope which can be properly manipulated by different people each year. This sounds a simple object but it is one that will be difficult to achieve.

FIFTY YEARS AGO

Of the several addresses to the Abernethian society in 1910, that given on midsummer's eve by Dr. Norman Moore seems to have attracted an unusually large audience. Dr. Moore's subject "St. Bartholomew's Hospital and Dr. Caius" was one of such interest to all students and old students that the text was subsequently published in the Journal of that year.

Dr. Moore recalls "The Chief entrance into St. Bartholomew's Hospital from the very beginning was in the present position of our Smithfield Gate, the roadway through which is thus the most ancient feature of the Hospital. The original gateway was repaired in the reign of Henry VI, and the present gate was built in the eighteenth century, but no alteration in position was made on either occasion, and when we enter the Hospital from Smithfield our footsteps exactly follow the track of those of Rahere".

Following this, there comes a brief outline of the early history of the Hospital, with particular reference to our benefactors in those early days. We find Richard, Bishop of London, who previously had been "A sort of viceroy in Shropshire", but in 1108 "Having been elected to the vacant bishopric of London, was ordained priest at Mortlake by St. Anselm". In a fleeting reference to the Peasants' Revolt in the early days of Richard II, we find that "Tyler was dragged into the Hospital through our gate, past the Chapel of the Holy Cross, and died, or was found to be certainly dead in the chamber of the Master of the Hospital".

Where there now stands the Pathology Department and the Medical School Office, there previously stood "A house and garden, occupied in 1456 by Lady Joan Astley, once nurse to King Henry VI". One of Lady Astley's successors in this "Important tenement" was John Caius, taking up his residence in 1551, and remaining there till his death in 1573.

"This great man was born in Norwich on October 6th 400 years ago . . He was admitted an undergraduate to Gonville Hall at Cambridge in 1529, and soon became deep in Greek, and in 1533 was elected fellow of Gonville Hall. Six years later, he went to the University of Padua, and studied Medicine."

"He lived in the house of the great anatomist Andreas Vesalius for eight months, and thus learned the modern anatomy based upon human dissection and not upon the books of ancient writers who had only dissected monkeys and pigs."

"Caius learned medicine from John Baptist Montana, of Verona. . . . Montana was interested in everything which bore upon his profession, but Caius was, perhaps, most drawn to him because of his Greek reading and through his thorough acquaintance with Galen. Caius graduated M.D. at Padua in 1541."

"In 1547 he was elected a fellow of the College of Physicians, and five years later he wrote his treatise on the sweating sickness, an epidemic disease, called in Latin *Ephemera Britannica* . . . As the first work on clinical medicine, the first description of a disease drawn altogether from the writer's observation, this book is original and was a great step in the study of medicine, although it is not full enough to be a very important addition to clinical knowledge."

"Caius lived in St. Bartholomew's the whole of his time in London, and several of his books were written here. In 1555 he was elected President of the College of Physicians and held office, though not continuously, during nine years. The plan of our College of Physicians was drawn from Italy, and Caius, imbued with the same spirit of learning that had animated Linacre, the founder of the College, had great influence in continuing its tradition."

The address ends: "The life of Dr. Caius shows the noble characteristics of the English physicians of the Renaissance, and we must all be glad to remember that he long lived within St. Bartholomew's Hospital, and is one of its benefactors."

"Vivat post funera virtus"

NEWS IN BRIEF

Work has now started on the conversion of the ground floor of the West Wing. Two wards each containing eighteen beds are being constructed for orthopaedic patients.

The central window on the first floor of the West Wing which was damaged by a bomb during the war is now being replaced.

The Radiotherapy Department is having a £50,000 extension which will contain, amongst new equipment, two cobalt bomb units.

Dr. Geoffrey Bourne has been appointed consulting cardiologist to British European Airways.

Royal College of Physicians of Edinburgh—Lord Adrian has been elected an honorary fellow of the Royal College of Physicians of Edinburgh.

Royal College of Physicians of London—Dr. P. F. Borrie and Dr. A. E. Mourant have been elected fellows of the Royal College of Physicians of London.

Birthday Honours—Dr. Edward Hammond Williams has been awarded the M.B.E. for public services in Uganda.

STUDENTS UNION

A meeting of the Students' Union Council was held on June 15th, 1960. Mr. A. H. Hunt was in the chair and 25 members were present.

In the report of the London to Brighton Stroll, Mr. Watson stated that of the 65 Bart's participants 42 had successfully reached Brighton, evidence of which was now to be seen in the wearing of the Toucan tie. Congratulations were given to all walkers and warm thanks to the noble body of helpers who had supported them throughout the night. Several factors had gone into making this a successful adventure, including the very pleasing manner in which friendships between the competing hospitals had been further strengthened.

The report of the Ball Committee was given by Mr. Gau, who was pleased to report that this year's View Day Ball had been successful, a profit of a few pounds being made.

Mr. Watson presented the Carnival Committee Report giving details of the float entered by Bart's in the U.L.U. Carnival Procession. The Royal Free Hospital had won the competition for the best float on a theme of "A penny for them" but we had been thanked by the organisers for participating in this event which altogether had raised £700 for World Refugee Year.

Mr. Hood made it clear that the Hospital's Symphony Orchestra was now being correctly managed in that all members of the constituent hospitals and their friends were invited to play in the orchestra. They were no longer being excluded because of the participation of professional players. This latter situation had been the cause for the Bart's financial contribution being lowered last year thus it was decided to reinstate the original grant of ten guineas.

A suggestion by Mr. Hore that a Freshers Dance be held in October led to a general discussion on dances in College Hall. It was eventually decided that a sub-committee consisting of all the interested parties be set up to discuss this matter at an open meeting which any student could attend.

THE CHRISTIAN UNION

Two open meetings have been held this summer. The first, on Tuesday, May 10th, was a forum on "Why be a Christian?", the speakers being Mr. A. Parks. M.Ch., M.D.,

from the London Hospital; H. Fawcett, Esq., M.B.E., a business man; and F. Sampson, Esq., an international athlete, with Dr. Lennard-Jones, M.B. B.Chir., in the chair.

A Christian was defined as one who believed and trusted in Jesus Christ as his own personal Saviour. Then the importance of the deity, crucifixion, resurrection and ascension of Jesus Christ were stressed. With this as their basis, each member of the panel gave his personal account as to how he became a Christian, and then spoke of the power of Christ which had come into his life.

After discussing some practical aspects of the Christian life, the need for everyone to find out what Christianity really is, and means, was emphasised; and reading a book, such as St. John's Gospel, and inquiring of experienced Christians, were suggested for this purpose. The climax of the meeting came with a question from the audience: "How can one help a dying man who has only, say, two minutes to live, and is enquiring after his salvation?" Mr. Fawcett answered with a quotation from Acts, chapter 16, "Believe on the Lord Jesus Christ, and thou shalt be saved".

On Tuesday, May 31st, Dr. J. Carlisle gave a talk, illustrated by many excellent and interesting slides, on his work in a Mission Hospital in Tangiers. He spoke of the appalling poverty and desperate needs, both physical and spiritual, of these Moslem people. The Mission Hospital endeavoured, through the relief of their suffering, to show them the power and love of Jesus Christ.

SOCCER CLUB DINNER

The Soccer Club had a most enjoyable dinner at the Talbot Restaurant on June 16th. The high standard of the food and drink was maintained by the speakers. Mr. A. Hunt proposed the club's health, to which Mr. Prosser replied. Mr. Jailler stated how glad we were to see our guests from Oxford and Cambridge attending the dinner. Mr. D. Woolley (Trinity Hall) replied on behalf of the guests.

MR. JOHN BETJEMAN

Because of his close association with the Hospital, the award of the Queen's Gold Medal for Poetry to Mr. John Betjeman will give especial pleasure to all members of the staff.

BRECHT'S GALILEO

The Mermaid Theatre is now one year old. During the past year they have produced four plays, the first, "Lock up your Daughters", was the most successful, but since then the standard has fallen. Now they are presenting for their fifth production Brecht's Galileo. This has been described as "One of the literary masterpieces of the century", telling the story of a man's fight to make the truth recognised, one that is only too real in this our time, the age of the atom.

Unfortunately the Mermaid company does not seem competent to deal with this play full of great potentialities. One would agree that the subject matter is heavy, written by an intellectual for intellectuals. Brecht's concept of alienation, making the audience think for itself, is quite unapparent, not in the delivery, for this is an original translation, but in the interpretation. Nobody in the cast seemed to have any idea of what the play was about, and without this no actor can give of his best, for the most this was evident as a string of words flowed forth in an often unintelligible stream.

There seems to be no continuity in production and the lighting is far too harsh and unimaginative. The lack of colour in the much publicised carnival scene is blatant. This all adds up to a dull and tarnished representation of Brecht's concept of a great man who, although forced by the church to recant his statement that the world was not the centre of a crystal sphere, "but as a speck of dust in the Universe", continued his researches and writing in secret, thus forming part of the foundations of modern physics.

No doubt many people will go to see this play because it is by Brecht, so they should, for this is the first time the play has been performed in England, and is bound to be a talking point for quite some time to come. Regular patrons of the Mermaid, however, will see the same faces they saw in "Great Expectations", "Henry V", and even "Lock up your Daughters". Originally it was stated that it was part of the policy of the Mermaid to give young actors and actresses a chance. This doesn't seem to have been done, so please Mr. Miles let us see some new faces who will perhaps put new life into future productions and do full credit to the superb little Theatre in Puddle Dock.

J.W.

MEDICAL STAFF

CASUALTY PHYSICIAN

Dr. H. J. Galbraith. 1.8.60 (in place of Dr. R. C. King)

ANAESTHETIC DEPARTMENT

Temporary Registrars: Mr. K. Shimmings 1.7.60, Mr. E. F. Brooks. Senior House Officer: Mr. M. Evans 1.7.60

DEPARTMENT OF DIAGNOSTIC RADIOLOGY

Senior Registrar: Dr. D. H. Trapnell. Registrar: Dr. P. McDonald 1.10.60.

DEPARTMENT OF RADIOTHERAPY

Registrar: Mr. I. Kazem. 3.6.60.

CHILDREN'S DEPARTMENT

Senior House Officer: Mrs. Anna Cope, 20.7.60 (in place of Mr. A. W. Galbraith).

DEPARTMENT OF OBSTETRICS & GYNAECOLOGY

Registrar: Mr. D. K. Williams.

DENTAL DEPARTMENT

Part-time Registrar: Mr. C. E. Rees (in place of Mr. Eisenstadt).

APPOINTMENTS

MR. A. J. P. CAMPBELL. General Practice Clinical Assistant. As from the 1st July, 1960.

DR. H. J. GALBRAITH. Casualty Physician/Medical Tutor. As from the 1st October, 1960.

DR. R. M. BUCKLE. Temporary Lecturer in Medicine. As from the 1st August, 1960.

MR. F. L. D. STEEL. Lecturer in Anatomy. As from the 1st October, 1960.

MR. J. O. ROBINSON has been appointed by the Governors to be the Chief in medical charge of the Surgery.

DR. R. A. SHOOTER has been appointed by the Governors as Medical Officer in Charge of the Central Sterile Supply Department.

DR. E. G. REES has been appointed consultant pathologist to the Shrewsbury group and the Robert Jones and Agnes Hunt Orthopædic Hospital.

HOUSE APPOINTMENTS

1st June, 1960 *to* 31*st December*, 1960

DR. E. R. CULLINAN
Dr. K. O. Black
J. L. C. Dobson
M. J. K. Hudson (until 30.9.60)
Miss D. I. Vollum (from 1.10.60)

DR A. W. SPENCE
Dr. N. C. Oswald
J. M. H. Buckler
J. R. Garnham (until 30.9.60)
J. H. Pennington (from 1.10.60)

DR. R. BODLEY SCOTT
Dr. W. E. Gibb
D. A. Richards
P. G. Cassell (until 30.9.60)
J. J. R. Almeyda (from 1.10.60)

DR. G. W. HAYWARD
Dr. H. W. Balme
D. J. Tooby
D. J. Peebles (until 30.9.60) (from 1.10.60)

DR. E. F. SCOWEN
Dr. A. G. Spencer
R. L. W. Cleave
J. P. Soobie (until 30.9.60)
G. J. Halls (from 1.10.60)

MR. J. P. HOSFORD
Mr. E. G. Tuckwell
D. C. Lyon
Miss D. I. Vollum (until 30.9.60)
M. J. K. Hudson (from 1.10.60)

MR. C. NAUNTON MORGAN
Mr. D. F. Ellison Nash
J. Townsend
J. H. Pennington (until 30.9.60)
J. R. Garnham (from 1.10.60)

MR. A. H. HUNT
Mr. J. O. Robinson
K. R. Bowles
J. J. R. Almeyda (until 30.9.60)
P. G. Cassell (from 1.10.60)

MR. A. W. BADENOCH
Mr. Ian P. Todd
D. G. Davies (from 30.9.60)
D. J. Peebles (from 1.10.60)

PROF. SIR J. P. ROSS
Mr. G. W. Taylor
J. C. D. Plant
G. J. Halls (until 30.9.60)
J. D. Scobie (from 1.10.60)

CASUALTY H.P.
M. D. Constable

CASUALTY H.S.
H. J. Pemberton

CHILDREN'S DEPARTMENT

DR. C. F. HARRIS
Dr. A. W. Franklin
J. D. Parkes
S. G. I. Hamilton

E.N.T. DEPARTMENT

MR. CAPPS
Mr. Jory
R. A. G. D'E Willoughby (until 30.9.60)
Mr. Cope
R. M. Simons (from 1.10.60)

EYE DEPARTMENT

MR. H. B. STALLARD
Mr. J. H. Dobree
R. P. Ellis

GYNAE. & OBST. DEPT.

MR. JOHN BEATTIE
Mr. Donald Fraser
Mr. J. Howkins
G. F. Abercrombie } Interns
M. J. L. Patterson }
Miss M. C. Goodchild Junior H/S

DENTAL DEPARTMENT

MR. HANKEY
Mr. Cowan
N. Shelley Smith

ORTHOPAEDIC DEPARTMENT

(Fractures)
P. C. Weaver

HILL END HOSPITAL
E.N.T. DEPARTMENT

MR. CAPPS
Mr. Jory
R. M. Simons (until 30.9.60)
Mr. Hogg
Mr. Cope
R. A. G. D'E Willoughby (from 1.10.60)

ORTHOPAEDIC DEPARTMENT

MR. H. JACKSON BURROWS
Mr. W. D. Coltart
Mr. J. N. Aston
D. L. Julier
Miss J. A. Hartley

THORACIC SURGERY

MR. O. S. TUBBS
Mr. I. M. Hill
Mr. R. M. Hadley
Miss D. M. Humphreys

DEPARTMENT OF NEUROLOGICAL SURGERY

MR. J. E. A. O'CONNELL
Mr. R. Campbell Connolly
C. P. Roberts

ENGAGEMENTS

BLOOMER—GILMOUR.—The engagement is announced between Dr. A. C. S. (Mike) Bloomer and Judith H. Gilmour.

EDWARDS—BINGHAM.—The engagement is announced between Dr. James Griffith Edwards and Dorothea Mary Ann Bingham.

HARTILL—HUNT.— The engagement is announced between Dr. Geoffrey Gordon Hartill and Mrs. Eve A. Hunt.

STANLEY—HAGGERSTON. — The engagement is announced between Dr. Harold Wheldale Stanley and Mrs. Hanka Claire (Poppy) Haggerston.

DAVIES—SANDGREEN.—The engagement is announced between Dr. Gareth Davies and Nina Marie Sandgreen.

MARRIAGE

WELLS—TURTON.—On June 4, Dr. David P. Wells to Gillian Hermoine Christian Turton.

BIRTHS

ARTHUR.—On May 30, to Joan and Dr. Timothy Arthur, a daughter (Barbara Mary).

CASSELLS.—On June 10, to Irene, wife of Dr. M. J. Cassells, a daughter.

GIRLING.—On June 8, to Bridget and James Arthur Girling, a son.

GODRICH. On June 19, to Chloe and Dr. John Godrich, a daughter (Angela Clare).

GOLLEDGE.—On May 21, at Aden, to Helen and Dr. A. H. Golledge, a daughter (Charlotte Lyde) a sister for Mark.

MCMASTER. On Trinity Sunday (June 12), to Elizabeth and Dr. Brian McMaster, a daughter (Julia).

OSBORNE.—On June 29, to Hope and Dr. Patrick Osborne, a daughter.

SMITH. On May 28, to Phillida and Dr. Roderick Smith, a daughter (Anthea Claire Venn).

WELLS.—On June 17, to Jenifer, wife of Dr. Bertrand Wells, a son.

CRAWHALL.—On July 22nd, to Pam, wife of John Crawhall, a sister (Hilary Joan) for Robert.

DEATHS

ABERNETHY.—On June 23, Douglas Allan Abernethy, F.R.C.S. (Ed.), M.R.C.O.G. Qualified 1925.

CHANGES OF ADDRESS

Dr. P. B. Palmer,
The White House,
Godstone,
Surrey.
Tel. Godstone 262.

Mr. H. A. Morton Whitby,
12a Prince Edward Mansions,
Pembridge Square, W.2.
Tel. Bayswater 7080.

Dr J. A. Struthers,
Croft Corner,
Aston Tirrold,
Didcot, Berks.
Tel. Blewbury 328.

H. Horwitz,
Radio Isotope Laboratory,
General Hospital,
Cincinnati 29,
Ohio, U.S.A. (From Sept. 1.)

Mr. J. P. Hosford — correspondence to 58 Harley Street, W.1., as he has left his country address.

Dr. A. F. Taylor,
Ardentallen Farm,
by Oban, Argyll.

Dr. Gabriel Ullmann,
8A Lotus Street,
Mount Carmel,
Haifa, Israel.

SCHOLARSHIPS AND PRIZES, 1960

Brackenbury Scholarship in Medicine: A. B. Shaw. *Prox. Access*: D. I. Vollum.

Brackenbury Scholarship in Surgery: J. R. Garnham. *Prox. Access*: P. G. Cassell.

Matthews Duncan Prize: M. C. Goodchild.

Burrows Prize: A. B. Shaw.

Skynner Prize: I. J. Tufft.

Roxburgh Prize: D. Gardner-Medwin.

Walsham Prize: J. R. Garnham.

Willett Medal: J. R. Garnham.

Senior Scholarship in Anatomy, Physiology & Biochemistry: J. E. McLaughlin. *Prox Access*: R. L. Powles.

Harvey Prize: J. O. de W. Waller. *Prox Access*: S. A. Minns.

Herbert Paterson Medal: R. L. Powles.

Foster Prize: J. E. McLaughlin and A. C. Robertson.

Treasurer's Prize: D. J. Goldie. *Certificates*: B. E. Bean, J. M Matthews and J. K. Shearman.

Bentley Prize: J. C. Crawhall.

Wix Prize: E. Knight.

Hichens Prize: W. S. Shand.

EDITOR

Mr. A. J. B. Missen has been succeeded as editor by Mr. H. White. Mr. J. Spivey has been appointed assistant editor.

UNIVERSITY OF LONDON
FINAL M.B. B.S. EXAMINATION

APRIL 1960

Pass

Abell, J. D.	Alabi, G. O.	Almeyda, J. J. R.	Arnold, J.
Birt, R. C.	Cassell, P. G.	Collier, B. R.	Constable, M. D.
Fasan, P. O.	Gletsu, A.	Goodchild, M. C.	Gould, S. E.
Gray, W. R.	Hadley, R. M.	Halls, G. J.	Harris, D. M.
Hartley, J. A.	Humphreys, D. M.	John, R. W.	Julier, D. L.
Juniper, C. P.	Kennedy, R. C.	McGrath, M. B. J.	Matthews, A W.
Musgrove, J. S.	Muzio, D. M.	Pemberton, M. J.	Pettavel, J. A. P.
Ponnampalam, M. S.	Pope, J. A. ff.	Roles, W.	Russell, Z. A.
Stalder, G. P. M.	Tabert, J. E. K	Thompson, A. J.	Tufft, I. J.
Vollum, D. I.	Walker, K. A.	Weaver, P. C.	Willoughby, R. A. G. d'E.

Supplementary Pass List

Part I

Andan, A.	Ashby, P. M.	Ballantine, B. N.	Beardwell, C. G.
Besser, G. M.	Brown, M. D.	Chapman, J.	Davies, R. R.
England, R. W.	Geach, A. R.	Harrison, R. I.	Holloway, A. M.
Horder, P. T.	Kilroy, A. W.	Kingsley, D. P. E.	Martinez, G. S.
Morrison, J D.	Noble, M. I. M.	Smith, C. R.	Stewart, A. F. S.
Tomkins, I.			

Part II

Andan, A.	Berry, W. H. C.	Craggs, J. C.	Makin, E. J. B.
Swallow, J.			

Part III

Alder, D. E.	Andan, A.	Booth, D.	Craggs, J. C.
Eddy, J. D.	Garrod, J. A.	Hijazi, H. K.	Makin, E. J. B.
Smith, P.			

Part IV

Alder, D. E.	Booth, D.	Craggs, J. C.	Eddy, J. D.
Garrod, J. A.	Hijazi, H. K.	Milburn, F. A.	

UNIVERSITY OF LONDON
Ph.D. EXAMINATION

(*Faculty of Science*)
April 1960
Nye, E. R.

EXAMINATION FOR THE ACADEMIC POST GRADUATE DIPLOMA IN PSYCHOLOGICAL MEDICINE

April 1960
Part I
Edwards, J. G.

EXAMINATION RESULTS

R. A. Roxburgh, F.R.C.S. (Edin.) April 1960; F.R.C.S. (Eng.) May 1960.

SMALLPOX AND VACCINATION IN THE ARMED FORCES

from the Eighteenth Century Onwards

by A. M. Ward

"SMALLPOX is a danger to armies both as a disease which is capable of producing many casualties, with a high mortality rate, and as a threat which has continually to be fought off by the medical services".[1] If that was true of the Second World War, how much greater a threat was smallpox in the eighteenth century, before Jenner published his work on vaccination.

George Washington showed his fear of the disease in a letter to Patrick Henry, the Governor of Virginia, in 1777. "I know that it (the smallpox) is more destructive to an army in the natural way than the sword, and I shudder whenever I reflect upon the difficulties of keeping it out, and that in the vicissitudes of war the scene may be transferred to some southern state."[2] The fears he expressed in this letter were first, that smallpox was largely pandemic in the southern states of the new republic, and secondly that his army was largely unprotected against the disease, the practice of inoculation being a penal offence in Virginia and certain other states at that time.

There are many medical references in the Amherst Papers—letters and papers relating to the 1756-1763 campaign in North America—but the first note of smallpox is in a letter dated July 1760, from General Amherst to his Director of Hospitals, James Napier. Amherst wrote that smallpox had broken out among the troops under his command at Oswego, but, as precautions (unspecified) had been taken, it was vainly hoped that there would be no further spread. The next mention of the disease was during the American Revolution. In Boston in June 1775 Howe is reported to have had 2,000 sick, half of these being smallpox cases. It seems fairly certain that these were, however cases of the inoculation disease. The practice of variolation had certainly been used throughout the British Army since 1750, and probably from a still earlier date. This report may not have been quite accurate, as the revolutionary officers gleaned their information from a deserter from the British Camp, but it was to modify Washington's tactics and orders later, in that he only allowed those troops that had had smallpox to join the force of occupation when Howe evacuated Boston. The difference between the opposing forces with respect to this disease was shown very clearly at the siege of Quebec later in the same year. Smallpox became epidemic among the American Colonial troops, and caused them to abandon the siege. In the retreat to Crown Point one regiment lost over a third of its strength in deaths from smallpox. In contrast, the British regiments that were sent to relieve Quebec had no cases of the disease. The First Regiment of Foot went out to Canada in 1756, and all men who had not had smallpox were inoculated before embarkation, the result of this procedure was that, during the regiment's nine year tour in North America and the West Indies, there were no cases of smallpox. Surgeon Reide of that regiment inoculated some American prisoners-of-war taken at Montreal, with the result that they were among the few of their regiment that did not succumb to the disease. In commenting on their losses from the disease, Congress said that the smallpox was ten times worse than the British, Canadians, or Indians and, as a result of this outbreak, it was ordered that all troops in the American Army should be inoculated. In 1779 the French Government had to call off their proposed invasion of England because of an outbreak of smallpox in the fleet that incapacitated over half the sailors. Count d'Orvilliers commented at this time that he had no means of preventing the disease, and that in England things were better organised. Smallpox did occur in the Royal Navy, but only on a limited scale, there being 42 cases admitted to the Naval Hospital as Haslar in 1780, and only 6 deaths in the whole of the Home Fleet in 1782.

Dr. J. Pringle, in his book "Observations on the diseases of the Army", the first edition of which appeared in 1752, recorded that smallpox caused no concern to the English Regimental Surgeons in the Low

Countries in the 1742-1745 campaign, and he expressed an opinion that the disease was of no great danger to an army. He called attention to the total lack of cases among the troops quartered in Inverness after the battle of Culloden Moor in 1746, when the disease was prevalent in the town.

Jenner published his first paper on vaccination in 1798, and the first reference to the use of this method of prevention of smallpox in military communities is found in 1799. In that year the Regimental Surgeon of the South Gloucester Regiment of Militia inoculated a number of troops with the "cow-pox matter". This is an isolated case, and the general treatment at that time was still inoculation, but this was by no means certain in effect, as may be seen in the outbreak in Guernsey in 1799. This was a severe outbreak, causing a high mortality among those members of the Militia that had not been inoculated, and a high proportion of modified cases occurred in those that had been inoculated. After this outbreak had died down, considerable trouble was taken to disinfect the barracks before the arrival of Russian troops, as inoculation was not practiced in the Imperial Russian Army.

In 1800 H.R.H. the Duke of York, the Commander in Chief, asked Jenner to conduct a clinical trial of the new vaccine on troops of the 85th Regiment stationed at Colchester, to judge the expediency of adopting it generally throughout the services. The trial did not go smoothly as the troops were suffering from the "itch", which was specific against the smallpox. But, after several attempts, a considerable number of vaccinations were made. Vaccination was introduced generally in the army and navy later that year, and in the following year it was introduced into the armed forces of France, the East India Company, and the Crown in India. In 1801, Drs. Walker and Marshall, pupils of Jenner, toured the garrisons and naval bases of the Mediterranean to vaccinate the troops. At Malta they parted company, Walker going with the army to Egypt to complete his work, and to vaccinate some Turkish troops. The vaccine was found to be effective in stemming a severe outbreak of smallpox in the fleet in Malta at the time.

One great advantage of vaccination over inoculation was noticed at an early date. After vaccination, the men could continue with their duties as before, but after inoculation they were confined to their beds for some days. "The Cowpox occasions no disturbance in frame or fitness for duty, and can therefore be performed either in the barracks or quarters."[3]

During the next twenty years there was a sharp fall in the mortality from the disease, and during the Peninsula War, 1811-1814, the disease disappeared from the list of those that caused loss of life or duty. Smallpox contributed only six admissions and four deaths, all of these being among camp followers and auxiliaries. During a similar period, 1806-1809, there were no admissions for smallpox to the Naval Hospital at Plymouth, and the log of H.M.S. Albion for 1812, after a years' cruise in North American waters, shows our 12 hospital cases, only one being smallpox. H.M.S. Tremendous, returning from a two-year cruise in Home waters at the same time reported no cases.

Vaccination seemed to be the answer to smallpox, but the military authorities were not allowed to congratulate themselves for long. Late in the 1820's there was a great increase in the cases of post-vaccination smallpox, and during the 1830's extensive revaccination programmes were carried out in the armies of various European states, but the question was not considered in England until 1857. The pioneer work in this field was done by Professor Heim of the Wirtemberg Medical Service between 1829 and 1831. His results were extensively tabulated, and served as a guide to all other authorities. During the next ten years revaccination was started in most European states, it being made compulsory in the armies of Denmark and Bavaria in 1843-1844. The results of this were almost as remarkable as those of the primary reaction.

At this stage it is perhaps relevant to recall that vaccination, although compulsory in the British Army since 1802, was not made compulsory for the civil population until the Act of Parliament of 1853. During this time the majority of the cases of smallpox in the army occurred in the large towns where the disease was usually present, and among the army in Canada, smallpox occurred exclusively among those troops quartered in Montreal and Quebec. In this matter the military garrisons had become a protected class, and in the epidemics in Ceylon 1819, and Malta 1830-1831 and 1838-1839, the deaths among the troops were

appreciably lower than those among the civil population as a whole.

In the last hundred years smallpox has ceased to be a scourge of armies in the barracks and the field, as it has been in the past. The British army has never had an epidemic of smallpox as disastrous as that suffered by the French in the Franco-Prussian War of 1871, when they had 125,000 cases and 23,470 deaths. This has been the only outbreak of any magnitude since vaccination was made compulsory in military circles. Early in the 1914-1918 war there was an outbreak in the British army. In 1914 the attention of Medical Officers was drawn to the need to vaccinate all men as soon as they joined their depots, and only those that would be vaccinated were accepted. This state of affairs lasted only until 1916, when an Army Council Order allowed unvaccinated men to be enlisted.

Over the space of the last two hundred years the danger of smallpox in military communities has changed. With the introduction of inoculation and vaccination, the incidence and mortality of the disease has been reduced, and, with the compulsory vaccination of the civil population, the risk of smallpox in the garrison towns has also been reduced. In recent years the compulsory vaccination of both civil and military communities has been waived, without, as yet, any ill effects. Current knowledge of the disease and its treatment has removed much of its horror and danger among the close community, and one can but echo the words of Dr. Pingle with respect to the smallpox. "As to the smallpox and measles, as they are never general, I shall not rank them with the epidemics of an army."[4]

1. Niven, Maj. R. J. 1947 *Journal R.A.M.C.* 89.166
2. Thursfield, H. D.M. 1940 *Annals Med Hist.* 3.2.313.
3. Instructions to Regimental Surgeons 1803.
4. Pringle, J., M.D. 1775 Observations on the diseases of the army.

HISTORICAL DIAGNOSIS

Don Ulloa, Voyages to South America, 1735, 1. 44.

THE Spanish city of Carthagena in Central America was first settled in 1533, and was destined to become the seat of a bilious complaint named by the Spaniards the Vomito Prieto, the first outbreak of which was in 1729. Don Antonio de Ulloa described this plague in his "Voyages to South America" vol. 1 p. 44, 1735.

"This distemper does not declare itself immediately after the arrival of European ships in the bay, nor has it been long known here; for what was formerly called Chapetonadas, were only indigestions, which, though always dangerous in these climates, were with little difficulty, cured by the remedies prepared by the women of the country."

"The Vomito Prieto was unknown along the coast until 1729, when Don Domingo Justiniani, commodore of the Guarda Costas, lost so considerable a part of his ships companies, that the survivors were struck with astonishment and horror at the havoc among their comrades. So sudden were the attacks of the disease, that persons walking about one day, were, the next, carried to their graves."

Don Ulloa described the symptoms as great oppressions in the breast, violent affections of the head, delirium that rendered the patient furious, black vomit, and death on the third or fourth day in the paroxysms of torture. The disease affected strangers only, and was never in the least contagious to the natives, and was no respector of rank, the officers and the common sailors being affected equally.

A.M.W.

PROFILE

Gerard William Taylor

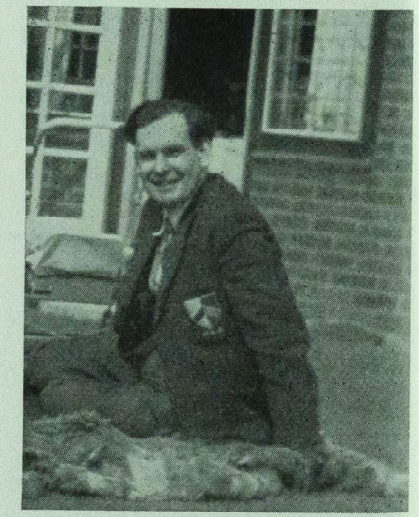
Oh, vanity of vanities!
How wayward the decrees of Fate are;
How very weak the very wise,
How very small the very great are!

IT is tiresome that quotations never seem to be entirely appropriate, yet this one is of value if it is used to draw attention to the many elements of greatness contained in Gerry Taylor's little bulk. It cannot be denied that he is short of stature, and has hands which are absurdly yet perhaps conveniently small for the great purposes to which he puts them. Yet equally it cannot be denied that he has greatness of heart and head quite out of proportion to their mere size.

His great-heartedness is shown in the courage with which he faces formidable undertakings, and also by the understanding and compassionate way in which he shares in the problems of his patients. It is a popular fallacy that academic clinicians lack human sympathy, and some might be tempted to say that Gerry learnt to handle patients so gently when he was for a while in general practice; those who know him well know better.

The greatness of his brain is manifested by a rare combination of knowledge and wisdom. Mere knowledge he absorbs with avidity, and he showed very early his capacity for storing, sorting, and discerningly using what he had absorbed by gaining in the final Fellowship examination the highest marks in living memory. However, one of the signs of his wisdom is humility "that he knows no more", and he might have slipped away into a less distinguished career had not a fortunate circumstance determined his return to Bart's, where his clinical years as a student during the early part of the second war had passed unnoticed. When he came back in 1948 he was given his first opportunity of showing his ingenuity in research, a quality which was further developed by a year at Stanford with Professor Emile Holman and Dr. Frank Gerbode, and has since won him a reputation not only in the Medical Research Council and the Surgical Research Society in this country, but also in the estimation of the Professors who have come from overseas to be temporary Directors of the Surgical Unit.

Humility is not the only sign of his wisdom, which is also shown by what seems to be a natural faculty for critical evaluation of his experience, which has enabled him to acquire a quality of clinical judgement rarely met with in a man of his age and scientific background. This same faculty makes him a first-class teacher, and his ability to make up his own mind and to explain how he does it is greatly appreciated by his dressers.



"How very weak the very wise"—this is only partly true, though its truth may be seen to be in the gentleness of the wise, and their belief in quiet perseverence when they want something, instead of blatantly fighting for it. This is Gerry's way, yet behind the gentleness and quiet perseverence lie tremendous stores of strong determination and tenacity of purpose in the pursuit of his ideals. And he isn't afraid of speaking out when circumstances require it.

Yet with all his virtues he is a thoroughly good chap. He may have learnt self-reliance when trooping in the war, but as a Professor it is of greater importance that he enjoys collaborating with his fellows in his own and in associated scientific departments. He has a twinkle in his eye and a quick sense of humour, and therefore makes a genial companion both on and off duty. His home is his principal hobby, and he shares with pride in the achievements of his versatile and enterprising wife. We therefore have confidence in wishing him happiness as well as success in directing the Surgical Professorial Unit.

THE NOT SO FROZEN NORTH

by A Tourist

MANY English people spend their holidays in Norway, and thousands are familiar with the magnificent scenery through which the railway passes from Bergen to Oslo reaching the snow line even in summer, and surrounded by snow-capped mountains rising to over 5,000 feet. Not so many, however, have gone up to the north, the land of the Midnight Sun, the land of the Lapps, and most of those who do make the trip are Americans. Such a trip, however, is well worth while and is full of surprises and points of interest.

At one time it was distinctly "non U" to travel in a crowd as a tourist, but such a procedure has its advantages. The alternative is to drive one's own car, but it is not all joy driving on Norwegian roads with a great many "hairpin bends", and one always seems to be on the precipice side of the road. Incidentally the right hand drive is a help in such cases and I noticed that in most of the long distance buses the driver sits on the right.

Again one has to pack and repack each day at a new hotel, it is much more convenient to take one's hotel with one, i.e. a ship. No, I am not an agent for a shipping company. Of course, to have one's own yacht would be ideal, and we passed the Norwegian Royal Yacht as the King went south after doing an extensive tour of the north, and some people with optimistic binoculars say that they saw him on the bridge.

Another advantage of travelling in a crowd is the possibility of meeting some interesting people. One such person was a naturalist, whom it transpired was a King's College man and a contemporary of mine at Cambridge, although we had never met. He had spent much of his life in Australia, where during the war he was a member of the Government Science Board. He told me an interesting story of the "Cactus pest" in Australia, where at one time the area of land rendered incapable of cultivation totalled more than the area of Ireland. At that time my friend heard that in America, where in some very dry places cactus is cultivated for a rather poor fruit, there was an insect which destroyed the cactus. He imported this insect into Australia and now there is practically no cactus.

Our ship, the "Ragnvald Jahl" a 2,000 ton coastal boat, called at 31 ports, some of them again on the return journey. We were lucky in having a cabin on the top deck with a shower bath, etc., attached. Most of the time we were protected by islands but when in the open sea the ship reacted to the rollers coming in from the Atlantic or Polar oceans, and the high position of our cabin accentuated the motion, but the movement was very quick, like a rowing boat, so very few people were ill and the dining room was always full. There were, however, casualties among the teacups, deck-chairs, and a table.

Those people who have ever travelled in a Scandinavian ship will remember the excellent food provided. At breakfast and supper there is a "smorgåas bord" or "walking table" on which I counted 24 different cold dishes in addition to jam, marmalade, etc. A hot course is also provided, egg and bacon, fish, or soup, etc., the Norwegians have good appetites second only to the Dutch. I was once sitting next to an R.N. sailor at a Lyons Corner House, and remarked on his good appetite. He said "Yes, but you should see the Norwegian's, they are the 'seventh wonder of the world' ", and then he added "but they are the Salt of the Earth'.' He did not know that my wife is Norwegian.

We left Bergen as usual in the rain, I did once see the sun shine in that town, and noted the picturesque old Hanseatic houses along the quays. A great many of the towns at which we called had been completely destroyed by the Germans when they retreated, and they are now being rebuilt. In the north the usual pattern is a concrete foundation and cellar with a square wooden house on top, but painted different colours which give the street a bright appearance. In the south more brick and stone buildings are being constructed. Christiansand is a good example of a town which, Phoenix-like, has arisen from the ashes.

On such a journey one has time to observe the costumes of one's fellow travellers, especially those of the young fair sex, but it would be wrong for a conservative old man to pass judgement. Some of the crinoline frocks had names and designs printed on them in large letters. One had "Moulin Rouge" written on it, but the serious face of the owner did not suggest that place of enjoyment. Tight jeans of all colours may be practical, but the same can hardly be said of the spike heels on a rolling deck.

One of the towns visited, Alesund, is of interest as being the original centre of the Vikings, and many interesting remains have been dug up. It is proposed to empty part of the fjord in the hope of finding some of the old ships.

The town of Trondheim was at one time the capital of Norway and was founded in the 9th century, but most of the original town was destroyed by fire in 1681. The Cathedral, a magnificent building, was originally built in 1320, but since then has suffered from fire on more than one occasion. The oldest part is of Norman architecture, but most of it is Gothic. It is still being restored. It was here that St. Olaf the patron saint of Norway was buried and pilgrims come from all over Norway, but his body was removed during the Reformation and has never since been found. Near Trondheim is an island from which Lief Erickson started his famous journey to Greenland, and which ended in his discovery of America about A.D. 1000.

Talking of churches, there are at Harstad examples of the oldest church and the most modern in Norway. The former, actually at Trondenes a few miles out, originally built in 1100 was rebuilt in 1250 and is a fortress church with walls 8 feet thick. The modern one is very colourful and ornate inside and has a large glass window stretching across behind the altar with many green plants growing inside. Another very beautiful modern church (a small cathedral) is to be found at Bodo. It is built entirely of concrete with a fine coloured glass East window and large hand woven symbolic mats hanging on the walls. The acoustics are improved by holes 10 cm. in diameter drilled into the walls, four of them per square yard.

Near Trondheim is an interesting collection of old musical instruments. Each room is dedicated to one of the old masters, and in several cases contains the instruments played on by him.

The visit to the Lofoten Islands is of interest as in this small area are over 30,000 fishermen who go out in trawlers, and export fish all over the world. The soil grows nothing, and was described by my naturalist friend as the poorest he had ever seen. There is a nice story that when the world was created, Norway was the last part to be formed, and by that time there was very little material left except rocks. Even those were in short supply, and it was therefore found impossible to complete the original plan of extending the earth to the North Pole, and the best that could be done was to drop the remaining rocks into the sea, the Lofoten islands being some of these. The Lofoten people, however, are well off thanks to the fish, and are smartly dressed. Not very long ago the inhabitants had the reputation of being dirty and not too moral. During the war many of the women were evacuated to England, and some of them were brought to the Bart's ante-natal clinic.

On one occasion the Norwegian Red Cross escort was severely ticked off by a member of the consultant staff who said "Nurse see that your patient is properly washed before bringing her again" to which the nurse meekly replied, "Yes Sir". Later I introduced him to the nurse, my wife. Another occasion a patient from those northerly islands pleaded "it was her first mistake" not realizing that an obstetrician can check up on such a statement. It is curious that people who live in the Lofoten Isles say they would not live elsewhere in spite of the complete winter darkness which lasts from the end of November to the end of January. There is no accounting for taste.

It is curious that although the Lofoten Isles are so infertile much further north there are splendid small farms, and large strawberry beds, the fruit of which we found was large and sweet. Our friend pointed out that many plants found in England are much larger in the North of Norway. On the way north we passed a cliff, the breeding ground of many thousands of sea birds, chiefly "Kittiwakes". The horizontal ridges of these rocks were outlined by these white birds, rather like festooned strings of pearls. After two or three rockets had been fired there was a dense cloud of birds. Another interesting sight was a mountain with a natural tunnel right through it over 500 feet long and about 170 feet by 80 feet in diameter, and there is a pretty fairy story told as to its origin.

One of our ports of call was Hammerfest, the most northerly town in the world, but the temperature one day was 70 deg. F. The north of Norway owes its prosperity to the Gulf Stream which keeps the ports open all the year round. In Hammerfest is the world-famous "Findus" fish factory, indeed the whole town reeks of a fusty smell which seems to be a mixture of diesel oil, fresh fish and fried fish. Curiously enough inside the factory only the smell of fresh fish existed. On visiting the factory we put on white overalls, but whether to protect the fish or our clothes was not stated! Everybody in the factory wears clean white overalls. Inside we saw the ice packed fish as it comes from the trawlers which is then sorted, washed and put into the deep freeze. It is then cut up and put on conveyor belts. Women then take it and fillet it, removing all bones, and put it on another conveyor belt to be packed. Some of it is made into "fried fingers", which many of us have bought in England. The women are mostly paid by "piece work" and become exceedingly expert. They rest five minutes in each hour, but owing to the noise conversation is impossible, and they lip read. Every town or village connected with fishing has "drying poles", which are arranged in arches about 15 feet high and 10 feet at the base. These arches are about 3 feet apart connected by horizontal laths about two feet from each other; in this way a tunnel is formed 200 to 300 yards long. On these thousands of fish are hung up to dry. Most of it is exported to Catholic countries, it is not often seen in England. At Hammerfest we saw the Midnight Sun at 10 p.m. when it was still about 5 deg. above the horizon, but alas after that it was blacked out by a rain cloud, nevertheless at midnight it was still easy to read a book on deck.

Eventually we reached the North Cape, the most northerly point of Europe, a cliff rising 1,000 feet out of the sea. A zigzag path and many wooden steps lead to the top, a breathless performance for the elderly, and some remained on the ship. A ship's officer brought up the rear of the party and signalled to the ship that we had all survived, and the ship left to meet us at the next port. From the Cape we went by bus for many miles over very wild moorland, a few reindeer were seen. We visited a Lapp settlement where the people were dressed in their colourful costumes for the benefit of the tourists. They showed a tent made of reindeer skins, but lived in wooden huts. It is said that some of the more nomadic tribes still use tents. There was a very fine herd of reindeer, and the people sold souvenirs, fur boots and shoes, etc. We then joined the ship and eventually reached Kirkenes, the turning point of our tour. This is quite close to the Russian frontier.

On the return journey we called in at many of the same ports and said goodbye to our fellow passengers in Bergen. After a very pleasant stay in a cottage with a friend in the mountains and bathing in the lake we said "Au revoir" to Norway, and its cheerful, friendly, smiling people whom the sailor rightly described as the "Salt of the Earth".

F

THE QUESTIONNAIRE: ASPECTS OF MEDICAL EDUCATION

by P. J. Watkins

THE three questions on Medical Education deal with the integration of parts of the medical curriculum, the desirability of a tutorial system, and the popularity of individual subjects. Those coming from Oxford and Cambridge have experience of tutorials, and it is interesting to compare their answers with those of the London students who have not. On the matter of integration, none has yet any experience, and it therefore seems appropriate to include a few words on such systems.

Question:— *In some medical schools, the teaching of clinical and preclinical subjects has been integrated; i.e. clinical conditions and associated pathology produced by diseases of an organ or system are studied at the same time as its anatomy and physiology. Do you think the teaching at Bart's should be: completely integrated; left as at present; or partially integrated?*

Two ways of integrating medical studies have been attempted—so-called "horizontal" and "vertical" systems. The recent Birmingham scheme provides one example of horizontal integration of preclinical studies—namely, of Anatomy, Physiology and Biochemistry. The scheme has been regarded as successful; Zuckerman and Gilding, the Professors of Anatomy and Physiology respectively, add: "The ultimate aim in any system of integration would clearly be for the same lecturer to be responsible for both the anatomical and physiological teaching in each particular field"[1] This attitude is a good sign of the present trend away from over-specialisation.

At Aberdeen schemes of both "horizontal" and "vertical" integration have been attempted. The former is represented by discussions of patients between physician, anatomist, physiologist and students—a valuable and stimulating method of learning, not, one must add, restricted to Aberdeen, but well developed in the reformed curriculum in Germany, and not unlike conferences of the clinico-pathological type which are a feature of many medical curricula (though unfortunately not that at Bart's).

"Vertical" integration has been tried in Aberdeen, by a return to anatomy, when students reach the stage of ophthalmology and E.N.T. Anatomy is a subject which has been "vertically" integrated in many schools, especially in the United States: the tendency is for a shorter preclinical anatomy course (for example, University College, London, have shortened their course by 100 hours) and to develop more extensive (i.e. applied) anatomy during clinical years.

Other subjects lend themselves to similar treatment. Pathology, for example, is most usefully learned preclinically, and resumed in later years with a different bias as, say, surgical pathology. Trends in psychology[2] too, show that it is useful if normal human psychology is taught preclinically before one embarks on the study of psychiatry in the later clinical years (a system already established at Sheffield and at Bart's).

In the United States, extensive (and expensive) schemes of integration (both "horizontal" and "vertical") have been introduced. In some schools, paediatrics, obstetrics and gynaecology, for example, are introduced at the preclinical level.[3] These subjects, after all, cannot be considered solely from the pathological angle, the physiology of children and that of pregnancy are surely only ramifications of normal physiology, and might well be introduced at a time when the mind is well exercised in this subject.

Other schemes are infinitely more complicated, and attempts to co-ordinate, for example, the basic sciences with obstetrics, psychiatry, and anthropology, have been made. In another course (Colorado University), the first week is spent in a rapid dissection of tiny cadavers ranging from the fifth foetal month to term in order "to help the student to see the need of a thorough understanding of the growth, development and adaptations of a human being". The value of these courses is not yet clear, but certainly they show a live interest in the techniques of medical education. However, in all this turmoil, it is well to take heed of Dr. Whitehead: "Knowledge and insight won for oneself are infinitely preferable to the predigested offerings of modern paternalism".[4]

The answers to this question are shown in the table below.

	LONDON		OXFORD		CAMBRIDGE		OTHERS
Completely integrated	26	*11*	7	*35*	4	*6*	1
Remain as at present	105	*36*	6	*30*	32	*46*	0
Partially integrated	148	*51*	7	*35*	31	*45*	2
(Didn't answer)	(9)				(2)		

Figures in italics represent percentages.

Discussion of the results

In the light of the preceding discussion, we must review the findings of the present questionnaire. One must assume that by "complete integration" is meant some radical scheme involving horizontal and vertical components, and by partial integration it must be assumed that one or other of the horizontal or vertical schemes might be attempted.

The answers to this question show that there is an almost equal division between the conservatives who would prefer to continue with the present system, and those in favour of partial integration. While it is interesting to find that a high proportion (37 per cent) of people are satisfied with things as they are at present, it is significant that more (60 per cent) are not. Whether these are largely people who want change merely for the sake of a change, or whether most of them feel more seriously about the subject of integration, is not immediately obvious; what is suggestive of a serious approach is the fact that 45 per cent of the Cambridge students are in favour of partial integration in spite of the fact that for those coming from Cambridge there is the least possible chance of integration as long as there continues to be no clinical teaching there.

The Oxford votes were distributed more or less equally over the three possibilities, and although the numbers were small, it is interesting that relatively so many (35 per cent) should want complete integration. Exactly why the Oxford vote should show this difference of distribution is quite inexplicable!

References

Much of the information for this summary was taken from the First Report of the Report on Undergraduate Medical Education in Great Britain and Northern Ireland made by the B.M.S.A. in 1956.

1. ZUKERMAN S. and GILDING H. P. (1953), First World Conference on Medical Education. Proceedings, O.U.P., London (1954), p. 243.
2. Report on the teaching of psychiatry and psychological medicine in British Medical Schools prepared for the B.M.S.A. by Roderick. N. M. MACSWEEN, 1958-59
3. H. CHRISTENSEN, *Medical Education in the U.S.A.* St. Bartholomew's Hospital Journal, November 1959, p. 292.
4. WHITEHEAD, R. (1956), *Brit. Med. J.*, 2.492.

Question:— *Would you favour an individual tutorial system as part of the teaching?*

A LARGE number of people have indicated that they would favour a system of individual tuition. Taken in its strictest sense this would be utterly impracticable, and Oxford is still the only place where this is available. It is encouraging to see from these results that those who have been at Oxford are, in spite of or because of the experience, still in favour of the system (85 per cent). A few seem to be against it (10 per cent represented by 2 people)—unfortunately there is no means of knowing why.

The system of tuition in small groups (2-4) as one finds at Cambridge, is probably of more value to the average student than individual tuition, which seems more suited only to the few first-class minds who have the opportunity to pick their master's brains! Group tuition allows for free discussion, guided by the tutor, and is probably one of the best and most stimulating ways of learning. The Cambridge vote once again shows that having experienced the system most (73 per cent) still deem it a successful one, although there is a discouraging 17 per cent—again, why? Perhaps they were unable to prepare their essays in good time!

A significantly high proportion of the London students (80 per cent) are asking for a tutorial system; 12 per cent were undecided, but this is excusable in a community in which there is no previous experience of teaching of this kind.

Comment

The necessity for tutorials for preclinical studies is very great, otherwise the course is largely unrelieved of "fact-finding" by lectures and practicals. With regard to clinical teaching, it is important because although ward and outpatient teaching is already conducted with groups occasionally of a reasonable size, there is no scope whatever for the consolidation of ideas by discussion, the necessity of which provides the vital indication for a tutorial system. There is certainly one "firm" in the hospital which meets once a week to discuss a student paper under the guidance of the registrar: an idea of this kind could profitably be more widely developed.

An addendum to this article would be to suggest the idea of a tutor "in loco parentis" as established by some universities: one feels that this would surely advance the relationship between students and staff, which is at present rather limited.

	LONDON		OXFORD		CAMBRIDGE		OTHERS
Yes	226	*80*	17	*85*	54	*78*	2
Undecided	36	*12*	1	*5*	3	*4*	0
No	25	*8*	2	*10*	12	*17*	1

Figures in italics represent percentages.

Question:—*In what subject (of those you have studied) do you think teaching at Bart's is Best/Worst?*

THE answers to this question are presented so as to indicate the popularity of subjects during each year of the course. Any subject which scored fewer than 8 votes has been ignored. It is also probably true to say that comments made by final year students on subjects taken many years earlier should probably carry more weight than comments made on more current studies.

Thus, in the second preclinical year, physiology and anatomy vie with each other as the best taught subjects (1st and 2nd places respectively), and at the same time they take 2nd and 3rd places (respectively) as the worst taught subjects. This apparent contradiction is probably a good indication that the subjects have aroused considerable interest, and for better or worse, are high on the list of talking points. They are similarly placed in the 3rd preclinical year (3rd and 2nd best, 1st and 2nd worst respectively), and later in the 1st and 2nd clinical years, physiology continues to take 2nd place as the worst taught subject.

High at the top of the poll in the 3rd preclinical year comes the teaching of pharmacology, and it is significant to observe that during the 1st clinical year, in the face of the many new subjects encountered, it is still considered the best taught, and by the 2nd clinical year, it comes 2nd only to surgery.

Surgery, after standing 2nd to pharmacology in the 1st clinical year, comes out well at the top by the 2nd year, and is again forced to 2nd place in the 3rd year by obstetrics and gynaecology, and it is significant that it maintains a high place for the entire period during which it is taught. Pathology maintains first place as the worst taught subject throughout the three clinical years.

In the final year, obstetrics and gynaecology appear well at the top. Therapeutics and Pathology tie as the worst taught, and are followed closely by "Specials".

Comment

Some general comments may be made at this point on some of the reasons for the popularity or not of the teaching of the various subjects. In general it may be said that successful teaching, from the student point of view at least, depends on the care with which the course is organised, its co-ordination with other departments, on the existence of tutorial groups or other possibilities for organised discussion, and on the individual attention which students receive. Two courses are exemplary in this way, and are accordingly popular: obstetrics and gynaecology is an example of a course in which systematic lectures, discussion groups ("midder grinds") and in-and-out-patients are well co-ordinated, and provide a most stimulating six month course. The individual attention which students receive in this department is greatly appreciated, and is one important result of reasonably small classes. This is an important factor in determining the value of any particular form of teaching, and on the whole, it is time to say that groups (especially those in Out-Patients) are too large—Similarly, in the pharmacology course there is a good balance between theoretical and practical work, and tutorials in small groups form a regular feature.

The difficulty of Pathology is surely the result of an unbalanced course in which too much time is devoted to Bacteriology and too little to Pathology in which attempts are

	YEAR	BEST		WORST	
PRE-CLINICALS	1st	1. Chemistry	*14*	1. Biology	*9*
	2nd	1. Physiology	*24*	1. Histology	*10*
		2. Anatomy	*22*	2. Physiology, Chemistry	*9*
		3. Physics	*8*	3. Anatomy, Biology	*8*
	3rd	1. Pharmacology	*46*	1. Physiology	*26*
		2. Anatomy	*11*	2. Anatomy	*16*
		3. Physiology	*8*	3. Biochemistry	*9*
CLINICALS	1st	1. Pharmacology	*18*	1. Pathology	*12*
		2. Surgery	*8*	2. Physiology	*9*
	2nd	1. Surgery	*20*	1. Pathology	*16*
		2. Pharmacology	*8*	2. Physiology	*8*
	3rd	1. Obst. & Gynae	*47*	1. Pathology, Therapeutics	*11*
		(2. Surgery	*4*)	2. "Specials"	*8*

The figures in italics in each column represent the numbers who voted for the individual subjects.

made to teach a fantastic amount in a relatively very short time: the result is that lectures are very much compressed and rather unsatisfactory, and it is quite utterly impossible for students to maintain the pace in their reading. There is also no adequate tutorial system: that existing is, generally speaking, infrequent and unwieldy.

That therapeutics is considered the worst subject of the final year is not surely because of bad but inadequate teaching in this extremely important subject. The course is of very limited length, comes but once a year, and that at the least advantageous time in relation to Part I. There are, of course, no tutorials in the subject, and knowledge gained in this subject from ward rounds is fairly limited because of the very nature of the ward round.

The "Specials" course exemplifies most of the undesirable features which have been outlined in this commentary. For example, the groups are almost invariably too large; there is an almost total absence of any practical work (i.e. the examination of patients), and there is no scope whatever for discussion. Fortunately with the revision of the medical curriculum, and the return of the departments at Hill End, teaching of the special subjects should soon be considerably improved.

STUDENT INTEREST IN THE JOURNAL

IT has been quite an interesting revelation to find out just what people read, and one hopes that the results shown below will be of some help to future editors.

Question:—*Do you intend to take the Hospital Journal after you qualify?*

IT was disappointing to find that while 65 per cent of the preclinicals had decided to take the *Journal* after qualifying, only 38 per cent of a riper age and nearer the day of qualification, were inclined to do so, and some 23 per cent had definitely decided that they would not. Whether this represents an increasing disinterestedness in "current affairs", or the unacceptable standard of the *Journal*, one cannot tell: either way it is unfortunate, and one hopes that whichever is at fault may quickly be rectified. As usual, a large percentage (35 per cent) were undecided—rarely a happy state!

	PRECLINICAL		CLINICAL		TOTAL	
Yes	111	*65*	78	*38*	189	*50*
Undecided	54	*32*	79	*39*	133	*35*
No	5	*3*	46	*23*	51	*14*

Figures in italics represent percentages.

Question:—*Mark any of the following that you read regularly in the Journal.*

IT is encouraging to editors to find that 67 per cent of students read the Editorial, and one only hopes that this is really true. Less encouraging is the observation that some of the most popular features of the *Journal* are those to which students are least likely to contribute. For example, humorous articles hold sway at the top of the poll (75 per cent), but few are ever received: similar comment may be made of Letters to the Editor (63 per cent). The item labelled "News" was also popular (68 per cent), and it is to be hoped that the recent expansion of this section of the *Journal* will meet this demand.

At the other end of the scale come verse (39 per cent) and Travel Articles (36 per cent). It is not easy to see why this should be, and one must postulate that either people are simply not interested in such articles, or that the standard is inadequate; certainly every effort is made by the Publications Committee to maintain this standard, and the selection of these types of articles is particularly rigorous. Surprisingly, Book Reviews came low on the list (37 per cent), and one really wonders why more people do not read about the books on subjects which sooner or later they will have to study.—And is it really true that only the 43 per cent who read the "Births, Deaths, etc" columns care about the fate of their colleagues?

In the middle of the list come Medical Articles (59 per cent), which seems an encouragement for more such articles; and at 52 per cent, Sports News would appear to justify the relatively large amount of space given to it in the *Journal*.

Perhaps the 24 per cent who read the Advertisements never reach the Editorial!

	PERCENTAGE OF TOTAL	PRECLINICALS	CLINICALS
1. Humorous Articles ...	*75*	132	149
2. News	*68*	107	150
3. Editorial	*67*	114	139
4. Letters to the Editor ...	*63*	104	134
5. Medical Articles	*59*	104	120
5. General Articles		103	118
6. Sports News	*52*	90	105
7. Births, Deaths, etc. ...	*43*	55	108
8. Verse	*39*	66	82
9. Book Reviews	*37*	63	78
10. Travel Articles	*36*	85	90
11. Advertisements	*24*	41	48

DEVIZES TO WESTMINSTER

by R. Courtenay Evans

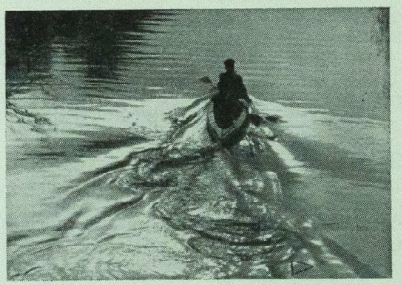
WHILE many of us were enjoying a few days of relaxation, with perhaps the odd visit to Goodwood or a point-to-point, three crews under Bart's colours were spending their Easter holiday competing in the Devizes to Westminster canoe race. This annual marathon consists of 125 miles of waterways—the first 50 from Devizes to Reading is over the shallow weed-strewn disused Kennet and Avon Canal, linking the east coast to the west and necessitates the portage of boats over 50 locks and the passage of the Savanake Tunnel. From Reading home the course follows the picturesque Thames valley, a less arduous stretch where riverside hostelries outnumber the locks.

The 130 crews competing could start at any time from 8 a.m. onwards and our three canoes, contemplating making a weekend of it, got off with the first rush soon after eight on a chilly overcast morning. Our boats were heavy, collapsible kayaks, more in the luxury touring class than the slim fibre glass and shell built craft of the seasoned competitors. They were laden with the compulsory gear of a tent, sleeping bags, cooker, spare clothing and rations; and in spite of using sheet sleeping bags and a makeshift tent of polythene and rope for lightness (we were not anticipating stopping for the night !) the canoe bent like a banana as it was carried to the start.

Once on the water, we settled down to a steady but leisurely pace heading for the first lock. Nevertheless over this first lap of fourteen miles there was a steady flow of competitors past us going at a less leisurely pace. Four hours later we reached the lock, hurriedly jumped ashore and dragged the boat along the grassy towpath. We reached the other end of the lock just in time to see the marine crew ahead of us rip the bottom off their boat on a submerged spike and so their ordeal was over for another year! Locks appeared regularly every 200 yards for the next two miles. In spite of the obvious danger to the keel our dragging method of portage seemed as efficient as any, but an endeavour to produce a really snappy effect for the benefit of a press photographer ended in humiliation as we both simultaneously slid down the four-foot bank into the mud at the edge of the canal.

After several hours the rain started, and we felt glad of our amateur status as we buttoned on the waterproof spray cover, a luxury denied to the hardy paratroopers and marines. It continued to pour all Friday afternoon and evening and contributed to our first disaster when Humphry Ward slipped on some wet grass and broke the rudder. This was roughly repaired with a stick and string and we pressed on after a stop of half an hour.

We reached Newbury at dusk 35 miles from Devizes wet but satisfied. There under a bridge we changed into dry clothes and donned our "yellow suits"—ex R.A.F. survival suits made in 1942 for airmen down in the drink—straight from the Commercial Road! Feeling traitors to our civilian status we downed a quick brandy and set off for Reading.



Patrick Ward, by courtesy of The Observer

A lone marine doubled up with stomach cramp drifted downstream. Night fell and a mist began to rise from the water. In spite of our headlamp the locks became increasingly hazardous, then at 10.30 disaster struck! A rending jar under the waterline told us that we had hit a submerged obstruction. Initially all seemed well to our great relief, but soon after the next lock Ward, at the back of the boat, announced that he was sitting in an ever increasing pool of water, and soon after it reached me in the forward position. We pulled the boat ashore, tipped out several gallons of water, and discovered a large gash in the canvas. After an unsuccessful attempt to patch it our frustration and disappointment waxed steadily, not relieved by the thought of our cynical colleagues on Tuesday morning. However, surgery provided the answer, and having procured a needle and thread we stitched up the rent to give a reasonably waterproof mend.

Meanwhile one of the other Bart's boats manned by Bernard Watkins and Peter Joy had passed us in apparently good form. We refloated the boat and found the leak temporarily stemmed. The mist by now had thickened reducing the visibility to about 5 yards and the banks were strewn with abandoned and damaged canoes. Then once again the water started to seep through and soaking wet and dejected at 1 a.m. on Saturday morning we felt compelled to "jack it in" at the next lock. But here our luck changed and we met two congenial soldiers who had discovered a nearby barn which proved to be dry and full of hay. Here in view of the adverse conditions they had decided to bed down until dawn and we gratefully accepted their offer to join them.

The dawn was fine and our spirits were further raised by the arrival of Watkins and Joy who, having spent the night in a deserted pillbox, looked even colder than we felt and so once again we decided it was County Hall or bust!

In the daylight two more holes were found in the canoe and repaired, and so almost 24 hours after the start we set off again still 10 miles from Reading. The boat was leaking much less now (only having to be baled every hour) and by 11.30 a.m. we had seen the last of the Kennet and Avon Canal. We reached Reading as the Aldermaston marchers passed over the river and we felt that we might at least beat them to the Metropolis!

We headed uneventfully down the Thames by-passing Shiplake lock by a fast flowing backwater and reached Henley early in the afternoon. Here we dropped in at Leander for a wash and brush-up before facing a force seven headwind up the Reach. At Marlow we heard that a Special Air Service crew had reached Westminster in 23 hours. We had been going for about 32! It was now just a long grind to the finish and we enjoyed a beautiful sunny evening through Bourne End, Cookham and Maidenhead. Here we noticed considerable excitement and on closer inspection we found several cabin cruisers blazing fiercely in the evening breeze. Among the wreckage drifting downstream was the upturned keel of a kayak canoe!

Night fell once more and we teamed up with a Royal Pay Corps crew with whom we could just about keep up! Between us we now worked the remaining locks in order to relieve our battered canoe the rigours of portage. At one of these locks we again met Watkins and Joy who had decided to camp out another night before coming up on the morning tide.

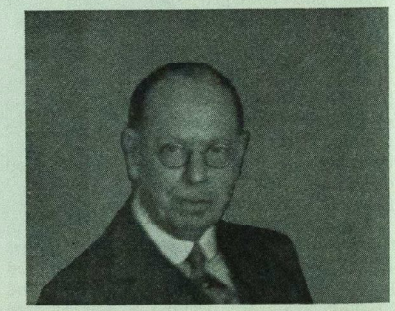
Early on Easter Sunday morning we passed two frozen parachutists whose fibre glass canoe had split several hours before but it was not until now that they had received permission from their H.Q. to bivouac for the night. By Molesley lock fatigue and the cold was beginning to get the better of us. Mutual irritation rose to a climax, conversation became incoherent, and every floating log or swan appeared like a kayak canoe. So five miles from the tideway at Teddington with the next high water at 8 o'clock, we knocked up the night lock-keeper who, after a few bronchitic grunts, put his tiny office at our disposal. Within minutes, after a cup of self-heating soup laced with brandy, the four of us were asleep, draped in macabre positions round the room.

Two hours later, warmed and refreshed, we set off and reached Teddington soon after high tide. The end now seemed very close, especially when the lock-keeper cheerfully announced that we would be home in two hours. So stimulated, we really cracked off down the Tideway imagining the Houses of Parliament to loom up round every corner. By Kew our finishing spurt had finished and a strong head wind just about cancelled out the flow of the ebb tide. This continued to the finish, whipping the river into an enormous millpond from Battersea onwards and when the Mecca of County Hall finally appeared we really felt that this was "the Poor Man's Everest" as Chris Brasher had called it in his article for *The Observer*. We had completed the course in just over 51 hours. Watkins and Joy came in a couple of hours later, arriving just as the tide turned, and Dupré and his partner turned up the following morning after 71 hours in their boat.

OBITUARY

Conrad Meredyth Hinds Howell

M.A., D.M. (Oxon), F.R.C.P.



Dr. C. M. Hinds Howell, who was consulting physician to Bart's and to the National Hospital, Queen Square, died on May 9th after a short illness, at the age of 83. He was educated at Marlborough, Trinity College, Oxford, and Bart's. At Oxford he obtained a first-class in the final honour school of natural science (physiology) and came to Bart's with a senior entrance scholarship. He was awarded the Kirkes scholarship and gold medal, the Brackenbury scholarship in medicine and the Lawrence scholarship. He qualified M.R.C.S., L.R.C.P. in 1902 and B.M., B.Ch. (Oxon), in 1903. He obtained the M.R.C.P. in 1905, D.M. (Oxon) in 1908 and was elected F.R.C.P. in 1912. After qualification he was appointed house-physician to Sir Dyce Duckworth and subsequently worked as demonstrator of physiology and pharmacology, medical registrar and casualty physician at Bart's, and registrar and pathologist at the National Hospital. In 1908 he was appointed physician to the Royal Northern Hospital and in 1912 assistant physician at the National. He became assistant physician at Bart's in 1920 and resigned his appointment at the Royal Northern shortly afterwards. In 1930 he was appointed physician and in 1937, under the retiring age of sixty in force at that time, he retired from the active staff when he was senior physician. At the beginning of the war, however, he returned to work at Hill End till 1946. He was Vice-President of the Medical College for five years. He continued on the active staff of the National Hospital till 1942 and was for a time Dean of the postgraduate medical school at that hospital. For varying periods Dr. Hinds Howell held consultant appointments at Finchley Memorial Hospital, Harrow and Wealdstone Hospital and the cottage hospitals at Uxbridge and Potters Bar.

He played an active part in the work of the Royal College of Physicians, holding the offices of councillor, censor and senior censor, and he was also treasurer of the college for four years. For twelve years he was on the committee of management of the conjoint board, being chairman of the committee for four years. He was an examiner for the Universities of Oxford and London and for the conjoint board. In 1935 he was president of the neurological section of the Royal Society of Medicine, giving his presidential address on arachnoiditis, and he was a founder member of the Association of British Neurologists.

H.H. (as he was usually called) was both an outstanding neurologist and a general physician of wide knowledge and experience. He was a first-class teacher, especially in the wards and out-patients, where he concentrated on basic principles and the methods of examination and avoided the recondite and the obscure. He developed a method of injecting the Gasserian ganglion under general anaesthesia for the treatment of trigeminal neuralgia, a difficult procedure but one in which he only rarely failed. He was one of the kindest and most understanding of men and showed these qualities repeatedly in dealing with his patients and with those who worked under his supervision. During his late fifties and early sixties he had a succession of illnesses which he faced up to with great fortitude and cheerfulness, and for the last twenty years of his life he was full of energy and was working until a week before his death.

As a young man he was a keen cricketer and was in the Marlborough first eleven for three years; and for many years he captained the Past in the annual Bart's Past versus Present cricket match. At Oxford he represented the university for three years at fencing, winning his matches against Cambridge on each occasion. Later he became a good golfer and a keen fisherman.

He married Mabel Gulland, an Edinburgh medical graduate, in 1905; she died in 1958 and he is survived by his three sons, one of whom is a doctor—Dr. C. A. Hinds Howell.

LETTERS TO THE EDITOR

FAITHFUL SUBSCRIBER

Dear Sir,

My daughter is typing this letter for me. I am now in my 91st year. For a considerable time, owing to failing sight, I have been unable to read the Journal myself and have had to rely on the goodwill of others to read it to me. With deep regret I am not continuing my subscription to the *Journal*, which over very many years has so greatly contributed to my pleasurable and informative reading. I shall always have the happiest memories of St. Bart's Hospital, its excellent teachers and its *Journal*—pre-eminent in varied activities.

My kindest thoughts and wishes are with them all, always. May they ever continue and increase all their very fine work as the times change and years roll swiftly by.

Yours sincerely,

ERNEST E. H. SAWREY.

7 Narvenu Court,
Hawthorn,
Melbourne, E.2.

One of the 38%. *See page* 208. *Ed.*

SQUASH COURTS

Dear Sir,

I feel that the editorial in last month's issue of the *Journal* is based on two misconceptions. As Secretary of the Squash Club at the time referred to in the editorial I feel that some elucidation of the relevant points is necessary.

The first misconception concerns the relationship between the Student's Union and its constituent clubs. One of the chief functions of the Student's Union is to allocate money derived from Student's Union subscriptions to the Clubs. The amount of money available is not unlimited. Thus many clubs find it necessary to raise additional funds. Most of the larger clubs do this by way of dances or sweepstakes. The Squash Club chooses to do it by imposing a sixpenny booking fee payable whenever a court is booked. Although this must be approved by the Student's Union, just as dances must be approved, it does not seem to me to be a measure to which they could reasonably object, for reasons which will appear below.

The second misconception seems to me to be the Editor's idea of the membership of the Squash Club. By virtue of their membership of the Student's Union all students of the Medical College are entitled to membership of the Squash Club. The club does not consist only of those comparatively few people who represent it in matches, it consists of all the squash players of the College. These people are the only ones affected by the booking fee. If they object to the fee it is really up to them to raise the matter at the Annual General Meeting of the Squash Club. Since squash matches are played in the evening our opponents have to be provided with a meal rather more substantial than the tea provided by other clubs, and, for this reason, considering the number of active squash players in the College, our expenses are relatively high.

I feel that it is preferable to ask for a comparatively small grant from the Student's Union and supplement it with booking fees, than to ask for a large grant and make no effort to raise money within the Club. I should have thought that efforts by individual clubs to raise money on their own initiative would have been worthy of praise rather than of blame.

Yours sincerely,

C. J. BEARDWELL.

Abernethian Room,
St. Bartholomews Hospital.

DRUDGERY

Dear Sir,

Your May number explains your March number's reference to "pre-registration drudgery" by saying that Bart's house jobs are not drudgery but provincial house jobs are.

Those of us who are on the visiting staffs of Provincial Hospitals will be sad to read this, and greatly helped to know how to change the conditions of our residents, strike off the shackles, pile on (maybe) the shekels, and "attract" a bigger and better entry. I would remind you that there are hospitals serving populations of several hundred thousands not much more than 50 miles from London having (to quote my own) visiting physicians (Bart's men) with F.R.C.P.'s and surgical colleagues of equal status, where clinical material is ample and clinical experience extensive, and contact with local G.P.'s capable of development to assistantship and partnership. The country is near, the sea nearer, social opportunities frequent. And if the art is long, the experiment difficult and the life short, is that truly drudgery?

But anyhow, please tell us what your pre-qualification readers would like and we will do our best.

Yours faithfully,
W. A. BOURNE.

46 Wilbury Road, Hove.

Dear Sir,

I am glad that Dr. Lindsey W. Batten took you to task for your remarks about pre-registration house jobs. Your footnote to Dr. Batten's letter serves only to underline your ignorance of conditions in what you disdainfully describe as "the provinces". Whilst it is true that conditions can sometimes be very discouraging in certain understaffed hospitals, especially up north, there are innumerable first-class house jobs available within fifty miles of Bart's.

It is an excellent thing to do a house job in one's own teaching hospital, but a resident who works in a good regional hospital gains far better all round experience than in the London schools. Teaching hospital experience in London is often far too specialised; provides too little opportunity for the study of emergency cases, and is generally unrepresentative of the type of community Medicine which most of us must practice later.

Since leaving Bart's I have been much impressed by the tremendous opportunities available at outside hospitals. Moreover, I have never had a house surgeon, either at my London or my "provincial" hospital, who has not been amazed and gratified by the experience gained. These young men and women often work very long hours, but I am glad to say that they never regard their work as drudgery. Whatever problems have been created by Nationalised Medicine in the registrar and later stages, one's early life after qualifying should still be an exciting adventure. Your student readers may rest assured that the opportunities are immense and it is entirely their own fault if they fail to make use of the many good appointments available in the regional hospitals.

Yours faithfully,
R. S. MURLEY.

95 Harley Street, London, W.1.

Dear Sir,

It seems that my observation in the March issue of the *Journal* ("The proposed rates . . . should do much to dispel the sense of injustice felt by many in what often seems to be regarded as a year of pre-registration drudgery") has been more widely interpreted than was intended, and as three of your correspondents have now taken me to task for my words I must claim the hospitality of your columns to offer an explanation.

In logic it is not permitted to generalise from the particular but such generalisations are not uncommon in journalism as they serve to stimulate thought and provoke comment from the reader. The habit is easily acquired and the comment to which Dr. Batten took exception was just such a generalisation, though in this instance it was not intended to be provocative. My footnote to Dr. Batten's letter seems to have provoked even more wrath—it would have been wiser here to say nothing or to have explained more fully.

Dr. Batten seems to find it incredible that housemen at Bart's, or elsewhere, should feel hard up on the old salary scale, whereas he and his colleagues "felt rich" on £60 p.a. How right he is to cry "*O tempora!*" for times have changed indeed and the financial pattern of 1960 will scarcely bear comparison with that obtaining forty years ago. If Dr. Batten means that the hardships of life on £60 p.a. were tempered by the very fact of working at Bart's then I am sure that the modern generation of housemen would agree with him. Dr. Batten may rest assured that competition for the honour of working at Bart's would be as fierce as ever even if the salary scales were reduced *below* their present level.

Nevertheless there must be few housemen who have not at some time or other compared their first year's earnings with those of friends who have become, for example, solicitors or chartered accountants. Surely Dr. Batten would not deny them the encouragement they must find in the words of the Pilkington Report (summarised as follows in the B.M.J.: "House officers are considered to have been greatly underpaid both in relation to their seniors and in relation to what is paid to comparable persons in other professions") and in the revised salary scales.

With regard to the provinces, Sir, the advantages of a house-job in the country, as opposed to a teaching hospital, are often debated. Undoubtedly the sheer weight of experience to be gained and the opportunities of meeting local G.P.'s, so invaluable to anyone contemplating general practice, are major advantages of a provincial post. Be that as it may, Sir, I have met men waiting to take up provincial posts who, apprehensive perhaps of what lay before them, have bemoaned the long hours (variously estimated at from 80-120 hours per week), the move away from their London friends and, perhaps most important, the indisputable fact that once a man has moved out of London he can very easily lose touch with medical circles and the return to a London appointment may be very hard to achieve. It was from these people that I made my generalisation.

I have no wish to decry the provinces where, like your correspondents, I am sure that the work is both full and rewarding. It is to be hoped that more informed opinion among senior students together with the new pay scales will provide the improved entry which Dr. W. A. Bourne desires.

Yours faithfully,

A. J. B. MISSEN.

Abernethian Room

BOOK REVIEWS

SMOKING AND LUNG CANCER by T. W. Lees. **Published by the Author, 1959.**

Dr. Lees, of Law Hospital, Carluke, has published a most interesting paper on a very controversial subject. His aim is clearly to disprove that any relationship between smoking and lung cancer exists. He even goes so far as to suggest that, from the available figures, one could equally well prove that heavy smoking might actually prevent lung cancer. His arguments in many cases are based on slender evidence and without due consideration of *all* the facts.

He does not appear to believe in multiple causation. He shows that lung cancer death rates are not proportional to the logarithm of the total amount of tobacco smoked. The absence of this proportionality excludes for him the possibility of a smoking—lung cancer relationship. He assumes that standards of diagnosis have not improved sufficiently to account for the enormous rise in lung cancer incidence in the past 90 years. Having dismissed these two possibilities, he therefore attributes the increase to a natural change in the incidence of disease. But he does not even consider that all three factors may play important parts: that is, that smoking, improved diagnosis and "natural change" all contribute to the rise in incidence. One could well add other factors: air pollution from cars and industry, greater stress arising from the increased rate of modern living, and so on.

Further, he does not distinguish between incidence and mortality. He discusses the mortality of cancer of the lung and of the tongue, comparing two groups of people born 25 years apart (1871-75 and 1896-1900). In the case of cancer of the tongue, death rates dropped to 10 per cent in the second group, relative to the first; whilst lung cancer deaths rose 13 times. Dr. Lees attempts to disprove that both have a common cause: smoking. He argues that since the one type increased 13 times and the other decreased to 10 per cent, they cannot possibly be due to the same cause. He therefore implies that lung cancer cannot be related to smoking. The first fallacy in this argument is that death rates are NOT directly proportional to incidence: cancer of the tongue is easier to diagnose and easier to cure than cancer of the lung. Therefore, the incidence/death rate ratio is higher for tongue than for lung lesions; i.e. the actual incidence of tongue cancer is relatively mich higher than the mortality figures suggest. Secondly, he takes little notice of the fact than in 25 years (1900-1925) cigarette smoking increased eight-fold, whilst pipe smoking decreased by two thirds. These two considerations, to a large extent, account for the apparent discrepancy in the death rates for the two types of cancer. This does not, in fact, prove that smoking causes lung cancer, but it certainly invalidates Dr. Lees' argument that it does not.

His discussion of the morbid anatomy is interesting, but unconvincing, as no figures are given. He concludes that "we can find nothing to suggest that smoking is more intimately concerned with lung cancer than the increase in banana eating, cinema going, or what you will in the last 50 years." However, one cannot forget Doll and Hill's data from which they showed that the lung cancer death rate in men who smoke more than 25 cigarettes daily, is 40 times that non-smokers. Even if this were an exaggeration, one might venture to suggest that Dr. Lees is wilfully turning a blind eye to evidence, which, though admittedly statistically inconclusive, is certainly highly suggestive.

His reasoning is not always at fault: sometimes it is his premises which are questionable. In a discussion on "Fallacies in Sampling" he states that "smoking is an addiction controlled by emotional, mental, social and, above all, economic factors." The first three factors are undoubtedly true. But the economic factor is doubtful: Dr. Lees would have us believe that people in higher income groups smoke more than those earning less. He gives us no figures other than the fact that doctors average 15 cigarettes daily, compared with 13½ in the general population. One only has to observe the people around us to be convinced that the smoking rate is not dependent on the level of income. Be that as it may, his first premise is that high income results in a high rate of smoking.

His second premise is that good health means high earning capacity. But one might equally well suggest that high income results in good health. Dr. Lees has here postulated primary and secondary factors amongst circumstances which clearly lie on a vicious circle of causation.

From these two (rather doubtful) premises he argues that: good health means high earning capacity; which in turn results in high income; which results in heavy smoking. He concludes that healthy people smoke much, and conversely that unhealthy people smoke little.

He then analyses Doll and Hill's data concerning death rates in doctors, and finds that the "healthy" doctors have a high, and the "unhealthy" doctors a low, death rate. But he has already "proved" that good health results in higher smoking rates.

Hence he assumes that the " healthy " doctors (with the low death rate) were smoking much ; and the " unhealthy " doctors (with the high death rate) were smoking little. (Incidentally, he gives us no figures indicating which group of doctors were in fact smoking heavily. One might consider that the poor health of the "unhealthy" doctors was due to excessive smoking !)

However, from this argument, he deduces that, not only is smoking not directly related to lung cancer, but that there is in fact an inverse relationship. His conclusion is that " we think it would be ingenuous to take this inverse correlation as proof that heavy smoking prevents lung cancer ; but no more ingenuous than taking the positive correlation within the sample as proof that smoking causes lung cancer." A conclusion such as this, based on questionable premises, and syllogistic reasoning, need not, I think, be taken too seriously.

One could go on like this at length, but it seems pointless. The reader would do better to consult the original article, and form his own opinions. Doubtless, Dr. Lees has excellent grounds for querying the statistical validity of a smoking—lung cancer relationship ; but we can likewise query his evidence of its non-existence. His review of the available facts and figures shows convincingly enough that smoking is not the *only* cause of lung cancer ; nevertheless, most people, smokers and non-smokers alike, will remain firm in the belief that smoking is at least a predisposing, if not actually causative factor in the aetiology of lung cancer. Dr. Lees' arguments show an extremely strong bias ; and it would be interesting to know just why this paper was " published by the author."

S.M,W.

A TEXTBOOK OF HUMAN EMBRYOLOGY by R. G. Harrison. **Published by Blackwell, Oxford, 1959.** Crown 4to. 244 pp.+ix, 144 figs. Price 45s.

This new textbook presents the fundamentals of human embryology in a refreshingly attractive manner, and in so persuasive and lucid a style that the author's enthusiasm is communicated to the reader, whose task is rendered both profitable and pleasurable. The author's achievement is notable in having so skilfully and informatively blended an essentially unalterable corpus of embryological knowledge with relevant considerations deriving from the biological, teratological and physiological fields and in having infused into this blend such new discoveries or refinements as enhance the embryological story, or render its presentation the more intelligible. His teacher confreres will congratulate Professor Harrison upon a signally successful accomplishment, and medical students will prove appreciative of his labours on their behalf, since in his pages the morphological becomes particularly dynamic and meaningful.

Indeed, the dominant feature of this textbook is the successful presentation of the facts, in a descriptive style so persuasively explanatory that the student, dipping half-hopefully, half-fearfully, into its pages, will find himself imperceptibly lured into further exploration and into a fuller appreciation of human developmental processes. The text runs engagingly and informatively, smoothly incorporating *nova et vetera*, and supported by a wealth of attractive illustrations.

Criticism is mainly directed to minor matters. Thus, it is felt, that Chapters II and IV (reproductive system) would profit by some excision of their purely topographical content : that Chapter XV might usefully include references to forms of congenital heart disease other than those listed : and that, in Chapter IX, the account of appendix differentiation would stand; amplification the non-supportive functions of mesenteries might receive some stress and a reference might be made to the infracardiac bursa as a pneumato-enteric recess derivative. It is arguable whether Chapter XXV (regeneration) is strictly relevant to the general subject matter. One sentence (pp. 116-7) requires rephrasing to be adequately informative : a reference (p. 124) to Fig. 86 should be to Fig. 87 : useful additions would be figures illustrating external genital development in the sexes, since Fig. 115 is insufficient.

(Incidentally, the demonstrably slack round ligaments are not responsible for uterine anteflexion and anteversion, as stated (p. 34) : the umbilical cord is customarily attached eccentrically to the placenta : and Graves' work does not justify his proposed segmentation of the kidney, his segments not being in agreement with the calycine pattern.)

It must be said that the majority of the clear and well labelled line drawings are disproportionately and uselessly large. Some score or more of these would lose nothing of their clarity by a considerable and space-saving reduction ; while certain further figures (e.g. Figs. 71-73, 78-81, 83-86, 87-89) would, by reduction and rearrangement in juxtaposition, gain greatly in emphasis. It is a matter of opinion whether Figs. 4-6 (inguinal canal) are strictly relevant and whether they were not better replaced by some diagram showing how the abdominal parietal constituents are severally prolonged over the extruded male gonad.

Since the students' prime difficulty in embryological study is to transpose two-dimensional sections and illustrations into a three-dimensional concept of the developing parts, one regrets the absence of the traditional, three-dimensional diagram of such items as the entire Wolffian and Müllerian apparatus, the pharyngeal derivatives and the developing diaphragm, figures which, economical equally of textual description and of space, have proved so helpful in affording the student a rapid and comprehensive grasp of the particulars of local organogenesis.

The execution of all the specially made illustrations, whether photomicrographs, line- or wash-drawings, is uniformly admirable—Figs. 96 and 97, for example, are probably unsurpassed for their clarity of exposition touching a region peculiarly difficult of appreciation.

References are included to all relevant recent work and a special author index is supplied. An extensive subject-matter index provides for quick and comprehensive reference to items in the text. The print is large and clear and " easy on the eyes," the illustrations are faultlessly reproduced and the whole volume reflects that impressive standard of production characteristic of the House of Blackwell.

This book cannot fail to commend itself to the student of human embryology.

A. J. E. Cave.

THE AETIOLOGY AND ARREST OF PRE-ECLAMPTIC TOXAEMIA WITH EARLY AMBULENT TREATMENT—by K. Douglas Salzmann. **H. K. Lewis & Co. Ltd., London.**

Dr. Salzmann, a General Practitioner Obstetrician in Reading, has written an interesting and stimulating monograph on Pre-eclamptic Toxaemia. He suggests that it is caused by vasospasm which results from the material stress reaction to "transplacental hormones" from the foetus.

Dr. Salzmann's hypothesis is largely conjectural and to these "transplacental hormones" he ascribes properties on flimsy evidence. Although the monograph is not to be regarded seriously as a scientific contribution, it is well worth reading by those in obstetric practice.

In explaining the association of pre-eclampsia with hydramnios, the author suggests that the placenta is compressed by the tense bag of waters leading to placental ischaemia with a fall in the output of progestin. Alternatively, the ureters may be compressed by the distended uterus as they pass over the pelvic brim, producing urinary stasis and a predisposition to infection of the kidneys, leading to vasopasm and hypertension. No clinical or experimental evidence is given to support either hypothesis.

In the treatment of pre-eclamptic toxaemia, Dr. Salzmann has avoided bed rest, but kept his patients ambulant and used reserpine as a hypotensive. He has had more success with this drug than most obstetricians but has employed it with the earliest rise in diastolic pressure (84 mm. Hg). A large scale trial would be useful.

D. K. Williams

PRACTICAL PROCEDURES IN CLINICAL MEDICINE.—by R. I. S. Bayliss. Third Edition. pp. 462 with 54 illustrations: **Published by J & A. Churchill Ltd.** Price 42s.

Originally published in 1950, we now have the third edition of a book which should have a wide appeal. It is for the student that it is chiefly written. There is a valuable and very clearly presented account of the various biochemical and radiological procedures on which many clinical investigations depend. Each text is considered under three headings. First there is a physiological introduction—which is at the same time a useful revision. Secondly the technique of the procedure is explained and finally the interpretation relates the laboratory investigation and the patient.

Although the detail is sufficient to satisfy the demands of examiners in this field it is probably not enough to be useful to those who work in a laboratory. This means that the book is just too large to be carried as a *vade-mecum* and yet not detailed enough to be a serious book of reference. However, for the student as a book of revision, and as an excellent addition to lecture notes it is invaluable.

The changing pattern of investigations has set many problems for those revising this edition. In general this has been successfully done but many will be surprised at the absence of any mention of the Van den Bergh reaction.

A book which is so cleary presented ought to help the student to understand the investigations which can be made and also when they will be useful in helping towards a diagnosis. It is unusual to find a book which is so successful in fitting the numerous laboratory investigations into the clinical picture which is required by students.

BIOLOGY STAINING SCHEDULES FOR FIRST YEAR STUDENTS by R. R. Fowell, M.Sc. **Published by H. K. Lewis, London, 1959.** Pp. 31. Price 3s.

This book is a simple and adequate outline of the various elementary histological procedures undertaken in first year courses in the Biology laboratory. An additional chapter entitled " Microbiology Schedules " appears in the current edition.

A.J.M.

ROYAL NATIONAL HOSPITAL FOR RHEUMATIC DISEASES, BATH, REPORTS. Vol. 10. 1958-1959.

This book consists of the reprints of papers published by the staff of the Royal National Hospital for Rheumatic Diseases, Bath, during the years 1958 and 1959. There are nine of them, and they vary in subject matter from "The Treatment of Gout" (The Practitioner) to "Entropy and Synovial Pathology" (Nature).

Volumes of "collected papers" give a very good idea of the work going on in any particular unit, and Bart's men will, I am sure, get both pride and pleasure from the perusal of this one. The Chairman of the Medical Board of the Hospital, Dr. G. D. Kersley, is certainly to be congratulated on it, and he has also included, in a Forword, an account of the history of the Hospital and of its plans for the future.

PRACTICAL CLINICAL BIOCHEMISTRY by Harold Varley. **Published by Heinemann.** 635 pp. Price 42/-.

The author states in his preface " the present book is a survey of the whole field of this subject from the standpoint of workers in hospital laboratories." It should be said at the outset, that the author has achieved this object, and his book is the most comprehensive of those published in Britain. In fact, the chief criticism one makes of this book is that in some directions it is too comprehensive. For example, it seems unnecessary to describe six methods for the determination of blood sugar, and while there is a short comparison of the methods, the beginner will be left still in doubt as to which method he should use. One would like to have had more of the author's personal views and experience, which is such a valuable part of earlier works on this subject, for example, the early editions of " Chemical Methods in Clinical Medicine," by G. A. Harrison. Harrison's book is still a mine of information, and a book of which Bart's may well be proud.

In a comprehensive book of this nature, one would have wished for a fuller treatment of the porphyrins, as the estimation of these is one of the most difficult with which the chemical pathologist is faced. The book is essentially a practical one and of interest chiefly to the technician, but medical students can profit by the short summaries of the findings in health and disease under each of the headings.

It has been brought well up-to-date in this second edition, and one can thoroughly recommend the book to all workers in hospital laboratories.

OUTLINE OF ORTHOPAEDICS, 2nd Edition, by John Crawford Adams. **Published by E. and S. Livingstone.** Price 35s., pp. 428.

The new edition of this book follows its predecessor's admirable clarity and simplicity of expression. Every subdivision of orthopaedics is adequately dealt with in a systematic manner using an excellent method of classification.

There is only one error to be found in the caption of Fig. 218, where "rare" appears in place of "rarefied."

It would be a great step forward if all surgeons could agree on what is meant by Charcot's joints, since here the term is used as a synonym for neuropathic arthritis, whereas the eponym should be restricted to a neuropathic arthritis due to syphilis.

M.L.P.

BASIC BACTERIOLOGY. Its Biological and Chemical Background. C. Lamanna, Ph.D. and M. F. Mallette, Ph.D. 860 pages, 137 illustrations. Second Edition. **Bailliere, Tindall & Cox Ltd., London, 1959** Price £5 8s. 0d.

Medical bacteriology is only one section of a wide field in which bacteriologists may work. Pure bacteriology will include studies devoted to the fundamental nature of bacteria. Soil bacteriologists are interested in the fertiliy of the soil and the relation of bacteria to plant nutrition. Preservation of food and the dairy industry each has its own special problems. In commerce bacteria are used to produce chemicals, or are utilised or have to be prevented from growing in the preparation or preservation of industrial products.

Workers in any of these sections need to use physics, chemistry and biology. This book is an attempt to provide a specialist treatment of these subjects for the student of bacteriology. This is therefore not a textbook of medical bacteriology but one in which such basic subjects as the structure, growth and surface properties of bacteria are discussed at length and bacterial nutrition and metabolism receive due attention.

The first edition of this book was published in 1953. Its popularity can be judged by the fact that two reprints were required. The second edition follows the arrangement of the first and much of the text is unaltered. New findings have necessitated changes in some places, and the references have been brought up to date. For what it is intended, this book can be recommended. The price may well deter the private purchaser.

AIDS TO TRAY AND TROLLEY SETTING, by Marjorie Houghton, M.B.E., S.R.N., S.C.M., D.N. **Published by Bailliere, Tindall & Cox Ltd. Sixth Edition.** Price 8s. 6d.

Six editions of this little book have appeared over twenty years, and this is an indication of its usefulness to nurses. Miss Houghton is held in esteem in this and many other countries for her work for nursing education. The students of a training school like ours may not feel the need of a book like this which by reason of its size must be dogmatic, but undoubtedly it will be as successful as in its previous editions.

AN INTRODUCTION TO CONGENITAL HEART DISEASE, by Leo Schamroth and Fay Segal. 115 pages, 82 Figs. **Published by Blackwell, Oxford.** Price 22s. 6d.

The recent rapid advances in the techniques of cardiac surgery have aroused a great deal of interest in this subject. Patients who were previously only of academic interest and poor prognosis, are now in a happier position. In congenital heart disease, as in other fields, early diagnosis often materially improves results and it is therefore proper that the G.P. and the student should take an interest in this subject. It is for them and not the specialist that this book has been written.

The book is eminently readable and straightforward in its approach. The various common forms of congenital heart disease are dealt with simply and concisely and the short lists of references at the end of each chapter are most welcome.

The text is illustrated with a wealth of line drawings which are cleverly devised but not too well executed — nevertheless they form a valuable adjunct to the text. The X-ray pictures are well reproduced.

The accent throughout the book is on medical treatment and a wider discussion of cardiac surgery would have been interesting but, all in all, this slim volume, beautifully produced as ever by Blackwell's, is thoroughly commendable.

CLINICAL DERMATOLOGY FOR STUDENTS AND PRACTITIONERS, by H. M. Robinson. 242 pages. Illus. **Published by Bailliere, Tindall and Cox.** Price 68s.

The first fifty pages of this volume are devoted to "general considerations" which comprise short sections on the anatomy and physiology of the skin, the actiology of the dermatoses, mycology, allergy, occupational dermatoses, etc., and methods of treatment. The text is economical of words and the facts concentrated, but these sections afford a very useful means of tying up loose ends and sorting ideas before settling to the serious study of skin disease.

The remainder of the book is taken up with descriptions of skin diseases. A morphological classification is adopted, and in a subject where the aetiology of a given disease is so often "unknown", this is probably the safest and certainly the simplest method to use. The text is again synoptic and the facts neatly packaged under subheadings.

The printing is excellent, the numerous black and white illustrations are of a high standard and the shiny paper will please some but not all.

This is a good book for the G.P. to use for checking diagnosis and therapy. The convenient format of the book allows all the relevant information to be available as soon as the morphological nature of the lesion has been decided upon. The book should also be useful for revision purposes.

SPORTS NEWS

VIEWPOINT

The Sports Editor has often received complaints about the length of time that is taken in printing reports and results, from the the time the actual events take place to when the journal is finally published. Indeed, inefficiency on the part of someone is generally thought to be the cause of this. The lag is, unfortunately, unavoidable. Reports of sporting events during any month should be handed in at the end of the month. There is then an interval of four weeks from the time the printers receive the reports to the publication of the Journal. Hence it can be seen that there is normally a gap of between four and eight weeks between the event and its appearing in print.

Numerous complaints have also been received to the effect that the minor clubs in the Hospital do not receive enough publicity, and that too much space is devoted to the bigger clubs. This can only too easily be rectified. There are well over twenty sporting clubs in the Hospital, and the Sports Editor has neither the time nor the energy to see every secretary in person. If any secretary wishes to have a report entered, he has only to hand it in at the end of the month, when all reports receive equal attention.

This month the Rifle Club is to be congratulated on winning the Armitage Cup at Bisley. It was indeed an excellent performance, as they not only won the Cup, but won it easily.

The Ladies' Tennis team has, unfortunately, lost the U.H. Cup they won last year, by losing in a very close and exciting game, to Guys. But on the same afternoon at Chislehurst, the cricket team managed to beat the Middlesex Hospital in the first round of the Cup. Mr. and Mrs. White were seen to be in a continual state of flux between the tennis courts and the cricket, as both matches ended within 10 minutes of each other.

SOCCER

The A.G.M. of the Soccer Club was held at 7 p.m. on Wednesday, 25th May, in the small A.R. Mr. Hunt was in the chair.

The officers for the 1960-61 season are:
President: Mr. A. Hunt.
Captain: Mr. J. Jailler.
Secretary: Mr. H. Philips.
Treasurer: Mr. B. Perriss.
Social Secretary: Mr. B. Hore.
Pre-Clinical Representative: Mr. T. Herbert.
Committee Member: Mr. M. Jennings.
Dr. E. D. Wills was elected a Vice-President.

SAILING CLUB

During the "Frostbite Season" the Hospital competed for the Max Rosenheim Winter Trophy at the Welsh Harp, against the other London teaching hospitals. This series, taking place on alternate Wednesday afternoons was won this year by the London Hospital. The standard gets higher each year, and even with some good helming from W. G. Fischer and J. Spivey, Bart's only came third.

Results:
1st: London Hospital 83½;
2nd: University College Hospital 76½;
3rd: St. Bartholomew's Hospital 73½;
4th: Guy's Hospital 66½;
5th: St. Mary's Hospital 52;
6th: Middlesex Hospital 51.

St. Thomas's and Charing Cross Hospitals also took part.

The United Hospitals Sailing Club held their Annual General Meeting and Dinner at the end of January. The Dinner was, as usual, a very well-attended and most enjoyable occasion. This year we were fortunate enough in having the Queen's Sailing Master, Surgeon Lieutenant Ross Coles amongst the speakers. He told us of Bluebottle's successful racing in North America, and invited one or two of the members from his own hospital, St. Mary's to crew in the Royal Dragon during the summer.

Bart's fared well in the distribution of prizes, winning the Bannister Cup as the hospital obtaining most points in inter-hospital races last season; the Harvey-Wright Gold Bowl, won by W. G. Fischer in Burnham Week and the Bourne Trophy for individual helmsmen in spoon races, which went to R. C. Birt.

During the winter a United Hospitals Sailing Club Sharpie was fitted out at Charterhouse Square. With the facilities afforded by the College authorities, Maid of Amsterdam was stripped and reclothed in a new type of marine finish, and a layer of fibreglass was placed along her keel. It is hoped that after this thorough refit, less maintenance will be required in future. Several Sharpies have been fitted out at other Hospitals, so with the new suits of terylene sails, the fleet is in excellent order.

The Hospital has been represented in two races so far this summer. In the first, on April 30th, W. G. Fischer with J. Spivey and A. Pyke came second to Guy's Hospital. While in the lead, the Bart's boat misjudged a buoy and lost a place which could not quite be made up.

On May 21st, again with W. G. Fischer at the helm, Bart's came first, with St. George's Hospital second and St. Mary's Hospital third. On this occasion Miss G. Hanson and D. M. Welch made up the crew. Being last at the start, W. G. Fischer excelled himself in going straight through the fleet, finishing about half-a-mile ahead of the next boat.

RIFLE CLUB

The Club has had a fairly successful small-bore season, which, however, does not bear comparison with the very successful season 1958-1959.

Nine teams have shot in the United Hospitals, University of London, and National Small bore Rifle Association Postal Leagues, and seven teams in the United Hospitals and University of London knock-out competitions. One team competed in the Browne-Martin knock-out competitions for teams in the London area.

The final analysis of all matches during the season is: Shot 97, Won 49, Drawn 2, and Lost 46.

UNITED HOSPITALS LLOYD CUP

The first team lost an important match against the Westminster Hospital, and because of this one defeat, could only gain second place in the league, albeit with a higher aggregrate gunscore than the winners, 3868-3848. The second team was placed fourth.

First team: Shot 8, Won 7, Lost 1.

Team: A. M. Ward (Sec.), R. P. Ellis, Miss A. M. Holloway, J. D. Hobday, and F. J. R. Hardy.

Second team: Shot 8, Won 5, Lost 3.

Team: M. T. Barton (Capt.), G. R. Hobday, A. J. B. Missen, P. N. Riddle, and P. A. Bennett. Also shot: K. S. Wise.

The leading places in the U. H. League averages were:

1st, A. M. Ward, 98.00; 5th R. P. Ellis, 97.12; 7th, A. M. Holloway, 97.00; 8th, F. J. R. Hardy, 96.88.

UNITED HOSPITALS TYRO COMPETITION

The first team, after drawing with the Westminster early in the season, lost to St. Mary's, and, as in the senior division, came second to the Westminster, again with a higher aggregrate gun-score. The second team came fourth, and the third team fifth, thus the club ended the season with all its three teams in the top half of the table.

First team: Shot 9, Won 7, Drawn 1, Lost 1.

Team: F. J. R. Hardy, P. A. Bennett, K. S. Wise, A. J. Austin, and A. M. Pollock. Also shot: M. M. Orr, K. E. Gray, and M. J. Course.

Second team: Shot 9, Won 6, Lost 3.

Team: K. E. Gray, M. M. Orr, C. L. Brewer, Miss A. E. Vartan, and M. J. Course. Also shot: H. R. J. Walker, and Miss Z. Gardner.

Third team: Shot 9, Won 4, Lost 5.

Team: C. A. Hood, R. G. Miller, G. B. Jackson, P. Dupre, and Miss J. Angell James. Also shot: W. D. Kelly and B. J. Metcalfe.

Pistol:

University of London League, Div 1. Shot 10, Won 5, Drawn 0, Lost 5, Position 3rd.

Team: G. R. Hobday, R. P. Ellis, and F. J. R. Hardy.

University of London League, Div. 2. Shot 8, Won 1, Drawn 1, Lost 6, Position 5th.

Team: J. D. Hobday, A. M. Ward, and K. E. Gray. Also shot: D. Metten, and G. B. Jackson.

Standing and Kneeling:

University of London League, Div 1.

The team shot well despite very good opposition, and three matches were lost by very small margins. The team set up a Club record with a score of 459 (ex 600) in the seventh round to beat Imperial College "A".

The final position in the table was fourth. Shot 8, Won 2, Lost 6.

Team: A. M. Ward, Miss A. M. Holloway, and M. T. Barton. A. M. Ward was placed third in the University League averages, 159.7.

N.S.R.A. League. Division 7. Shot 9, Won 3, Lost 6, Position 8th.

Team: A. M. Ward, G. R. Hobday, and J. D. Hobday. Also shot: R. P. Ellis.

Two teams were entered in the University of London knock-out competition, one being placed in Division 1, and the other in Division 2. Both teams met strong opposition in the first round and were eliminated.

The five teams entered in the United Hospitals knock-out competitions had longer runs. One team reached the semi-finals, only to be beaten by the eventual winners of the competition. Three other teams were eliminated in the quarter finals.

Team A: A. M. Ward, P. N. Riddle, and A. J. B. Missen. Lost to Westminster "A" in the semi-final.

Team B: J. D. Hobday, G. R. Hobday, and R. P. Ellis. Lost to Bart's "A" in the quarter final.

Team C: Miss A. M. Holloway, Miss A. E. Vartan, and K. E. Gray. Lost to U.C.H. "A" in the quarter final.

Team D: F. J. R. Hardy, K. S. Wise, and M. M. Orr. Lost to St. Mary's "A" in the quarter final.

Team E: M. T. Barton, P. A. Bennett, and A. J. Austin. Lost to Bart's "A" in the first round.

Browne-Martin Competition:

The disappointment felt at the defeat of the VIII in the first round of this competition was tempered a little when it was heard that the victors in this match, Walthamstow Ensign, beat London University in the final to become the London Area Champions for the current year.

Shoulder to Shoulder Matches:

VIII v. St. Mary's Hospital. Won 745-726

VIII v. The City Police. Lost 763-773.

IV and S & K. II v. St. George's Hospital. Won 590-580.

VI v. The Staff. Won 575-538.

VIII v. The London Hospital. Won 487-469.

VI v. The City Police. Lost 1157-1165.

The following members of the Club have shot for the United Hospitals during the past season.

1st VIII: A. M. Ward, Miss A. M. Holloway, F. R. J. Hardy, and R. P. Ellis.

2nd VIII: M. T. Barton, P. N. Riddle, and P. A. Bennett.

The Lady Ludlow Cup, for the highest individual average over the season, is awarded to A. M. Ward, average 97.86. Runner-up R. P. Ellis, 97.36.

The Mrs. Waring Handicap Cup, for the best increase in average over the season, is awarded to P. A. Bennett. Runner-up, Miss A. E. Vartan.

United Hospitals Rifle Club Prize Meeting

The United Hospitals Prize Meeting was held at Bisley on June 19th under almost ideal weather conditions. The wind, however, proved a little decentive, the flags showing only a selection of the changes in strength and direction.

The meeting consisted of three competitions, shot concurrently under Queens I conditions, that is 2 sighting shots and 7 shots to count at 200, 500, and 600 yards.

Armitage Cup Competition

The Hospital team shot steadily at all ranges, and by the end of the 500-yard shoot had gained a slight lead, which they held to the end.

St. Bartholomew's

P. N. Riddle	...	32	33	31	96
A. M. Pollock	...	32	32	31	95
G. R. Hobday	...	32	33	27	92
A. M. Ward	...	28	32	31	91

The Armitage Cup was last won by the Hospital in 1957.

"B" Team Competition

Competition in this division was of a high standard, and the Hospital team did well to come second to a very strong St. Thomas' team.

St. Bartholomew's

F. J. R. Hardy	...	29	34	31	94
M. T. Barton	...	30	31	32	93
Miss Z. Gardner	...	33	30	30	93
R. G. Miller	...	31	29	29	89
		123	124	122	369

Individual Competition

All competitors also shot for the individual range prizes, and the aggregate trophy. F. J. R. Hardy placed 1st in the 500 yards with a score of 34.

The Annual General Meeting of the United Hospitals Rifle Club was held at Bisley after the Prize Meeting. At this meeting the following Officers were elected for the season 1960-1961:—

Captain, A. M. Ward; *Full-bore Secretary*, A. M. Pollock.

CRICKET

1st XI v. Middlesex Hospital on Wednesday, June 15th, at Chislehurst (Cup match)—Won by 54 runs.

Bart's enjoyed an encouraging start in the U.H. Cup. We batted first and found the pitch livelier than expected. However Davies and Jeffreys both batted very well and gave us a good start. At lunch we were 100 for 2, but after the interval accurate bowling and keen fielding by Middlesex prevented us from increasing the scoring rate. Davies batted very well, but was the first of many to be dismissed trying to force the pace. Warr batted very well but no one else stayed long and at 4 o'clock we declared at 208 for 7, leaving Middlesex 150 minutes in which to get the runs. Our attack proved rather ineffective until with only 45 minutes left Niven managed to extract enough response from the wicket to effect a break through. After this wickets fell at regular intervals and we eventually got them out for 154 with 9 minutes to spare. Niven bowled very well, and Stoodley at the end managed to produce some very good balls to capture the last vital wickets.

Barts, 208 for 7 dec. (Davies 69, Jeffreys 25, Warr 52).

Middlesex, 154 all out.

1st XI v. Queen's College, Cambridge, at Chislehurst, Saturday, June 4th.—Match drawn.

Our game with Queen's always seems to provide a good deal of excitement, and this year was no exception. Bart's batted first on a perfect hand pitch and Pagan, Jeffreys and Davies all batted well and saw us off to a good start. Our progress became somewhat retarded in mid-afternoon, however, and it was mainly due to a fine attacking innings by Abell, and to a lesser degree by Merry, that we were able to declare at 217 for 6, leaving Queen's 150 minutes in which to get the runs. They profited from a run of dropped catches early in their innings and made a spirited attempt to get the runs, but at the close both sides were equally near victory. Stoodley bowled well but all chances offered from his bowling were missed.

Bart's, 217 for 6 dec. (W. H. Pagan 58, J. D. Abell 45, J. D. Davies 32, R. V. Jeffreys 31, R. T. G. Merry 26 not out).

Queen's College, 204 for 8.

"A" XI v. Parkfield, at Chislehurst, Sunday, June 5th.—Match drawn.

Bart's must be very grateful to the Parkfield batsmen for their timidity, for this was all that saved us from defeat. We batted first, and with Pagan, Davies and Phillips all batting very well we were able to declare at 178 for 8. Parkfield had just over 120 minutes in which to get the runs, and with 30 minutes to go and 9 wickets in hand, were only 50 runs short. However for some reason their batsmen left the final fling until too late, and at the end both sides were at the same total.

Bart's, 178 for 8 dec. (Pagan 57 not out, Davies 44, H. Phillips 39).

Parkfield, 178 for 3.

1st. XI v. Wimbledon, at Chislehurst, Saturday, June 11th.—Won by 107 runs.

We were very eager to avenge our defeat earlier this season and winning the toss we batted first. Everyone took a few runs off the poor bowling, but Warr in particular batted very well and we eventually declared at 196 for 4, leaving Wimbledon 150 minutes for their innings. After a preliminary sortie by our quick bowlers, it was obvious that the pitch would be more helpful to the cutters and slows, so Niven and Merry came on at opposite ends. These two bowled for the rest of the match, and, splendidly supported by good fielding in the covers, were able to bowl out the opposition for 89. A very convincing victory.

Bart's, 196 for 4 (A. C. Warr 64, Merry 39, Pagan 31, Davies 26, Harvey 26 not out).
Wimbledon, 89 (Merry 5-35, Niven 3 for 26).

1st XI v. Horlicks, at Slough, on Sunday June 12th.—Match drawn.

A slightly weakened Bart's side batted first and were soon four wickets down with few runs on the board. However, Jailler and Harvey did not seem to mind facing the Horlicks minor-county bowlers, and not only saw us out of trouble but then proceeded to disperse the field with some vigorous hitting. Our innings was unfortunately interrupted for 2 hours by rain, and in order to keep the game interesting we declared at 143 for 8, leaving Horlicks 120 minutes in which to bat. When the last over arrived they needed five runs for victory, but amid much excitement were only able to get four, so that for the second Sunday in succession both sides ended with equal scores.

Bart's, 143 for 7 (Harvey 44, Jailler 44).
Horlicks, 143 for 8 (Merry 3 for 52).

Saturday June 18th.—Match drawn.

1st. XI v. Charing Cross Hospital, at Chislehurst.

A very dull game. Charing X batted first and made 159 for 5 very slowly, so that we were left 90 minutes in which to knock off the runs. Davies and Merry started well, but in an endeavour to keep up with the clock wickets were thrown away, and so the chase had to be abandoned.

Charing X, 158 for 5 dec. (Harvey 3 for 59).
Bart's, 120 for 7 (Merry 48, Davies 30).

1st. XI v. Old Cholmelians, at Chislehurst, Sunday June 19th.—Match drawn.

Bart's batted first on a good wicket; after we had lost two wickets cheaply Pagan and Merry batted soundly but slowly. In the afternoon Harvey managed to increase the scoring rate as did the later batsmen, but the slow start meant that we could only reach 196 before declaring. Old Cholmelerians were left 150 minutes in which to get the runs, but after losing 2 wickets before tea they were never up with the clock. Harvey bowled extremely well but the fielding was again appalling, no fewer than eight catches being put on the ground. Old Cholmeleians had little difficulty in holding us to a draw.

Bart's, 196 for 9 dec. (Harvey 52, Merry 47, Pagan 31).
Old Cholmeleians, 140 for 7 (Harvey 5 for 67).

1st XI v. Jesters, at Chislehurst, Saturday, June 25th.—Match drawn.

Again our fielding let us down and we had to be satisfied with a draw. The Jesters were put in to bat and would soon have been in trouble if catches had been held. As it was, we became so demoralised that they were able to score 70 in the last 20 minutes of their innings. Bart's had to get 177 in 120 minutes; Davies and Pagan gave us a good start with a sound partnership, and Harvey, Merry and Stoodley then set about the bowling. However, after five weikets had fallen we seemed to lose confidence and instead of taking a gamble we settled for a drawn game. A very disappointing finish.

Jesters, 176 for 6 dec.
Bart's, 149 for 6 (Stoodley 42 not out, Davies 34).

1st. XI v. Old Roans, at Chislehurst, Sunday, June 26th.—Match drawn.

The Old Roans were bold enough to put us in on a perfect wicket, a decision which must soon have been regretted. Merry and Pagan scored so rapidly that in the 100 minutes before lunch they scored 129 runs. After lunch Pagan was out but Merry continued to bat well, and eventually reached his century in 75 minutes. Jeffreys also batted very well and we were able to declare at 237 for 8, leaving the opposition 150 minutes in which to bat. After Davies had dismissed their two openers cheaply Old Roans lost all hope of winning, but for the third game in succession vital catches were dropped and we had to be satisfied with yet another drawn game.

Bart's, 237 for 8 dec. (Merry 109, Jeffreys 43, Pagan 38).
Old Roans, 193 for 7 (Davies 3 for 29).

RECENT PAPERS BY BART'S MEN

ABERNETHY, D. A. The Osler Socety. *Oxf. Med. Sch. Gaz.*, 12, Hilary, 1960, pp. 23-25.

*BETT, W. R. The phenothiazines in psychiatry, with special reference to trifluoperazine ("stelazine"): a review of the literature. *W. Afr. Med. J.*, 9, Feb., 1960, pp. 33-36.

BICKFORD, B. J. Surgical aspects of patent ductus arteriosus. *Arch. Dis. Childh.*, 35, Feb., 1960, pp. 92-96.

BIRNSTINGL, Martin. Subacute bacterial infection in a traumatic arteriovenous fistula. *Proc. Roy. Soc. Med.*, 53, March, 1960, pp. 229-230.

BORRIE. Peter. Two cases of primary lymphoedema. *Proc. Roy. Soc. Med.*, 53, May, 1960, pp. 382-383.

——, *see also* SCOTT, A., and ——.

*BOURNE, Gordon L. (and Benirschke, Kurt). The incidence and prognostic implication of congenital absence of one umbilical artery. *Amer. J. Obst. Gynec.*, 79, Feb., 1960, pp. 251-254.

CAPENER, Norman. Exeter's medical history. *Brit. Med. J.*, June 4, 1960, pp. 1732-1733.

—— (and Bertelsen, Arne). Fingers, compensation and King Canute. *J. Bone Jt. Surg.*, 42B, May, 1960, pp. 390-392.

CORBETT, R. S. Retroperitoneal tumours: some clinical aspects. *Clin. Radiol.*, 11, April, 1960, pp. 83-84.

*CRAWHALL, J. C. and WATTS, R. W. E. Acylative decarboxylation with particular reference to the acetylative decarboxylation of the 2:4—dinitrophenyl derivatives of some amino acids. *Biochem. J.*, 74, 1960, pp. 514-560.

DAWSON, John B. Exploring will we go: some notes on an expedition to Labrador. *Practitioner*, 184. June, 1960. pp. 771-778.

——. The F.S.R. in a new dress. *Brit. Med. J.*, June 4, 1960, pp. 1697-1704.

*DE MOWBRAY, R. R. Cushing's syndrome with bilateral calcification of the adrenal glands. *Proc. Roy. Soc. Med.*, 53, March, 1960, pp. 221-222.

*DONALDSON, Malcolm. Cancer information among the public. *Med. Press.* 243, June 15. 1960. pp. 515-518.

FRANKLIN, A. White. The press, the patient, and the hospital doctor. *Lancet*, May 14, 1960, pp. 1065-1066.

*GALE, N. H., and INNES, G. S. The advantages of employing mixed high energy x-ray and electron beams in radiation therapy. *Brit. J. Radiol.*, 33, April, 1960, pp. 261-264.

GARROD, Oliver. Primary myxoedema with severe cardiac involvement, masquerading initially as hypo-pituitary myxoedema. *Proc. Roy. Soc. Med.*, 53, March, 1960, pp. 218-220.

HADFIELD, John. Excision of the major duct system for benign disease of the breast. *Brit. J. Surg.*, 47, March, 1960, pp. 472-477.

HAMILTON, W. J. (and Boyd, J. D.) The giant cells of the pregnant human uterus. *J. Obstet. Gynaec. B.E.*, 67, April, 1960, 66. 208-218.

*HARPER, R. A. Kemp. Radiology in the diagnosis of retroperitoneal tumours. *Clin. Radiol.*, 11, April, 1960, pp. 69-79.

HAVARD, C. W. H., and WOOD, Philip H. N. Antidiuretic properties of hydrochlorothiazide in diabetes insipidus. *Brit. Med. J.*, April 30, 1960, pp. 1306-1308.

——. and ——. Clinical evaluation of benzthiazide, an oral diuretic. *Brit Med. J.*, June 11, 1960, pp. 1773-1776.

*HAYES, D. S. (and Posner, E.) A case of Caplan's syndrome in a roof tile maker. *Tubercle*, 41, 1960, pp. 143-145.

HEATHFIELD, K. W. G. (and Williams, John R. B.) Diagnosis of polymyositis. *Lancet*. May 28. 1960, pp. 1157-1161.

HUCKSTEP, R. L. Recent advances in the surgery of typhoid fever. *Ann. Roy. Coll. Surg. Engl.* 26, April, 1960, pp. 207-230.

HUNT, John H., and LINNETT, Michael J. Intractable pain. *Brit. Med. J.*, June 4, 1960, pp. 1723-29.

*HUNTSMAN, R. G., and others. Observations on the effect of magnesium on blood coagulation. *J. Clin. Path.*, 13, March, 1960, pp. 99-101.

HURN, B. A. L., *see* HUNTSMAN, R. G., and others.

INNES, G. S., *see* GALE, N. H., and ——.

JONES, R. F. McNab. Tuberculosis of the palate—an unusual presentation. *J. Laryngol.*, 74, March, 1960, pp. 174-177.

*JOPLING, W. H. Onchocerciasis presenting without dermatitis. *Brit. Med. J.*, March 19, 1960, p. 861.

*LAWTHER, P. J. Cancerogene in der städtischen Luft. *Zbl. Bakt., I. Abt. Orig.*, 176, 1959, pp. 187-193.

*——. Chronic bronchitis and air pollution. *Roy. Soc. Health J.*, 79, Jan.-Feb., 1959, pp. 4-9.

*——. The effects of atmospheric pollution on man. *In*, Institute of Biology. *The effects of pollution on living material*. 1959. pp. 89-93.

*——, and WALLER, R. E. Atmospheric pollution and lung cancer. *Trans. Ass. Industr., Med. Offrs.*, 9, 1959.

*LEHMANN, H. (and Ager, J. A. M.) The laboratory detection of abnormal haemoglobins. *Ass. Clin. Path. Broadsheet*. No. 27 (N.S.), Feb., 1960.

—— (with others). Haemoglobin "Singapore-Bristol" a "fast" haemoglobin found in infants. *Brit. Med. J., May* 21, 1960, pp. 1537-1539.

*—— (with others). L'hémoglobinose P: à propos d'un cas d'association des hémoglobines P et S. *Rev. Hémat.*, 15, 1960, pp. 10-18.

——, *see also* HUNTSMAN, R. G., and others; MACKENNA, R. M. B., and——.

LINNETT, Michael J., *see* HUNT, John H., and ——.

*Longland, C. J. Harvey and Padua. *Scot. Med. J.*, 5, April, 1960, pp. 172-175.

*LUMB, George (and Shacklett, R. S.) Human cardiac conduction tissue lesions. *Amer. J. Path.*, 36, April, 1960, pp. 411-429.

*MACKENNA, R. M. B., and LEHMANN, H. The glucose tolerance curve in hidradenitis suppurative. *Brit. J. Derm.*, 4, April, pp. 142-144.

MCMENEMEY, W. H. (and Newman, M.) Sudanophilic diffuse sclerosis ("Schilder's disease") with ictal onset. *Brit. Med. J.*, May 14, 1960, pp. 1461-1464.

MAXWELL, James. Respiratory rhythm. *Brit. J. Clin Pract.*, 14, April, 1960, pp. 298-299.

MENDEL, David. An easy method for the determination of the pCO_2 of the blood, *Lancet*, April 9, 1960, pp. 807.

MOURANT, A. E. Blood groups in the study of human populations. *Eugen. Rev.*, 52, April, 1960, pp. 7-18.

*NICOL, C. S. (and Catterall, R. D.). Is trichomonal infestation a venereal disease? *Brit. Med. J.*, April 16, 1960, pp. 1177-9.

*NICOL, W. D. Administrative aspects of acquired pp. 420-422.
mental disease. *Med. Press*, 243, May 18, 1960.

RICKHAM, P. P. Vesico-intestinal fissure. *Arch. Dis. Childh.*, 35, Feb., 1960, pp. 97-102.

*—— (and Jenkins, Jean M.). Incubator for infants undergoing surgery. *Arch. Dis. Childh.*, 35, Feb., 1960, pp. 71-75.

SARMA, Vishnu (and Sitaratna, A.). Twin pregnancy: well-formed hydatidiform mole associated with a normal viable child. *J. Obstet. Gynaec. B. E.*, 67, April, 1960, pp. 301-302.

SCOTT, A., and BORRIE, Peter. Argyria of face. *Proc. Roy. Soc. Med.* 53, May, 1960, p. 382.

*Scowen, E. F., and others. Clinical manifestations of primary hyperoxaluria. *Arch. Dis. Childh.*, 35, Feb., 1960, pp. 108-112.
Seddon, H. J. (and Clawson, D. K.). The late consequences of sciatic nerve injury. *J. Bone Jt. Surg.*, 42B, May, 1960, pp. 213-225.
*Stallard, H. B. Dumb-bell-shaped dermoid cysts of the orbit. *Brit. Med. J.*, April 30, 1960, pp. 1322-1323.
Thorne, Napier. The skin clinic. *Brit. J. Clin. Pract.*, 14, April, 1960, pp. 303-306; May, 1960, pp. 399-402.
*Waller, R. E.. Air pollution as an aetiological factor in lung cancer. *Acta Un. int. Cancr.*, 15, no. 2, 1959, pp. 437-442.
——, *see also* Lawther, P. J., and ——.
Watts, R. W. E., *see* Crawhall, J. C., and ——; Scowen, E. F., and others.
*Weber, F. Parkes. *Miscellaneous notes.* (*Sixth series*). 1960.
Weitzman, David. The investigation of patients for cardiac surgery. *Brit. J. Clin. Pract.*, 14, April, 1960, pp. 255-262.
Wendell-Smith, C. P. The assessment of the film "An Introduction to Human Dissection"? *Scientific Film Review*, 5, 1959, pp. 108-9.
*——. Objective film testing. *Med. biol. Ill.*, 10, April, 1960, pp. 110-116.
*—— (and Joseph, J.). Nuclear population changes in degenerating non-myelinated nerves. *J. Anat.*, 93, Oct., 1959, pp. 460-464.
*Williams, I. G. Retroperitoneal tumours. *Clin. Radiol.*, 11, April, 1960, pp. 80-82.
Wood, Philip H. N., *see* Havard, C. W. H., and ——.

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

NOTICES

ST. BARTHOLOMEW'S HOSPITAL JOURNAL

Vol. LXIV, No. 8 AUGUST, 1960

Calendar

September
Sat. 10—On duty: Medical and Surgical Units
Mr. G. H. Ellis
Mon. 12—Film Society
Wed. 14—Students' Union Meeting 12 noon
Sat. 17—On duty: Dr. R. Bodley Scott
Mr. A. H. Hunt
Mr. F. T. Evans
Cricket v. Clavering (A) 2.30
Sun. 18—Cricket v. Arksden (A) 2.30
Sat. 24—On duty: Dr. A. W. Spence
Mr. C. Naunton Morgan
Mr. R. A. Bowen
Rugger v. Reading (A)
Mon. 26—Film Society
Wed. 28—Students' Union Tea 4.30

October
Sat. 1—On duty: Dr. G. W. Hayward
Mr. A. W. Badenoch
Mr. R. W. Ballantine
Rugger v. Trojans (H)
Chislehurst: Tea and Sports for Freshers
Thurs. 6—Christian Union, Freshers Tea, Charterhouse 4.00 p.m.
Fri. 7—Christian Union Service 1.00 p.m.
Sat. 8—On duty: Dr. E. R. Cullinan
Mr. J. P. Hosford
Mr. C. Langton Hewer
Rugger v. Woodford (all Teams)

Editorial

THE Royal Society was founded three hundred years ago. When King Charles II was established as its patron he expressed the belief that the activities of the learned men who formed the Society would bring advantage to his realm and to the world.

Much of the work by the early members like Boyle and Hooke and Newton was in solving the main technical problems of the day which were posed by the demand for power. This tradition has continued—inevitably. During its long course of history, however, the Royal Society has fostered the great men of medicine and conferred the prized honour of its fellowship on many of the pioneers of experimental medicine.

Indeed it was at the time of the foundation of the Society that William Harvey was making his great discoveries. From such beginnings, the part which Medical Science played in the transactions which followed could hardly fail to grow to the present position of importance.

The early members were united by their acceptance of the authority of observed fact and measurement in their investigations of the Natural World. Sir Cyril Hinshelwood, the President, has recently stated that the central aim of the Society is still the "improvement of natural knowledge". So today the tradition is unshaken and in Medicine we are more conscious of the need for a scientific basis which is dependent on the yardstick

which was set for us by the founders and then developed through three centuries.

St. Bartholomew's has always had a leading part in the affairs of the Society. Today the work of many who have trained here or have come to work here has been rewarded by fellowship. The honour which they have brought to the Hospital is especially great. And the pride which we have in their achievements is increased by the fact that we know that from the earliest times it was men from this hospital who helped to develop the principles of investigation for which now their successors have been rewarded.

The following list of fellows is arranged in order of election and shows those who have trained or worked at St. Bartholomew's.

1914
SIR HENRY DALE
(*past President*)
1923
LORD ADRIAN
(*past President*)
1925
SIR CHARLES LOVATT EVANS
1926
DR. HAMILTON HARTRIDGE
1935
PROF. SIR WILFRID Le GROS CLARK
SIR RUDOLPH PETERS
1936
PROFESSOR G. B. VERNEY
1939
DR. C. H. ANDREWES
1943
PROFFESSOR I. De B. DALY
1952
DR. R. R. RACE
1955
PROFESSOR K. J. FRANKLIN
1956
DR. R. G. MACFARLANE
PROFESSOR A. WORMALL

Fifty Years Ago

IN these enlightened day's of women's suffrage, now that the equality of the sexes is unquestionably accepted, it is interesting to find that the first "lady doctor" was trained, in part, at this Hospital.

The *Journal* of 1910 in recording her death seems to have taken a rather conservative view. "Miss Elizabeth Blackwell, whose death recently occurred, was the first of her race and the only one to study at this Hospital. The arrangement worked well in this instance, and we are glad to reflect that Bartholomew's extended this courtesy to one who found so many difficulties in her path. *A propos* of this we note that the Royal Free Hospital is much excercised at the suggestion that the London Hospital should open its doors to women students. We should be as much against any such innovation at this Hospital as the women appear to be in the case of the London . . . The Question of the suitability of women for a medical career may be a controversial one, but that they should be trained apart from men wherever possible we thought everyone agreed."

In an obituary which appears later in the same issue, the writer tells us: "After considerable trouble she (Miss Blackwell) obtained leave to attend the medical school attached to the University of Geneva in the State of New York. Though educated in America, she was born in England, and shortly after graduating she returned to her native land. She came to London with an introduction to Mr. Paget, who was then Warden of the College, and by whom she was admitted as a student, receiving an 'unlimited' ticket. She attended Mr. Paget's lectures on Pathology, and daily walked the Hospital for a year and a half."

Miss Blackwell evidently won the heart of the Warden's wife, for in the memoirs of Sir James Paget, written by his son, Stephen Paget, there is a note of a letter written by his mother on October 17th, 1850:

"Well we have our 'Lady Doctor' here at last, and she has actually attended two of James's lectures, taking her seat with perfect composure. The young men have behaved extremely well, and she really appears to go on her way unmolested. She breakfasted here one morning with several of our students, and last evening we had a few medical friends to dinner and she joined us in the evening. Her manners are quiet, and it is evident that her motives for the pursuit of so strange a vocation are pure and good. So let us hope that she will become useful in her generation."

"Miss Blackwell was a subscriber to this *Journal*, and in the September issue, 1894, contributed an article entitled: 'A Reminiscence of Forty Years Ago,' in which she describes the details of her admission, a slight account of the physicians of that day, and her great appreciation of the kindness she received at Bart's."

News in Brief

SIR JAMES PATERSON ROSS has retired as President of the Royal College of Surgeons.

DR. E. F. SCOWEN has been appointed to the Central Health Services Council and Standing Advisory Committee for Cancer and Radiotherapy.

SIR HENRY DALE has retired as chairman of the Wellcome Trust.

MR. J. C. HOGG has been appointed as Dean of the Institute of Laryngology and Otology.

DR. J. P. QUILLIAM has been appointed a member of the General Optical Council.

ROYAL ANTHROPOLOGICAL INSTITUTE of Great Britain and Ireland: The Huxley Medal for 1961 has been awarded to Dr. A. E. Mourant. Dr. Mourant will give the Huxley Lecture on November 24, 1961.

A MEDICAL EXPEDITION led by Dr. Richard Herniman (Bart's) and Dr. Anthony Brown (Thomas's) left for Laos on July 4th. Financed by the British Government, it is the first of 3 teams to be sent. On its arrival in Bangkok it will collect equipment and then drive 500 miles to Vientiane. The first two years will be spent setting up a base hospital and visiting the surrounding villages with a mobile clinic. The *Journal* will be receiving reports of the progress which is being made when the team begins its operations.

SIR HAROLD GILLIES offered a solution to the International Cricket dispute about "throwing" when he suggested that the remedy for Griffin's doubtful action was to wear a plastic splint when bowling.

Students' Union

A MEETING of the Students' Union Council took place on Wednesday, July 13th, 1960, with Mr. A. H. Hunt in the chair. Several subjects were discussed, the main points of interest being

1. Mr. Hood, the Senior Secretary, stated that the draft for a proposed new constitution of the Students' Union had been completed. He outlined the main points in it. It was decided that all Council members should read this draft and discuss it at the August meeting of the Council. The final draft of the proposed new constitution would then be presented at an Extraordinary General Meeting of the Students' Union on 27th October, 1960.

2. As Mr. Ellis is in America it had not been possible to arrange the general meeting to discuss the question of dances in College Hall. This meeting would be arranged as soon as possible.

Tenth Decennial Club

THE Tenth Decennial Club will hold its annual dinner on Wednesday, October 19th, at 7 for 7.30 p.m. at the Royal Thames Yacht Club, Dr. W. F. Eberlie being in the Chair. The Committee has decided not to circularise the three hundred members of the Club, but to write individually to those who have attended any or all of the dinners over the last five years and to all the overseas members. It is, however, hoped that any member who is not so included and who would like to come to this year's dinner, will write to Dr. Geoffrey Bourne, 20 Harley House, London, N.W.1, enclosing his cheque for £2 10s.

Student Nurses' Association

THE St. Bartholomew's Hospital Unit of the Student Nurses' Association would like to thank all those who helped us to raise the sum of £130 in aid of the World Refugee Year.

Film Festival

THE first British Medical Film Festival was held in the British Council Film Theatre on the 5th, 6th and 7th July. This enterprising undertaking was sponsored by the British Journal of Clinical Practice. The fourteen winning exhibits were selected from over fifty entries, with five countries and seven firms represented by the winning films. The films were "selected . . . on a basis of their high teaching value combined with technical quality. It was considered that direct advertising in such films marred their value as teaching material, and many, although extremely well produced, had to be rejected because of this".

The subjects were as varied as they were topical, and included new surgical procedures, and new approaches to old medical and gynaecological problems. Of particular interest was a film demonstrating the use of ether to produce surgical analgesia with amnesia, but without anaesthesia.

Professor C. A. Wells of Liverpool, in his introductory speech to the second session, stressed the tremendous value of films in medical education; for, whereas television gives an insight into the ways situations are dealt with as they arise, films, on the other hand, can (and should) be "cooked to a turn" to illustrate the ideal handling of a given problem.

This Festival is an exciting new venture, and is to be greatly commended for the stimulus given to the production of medical films, and for the valuable opportunity given to members of the medical, nursing and pharmaceutical professions. The only regrettable aspect was the poor publicity, and hence the many empty seats. It is to be hoped that the second British Medical Film Festival will be well advertised, in order that more people may benefit from this excellent opportunity.

S.M.W.

ANNOUNCEMENTS

Engagements

GRAY—CLARK.—The engagement is announced between Dr. John Michael Gray and Rosemary Ann Clark.

HUNTER—PANGBOURNE.—The engagement is announced between Dr. Christopher John Warburton Hunter and Juliet D. M. Pangbourne.

NICHOLS—AIYAR.—The engagement is announced between Dr. John Bowes Nichols and Margaret Lakshmi Aiyar.

Births

BONNER-MORGAN.—On July 23rd, to Barbara Mary and Dr. Robin Bonner-Morgan, a daughter (Sarah Elizabeth).

CANNING.—On June 29th, to Dr. Sheila and Dr. William Canning, a brother for Alison (Miles Andrew).

DROWN.—On July 14th, to Dr. and Mrs. Geoffrey Drown, a daughter, a sister for Rosemary, Wendy and twins.

PEMBERTON.—On June 26th, to Sally and Dr. Michael Pemberton, a daughter (Victoria).

REED.—On July 13th, to Elizabeth and Dr. Gordon Reed, a son (Philip Allard), a brother for Susan and Janet.

SLEIGHT.—On July 13th, to Ann and Dr. Malcolm Sleight, a daughter (Nicolette Ann).

WARWICK-BROWN.—On July 4th, to Jean, wife of Dr. R. Warwick-Brown, a daughter (Caroline Sarah), a sister for Nigel and Janet.

Deaths

THOMAS.—On June 30th, Dr. Charles James Thomas, aged 84. Qualified 1898.

Marriages

CROSFILL — STEWART. — On February 6th, Martin Crosfill to Jean Stewart.

COOK—WATFORD.—On May 21st, Richard Charles Cook to Ann Vellacott Watford.

Changes of Address

DR. R. C. COOK, c/o Permanent Secretary, Ministry of Health, P. O. Box 30016, Nairobi, Kenya.

DR and MRS. N. ROLES, c/o Permanent Secretary, Ministry of Health, P. O. Box 30016, Nairobi, Kenya.

DR. M. F. D. BURTON, 47 Otley Street, Skipton, Yorks.

DR. E. GODRICH, Redcourt House, Tamworth Street, Lichfield.

MR. S. H. C. CLARKE, 105 The Drive, Hove 4, Sussex.

UNIVERSITY OF OXFORD

Second B.M. Examination
Trinity Term 1960

Qualified —

Burke, C. W. A.
Williams, C.
Greaves, C.W.K.H.
Lane, D. J.

Supplemetary Pass List

Pharmacology & Principles of Therapeutics
Stephan, J. C.

General Pathology & Bacteriology
Busfield, H. M. B.

Surgery
Millward, J.

Midwifery
Millward, J.

UNIVERSITY OF CAMBRIDGE

Final M.B. Examination
Easter Term 1960

Qualified —

Clow, E.
Gray, D. J. P.
McFarlane, A. A.
Seaton, A. T.
Davies, R. N.
Holland, J. H.
Pennington, J. H.
Sibson, D. E.
Garnham, J. R.
Lehmann, N. J. P.
Scobie, J. D.

Supplementary Pass List

Part I. Pathology & Pharmacology
Durston, J. H. J.
Gibson, D. F.
Recordon, J. P.

Part II. Medicine
Dean, R. S.
Griffiths, C. J.
Fisher, J. R. H.
Gordon, A. J.

Part II. Surgery
Dean, R. S.
Middleton, B. R.
Fisher, J. R. H.
Griffiths, C. J.

Part II. Midwifery
Bamford, J. K.
Gordon, A. J.
Middleton, B. R.
Dean, R. S.
Griffiths, C. J.
Gibson, D. F.
Mackenzie Ross, R. K.

CONJOINT BOARD

Final Examination
July 1960

M.R.C.S., L.R.C.P. —

Mercer, J. D.
Hijazi, H. K.
Booth, D.

Supplementary Pass List

Medicine
Evison, P. R. H.

Surgery
Gray, D. J. P.

Midwifery
Darmady, J. M.
Chawner, J. M.
Gray, D. J. P.

Pathology
Hare, B. W. E.
Lines, A. J.
Telfer, A. C.
Darmady, J. M.
Childe, M. W.
Robson, J. R.
Durston, J. H. J.

SOCIETY OF APOTHECARIES

June 1960

L.M.S.S.A. — Alder, D. E.

Supplementary Pass List

Surgery
Swallow, J.

Medicine
Swallow, J.

Midwifery
Swallow, J.

ROYAL COLLEGE OF SURGEONS

Primary F.R.C.S. —
May 1960

Boxall, T. A.
Richards, B.
John, A. H.
Smart, P. J. G.
Pugh, M. A.
Vernon, J. D. S.

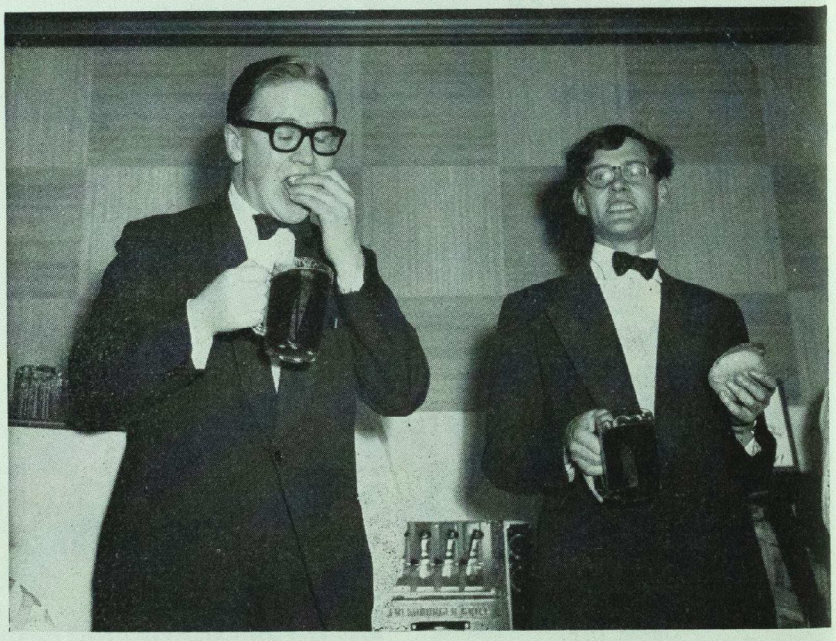
Final F.R.C.S.
May 1960

Cozens-Hardy, J.
Roxburgh, R. A.

Primary F.F.A.R.C.S. —
June 1960

Dingle, H. R.
Pickering-Pick, M. E.
Nainby-Luxmoore, R. C.
Gillett, G. B.

Soho Fair 1960



FIVE gentlemen of Bart's—Paddy Ross, Brian Metcalfe, John Ind, Richard Bergel and Alan Howes (team manager), arrived at the Café Royal on July 13th, 1960, to accept the challenge of a team from Guy's Hospital to a "freshburger race". This was one of the events in the Soho Fair programme of competitions, fashion shows, and music.

A great psychological victory was gained for us right at the start of the evening when the Guy's team, arriving in their lounge and sports wear, were shattered to be met by a Bart's contingent resplendent in evening attire. The Guy's men soon retaliated, however, by producing a medical officer in addition to a team manager. But, temporarily putting gamesmanship aside, both teams were soon together enjoying the splendid hospitality of the Café Royal.

Fully primed and in fine shape, the teams lined up for the race. A freshburger (looking remarkably like a hamburger) in one hand and a pint of ale in the other, each man stood keyed up to eat and drink in turn as quickly as possible. Guy's went into a very narrow lead early on, but the Bart's team with masseters pounding at full throttle were hot on their tail. Chew for chew we were level and then it happened — the Guy's number 3 "blew up" on a freshburger. Bart's forged ahead and were worthy winners, fully deserving the liquid prize presented by the Soho Fair Queen.

A.C.H.

THE QUESTIONNAIRE WOMEN STUDENTS

by A. M. E. Macdonald

IN December 1957 a Questionnaire was circulated to all medical students at Bart's.

Its aims, as stated, were:

(1) Determination of the reasons which influenced Bart's students to take up Medicine;

(2) The nature of the career they wished to follow;

(3) Their attitude towards Emigration.

The object of this article is to discuss the results of the answers to the Questionnaire sent in by the women students at Bart's in the light of the three aims given and to compare these answers with those of the male students—where there is any significant difference.

Although replies to the Questionnaire were given in 1957 it is interesting to note that 46 out of the 60 women who answered the Questionnaire (there were 77 women students at Bart's at that time) were in the 2nd and 3rd preclinical and 1st clinical years and constitute almost the entire number of present (1960) clinical women students.

Schooling and background

The principal schooling of the women students was public—50 per cent or grammar 38 per cent. This was in direct contrast to the men where students with public schooling outnumbered those from grammar schools by more than two to one. Similarly fewer women had received their pre-clinical training at Oxford or Cambridge 92 per cent having been at Charterhouse as compared with 72 per cent of the men.

Naturally none of the women had done national service but 18 per cent of them had either done some other non-medical study for six months or more, or had held down a job for that length of time.

One quarter of the women first became interested in Medicine as a career before the age of 8 and 83 per cent were interested by the time they reached the age of 16. Indeed 58 per cent of the women (compared with 52 per cent of the men) were quite decided on becoming doctors, by the age of 16, and 97 per cent were settled in their choice of career before leaving school. A higher proportion of women, 17 per cent, to men, 11 per cent, took up science only after leaving school but science specialization while at school was the general rule for both groups.

The vast majority of the women, 97 per cent, if in a position to choose their career again would still have chosen Medicine; 3 per cent were undecided but none felt they had made the wrong choice of career as did 4 per cent of the men.

Domestic Details

Most of the women students were neither engaged nor married and of the 7 per cent who were engaged 5 were deferring any matrimonial celebrations until after qualification. Most unmatched women (like the men) were unattached because they had not met anyone suitable and none of the women wished to remain single (as opposed to the 4 per cent of the men who were definitely misogynistic).

Most women students lived with parents or relatives (40 per cent) or in College Hall (20 per cent). The rest were living alone or with friends in flats or furnished rooms. 40 per cent of the women students at Bart's had no grant or scholarship (compared with 34 per cent of the men) but 43 per cent received £200 or under (34 per cent of the men also received a similar amount). The rest received between £200 and £300 per annum from these sources.

Politically, 62 per cent of the women favoured the Conservatives, 10 per cent supported Labour and 12 per cent followed the Liberal cause. Alas 16 per cent registered as "don't knows".

Family and Medicine

Forty-two (42 per cent) of the women students had fathers in the medical profession and 17 per cent had mothers who were or had been connected with the medical world so it was not surprising that 15 per cent gave "parents' wish" and 30 per cent gave "advice or example of a friend or relative" as important factors influencing their choice of medicine as a career.

Family associations with Bart's was a very important reason why many of the women students chose to train in the city and was the most important reason for 36 per cent of them. The professional reputation of the hospital came a not very good second (25 per cent), which suggests that blood is thicker than water! From the answers given it was obvious that teaching facilities and the professional reputation of the Hospital together with its traditions had played a very big part in influencing women students to choose Bart's.

The possibility of getting on the staff at Bart's was not suggested as a reason for choosing to study there. This is just as well for although 52 of the 60 women students answering the Questionnaire said they would in due course apply for a House Job at Bart's, it must be put on record that only 29 house jobs have been awarded to women since 1947. Hope springs eternal in the human breast!

"Why do you want to be a doctor?" is a stock question for prospective medical students at their interviews and most go prepared with stock answers. The four most important factors influencing women students in their choice of career were the prospect of meeting people, humanitarian reasons, the opportunity to use both brain and hands and interest in science and natural history. But when asked to give the most important single influencing factor 21 per cent of the women said humanitarian reasons, 17 per cent the prospect of meeting people, and 13 per cent said it was their upbringing in a medical family. With the men humanitarian reasons came third to interest in science and the prospect of meeting people. 13 per cent of the men were influenced by the good financial prospects of medicine, while none of the women considered that this aspect influenced them at all!

Emigration

The women students were a (relatively) much travelled crowd, 85 per cent of them having resided in or visited a foreign country; but only 58 per cent had seriously considered emigration, as opposed to 65 per cent of the men. Of those who had considered emigration 20 per cent still remained undecided, 6 per cent had decided against the idea, and 60 per cent were postponing their final decision until after qualification. The most popular country of choice was Canada, which was three times as popular as either Australia or New Zealand. America was surprisingly unpopular and the African colonies and Protectorates came a close third to the Antipodes.

It was clear from the replies that some of the women students had viewed the emigration question very seriously and had taken trouble to acquaint themselves with facts concerning the practice of medicine in the country of their choice. Of the 58 per cent who had seriously considered emigration 31 per cent had made active enquiries from embassies, etc., and 56 per cent had sought the advice of medical people actually practising in the country concerned.

The opinion of the women students regarding possible reasons for emigrating reflected their views on the N.H.S. and its effects on the practice of Medicine. Since 53 per cent felt that the practice of Medicine had been adversely affected for the specialist and 70 per cent felt it had been adversely affected for the general practitioner, greater professional freedom, better financial prospects abroad, less professional overcrowding and greater possibility of combining specialist and general practice figured high on the list of possible reasons for favouring emigration. But travel and adventure was the most popular reason in favour of emigration and 31 per cent of the women believed it to be the single most important reason for which they would leave Great Britain. 20 per cent of the women said better financial prospects was the single most important reason for which they would emigrate and 13 per cent said they would leave to do missionary work. The men when answering this question were generally much more concerned with financial and professional factors.

Careers

Most women students at Bart's wished to enter some branch of Medicine (as opposed to Surgery), 37 per cent favouring general practice and 32 per cent some form of medical speciality. Midwifery and gynaecology was the next most popular—15 per cent—and 52 per cent of the women were either definitely decided in their choice or very strongly inclined. Only 20 per cent were as yet quite undecided and all were quite sure they would have settled their choice of career once and for all by the end of their pre-registration year. As might be expected surgery interested far more men (24 per cent) than women students (10 per cent).

Women were most interested by pediatrics, midwifery and gynaecology, psychiatry and general practice (the men favoured general surgery, psychiatry, midwifery and gynaecology and general medicine) but when asked if they would definitely make their career in the subject which interested them most both men, 75 per cent, and women, 78 per cent, temporised with "possibly".

Women were influenced towards general rather than specialist practice by such factors as responsibility for the health of individuals from birth onwards and the opportunity to diagnose and treat a greater variety of complaints (28 per cent gave the former and 13 per cent the latter as the most important single factor influencing their choice). But the women were also realistic and 20 per cent felt that the competition and uncertainty of becoming a consultant would also influence them in their decision. (8 per cent of the women and 15 per cent of the men gave this as their most important influencing factor.) 10 per cent of the women felt quite sure their mental capacity was not suited to specialist practice—only 5 per cent of the men were as modest as this!

On the other hand the women felt that if they took up specialist practice they would have more time to spend on the diagnosis and treatment of each patient, could enjoy regular hours of work and retain a closer contact with colleagues in hospitals and have greater opportunities for research. They were far less impressed than the men by the thought of greater financial rewards and the social and professional prestige afforded by specialist practice.

Branches of medicine, e.g., pathology, where the human element is somewhat lacking, were generally unpopular with men and women alike and the women (unlike the men) felt they would not be influenced towards a particular type of job because of an opportunity for teaching associated with it. Research was a different matter—33 per cent of the women were sure they would be attracted to a job which carried the possibility of combining research with professional duties.

Most women felt that their clinical training should include a course on general practice to give them practical experience of the duties, work and life of a general practitioner —25 per cent of them had in fact had some small experience of a G.P.'s work. 47 per cent of them felt that if they did enter general practice they would prefer to work in a town (as opposed to a city), 35 per cent preferred the idea of a country practice and only 5 per cent felt they could enter general practice single handed—the rest wanted to join a small partnership or a group practice. Southern England (45 per cent) and the West Country (17 per cent) were the two most popular areas in which the women wished to practice.

It is hoped to follow this article with another at a later date giving details of the subsequent careers of those women students who were at Bart's between 1948 and 1958 and who qualified during that time.

Why ?

How quickly does the student learn
The ways of all his Chiefs in turn
From Bodley-Scott to Jory.
But still his mind cannot explain—
Physicians seem to have the brain,
Yet surgeons steal the glory!

R.N.W.P.

THE DOCTOR AND THE POLICE

Summary of a "General Practice" Lecture ***by R. Hunt Cooke, M.D., M.R.C.P.***

PRIOR to 1948, the Metropolitan Police Surgeon was appointed to look after the health of the members of the Force. He was attached to a particular Station and paid on a capitation basis according to the numbers of men under his immediate care. Police work as such was no part of his duties, but naturally being known, he was called in to assist whenever a medical opinion was required. Payment was on an "items of service" basis plus court fees, etc.

The N.H.S. altered all this. From 1948 the members of the Metropolitan force became as members of the general public and registered on the "list" of the doctor of their own choice. The appointment of Divisional Surgeon ceased to exist. The police whenever they required a medical opinion were left to obtain it from any medical man willing to respond to their call. Again the choice fell frequently on their old divisional surgeon, but where he had ceased practice or was unwilling to fit into this scheme of things, the Police were often hard put to get medical help. The very specialised nature of the work and the time-wasting involved in court procedures makes police work something that a General Practitioner must regard as vocational. Speaking of Court procedure, the average doctor has a fundamentally different outlook on his evidence to that of the legal mind. He forgets that all the defending Counsel has got to do is to implant a "reasonable" doubt in the mind of one juryman. He has not got to prove his client innocent. His endeavour, having a weak or doubtful case, is to weaken the medical evidence by making the medical witness either contradict himself or lose his temper. To one not used to cross-examination and all its imputations and nuances, either of these is fatally easy, and the value of the evidence is weakened as a whole. There are after all only three answers to any question: I quote, "Yes. No. It all depends". The only body of citizens capable of establishing a fact in a law court is the jury.

The police surgeon *must* be fair, and *must not* take, or give the impression that he has taken, sides.

A very important factor in this type of speciality is the ability to recognise the normal. The texture of healthy skin, the appearance of the intact hymen, the amount of exudate normally present in a cavity, will help materially to make a diagnosis in a case of alleged sexual assault, or the length of time a body has been dead, and whether injuries are ante- or post-mortem.

Nowadays the recognition of alcoholic intoxication and its effects on various skills, especially car control, and its differential diagnosis from diseases affecting the same skills, looms out of proportion to other questions, owing to the type of publicity it is receiving. Here, Breathalisers, blood and urine alcohols, and other chemico-pathological tests occupy much space in the literature. They have their place, but are far and away below the importance of a full and accurate clinical examination. Such an examination can say—"This man is not suffering from any condition other than alcohol, which will account for his behaviour." It can say also "At the time of examination, *in my opinion* . . . This man was, or was not, capable of having control of a car, irrespective of the amount of alcohol he is said to have consumed".

It is important to remember that nobody can be examined without consent. This is one of the fundamental facts that all doctors called to examine any person must remember. Consent having been refused, the only course open is to make accurate observations and records, from which the doctor is at liberty to express an opinion if he feels he can do so.

On occasion some rapidity of thought is called for. My most difficult decision was when I was called to the police station to examine a man alleged to be under the influence, etc., and not fit to be in control of a car. It so happened that I had shortly before left a cocktail party, at which there were a number of eminent consultants, to commence my evening surgery. As I stepped into the charge room at the station I was greeted by a cheery shout from one whom I had seen shortly before at the same party. "Hello Hunt Cooke! Have they got you, too?" It took some of my laboriously acquired reputation for impartiality to convince the station sergeant that this was only high spirits and not the other variety.

It is very necessary to possess a low retching reflex when called to the scene of some discovered remains. I live near a large reservoir which is handy for suicides and getting rid of new-born babies. I am, therefore, fairly often asked "How long has this been in the water?", or "Can you say whether it was born alive?" I usually can't then and there.

Unless the doctor called to the scene of an "incident" has some experience, it is fatally easy to vitiate evidence. My practice on arrival is to put my hands in my pockets until I have had a good look. In the vast majority of cases that is all that is required. Where it is necessary to turn a prone body to make an examination as to the possibility that life is still present, the minimum of interference should take place until those skilled in interpreting the conditions found have had their turn.

The examination of injured prisoners especially drunks, as to their fitness to be detained is a frequent occurrence. It is important to distinguish the relative importance of head injuries in this connection. I remember nearly dropping a very large brick in the case of a man with one glass eye because on my first examination of him I had not examined them both and had concluded he had fixed inactive pupils.

Within the last year, as the result of negotiations between the various bodies concerned, it has been agreed to advertise vacancies in the Police Divisional Surgeons establishment (the optimum is one per police station) in the medical press and to choose from the applicants those best fitted for the job. For some 2 or 3 years the Metropolitan Police have been paying a small retaining fee to those doctors that have been reappointed as a sop to "availability".

Thomas Young (1773-1829)

THE issue of the New England Journal of Medicine for June 2nd, 1960, carries an article on Thomas Young, possibly the most versatile genius ever to have studied at Bart's. He was taught to read at the age of two, and had memorised long pieces of poetry, and read the Bible twice by the age of four. At the age of thirteen he was able to construct his own microscope and telescope, and knew Italian, French, Latin, Greek and Hebrew, and was studying Syriac and other ancient languages.

He entered Bart's in 1792, with the help of his uncle Dr. Brocklesby, at whose house he met Edmund Burke, Samuel Johnson, and Sir Joshua Reynolds. At the age of 20 he was elected a member of the Royal Society, for his original work on the accommodation of the eye. He then studied for a while at Edinburgh, obtained a medical degree at Gottingen, where he learned to play most of the known musical instruments of that day, and in order to become eligible for the Royal College of Physicians he spent two more years at Emmanuel College, Cambridge, where he graduated M.D. He tried to combine the practice of medicine with teaching physics, but found that he could not do both, and as he became financially independent on the death of his uncle, he stuck to medicine, having a private practice in London. Nevertheless, he still had time for other pursuits, and especially the studies on optics, for which his name is remembered in conjunction with Helmholtz, and physicists remember him for Young's modulus of elasticity. He also studied the tides, supervised the Nautical Almanac, acted as a consultant on naval architecture, wrote articles for the "Encyclopaedia Britannica" on Herculaneum, bridges, tides, annuities and Egyptology, and succeeded in deciphering the Rosetta stone. He was elected Physican to St. George's Hospital in 1811. Young's doses for children are still quoted.

'X' *His Mark*

by M. Barton

AUNT Elsie is a devoted letter writer, but you must read her letters like a horse jumping the Grand National. No pause for the impenetrable barrier of this or that incomprehensible word, a clean vault over it and down through the pages at a rattling gallop until finally the winning post looms ahead—love. Elsie. Then, having grasped the gist of it, you may wander back through the pages, picking up the fallen phrases at leisure. It is essentially a leisure occupation understanding Aunt Elsie's letters.

I once gave my landlady an electric toaster. She was seventy-five and too old to learn how to make good toast. But to give Aunt Elsie a typewriter, even with the co-operation of my bank-manager, would be an affront not lightly forgotten. I had to make my own toast, and would probably have to write my own letters. It is no more easy to criticize a man's handwriting than it is to criticize his driving, yet the latter can be a mortal danger, the former a mark of crass arrogance and inconsideration to the reader. Of course, doctors are exempt from this complaint. We all know that their handwriting is appalling, but there are good reasons. The old one about the patients not reading their prescriptions now has no force, the *Readers Digest* has seen to that, and by the time the patient comes to his doctor, both diagnosis and treatment are already firmly decided. The real reason is that doctors cannot spell the multisyllabic names of modern drugs, so if they prescribe a squiggle trailing off into a flourish, the chances are they'll get what they meant, not what they ordered. When a patient comes to hospital bearing a doctor's letter of quite unintelligible scrawls and scratches, we see in operation one of the greatest safeguards of modern medicine. The patient gets a second opinion that can be in no way biased by a previous diagnosis.

The lay public suffers the very unfair disadvantage that it has no vested interest in bad writing. How terrible to think of so many people blissfully unaware of the fact that they should have guilt complexes. But of course they haven't. If I cosh an old lady or take an interest in choir boys, I don't get a guilt complex because you see daddy drank and hit mummy and so I did not get the love and attention I needed as a child. When I went to school I was taught to write, using as a model Victorian copperplate which, with its loops and round open forms, is ideal for all kinds of future degradation. Thus I can blame everything on a bad childhood influence and my psychologist is right behind me. The snag is, if I have still got a taste for coshing old ladies society has a remedy for it. But against bad handwriting society has no remedy. In self defence it adopted the typewriter, and contributed to the emancipation of countless young girls who now face years of repetitive tapping until they accept, with a gratitude becomingly concealed, the offer of a more or less presentable young man to exchange such drudgery for another at the sink of "Mon Repos", Suburbia. Conveniently forgotten is the fact that bad training in childhood is wilfully perpetuated through carelessness and blind selfish slovenliness in the multitude of indecent scrawls that we call handwriting. But what about character? A Daniel come to judgment! Character, that great god raised to cover the sins of ommission of countless bad hands, does not this justify all? But take a little closer look at your Moloch of modern times and you'll find him a frail and deceptive idol. He stands for selfishness for you don't care whether anyone can read you; arrogance, that you expect to be understood: carelessness, untidiness, ugliness, inaccuracy . . . do you want to go on? And as for those people who believe in graphology they have my pity but not my sympathy. If any man thinks he can tell my *ego* from my *id* by ink marks on paper then he is a charlatan. Perhaps he deserves to succeed if there are fools enough to believe him.

It's a mournful thought, to be convinced that beautiful handwriting has a place in this modern age. I feel rather like the old man who slouches down Piccadilly on a Saturday night bearing a sandwich board—"Prepare to meet thy doom". I mean Aunt Elsie is against me; that's bad enough; but the medical profession—th[illegible] and of learned but cautious men will be at their most reactionary over this matter. And the typist's union? No shop will be more firmly closed. Well, there's you . . . I wonder? Are you going to try to bring something of grace and beauty into your everyday life? Not to mention legibility? Do you know that you carry around with you every day the cheapest, most portable tool for artistic expression that we have these days? Don't despise your pen. There was a young girl living at Hatfield who used to write letters in the most lovely script. Later her hand became crabbed and scratchy, but then she could always blame the Armada, or Sir Walter Raleigh or all that sleeping in different country houses. Don't *you* presume to use the excuses of a Queen.

In Italy, in the sixteenth century, there flowered a culture that despite its excesses, gave birth to some of the most lovely things we have known. And among the beauties of painting, music, poetry and sculpture, that culture counted the beauty of handwriting. In a series of writing books, published over 70 years, the italic script was born. This script is a model, out of which any man may develop a hand of originality and clarity, with a rhythm and beauty that will give pleasure to both writer and reader. I cannot teach you to write, but there are many who will, and their books are cheap and yet invaluable. But I do hope that next time you sit down to write a letter you will stop to think just what sort of a mess it is you call your handwriting. Of course, I may be preaching to the converted. Like Aunt Elsie.

ALTNAGELVIN HOSPITAL, LONDONDERRY

by S. M. Watkins

SITUATED on a windy hill outside the city of Londonderry, stand the magnificent new buildings of Altnagelvin Hospital, with superb views extending in all directions. Opened in February of this year, it cost £2½ million, has nearly 400 beds, and houses the most modern equipment in every department.

The main building is L-shaped, facing south and west, with a single floor north and east completing the quadrangle. The main entrance, well guarded by Princess Macha, a highly controversial bronze statue, leads into a spacious hall, which is soon to be decorated with an enormous mural.

The main building is L-shaped, facing ward" system. Each has 31 beds: one 6-bed, four 4-bed, three 2-bed and three single-bed rooms. All the ward rooms face south or west (whilst the kitchens, sluice rooms, etc., face in towards the quadrangle). Each ward also has a large, sunny and comfortable day room for the patients. All the furniture is modern and elegant. Beside each bed is a panel with the usual wireless headphone; and also a two-way speaker to the nurses' room. (This gadget, though doubtless very ingenious, seems slightly superfluous, since the nurses are never far away, and in any case most patients would prefer the comfort of a nurse's presence, rather than a disembodied voice!) Another feature is the "treatment room", all surgical dressings are carried out here, to avoid every risk of cross infection; and, as an added precaution, these rooms are kept under positive pressure. Laundry, dirty dressings, etc., are all disposed of in large paper bags, avoiding the use of septic bins. It will be interesting to see how much difference these precautions make to the incidence of ward infection.

The hospital is laid out as follows:

East side: Records Offices

North side: Out Patients

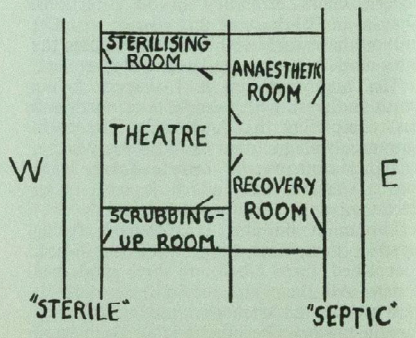
South side:	West side
Ground Floor, Casualty and Admission	Entrance Hall.
First Floor, Ward 1: General Medicine	Administration and Catering.
Second Floor, Ward 2: General Medicine	Physiotherapy and Pathology.
Third Floor, Ward 3: ENT; Eyes	Ward 13: Radiology. X-ray Department.
Fourth Floor, Ward 4: Midwifery	Ward 14: Midwifery and premature babies.
Fifth Floor, Ward 5: Midwifery	Ward 15: Antenatal: Neonatal.
Sixth Floor, Ward 6: Orthopaedics	Ward 16: Dermatology. Central Syringe
Seventh Floor, Ward 7: General Surgery	Service Department.
Eighth Floor, Ward 8: General Surgery	Theatres (4).
Ninth Floor, Ward 9: Gynaecology	
Tenth Floor, Ward 10: Paediatrics	

The hospital houses six theatres, one being in the Midwifery unit, and one in the Casualty Department. The other four (two general surgery, one eyes and ENT, one orthopaedic) are all together on one floor, which is entirely under positive pressure. An interesting feature is the use of two corridors. The west ("sterile") corridor can be entered only by gowned people, wearing bootees; the surgeon enters the theatre from this side. The patient's bed is pushed into the anaesthetic room from the ("septic") east corridor. In the anaesthetic rooms, and theatres (as well as in the wards and dressings rooms throughout the hospital) are taps supplying oxygen, nitrous oxide, and vacuum for suction. Connected with the orthopaedic theatre is a dark room, speeding the development of operative X-rays.

The X-ray department has four rooms, each specially adapted for a particular type of radiography. Each is lead lined throughout (including a keyhole cover!) and is equipped with an anti-static floor. The small adjacent Ward 13 accommodates patients admitted for a single night for a barium meal or other similar investigation. The Physiotherapy department is nothing short of fabulous: a magnificent hydrotherapy pool, ultra-modern gymnasium, electrotherapy, U-V therapy rooms, etc., make up a department, which must be one of the finest of its kind in Great Britain.

Out-Patients and Casualty are neatly designed and excellently equipped (including a dictation machine in every consulting room). Internal communications are on the "bleep" system, with all its advantages and disadvantages. (cf. *Journal*, December 1959). As yet, no Clinical Photography department exists, but the good attendance at a recent lecture on the subject, given in the hospital, is indicative of their interest in such a development. It is hoped that one will soon be opened.

The 300 nurses (about one-third of whom are qualified) are housed in a Home of spacious design, all beautifully furnished, and including a large recreation room. Unfortunately the size of the Home limits the number of nurses, which is already insufficient. A small house near the hospital accommodates



the resident staff: 2 house surgeons, 1 house physician, 1 orthopaedic house surgeon, 1 anaesthetist, and 2 midwifery housemen. This again would seem a small number of residents to run a hospital of this size. (An additional doctor's Home, including 3 married quarters, is soon to be erected). It is to their credit that, in spite of being so hard working, the staff always seem to welcome the visits of the general practitioners, who are delighted thus to be able to follow the progress of their patients.

The hospital is not ideal. It is rather far from the town, though there is a reasonably frequent 'bus service. It has already been accused of being "out of date", as it has no acute psychiatric ward but it is hoped that one will be included in the proposed new extension. It is really rather small and understaffed to cope with the large numbers of patients coming from far afield. A few pieces of equipment seem perhaps an extravagance, whilst others might be more necessary. No such venture can expect to be perfect, and in spite of all criticism the fact remains that Altnagelvin is a very fine hospital, and perhaps a model for the hospitals of the future.

Acknowledgment:

I should like to thank the Staff of Altnagelvin Hospital for their co-operation and help.

LYCANTHROPY

by D. H. S. Missen

IN his *Duchess of Malfi* John Webster delineated the product of much intermarriage in Duke Ferdinand, a most sadistic Renaissance prince:

"I would have their bodies burnt in a coal-pit with the ventage stopp'd
That their curst smoke might not ascend to heaven;
Or dip the sheets they lie in in pitch or sulphur,
Wrap them in't and then light them like a match . . . "

In the Duke's case, sadism, followed by remorse, unhinges his weak-seated reason, and he imagines that he is a wolf:

"One met the Duke 'bout midnight in a lane
Behind Saint Mark's Church, with the leg of a man
Upon his shoulder; and he howled fearfully.
Said he was a wolf, only the difference
Was, a wolf's skin was hairy on the outside,
His on the inside."

Webster may have borrowed his idea from Wier, *De Praestigiis Daemonum*, who describes the case of a peasant near Padua who in 1541 became a *Lupo manaro*, stating that he had grown "wolf's hair", but "turned inside under the skin". Whatever Webster's source, the affliction he describes is not uncommon and usually takes much the same form. Lycanthropists imagine, or actually experience (as with the stigmata) a physical wolfishness. They become hairy; sometimes their eyes turn green or yellow, and they often suffer the symptoms of rabies. They imagine they have fangs in place of teeth and claws instead of finger-nails and walk on all fours. These changes are frequently accompanied by a craving for human flesh. "The werewolves are certayne sorcerers", wrote a sixteenth century authority, "who . . . doe not onely unto the view of others seem as wolves, but to their own thinking have both the nature and shape of wolves . . . and they doe dispose themselves as very wolves in worrying and killing, and most of humane creatures." A typical case was recorded more recently by Hack Tuke in his Dictionary of Psychological Medicine:

"He trembled and said 'See this mouth, it is the mouth of a wolf, these are the teeth of a wolf. I have cloven feet, see the long hairs which cover my body; let me run into the woods and you shall shoot me'."

This type of hallucination is extremely ancient. The Book of Daniel tells us that Nebuchadnezzar spent four years of his reign grazing as an ox. Cases of lycanthropy are recorded in Pliny, Herodotus and Vergil and the disease was known to Avicenna and Gallen. In the 20th century it still persists. On July 15th, 1949, the *Daily Telegraph*

published the following cable from its Rome correspondent: "Howls coming from bushes in the centre of Rome last night brought a police patrol to what seemed a werewolf. Under the full moon they found a young man, Pasquale Rossini, covered in mud, digging in the ground with his fingernails, and howling. On being taken to hospital Rossini said that for three years he had regularly lost consciousness at periods of the full moon and had found himself wandering the streets at night, driven by uncontrollable instincts".

Lycanthropists may take forms other than the wolf. There have been wer-tigers in India, and in northern Europe wer-bears or *berserkers* of which the Footguards in their bear-skin helmets are a curious relic. There have been wer-foxes in Japan and wer-jaguars in South America. In Africa there are still brotherhoods of leopard-men who use specially carved sticks to impress leopards' spoor in the soft earth and iron claws to lacerate their victims. In countries where the wolf became extinct, lycanthropists took the forms of such lesser animals as stoats, hares and cats.

In England, cases of lycanthropy have been rare since the sixteenth century. Whilst France was still infested, and werewolf trials raged in every part of the country, James I could write placidly in his *Daemonologica* that "warwoolfes" were the "victims of delusion induced by a natural superabundance of melancholic".

Of the galaxy of myths and legends that surround lycanthropy much has been written but little with certainty—it is the subject of many anthropologists. The lycanthrope is related on the one hand to vampires and zombies (though it is essential not to muddle these two categories, the distinction being that lycanthropists are very much alive) and on the other to witchcraft and familiar spirits—and here the distinction is tenuous in a country where the cat is regarded both as a possible form of lycanthropy and the usual familiar of witches. Sorcerers were popularly supposed in mediaeval times to be able to turn themselves into wolves by annointing their bodies "with an oyntment which they make by the instinct of the devill, and putting on a certayne inchaunted girdle" of the relevant animal's skin. Lycanthropic myth or practice appears to have existed in most major religions. We find it in the Icelandic sagas and the Roman Lupercalia alike, and in ancient Arcadia an entire cult was devoted to the worship of a Wolf-God. Even in Christian mythology, a wolf guarded the head of St. Edmund, while St. Patrick is said to have transformed Vereticus, the King of Wales, into a wolf. *Omnes Angeli, boni et mali, ex virtute naturali habent potestatem transmutandi corpora nostra.* Even in the 20th century mass lycanthropy has reared its head in the German werewolf organisation and the sinister rites of Mau-Mau.

There is an ingenious explanation of this disease. The lycanthrope may be no more than an archetypal throw-back to the days when primitive man first changed from a peace-loving vegetarian society to a genus that imitated predators, hunted in packs and practised cannibalism; to a race that has differed little basically from that day to the present.

REFERENCE

Man into Wolf, by Robert Eisler. (A lecture delivered to the Royal Society of Medicine). Introduction by Sir David K. Henderson. Spring Books Ltd., London.

SOMATO PSYCHIC DISEASE ?

ANOTHER one! He was three. The Doctor's letter said he was nervy and highly strung, with parents who were over anxious and handled him badly. The mother said that for three months he had been short tempered and irritable, listless, and had complained of toothache which had not been relieved by extraction of the bad teeth. He would wake in the night and want to get into his parents bed, and by day he was miserable, crying for the least little thing, and wanted his mother to nurse him. His face wore a pinched look and his eyes had become very small.

Accompanying these symptoms was the inevitable nasal catarrh, and a week before coming to see me he started soiling. "He's never been bothered with constipation, but now appears to have no control whatsoever. He just soils his pants, and when put on the lavatory he can't finish. No sooner is he washed and changed than he soils his pants again. Twice he has actually done a full motion in his sleep, and now he is more unsettled than ever, whimpering all the time, and the slightest remarks to him, remonstrative or otherwise, immediately upset him. He tires of all his games and toys quickly, and is no sooner out of doors than he is back, either lying on the floor or wanting to be nursed".

Well, I looked him over, and found nothing very startling. The bowel story sounded like constipation with overflow, and a rectal examination confirmed a loaded rectum.

I put on the "constipated record", recommended a regular aperient and started to usher an unwilling mother out of the room. She then asked whether she should do anything about the nasal catarrh, adding that it was only on one side of the nose. She had mentioned this before, but somehow it had been overshadowed by the lucid description of all the boy's behaviour problems. I called her back and sure enough there was a thick green discharge blocking one nostril. He had recently eaten, so next day I had him back hungry, gave a whiff of ethyl chloride, which turned out to be unnecessary, and with some forceps removed a small piece of plastic sponge soaked in a bath of pus.

The family lived a long way away, and I asked the mother to write and let me know how he got on, and also to give me a more complete description of his symptoms. Actually much of the above history is taken from this letter with slight alterations in tense. I am fond of writing down verbatim what mothers say, but must admit that it is not usually in quite such detail!

In her letter a fortnight later she said "since the removal of the piece of sponge he has been a new child. The bowel trouble cleared up within a couple of days, and his face and eyes are back to normal. We've heard no more complaints about this toothache, and he stays out of doors all day long. He sleeps all night long, too—infact he's no trouble at all now!"

Well, that was a near escape! I nearly missed that one, and wonder how often a similar cause for a behaviour problem has been missed. Alternatively how often are such forms of behaviour due to some reflex irritation of a less obvious nature—a blocked nose makes you think, don't it".

"The Ballad of the Breech"

by P. E. Pym

I started in life a diminutive speck,
A zygote, and firmly embedded
In the wall of a womb which was cosy warm
And whose owner was legally wedded.

By a process of fission I grew and I grew
And soon became quite recognisable
As an embryo human with torso and limbs
And a head which appeared much too sizeable.

I developed a nose and a couple of eyes
But no sense of sight or of smell;
For I lived an aquatic existence, you see,
In a cavity darker than hell.

I floated around with hardly a care
Though sometimes I got a bit bored
Till suddenly one day it shook me to find
That my navel was fixed to a cord.

Where did it go to? I had to find out
For to me it became a tormentor;
So hand over hand I shinned up that cord
Till I bashed my head on my placenta.

About this time too I discovered my ears
And noises became quite specific
I thought, borborygmi, a sonotous burp,
And the passing of flatus terrific.

Snoring I hated and when Ma let rip
I'd kick out like someone insane
And she'd whisper to Pa, as she rolled off
her back,
"Our Darling is stirring again".

As I increased in size I'd no room to move
And just had to squat on my rudder
With hands on my chest supporting my chin
In a pose reminiscent of Buddha.

About the eighth month I received a rude
shock
A jolting I feared might prove fatal,
From what I could hear it was something
to do
With a knock-about called "antenatal".

My arms and legs were seized in a grip
As if someone was trying to knot 'em
And my tummy was squeezed like a denti-
frice tube
Whilst something hard prodded my bottom.

But worse was to follow the very next day
Such a bashing I thought I was dead
I was pushed, I was pulled, I was twisted
and twirled
Till I finished up heels over head.

Now up-ended like this I feel such a fool,
Of discomfort I've more than enough
But unable to move I just stand on my head
Like a Yogi who's doing his stuff.

How long will it last? Well, who is to say
But God give me strength and persistence
To hang on to life till I'm shoved through
the os
And I start on a separate existence.

OBITUARY

Sir Archibald McIndoe

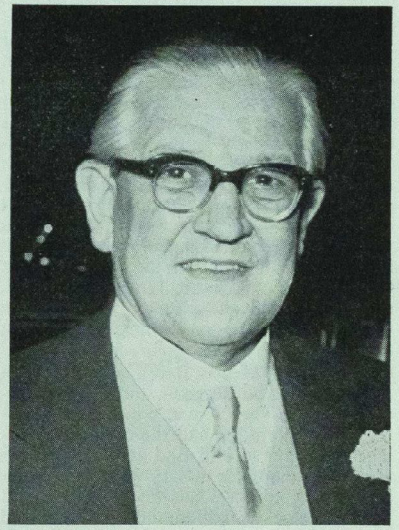
ARCHIE McINDOE had an enthralling career, both as a surgeon and as a man. A delightful attribute of his make-up was his unfailing ability to attract friendship from his surgical colleagues and, of course, his patients. It is not surprising that his circle of friends embraced the world. He never forgot anyone and would remember what a surgeon's appointments were, from where he came, and when they had worked together.

The same wide and charming friendship he exhibited to his many Transatlantic colleagues. No doubt much of this arose from his nine long years at the Mayo Clinic in Rochester, Minnesota, but much of its success was due to a very large and retentive brain. A.H.M. had no difficulties with any of his medical exams, his knowledge of anatomy being quite exceptional.

He was ruthlessly outspoken in the presence of bad surgery but his many scientific papers were always well conceived and eagerly received. His lectures to students and medical societies were crisp, forceful, even domestic, but always intriguing. Speaking at dinner functions came easily to him and he invariably held and entertained his audience.

From this background sprang his deeper interest in inoculating many wealthy philanthropists in the welfare of the Royal College of Surgeons. His work for the College will not be forgotten and in this direction we may perhaps mourn his loss more than in any other.

Actually, as I remember the story, one of the strong reasons for his packing up at the Mayo Clinic to come over here was a promise from the late Lord Moynihan to recommend him for the post of Abdominal Surgeon to the new Post Graduate Hospital at Hammersmith. In passing, it should be remembered that McIndoe's abdominal surgery was of a very high order and would surely have gained for him a great technical reputation. Unfortunately, the Hammersmith job hung fire and things were pretty tough in London for him and the young family. When he made himself known to me in 1930, I was able to take him to Girling Ball, the Dean, and then to Professor Woollard in the Anatomy Department. He thus got a foot in and, later, with recommendations from T. P. Kilner, myself and Manson-Bahr, he got a general surgical appointment at the Hospital for Tropical Diseases.



Photograph kindly lent by Reuter Press Agency which the Editor gratefully acknowledges.

At this time I found myself short of any help in my private practice. He came and saw the work and was deeply inoculated with the bug of plastic restoration, and the joy of creating something new. It was a great pleasure to see this fine operator take reconstructive work in his stride and it was not long before the tail was wagging the dog. Just as I was able to hand him out the experience of the 1918 war, and of the ten following years of peacetime struggles, so he was teaching me many new things. It was a true partnership. After three months hard work with me he said, "Gillies, this is the only surgery for me"—a most fortunate decision whose beneficial influences are still spreading through the operating theatres of the world. I would take him to my special new baby at the Royal North Staffs Hospital, Newcastle, and Stoke-on-Trent, where the senior surgeon and old Bart's friend,

Eric E. Young, made a whole-hearted acknowledgment of the up-and-coming value of this new plastic surgery. I would push him up to St. Andrew's, Dollis Hill, where Gordon Watson had been my patron saint and paved the way for a most valuable haven for our difficult and not always popular work but, wherever it was, Archie took over and endeared himself to everyone with his personality and ability to deliver the goods. It was therefore extremely fortunate but not difficult in 1938 to suggest to the R.A.F. Chiefs that A.H.M. should succeed H.D.G. as Consultant. We all know what he did with that appointment when war broke and airmen were not only burned but were wanted back in the air. For it is for this work at East Grinstead, and in particular for the R.A.F. aircrews burned and battered in the Battle of Britain, that he has earned an undying reputation.

It was in 1935 that Bart's appointed him Assistant Plastic Surgeon and our department became very active. When war eventually came, McIndoe had the option of moving with Bart's to Hill End or of opening up East Grinstead. He wisely chose the latter as his imagination could foresee the advent of Air Force casualties and that it would be better to be free of an overload of civilian injuries. His concentration on the R.A.F. was therefore most fortunate.

One of his chief "buddies" at that time was our old friend Dr. John Hunter, whose life as an anaesthetist was very closely connected with Plastic Surgery. He was finally taken over and his friendship absorbed by Archie. No history of the early days at East Grinstead, and the struggles and battles, could be complete without a record of John's help to Archie and his influence in raising the morale of all the troops.

Then the urge within him to serve by his creative surgery, the ambition to be world-famous and his palpable progress towards the presidency of the Royal College of Surgeons were very human factors in his make-up. They certainly did not detract from his reputation nor mar his friendships. And now this facile surgeon, this incomparable friend has gone from our midst at the very height of his career and on the verge of further triumphs. The drama of his death left the world breathless and bewildered, but the love of him will carry on.

Following the grim gunshot injuries of the Battle of the Somme in 1916, the orders were to "mind and mend" these ghastly disfigurements. In 1930 these orders were passed on to McIndoe whose imaginative enthusiasm saw at once the great need for mental as well as physical reconstruction. So when the burns of Dunkirk and the Battle of Britain came pouring in, Archie was there, always improving his skin-grafting technique or devising methods of making better the piteous constriction of the gnarled hand, the sobbing silence of the staring eye and the red glare of the burned face. The boost in morale to the Battle of Britain pilots when they knew they could have new faces and restored hands was such that it can be said without exaggeration that McIndoe's share in that triumph is a glory, not only to our special branch of surgery, but also to the spirit and foresight of Archie himself.

The last enemy has gone by and a prince of surgeons is dead but the first friend of the world is there—over to HIM.

ARCHIBALD HECTOR McINDOE was born at Dunedin, New Zealand on May 4th, 1900. He spent his school days in Dunedin and graduated in medicine from Otago in 1923.

In the following year he gained a foundation fellowship at the Mayo Clinic and by the time he left the Clinic in 1930 he was an assistant surgeon on the staff. His main interest had so far been in abdominal surgery and it was not until he came to London in the early thirties that he began to specialise in plastic and reconstructive work.

He received all his plastic training from Sir Harold Gillies and after a few years joined him in partnership. McIndoe was appointed Assistant Plastic Surgeon to Bart's in 1935 and his other hospitals included St. Andrews, Dollis Hill, the Hospital for Tropical Diseases, the Chelsea Hospital for Women, the Croydon General Hospital and the North Staffordshire Royal Infirmary.

In 1938 he succeeded Gillies as Consultant in Plastic Surgery to the Royal Air Force and at the outbreak of the Second World War he was appointed surgeon-in-charge of the plastic unit at East Grinstead. Under his leadership this unit was gradually developed into one of the finest centres for plastic surgery in the world and surgeons from many countries were attracted for post-graduate training.

McIndoe's outstanding contribution to the treatment and rehabilitation of war casualties, particularly the burned pilots of the Royal Air Force, quickly carried him to the pinnacle of his profession and after the War he enjoyed an international reputation which has rarely been equalled.

He was appointed C.B.E. in 1944, knighted in 1947 and received honours from the Governments of France, Netherlands, Poland and Czechoslovakia.

McIndoe was the first plastic surgeon to be elected to the Council of the Royal College of Surgeons and in the post-war years he worked with tireless enthusiasm for the College becoming Vice-President in 1958. He played an invaluable part in the rebuilding and expansion of the College and was instrumental in obtaining much of the financial support which is so vital to this programme.

LETTERS TO THE EDITOR

THE HOGARTH MURALS

Dear Sir,

The only reference to the painting of the murals on the Great Staircase in the Hospital's own Archives is the minute of 21st July, 1737, recording the governors' vote of thanks to "William Hogarth, one of the Governors of this Hospital, for his generous and free gift of the paintings of the Great Staircase performed by his own skilful hand in characters taken from sacred history, which illustrate the charity extended to the poor, sick and lame of this Hospital." [Ha 1/11 p. 128.]

There is no more information in the 2nd edition (1782) of John Nichols' "Biographical Anecdotes of William Hogarth", and "Works of William Hogarth" (1808-1810). He states that "Hogarth paid his friend Lambert for painting the landscape in the Good Samaritan and afterwards cleaned the whole at his expense . . . all the ornaments [? scroll work or foliage on the stairs?] were the work of Mr. Richards". Unfortunately Nichols did not make these remarks in his first edition of 1781, nor does he give any evidence to support them. This is strange as he usually gives his authorities, and always indicates clearly when he is quoting from Hogarth's own writings. Later biographers in the XIX and XX centuries do not repeat Nichols' statement. So we really are unable to state definitely who painted the lower scenes on the staircase. However, it is interesting to note that the governors employed a Mr. Richards to paint in the benefactors' names and the shields or cartouches between the upper and lower panels in the Great Hall in 1737. [Ha 1/11 p. 134.]

Your faithfully,

R. VERONICA STOKES,
Assistant Archivist

Department of Archives,
St. Bartholomew's Hospital

Dear Sir,

The answer to the query by your correspondent in the June *Journal* about the artist responsible for the decorations around the Hogarth murals seems to be supplied at least in part by Nichols in his "Anecdotes" which, if not entirely reliable, are one of the earliest sources being first published in 1781.

"Both pictures," he states, "are surrounded with scroll work which cuts off the corners of them, etc. All these ornaments together with compartments carved at the bottom were the work of Mr. Richards. These the late Alderman Boydell caused to be engraved on separate plates and appended to those above them on which sufficient space had not been left." This presumably includes the flower decorations composed of "excellent herbs". Nichols goes on to state "Hogarth requested that these paintings might never be varnished. They therefore appear to disadvantage the decorations about them having been highly glazed. 'The Pool of Bethesda' has suffered much from the sun and 'The Good Samaritan' when cleaned about the year 1780 was pressed so hard against the straining frame that several creases were made in the canvas". I have been unable to find any further reference to Richards in Nichols' or Ireland's work on Hogarth nor is he mentioned in the Autobiographical Sketches where Hogarth writes of the murals at some length.

The murals were greeted with such severe criticism from Walpole, Vertue and others that Hogarth confirms that although "He had entertained some notions of succeeding in what is called the grand style of history, and this failing still unwilling to fall into the manufacture and a desire of being singular he next conceived morality". The manufacture he speaks of is the wholesale production of portraits with the use of background and drapery painters which he attacked so

fiercely throughout his life and his writings. On 14th July, 1737, the Grub Street Journal says "Yesterday the scaffolding was taken down from before the picture of 'The Good Samaritan' which is esteemed a very curious piece". Both pictures can now be considered curious for two other reasons. Hogarth not only paid Lambert to paint the landscapes in the pictures but the main female figure in 'The Pool' is from an earlier drawing done at a drawing Academy, although Hogarth criticises the copying of drawings from posed models. It is more typical of Hogarth that in 'The Pool', as Nichols was assured by Dr. Ducarel, there is "A portrait of Nell Robinson, a celebrated courtezan, at whose shrine both Hogarth and the Doctor had in early life, occasionally paid their devoirs". Lambert is the George Lambert whose painting of skies Hogarth praised in "The Analysis of Beauty' and who was a petitioner with Hogarth and others for the Copyright Act of 1735 usually known as Hogarth's Act. One cannot help wondering whether Hogarth would have attacked the use of posed models and drapery painters so fiercely had these murals, his first attempt at the grand style, been a public success.

Your faithfully,
R. S. DEAN

Abernethian Room

BOOK REVIEWS

AIDS TO BIOCHEMISTRY, by S. P. Datta and J. H. Ottaway. **Published by Bailliere, Tindall and Cox, 1960,** 5th Edition. 265 pages. Price 15s.

Originally published in 1927, this well known little book is now in its 5th edition, the 4th having been published twelve years ago. In fact, it should be considered as a new book as two new authors have been commissioned to write it without reference to the original version. The book is based on the course in biochemistry for preclinical medical students at University College, London, and corresponds fairly closely with the requirements for 2nd M.B. at this medical college.

The opening chapter on hydrogen-ion concentration can be recommended to anyone who has difficulty in understanding acid-base balance, if his grasp of the fundamental theory is shaky. The subsequent chapters are, of course, brief, but are distinctly written and could offer a valuable summary from which to revise biochemistry for the 2nd M.B. examination.

The twelfth chapter on the common terminal pathway of metabolism contains a very incisive account of the role of the pyridine nucleo-tides, flavoproteins and cytochromes but the explanation of the significance of oxidation-reduction potential is extremely brief and the student at 2nd M.B. level would have found the chapter more easily understood if this concept had been dealt with more fully.

THE PRINCIPLES AND PRACTICE OF MEDICINE. Fifth Edition Sir Stanley Davidson. **Livingstone.** 35s.

Sir Stanley Davidson's text book of medicine has become within 8 years a tradition. It is a superb text book, authoritative, concise, easy to read, with a good format and fair illustrations. I would unhesitatingly recommend it as a companion to bedside teaching—the best text book of medicine for students available. Other medical text books in certain sections are outstanding, but no other book keeps the same lucid standard throughout.

The classification and nomenclature of disease is good. The build up of disease entities from physiology and pathology is the best way to present medicine. The paragraphs on preventitive medicine at the end of each systematic section are outstanding and the chapters on fluid balance and the introduction of neurology are both excellent. The short references to major text books on specific subjects are useful to students.

Davidson, as a concise, well-written presentation of observed, scientific medicine is a great thirty-five shillings worth—and worth double, too.

J.D.P.

DIAGNOSIS IN LOCOMOTOR DISORDERS, by Kenneth Stone. **Oxford University Press,** price 25s. net.

In this book the author has set out to provide the general practitioner with a means of ready reference in the diagnosis of locomotor disorders.

The main substance of the work is set out, not under academic headings, but rather under the common presenting symptoms of the various conditions, and thus, particularly for the practitioner, ease of reference is greatly increased. The subject matter is clear, concise and easily readable, but, unfortunately, the reproduction of some of the radiographs leave a good deal to be desired. Nonetheless, the aim of the book succeeds, and it succeeds in a manner much to be admired.

R.C.F.

BOOKS RECEIVED

Miscellaneous Notes (Seventh Series), by F. Parkes Weber, pp. 12. Price 3s. Published by H. K. Lewis & Co. Ltd.

Vaccination Against Whooping-Cough, Diptheria and Tetanus Conquest Pamphlet, No. 11. Price 6d.

PRINCIPLES OF BONE DIAGNOSIS, by George Simon, M.D., M.R.C.P., F.F.R. pp. 170. With 24 figures and 7 tables. 1960 London. **Butterworth & Co. Ltd.** Price 57s. 6d.

During the last few years several medical textbooks have appeared in which a novel approach to their subject has been adopted. It is very gratifying when a volume successfully utilising such an approach is written by a member of the staff of St. Bartholomew's Hospital.

Dr. Simon in this work sets out to group radiographic material according to the type of shadow seen, rather than to the disease entitles themselves. To the student, presented with a specific X-ray problem, a book which links the various clinical conditions directly with what he sees is of much greater value than one arranged in conventional manner according to the basic pathology. But, because this method of layout is unusual, it is all the more important to give the reader a clear classification of the various appearances described. A little more space devoted to this aspect might have been included in the introductory section at the beginning of the chapter.

After a preliminary page defining the trems used there are twelve chapters with headings such as "Increases in Bone Density", Alterations in Bone Architecture", etc. In conclusion there is an appendix of pathological tables for reference.

The descriptions given of the various lesions are clear and accurate: though many orthopaedic surgeons would not accept the statement, on page 25, that in scoliosis "the drawing of selected lines to record the angles of curvature is rarely necessary" and, on the previous page, "Congenital Dislocation of the Talus" is perhaps more commonly known as "Congenital Vertical Talus".

The book is well printed, on good quality paper, with—very rightly—a large number of illustrations from X-ray plates, whose standard of reproduction is high. The price (57s. 6d.) is most reasonable and the book should prove popular not only with radiologists and orthopaedic surgeons but, also, with all members of the medical profession who wish to study the features they see on X-rays of the skeleton.

MORE MEDICAL AND OTHER VERSES
Alex E. Roche, **H. K. Lewis & Co. Ltd.**

Mr. Roche would have done well to heed the proverb contained in the last verse of his collection "Nothing to excess". His excessive efforts in finding medical words to rhyme leave one wishing he had avoided the subject altogether.

The second section is but little more enjoyable and on the whole it savours of the obituary column of the local press.

As Grandma Brigg's—

'Farewell ! May death when strikes for us the hour,
Seem thus like the soft closing of a flower.'

The page of limericks suddenly thrown in is intended to be humorous no doubt—alas, this is scarcely achieved:—

'There was an old woman of Norwich,
Who for food would untiringly forage;
Though she didn't like cheese,
She liked pulses and peas.
Pies, potatoes and puddings and porwich;
And worse follows ! !

There is for the most part, neither rhyme nor reason to these varying compositions of Mr. Roche's—I did not enjoy them and cannot recommend this publication at all.

A LAMP IS HEAVY. Sheila Mackay Russell. **Pan Books.**

First published in 1954 and now reprinted in the Great Pan Series, this is an account of the life of an American student nurse from first to last days of training.

Miss Russell has first-hand experience of the nursing profession and manages to write in a fairly enjoyable fashion. Some of the escapades described are rather exaggerated; if true, the patients surely trembled for their safety at times. The more everyday occurrences make amusing reading.

Student nurses will probably enjoy this; more seasoned readers will take it with a pinch of salt.

The line drawings illustrating some of the events are very effective.

B. A. F.

SPORTS NEWS

Viewpoint

This will certainly not go down on the records as one of the driest summers that have been known. Despite a short spell in May, there has been a good deal of rain, and many sporting activities have been cancelled. Even so, the cricket inter-firm 6-a-side competition was held on a dull but dry day. This event was held for the first time last year, and was a huge success. This year, although a great number of people were on holiday, eight teams were entered, including a Ladies Team and a N.A.T.O. six. The Americans in the latter team acquitted themselves admirably, though one or two of them would perhaps have used with profit the "Griffin Splint" which, one hears, a cricketing "orthopod" (or orthopaedic cricketer) has invented.

The clubs in the Hospital still in U.H. competitions have not had much recent progress. The semi-final of the cricket cup was rained off, the whole team arriving at the opponents ground, to find it under water. The men's tennis team have had a bye to the semi-final which they have yet to play. The bridge team appear to have reached the final of the U.H. Cup, although no reports are yet forthcoming.

1st. XI v. Hampstead. Sunday July 1st, at Chislehurst.—Won by 9 wkts.

On a damp dreary day, after the start had been delayed until after lunch, Hampstead batted first and were soon in trouble. Harvey bowled particularly well and after 55 runs had been scored in 90 minutes the last of a very weak Hampstead side succumbed. We knocked off the runs with the loss of only one wicket. Davies batted well.

Hampstead 55 (Harvey 4 for 6).
St. Bart's 57 for 1 (Davies 34 not out).

1st XI v. U.C.S. Old Boys, Saturday July 2, at Chislehurst.—Won by 1 wkt.

U.C.S. batted first on a hard true wicket and were soon scoring very rapidly. We were fortunate to take three wickets cheaply, but once again Slack proved too good a batsman and they eventually declared at 195 for 3, leaving us 130 mins. in which to score the runs. Davies and Pagan saw us off to a good start and the later batsmen kept the score moving at an adequate rate, but with only 40 minutes left 100 runs were still required. In almost total darkness Jailler and Harvey then set about the bowling with such gusto that after 30 minutes we were only ten runs short. The score coasted easily to 195 but at this total, with only one run to get, four wickets fell, and it was left to our orthodox No. 11 to see us to victory. To everyone's surprise we won!

U.C.S. Old Boys 195 for 3 dec. (Slack 95 not out)
St. Bart's. 199 for 9 (Harvey 44; Jailler 43).

1st. XI v. a "Past XI", Sunday, July 3rd, at Chislehurst.—Match drawn.

We were fortunate to have a fine day for this occasion, and to add to everyone's enjoyment the game turned out to be very exciting. The Present batted first and scored rapidly and fairly easily against the Past attack. Pagan, Merry and Warr all batted well and in the afternoon Harvey and Walker were able to have a quick swing before we declared at 218 for 6, leaving the Past 150 minutes in which to bat. After a shaky start Brainbridge and Hunt settled down and batted very confidently. Even after these two had been dismissed the Past continued to make a spirited attempt to get the runs and at the close were only 7 short with the president of the club still to come in. An exciting and fitting ending to a most enjoyable day.

Present 218 for 6 dec. (Pagan 59; Merry 44.)
Past XI 211 for 9 (Hunt 77; Bainbridge 61).

1st XI v. Nomads, Saturday July 16th, at Chislehurst.—Match drawn.

Nomads batted first and were soon in trouble, losing their first 3 wickets very cheaply. However their captain and another then shared in a very bold partnership of 130 before they declared at 187 for 3. Bart's had 120 minutes in which to bat and in an effort to get off to a fast enough start we lost three of our best batsmen. Warr and Jeffreys then batted very well and with half an hour left only 70 runs were needed. However, the final fling was left too late and the match petered out in a draw. A disappointing result as we had ignored a reasonable chance of winning. Warr batted extremely well throughout his innings and at the close had scored 105 not out.

Nomads 187 for 3.
St. Bart's 164 for 4 (Warr 105 not out).

1st XI v. Dartford, Sunday July 17th, at Chislehurst.—Lost by 1 wkt.

A thrilling game. We batted first on the lower pitch and most of the early batsmen found Dartford's accurate bowling and keen fielding too much for a Sunday morning. However Warr and Harvey batted well and it was largely due to their efforts, together with a little support from the tail, that we managed to score 123. Dartford had hours in which to knock off the runs, but during their innings the luck was certainly with Bart's. Garrod, Harvey and Niven all bowled very well and, helped by keen fielding and an exceptionally fine display of wicketkeeping by Warr, they managed to capture 9 wickets for 88. Dartford's last man was dropped as soon as he came in, but they then proceeded to bat very well and together scored the final 35 runs needed for victory. A thrilling finish to a very enjoyable game.

St. Bart's 123 (Harvey 40; A. C. Warr 33).
Dartford 127 for 9 (Garrod 5 for 17).

1st XI v. R.N.V.R., Sunday July 24th, at Chislehurst.—Won by 9 wkts.

We won the toss and decided to field with a much weakened side. Davies and Harvey bowled throughout the R.N.V.R. innings and each took 5 wickets. The bowlers were helped by good catches by Fell and Powles and by the inadequacies of the batsmen. When the hospital batted Davies, after being nearly bowled first ball, dominated the scene and Bart's won by teatime. After tea an enjoyable 20 overs match was played in which the hospital found new bowling reserves. We also won this game.

R.N.V.R. 47 (Harvey 5 for 23; Davies 5 for 17).
St. Bart's 49 for 1 (Davies 35 not out).

RUGGER CLUB

The following elections were made for the 1960/61 season.

President:	Mr. F. C. W. Capps
Captain:	Mr. J. E. Stevens
Vice Captain:	Mr. M. Jennings
Secretary:	Mr. P. A. R. Niven
Treasurer:	Mr. A. P. J. Ross
Pre-Clinical Rep.:	Mr. A. J. S. Knox
Social Secretary:	Mr. M. Britz

Dr. F.F. Scowen was elected Vice President following his resignation as President.

ST. BARTHOLOMEW'S HOSPITAL JOURNAL

Vol. LXIV, No. 9 SEPTEMBER, 1960

Calendar

OCTOBER

Sat. 1—On duty: Dr. G. W. Hayward
Mr. A. W. Badenoch
Mr. R. W. Ballentyne
R.U.F.C. v. Trojans (H)
A.F.C. Trial
Tea and sports afternoon for Freshers (Chislehurst)
Dean's Party

Tues. 4—Exhibition Squash Match 6.30 p.m.

Wed. 5—R.U.F.C. Trial Matches

Thurs. 6—C. U. Freshers Tea: Recreation Room, Charterhouse, 4.00 p.m.

Fri. 7—Service: St. Bartholomew-the-Less, 1.00 p.m.

Sat. 8—On duty: Dr. E. R. Cullinan
Mr. J. P. Hosford
Mr. C. Langton Hewer
R.U.F.C. v. Woodford (all teams)
A.F.C. v. Swiss Mercantile

Mon. 10—Film Society—"The Inspector General"—Danny Kaye

Tues. 11—C.U. Open Meeting; Recreation Room, Charterhouse, 5.45 p.m.

Wed. 12—S.U. Council Meeting
R.U.F.C. v. C.U. LX Club (H)
A.F.C. v. Royal Naval College (H)

Thurs. 13—Abernethian Soc. Lord Cohen; 5.45 p.m. Great Hall: "Straight Thinking in Medicine"
Squash v. Old Paulines (A)

Sat. 15—On duty: Medical and Surgical Units
Mr. G. H. Ellis
R.U.F.C. Fixture to be announced

Mon. 17—R.U.F.C. Film

Tues. 18—Squash v. Westminster (H)

Fri. 21—G. & S. Musical Evening, 8.30 p.m.

Sat. 22—On duty: Dr. R. Bodley Scott
Mr. A. H. Hunt
Mr. F. T. Evans
R.U.F.C. v. Old Blues (all teams)
A.F.C. v. North College (University Cup) (A)

Mon. 24—Film Society—"The Wages of Fear"

Thurs. 27—Extraordinary Meeting of the S.U. Council 5.30 p.m.
Squash v. Aspro (H)

Sat. 29—On duty: Dr. A. W. Spence
Mr. C. Naunton Morgan
Mr. R. A. Bowen
R.U.F.C. v. Harlequins
A.F.C. v. City of London College (A)

NOVEMBER

Tues. 1—Squash—Cumberland Cup

Thurs. 3—A.F.C. On Tour: Cambridge

Fri. 4—Service: St. Bartholomew-the-Less, 1.00 p.m.

Sat. 5—On duty: Dr. G. W. Hayward
Mr. A. W. Badenoch
Mr. R. W. Ballantyne
R.U.F.C. Cornish Tour