

1st XI v. Hampstead, Sunday July 1st, at Chislehurst.—Won by 9 wks.

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; Rainbridge 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 wks.

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-Chirnal Rep.: Mr. A. J. S. Knox
Social Secretary: Mr. M. Britz

Dr. E.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 (II)

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. Ballentyne
R.U.F.C. Cornish Tour

Editorial

AT this time of the year we welcome to the hospital from the pre-clinical laboratories many who must eagerly have awaited the opportunity to walk the wards and watch the arts and skills of physicians and surgeons. It needs only a quick visit to some instrument maker to purchase a stethoscope before they have truly inherited the traditions of the hospital and with them those of Hippocrates and St. Luke!

Until now, exacting examiners have always made a demand for facts. There has been little tolerance of those who don't know the origin and insertion of *sartorius* or the meaning of Starling's Law. Alas, life will be very similar. However some slight hope does remain for those of us who can't remember all that we are told (for some of us will never remember the witchcraft of acid-base balance or just what Mikulicz described). This hope is experience. Above all, in medicine, no facts are useful without experience; and the importance of our clinical training lies in the blending of both. This is easy to say but it is important in explaining the inevitable repetition which will overshadow the rest of our lives. Without repetition we cannot have experience. The outlook is not so dull, though; the wisest clinician will always explain how no two cases are ever the same and how each new case is a research.

Repetition fortunately comes easily to us all. Pavlov knew this and nobody has ceased to speculate on the place of repetition since. It is always a joy to come to the chorus in a carol after fumbling through the small print of the lesser-known verses. And eventually to be able to sort the relevant facts from all the uncharacteristic ones which try to obscure a case..... It is only experience which will show us the pattern and only repetition which will make us proficient.

As we welcome so many, we lose two whose presence will be deeply missed by all. Sir James Paterson Ross and Mr. Hosford retire on September 30th. Although we will be publishing appreciations of all they have done for the hospital, any tribute would fall short of all we have received. We wish both every happiness in their new lives and are sad to lose their presence in the hospital and the wisdom of their experience.

Fifty Years Ago

THE Journal of 1910 contains the following sketch, contributed to the writer, H. V. Wenham of the Union of the Medical College, Peking, by "A Chinese doctor of the old school".

"A Door Case"

Yesterday, early in the morning, a tradesman of some forty years of age came to my house to ask me to see his sickness. He entered my pulse-room and said: "Sir, these few days I have been feeling a little out of sorts." I looked at his face; it was somewhat pale. I listened to his speech, it was neither clear nor free. So I asked him, saying "Do you not experience a feeling of obstruction in your chest?" "Quite right", he answered, "there is a feeling of fullness in the chest". Said I: "In my opinion, you must be a man who readily gives vent to passionate breath." "Right again", said he, "I am a little hasty tempered". "If that is the case, in the pit of the stomach on the right hand side what fashion?" The patient replied "on the right hand side there is as it were a lump which throbs continually and, moreover, it has a gripping pain".

So I said to him, "Put out your left hand so that I may feel your pulse and determine what is the matter". Accordingly, after I had taken his left and right hands, and had examined the three pulses in each, I told him, "The rest of your pulses are as usual, only the right lower and middle pulses are indeed delayed and ruffled. Your sickness, Sir, is due to the depressed and gloomy breath and loss of ease".

The sick man replied: "Indeed, Sir, you are a marvellous physician! How could you, with one feel of my pulse, know all so truly?" Said I, "You had no sooner entered my room than I knew you were suffering from a little heated breath".

"Sir! how did you know that?"

"Because your face was pale; there was not a trace of colour left. Moreover, I saw that your breathing was fast and deep, and that the front of your chest was full, surely because your breath was ill at ease. So when I asked you, "In the pit of your stomach, the right side, what fashion," you told me of a lump and gripping pain. I went on to feel your wrist, and discovered that the right lower and middle pulses were delayed and congealed. Then I knew that you must have been affected by the angry breath of other

men—it would be no ordinary cause—and that this sickness of yours was called 'breath depressed and ill at ease'."

"Then, doctor, bestow on me a prescription if you please." So I prescribed for him a few tastes of medicine, which would open the chest, facilitate the breath, and disperse the melancholy, using as a vehicle the lotus husks. This I gave to him, and he departed. If you wish to know whether, after eating this prescription his malady was cured or not, well! you must seek the patient and enquire of him!

The medicines employed were as follows: Orange peel, 4 drachms; aromatic bark(?), 2 drachms; orange extract (?), 1 drachm; fragrant root (*R.cyperis*), 3 drachms; betel nut, 4 drachms; apricot kernels, 1 drachm; (as vehicle) lotus husks, one cupful; in water, three cupfuls. Evaporate to make half a cupful and take warm. The prescription, according to custom, was accompanied by the following note as to the prognosis of the case:

"Today, determining the character of the pulses, all are manifestly depressed and slow. This is due to constricted breath".

"The treatment should aim at opening the chest, facilitating the breath, stirring the liver, and freeing the constriction. By such means, a cure will be obtained."

News in Brief

SIR JAMES PATERSON ROSS and MR. HOSFORD retire from the staff on September 30th.

The title of Professor Emeritus of Surgery in the University has been conferred on Sir James Paterson Ross on his retirement from the Chair of Surgery at St. Bartholomew's Hospital Medical College.

Theatre J in the basement of the West Wing is being converted into an Ortho-theatre, and is expected to be in service shortly.

The Squash Courts have been renovated. The season this year will open with an exhibition match by R. M. H. Boddington (Great Britain) and M. A. Oddy (Great Britain) on October 4th at 6.30 p.m.

Students' Union

AT a meeting of the Students' Union Council held on August 10th, 1960, with Mr. A. H. Hunt in the chair, the chief topic of discussion was the draft of a new Constitution for the Students' Union. The main points of this draft had been introduced at the previous Council meeting and it was considered clause by clause. After suitable amendments had been made it was decided to present the new Constitution for ratification at an Extraordinary General Meeting of the Students' Union to be held on October 27th, 1960.

Student facilities in the Hospital were discussed with special reference to the Rifle Club's recent loss of the miniature range (required by the Hospital for the storage of notes). The Rifle Club pointed out that they wished it to be known that they were concerned at the loss and did hope for assurance that an alternative site could be found in the future.

Lectures

Dr. Alvin F. Coburn of New York gave a lecture on Tuesday, Sept. 27th at 5.30 p.m. at the Medical College, Charterhouse Square. He spoke on "A New Concept in the Mechanism of Rheumatic Fever".

At 3.15 p.m. on the same day Dr. Coburn addressed students on "The Use of Adversity and the Pathogenesis of Rheumatic Fever".

Film Society Programme

- October 10—"The Inspector General".
- November 7—"High Society".
- 21—"Jour de Fêtes".
- 24—"The Wages of Fear".
- December 5—"Scott of the Antarctic".

Appointments

DR. J. H. GALBRAITH—Medical Tutor from 1st August, 1960

DR. M. A. BEDFORD—Lecturer in Anatomy from 1st August, 1960.

DR. D. W. DOWNHAM—Junior Lecturer in Anatomy from 1st September, 1960.

DR. E. P. W. TATFORD—Junior Lecturer in Anatomy, from 1st September, 1960.

DR. J. T. SILVERSTONE—Junior Registrar to Dr. Cullinan, from 1st October, 1960.

DR. B. P. HARROLD—Junior Registrar to the Medical Professorial Unit, from 1st September, 1960.

MR. B. MEASDAY—Resident Assistant Physician Accoucheur, from 1st April, 1960.

DR. H. W. BALME—Sub-Dean of the Medical College, from 1st September, 1960.

Examination Results

UNIVERSITY OF LONDON

Ph. D. Examination
(Faculty of Medicine)
Bergel, D. H.

Special Second Examination for Medical Degrees

July 1960

Abayomi, I. O.
Brewer, C. L.
Davies, W. A. M.
Littlewood, P.
McPhail, L. M.
Newstead, F. B.
Sibunruang, S.
Wan Ping, I. H.
Benison, R. S.
Cannon, J. P. G.
Evans, J. P.
Lloyd, C. M.
Miller, A. J.
North, P. J.
Stephenson, T. P.
Ying, I. A.
Bousfield, J. D.
Challis, J. H.
Frank, A. J. M.
McLaughlin, J. E.
Nash, A. V.
Savege, P. B.
Tandy, W. R.

ROYAL COLLEGE OF SURGEONS.—F.R.C.S.
J. N. Cozens-Hardy.

Engagements

BELL—LONG.—The engagement is announced between Dr. Thomas John Cranston Bell and Dr. Daphne Nevill Long.

O'KEEFE—BASS.—The engagement is announced between Dr. Charles James Maunsell O'Keeffe and Joy Bass.

SIBSON—LANGTON.—The engagement is announced between Dr. Derek Edmund Sibson and Elizabeth Jane Langton.

Births

BIDDELL.—On July 30th, to Sheclagh, wife of Dr. Paul Biddell, a son (Hugh John).

CAIRNS.—On August 3rd, to Valerie and Dr. David Cairns, a daughter.

CARR.—On July 31st, to Audrey, wife of Dr. Conor Carr, a son (Nicholas John).

CHAMBERLAIN.—On April 5th, to Drs. Jennifer and Douglas Chamberlain, a daughter (Mary Ann).

GARROD.—On August 2nd, to Gwyn, wife of Dr. D. C. H. Garrod, a fourth son.

MOLESWORTH.—On July 28th, at B.P. Refinery Hospital, Aden, to Rosemary Ann and Dr. Peter R. H. Molesworth, a son (Nigel Piers Henderson) a brother for Simon and David.

TABOR.—On August 17th, at R.A.F. Hospital, Akrotiri, Cyprus, to Shiona, wife of Flg. Offr. A. S. Tabor, a daughter (Mary Claire).

Deaths

GRAETZ. On August 16th, Dr. Gerhard Herman Arnold Graetz. Qualified 1929.

GRANT.—On August 20th, Col. M. F. Grant (Late R.A.M.C.), aged 82. Qualified 1904.

HEATH.—On July 31st, Surg. Captain George Edwin Heath, R.N., aged 70. Qualified 1916.

LITTLEJOHN.—On August 4th, suddenly in Melbourne, Victoria, Dr. Charles Littlejohn of a coronary attack. Qualified 1914.

PEARCE.—On August 6th, Cyril Morgan Pearce, F.R.C.S., aged 61. Qualified 1923.

RICHMOND.—On August 11th, Dr. Arthur Richmond, Qualified 1902.

WILLIAMS.—On August 8th. The Very Rev. Frank Garfield Hodder Williams, aged 78. Dean Emeritus of Manchester. Qualified 1908.

ROBERTS.—On May 27th, Coral Roberts, widow of J. E. H. Roberts, O.B.E., F.R.C.S.

Marriages

BLOOMER—GILMOUR.—On July 27th, Dr. A. C. S. (Mike) Bloomer to Judith H. Gilmour.

EDWARDS—BINGHAM.—On August 12th, at St. Bartholomew's-the-Great, Dr. J. Griffith Edwards to Dorothea M. A. Bingham.

Change of Address

Dr. A. M. Pocock (née Tressidder), 59 Purewell, Christchurch, Hants.

A CASE OF NEGLIGENCE?

From an article by R. M. S. McConaghey, Medical History, Vol. I, No. 2, April 1960

THE Medical Records of Dartmouth, 1425-1887, give an interesting account of practice in the 19th Century. Under the Poor Law Amendment Act of 1834 the chief reform was to unite groups of parishes into unions administered by guardians. Each union appointed medical officers to several districts under their control who gave medical attention to poor parishioners. There were inevitable disputes between the guardians and the commissioners of His Majesty's Government about the running of the unions.

One dispute was related to John Morgan Puddicombe who was either in partnership with or assistant to his father. He had studied at St. Bartholomew's and achieved his M.R.C.S. in 1837 and his L.S.A. in 1838. The evidence of Puddicombe gives an intriguing picture of the methods of practice in those days. A pauper had met with an injury in the middle of the night . . .

"The noise he made alarmed a gentleman living near the spot. On finding what had occurred and that the man was unable to move, owing to a fall from a considerable height, he ran to the nearest surgeon, and soon returned with my brother, a young man now serving his apprenticeship with my father, the latter being indisposed, and not able to attend. Finding themselves insufficient to remove him to a place of safety, they, with some difficulty, in consequence of the lateness of the hour, obtained the assistance of two men, and carried him to the poor-house, in the parish of Townstal, where he was placed on a kind of bed, and left until morning when I was sent for to attend him; on my arrival I found a considerable shortening of the left leg, with the foot turned over to the right tibia, at about the commencement of the lower third; combined with this was tremendous swelling of the muscles about the hips and thigh, so much

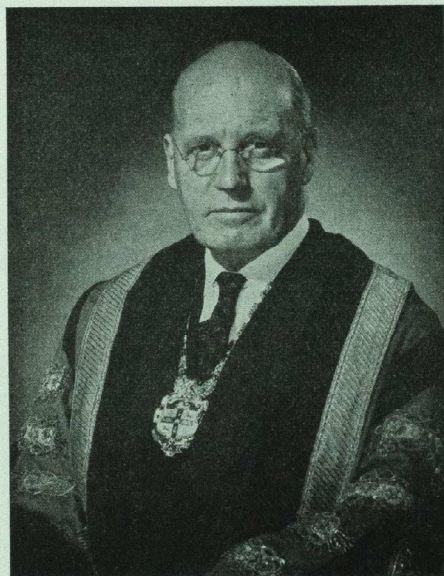
so, that at my first visit the cause appeared so intricate and the pain the man suffered so intense, that I hardly knew how to act; I remained with him about twenty minutes, and after making gentle extension for a short time, the foot suddenly resumed its natural position; at this time the hip and thigh were at least double their natural size, and still remained so after this operation. On my next visit I found still considerable swelling and pain, which continued for many weeks; the patient was unable to move from the position in which he was placed. Mr. Paige and myself with the assistance of the two overseers of the parish, with considerable difficulty removed him from the bed to a chair placed beside it, his bed was then made up for the first time since the accident, and he returned to it after remaining out a short time. About three weeks after this I stated he might be safely removed to the union house."

In the enquiry about the case the chairman of the board of guardians stated:

" . . . that he (the doctor) never used a pulley or any other instrument to replace the dislocated bone; that he neither gave him any kind of lotion to strike it with, nor did he give any medicine; that he only felt the thigh, and I think said attended him but once . . . Again in the parish of — I am informed that the same medical man was called to a case of midwifery, and attended it for a week or a fortnight, and then finding the woman incapable of paying the amount incurred, applied to the overseer of that parish for an order" . . .

Despite this unfortunate incident Puddicombe became an influential and respected citizen of Dartmouth; he was three times mayor and was elected alderman. Perhaps his practice wasn't so much at fault after all!

Sir James Paterson Ross



By permission of the Royal College of Surgeons

PROFESSOR Sir James Paterson Ross, Bart., K.C.V.O. was doomed to retire from the staff of the Hospital on May 26 when he reached his sixty-fifth birthday—nominally, that is—his retirement does not in fact take effect until the end of September. This might be called a milestone on the journey of a professional man through life, but it is also a kind of tombstone, and an appraisal of what the Hospital is losing is almost an obituary. We are sad to lose him, and he, we may be sure, is sad to go. It is true he will become a Consulting Surgeon, but that is a title, not an occupation; it is part of the inscription on the tombstone.

Sir James was born in Hornsey, North London, and was schooled at Christ's College, Finchley. He entered St. Bartholomew's Hospital Medical College in 1912 at the age of 17, and from the start was a winner of academic distinctions. His childhood had been passed mainly in London, but holidays were spent running wild on his grandfather's farm in the north of Scotland. Sir James is unmistakably a Scot—he never refers to his friends without the prefix Mr. until he has known them for quite a number of years. He recalls that his home life was simple, but filled with a sense of security and happiness. This tended to make industry and a sense of

duty come to him naturally, as was reflected in his College and Hospital career. At the end of his first year he won the entrance scholarship in science. At that date no undergraduate was registered as a full student until he had started work on anatomy, so that it was still possible, while working on the preliminary sciences, to win an entrance scholarship. In the following year he won the Treasurer's Prize and the junior scholarship in Anatomy and Physiology. Though never a notable athlete, he represented the Hospital at cricket and hockey. In August 1914 he returned from a holiday in Scotland to find himself, by virtue of being a member of the O.T.C., "directed" by Sir Wilmot Herringham to the 1st London General Hospital, where, after a brief course of dispensing at Bart's, he served as a Sergeant Dispenser until February 1915. In March he was demobilized and was allowed to return to Bart's to begin his clinical studies. He obtained the qualification of the Conjoint Board less than two years later in January 1917.

Sir James had been dresser on the firm of Cozens Bailey and Girling Ball, and it was the example of Bailey which turned his mind to surgery as a career. Both his chiefs were also popular teachers. In those abnormal times the "house job" was curtailed to three months and, despite his inexperience, the young house-surgeon had to take regular teaching sessions too. His choice for war service had fallen on the Navy, and in May 1917 he went to Haslar Hospital, going to sea a few months later in the light cruiser "Celedon". After the armistice he was transferred to the "Baltic" and was not released until October 1919.

Sir James confesses that, although not a warlike type, he thoroughly enjoyed his naval service and has liked to remain in touch with his shipmates through membership of the Royal Navy Medical Club. Surgical experience on active service was necessarily limited; yet he has felt, as have so many others, that the wider view furnished by service life has been an asset for which he has always been grateful. Nevertheless he was able to return with zest to more academic surroundings at Bart's and was at last able to take the London M.B., B.S. in May 1920, gaining distinction in surgery and the University Medal. He had done much reading in surgery while at sea, and gained extra

medical knowledge by working as clinical assistant to Dr. (later Sir) Arnold Stott at the Royal Chest Hospital, City Road. After working as junior Demonstrator of Physiology under Professor Bainbridge he passed the Primary F.R.C.S. examination and then moved over to the department of Pathology under Professor Sir Frederic Andrewes. It is almost a satisfaction (and an encouragement to others still engaged in the battle of life) to be able to record that Sir James failed in the final F.R.C.S. in November 1921. Nevertheless Professor George Gask, head of the first professorial surgical unit to be established in London, had his eye on the young surgeon and enabled him to do a *locum* on the unit early in 1922. In May he defeated the examiners at the Royal College (he won the degree of M.S. London in 1928). Nine months work in the Pathological Department followed, and then came one of the most formative periods of Sir James's life—six months as Associate in Surgery at the Peter Bent Brigham Hospital in Cambridge, Massachusetts, under Harvey Cushing. The object was to gain experience in neuro-surgical technique under its greatest exponent, but Sir James profited also in many other ways. Cushing treated him almost as a son, and he obtained an intimate view of life in New England. He visited many other clinics from Chicago to Washington, and, of course, the Mayo Clinic. There were no travelling Fellowships in those days, and the savings out of naval pay had to be sacrificed. He returned home in September 1923 to take up an appointment as Junior Chief Assistant on the Surgical Unit. Earlier in the year T. P. Dunhill had joined Gask as Assistant Director, and he now became one of the major influences in Sir James's life. "Respect for tissues" has always been one of his first principles in surgery, and he likes to attribute this to having worked with Cushing and Dunhill.

Meanwhile he had been working for part of his time at the National Hospital for Nervous Diseases, Queen Square, and this fitted in well with Gask's growing interest in the surgery of the sympathetic system. Together they gave great attention to the problems of sympathetic control of the vascular system. Professor Woollard helped in the anatomical studies which had to precede the surgical treatment of conditions such as Reynaud's disease, causalgia following the many nerve injuries sustained during the first

World War, and the many obscure vascular anomalies thought to be due to disorders of the sympathetic system. It was a new field for surgery, and demanded profound knowledge of physiology as well as of anatomy; the clinical material collected over several years provided the basis for the Jacksonian Essay, which gained the prize in 1931. In the same year Sir James gave his first Hunterian Lecture at the Royal College of Surgeons on the treatment of cerebral tumours by radium. He gave two more Hunterian Lectures in later years on "Sympathectomy as an experiment in human physiology" (1933) and on "The effect of radium on carcinoma of the breast" (1939). He was also co-author with Gask of a monograph on *The Surgery of the Sympathetic System*, published in 1934.

In 1931 Sir James had been appointed Assistant Director of the Surgical Unit, in association with Dunhill, and University Reader in Surgery, and in 1935, on Gask's retirement from the Chair of Surgery and from the staff of the Hospital, he was the obvious successor. It had always been recognized that Dunhill would not succeed Gask, but would retire simultaneously from the Unit, so that there was no embarrassment for anyone when Gask was followed immediately by his junior Assistant Director.

Sir James had never had any doubt about his preference for the academic life and had seen little of the more worldly side of surgery in private practice—indeed, his only experience of this was as one of the assistants employed by Dunhill and by Lord Moynihan of Leeds when he operated in London at Lady Carnarvon's nursing home in Portland Place. All this activity, together with his chances of doing further laboratory researches, ended with his appointment as Professor of Surgery. Henceforth he was compelled rather to direct the work of others, and even this role was shattered after less than four years by the outbreak of the second World War. As Sir James has said, the Unit disintegrated at the end of 1939 as completely as if it had received a "direct hit". He moved to Hill End where he was in charge of eighty beds and was responsible with Professor Christie for directing the clinical studies of all the Bart's students during their first nine months. He also organised for the Emergency Medical Service the neurological casualty service in all the London sectors north of the Thames and later

in a large area embracing all the Eastern Counties. Other war duties were membership of the War Wounds Committee, investigation of the cross infection of wounds in hospitals, and a tour with Howard Florey in 1940 to see all the experimental work being done in the United Kingdom on the healing of wounds. Sir James also found time to look after a centre at Hill End for treating wounds of the blood vessels. This enabled him to collect some original observations on sixty patients with arterio-venous fistulae. His hands were more than full, since he filled also the posts of Consulting Surgeon to the King Edward VII Convalescent Home for Officers at Osborne, and to the Papworth Tuberculosis Settlement.

With the end of the war Sir James was at length able to return to Bart's to resume the professorial duties which he has performed with so much distinction during the last fifteen years. Even so he was not allowed to carry this through without interruption. He had been elected to the Council of the Royal College of Surgeons in 1943 and was persuaded, though very reluctantly, to accept the office of President in 1957, being re-elected for the next two years. Sir James is the least self-seeking of men, and his reluctance to accept presidential office was increased by his wish not to neglect his hospital and teaching duties during the last three years of his professorship. But his personal distinction was such that there was no escape. His quiet efficiency had not, it is true, brought him conspicuously into the public eye, until, on Sir Thomas Dunhill's recommendation, he was chosen to collaborate with Sir James Learmonth in bringing King George VI in March 1949 through the serious operation of lumbar sympathectomy to counteract an incipient gangrene of the foot. King George showed his appreciation of the skill and care he had received when, during his convalescence, he unexpectedly commanded his surgeon to kneel beside his bed to be dubbed a Knight Commander of the Victorian Order. There is no other recorded instance of a knighthood having been conferred by a monarch clad only in pyjamas. At a later date Sir James collaborated with Dunhill in operating on Sir Winston Churchill, an exacting patient who insisted on understanding for himself the precise reason for everything that was to be done. After the death of King George Sir James was appointed surgeon to H.M.

the Queen. In the early part of 1957 he visited many medical centres in Australasia as Sir Arthur Sims Commonwealth Professor.

Despite his modesty Sir James has conferred distinction on his Hospital throughout his career. He has not been a prolific writer, but he shared with the late Sir Ernest Rock Carling the great task of editing the eight volumes of *British Surgical Practice*, published in the years 1947 to 1950, with annual supplements to date.

This is all of a piece with his general character as a surgeon and teacher. Being convinced of the paramount importance of putting diagnosis far before everything else, he takes every possible care in examination of a patient and in clinical investigation. As a diagnostician he is much better than "brilliant"—he is infinitely careful and logical and allows students to hear his mind working towards the desired end. As a technician he is correspondingly careful and gentle, and his colleagues have not infrequently paid their tribute to his qualities by unhesitatingly committing their bodies to his competent hands. His patients have always known instinctively that implicit trust could be placed in his integrity, judgment, and common sense. His students have felt that he is their friend and mentor—in fact, little as Sir James may like to see it down in print, he has established himself at Bart's as what psychologists sometimes call a "father-figure" and

MY first memories of Sir James Paterson Ross and of the unit, date from that period just at the end of the war when a great deal of change was taking place. I first came as a visitor. I was still in the Air Force and had charge of a Vascular Unit and wanted to learn as much as I could that might help to improve it. Professor Paterson Ross at Bart's and Professor Learmonth in Edinburgh had been the pioneers in this type of work in Britain and their units were the places to go to learn new things in vascular surgery. No secrets were kept and I, like many others, found valuable help and advice. The unit was a hive of activity in all sorts of ways and many changes were going on. On its staff at the time were Rundle and Lowenthal, now both professors in their native Australia, Walker who is now in Canada, and Longland who later crossed the

border in an unconventional direction to take charge of a large surgical unit in Scotland. Professor Boyd of Manchester, an ex-assistant director, used to visit from time to time always with unusual and original ideas which provoked argument and intellectual stimulus although they did not invariably gain complete acceptance. Robertson, one of the leading surgeons in Sheffield, and Tuckwell and Nash also worked on the unit in the period after the war.

At the head of all this change and development and keeping it all together and running efficiently was Sir James. Naturally he was in great demand. Not only did he have the normal load of surgical responsibility and teaching (and he was reputed to be the best undergraduate clinical teacher in London) but his opinion was sought in committees and endlessly on individual problems in

he will be missed to a corresponding degree when he has left the active staff. It was no surprise to anyone and a satisfaction to everyone when Sir James figured as a baronet in the Honours List last year. He does not retire into idleness, having been appointed successor to Sir Francis Fraser in the office of Director of the British Post-graduate Medical Federation. Sir James will naturally protest that he owes much of his distinction to the education and companionship he has received at his hospital—and indeed no one will deny that he does have to acknowledge at any rate one great debt to Bart's. In 1924 he married Miss Marjorie Townsend, a sister in one of Professor Gask's wards, and their two sons, Keith and Harvey, are carrying on the Ross tradition, one having been educated at the Middlesex Hospital and the other at Bart's.

Sir James does not shoot or fish or do any of "the other things that gentlemen do", as he puts it: His tastes are simple and nothing delights him more than a cross-country walk. It has long been one of his ambitions to walk along the whole of the Pilgrim's Way—he has accomplished so far no more than the stretch from Winchester to Dorking. But his pilgrimage is not yet over and he and Lady Ross carry with them on their way the affection and good wishes of all students and colleagues who have been privileged to know them during the past thirty-five years.

St. Damian

this period. It was only by his great industry and ceaseless activity that all the demands were met and the ground covered. I remember two members of the unit discussing the Professor's problems and the problem of catching him for a discussion on some point. "The Professor is so busy now that you have no hope of catching him for a leisurely half an hour", it was said. "Your best plan is to walk rapidly beside him as he moves from his office to some assignment elsewhere. You will then be able to discuss your problem as you move along. There is, however, one warning sign to observe. Should the Professor be moving so fast that the tails of his white coat are extended horizontally behind him, it is better to desist and to seek an opportunity to raise the matter on a more favourable occasion." The advice and help that were rendered were in fact so good and so willingly given that the demands became almost greater than one human could fulfil in each twenty-four hours of a day.

It is most remarkable to realize that all

I AM grateful to the Editor for giving me the opportunity of paying tribute to Sir James Paterson Ross. Although it is always difficult for the living to write about the living, it is imperative that on the occasion of his retirement from the Chair of Surgery at Bart's there should be some printed expressions of the respect and affection in which he is held by his colleagues.

It is I think germane to bear in mind that his career has occupied approximately the second quarter of the twentieth century, a period during which great advances have been made in medicine as a whole, and notably in those basic sciences which contribute to diagnosis and therapeutics—including surgical therapeutics and all that this term has come to include. During this period Paterson Ross has held a number of great offices, and happily will continue to hold certain of these; and he will add others to his responsibilities. He has been one of the first to direct a Department of Surgery as a whole-time Professor; he has been President of the Association of Surgeons of Great Britain and Ireland; he has been a distinguished and always welcome ambassador of British surgery in many lands; he has been President of the Royal College of Surgeons of England. His own exceptional qualities exercised in these positions gave him the opportunity of profoundly influencing British

this work was done at Bart's and that at the same time Sir James undertook and brought to success great tasks at the Royal College of Surgeons and at the University.

Later I had the good fortune to work for a number of years with Sir James on the unit. It was one of the most pleasant and fruitful periods in my surgical lifetime. I know that there are very many others who feel the same and who realize that it was his work and help that really made everyone else's efforts of value and which made the unit at Bart's a fine example to other schools.

The University of London and all of us who are interested in postgraduate medical training, as well as the younger men who are going to do it, are indeed fortunate that we shall have Sir James as Director of the British Postgraduate Federation. We congratulate ourselves on our good fortune and wish him well in this new task which he takes up on his retirement from the Chair at St. Bartholomew's.

John Kinmouth

surgery, and I suspect that his object has been to arrange a harmonious fusion between the newer scientific surgery and the older art of surgery—a union seen at its best in the last edition of his book on the surgery of the sympathetic nervous system.

What are the exceptional qualities his colleagues have recognised in Paterson Ross, which enabled him to exercise so good an influence on surgery? Of course he has all the ordinary ones—industry, clinical judgment, technical skill. I would place first that he has always been himself: never spectacular, influencing by example rather than by precept, making his points by demonstration rather than by proclamation. A direct result of being himself has been his power of making lasting impressions upon people he meets—a power said by Sir Winston Churchill to be one mark of a great man. For the other qualities I cannot do better than go back six hundred years to Guy de Chauliac and his notion of what a surgeon should be: "Bold in those things that are safe, or that he can safeguard by his own judgment and experience; prudent in those that are dangerous; avoiding all evil methods and practices; tender to the sick, honourable to the men of his profession; truthful, wise in his predictions; chaste, sober, pitiful, merciful, not covetous nor extortionate."

James Learmonth

THE QUESTIONNAIRE

General Practice

by J. T. Silverstone

Numbers

"Do you want to be a General Practitioner?" "Yes, definitely", answered 17. "Probably", answered a further 127. Thus it would appear 144 students (38 per cent) wished to take up General Practice. Yet, to confuse the statistician, when asked which branch of medicine they wished to enter, only 107 selected General Practice from a list of five including medicine, surgery, midwifery and "other". I propose to limit the discussion to the 144 who probably want to become general practitioners, assuming that this number includes the 107 who "wish to enter general practice", ignoring the semantic niceties which have obviously been important to at least 37 who answered differently to questions 18-21.

In the country as a whole during 1958 there were 90,692 doctors on the register, of whom 20,295 (22 per cent) were principals and 1,394 (1.5 per cent) were assistants in general practice. There were 1,911 doctors qualifying in England and Scotland who were newly registered in 1958. In the same year 1,062 became principals in general practice. Although no firm conclusion can be drawn from these last two figures, they would indicate that over a period about 50 per cent of newly qualified doctors will become principals in general practice.

Thus the Bart's figures seem to be only slightly at variance with the national trend.

Background

Of our 144 enthusiasts, 120 were men and 24 were women, i.e. a slightly higher proportion of women (2 per cent). 33 of the total had been to Grammar School and 93 to public school; the proportions are 29 per cent of all those from grammar schools and 40 per cent from public school, a slight indication that public schools provide more aspiring G.P.'s. When considering previous university education, we have to select only clinical students, 8 (40 per cent total) Oxford alumni elected for general practice, whereas 35 (50 per cent total) from Cambridge so

elected. Proportionally even fewer of those clinical students who have crossed Smithfield Market from the green fields of Charterhouse wish to become G.P.'s—45 (35 per cent total).

Whether due to the influx of would-be G.P.'s from Cambridge or not, there were proportionately more clinical students than pre-clinicals who preferred general practice. By years, the figures are: Pre-clinical 1st year—8 (20 per cent), 2nd year 20 (33 per cent), 3rd year 18 (25 per cent), clinical 1st year 28 (35 per cent), 2nd year 29 (45 per cent), 3rd year 26 (42 per cent).

Perhaps more decisive in a student's choice is his family background. Of the 144 inclining towards general practice, 79 had a relative who was a doctor. But the total number of students with relatives as doctors form a much smaller proportion of the total number. Those with more intimate knowledge of medical life tend therefore towards general practice; more than those coming into the profession with perhaps a more naive outlook. Yet of those with medical family associations, only 55 (32 per cent) have an opportunity to join a given practice. These figures are not strictly comparable as the 79 with relatives in the profession are selected from those wishing to enter general practice, whereas the 55 with a given opportunity in general practice relate to the total number of students. It is still valid to comment that a student with a medical background is not necessarily going into general practice because there is a partnership waiting.

One supposes that general practice would offer more security than a speciality. One might also suppose that those who are engaged and married would be concerned particularly with security. Yet of those engaged (37) only 16 opt for general practice and of those married without children (15) only 5 opt for general practice. More strikingly not one of 7 students with children seek the "security" of general practice. Perhaps the presence of children in the home encourages the fathers to continue in resident jobs as long as possible!

One sobering fact to emerge is that of all those wishing to do general practice 80 (more than half) had not spent even a day observing or assisting a general practitioner. Is this a reflection on the students for not trying to broaden their outlook, or a reflection on the College authorities for not providing adequate experience?

Reasons

Seven possible advantages of general practice were listed in the questionnaire. Students were asked to mark those which influenced them in their choice of general practice as a career and which was the most important. If the dominant reason was not among those listed, they were asked to state it.

Here is the list in order of importance to students, with the number of prospective G.P.'s who gave this as their most important reason for wanting to be a G.P.

- (a) Responsibility for the health of individuals from birth to grave (23);
- (b) Diagnosis and treatment of a greater variety of complaints (20);
- (c) Too much competition and uncertainty of becoming a consultant (16);
- (d) Opportunity to join a given practice (14);
- (e) Mental capacity not suited to specialist practice (11);
- (f) Important role in the social life of your community (10);
- (g) Better early financial rewards (5).

Several (26) appeared not to answer this question and 19 wrote an alternative reason. The most popular alternative reason was "Getting to know and help people"—the others fell broadly under the headings already given.

It would seem that 43 wanted to be a G.P. from a positive desire to practice the type of medicine that can be practiced only by the family doctor. However, rather more (56) preferred general practice for no positive virtue in the calling—35 of them were hard-headed realists who felt they could not make the grade in specialist medicine, or those who were not going to give up a ready-made opening or those who were going for an immediate living wage with home life, rather than live the monastic life of a junior hospital doctor.

While several of these realists might well have been very happy to enter general practice even if they could climb the ladder of

specialist medicine, we must assume honesty and reliability when they tell us their most important reason.

Their colleagues who aim to specialise have rather different feelings. They appear to be a timid lot for if they were to enter general practice the factor that apparently inclines them towards it most is the competition and uncertainty of specialist practice.

Type of practice

Fifteen (10 per cent) wanted to "go it alone" in a single-handed practice; 57 preferred a partnership, of which 52 preferred a true group practice in which each partner spent some time in specialist work within the practice. When we remember that less than half those selecting a given type of practice have any idea what they are choosing, the figures take on an air of unreality. The competition for each single-handed vacancy is still intense—there were 184 vacancies in 1958 for which there were 5,735 applications, an average of 31 applications per vacancy. This application/vacancy ratio was 35 in 1957, 43 in 1956 and 44 in 1955. The equivalent figures for partnership applications are probably higher.

If the preferences of Bart's potential G.P.'s could be met, the cities would be suffering a severe shortage of doctors. Only 12 (10 per cent) wished to practice in the city, while 66 (50 per cent) wanted to settle in the country, 48 (40 per cent) thought they might get the best of both worlds by practicing in a town. What actually happens to the 68 per cent of doctors who are partners in general practice is as follows: 35 per cent practice in urban areas, 40 per cent in semi-urban and 25 per cent in rural areas.

It would appear from the Ministry of Health's report that a greater proportion of the partnerships in the urban areas consist of two or three doctors (94 per cent) than in the semi-urban (86 per cent) and rural areas (85 per cent).

Again the 144 students were preponderantly in favour of the southern half of England, 51 were for the South, 24 for the West country and 15 for East Anglia. Only 10 each were for the Midlands and the North, 8 for Wales and 6 for Scotland.

The Ministry of Health reports that in 1958 there were 13,253 doctors in partnership—about half of these were in two-man

partnerships and a quarter in three-man partnerships. Larger practices were much more uncommon. During this year there were 6,346 (32 per cent) in single-handed practices.

The trend seems to be away from single-handed practices, for in 1956, 18.9 per cent of doctors who were under 35 were in single-handed practices as compared to 50 per cent of those over 66, in 1958 only 18 per cent of those under 35, as compared with 45 per cent of those over 66 were in single-handed practices. It would seem that the figure of 10 per cent of those at Bart's who want to enter single-handed practice is a reflection of this trend towards more partnerships.

GASTROSCOPY

by Peter Knipe

ENDOSCOPY is the art of direct visualisation of body cavities and is widely employed in medicine. Gastroscopy is one method of endoscopy which has lagged behind in general acceptance, although most of the technical difficulties were solved in 1932 with the introduction of the flexible instrument. As one of this country's foremost experts (Avery Jones) is a Bart's man it would seem appropriate that we should study the art. It is unfortunately the most difficult of endoscopic studies, not only in its technique, but also in the interpretation of the findings.

History

Kussmaul in 1868 was the first to attempt to see the stomach cavity directly, although a Dr. Campbell in Glasgow some years earlier had asked a professional sword swallower if he would act as a "guinea pig". The man is reported as saying in refusal "I know I can swallow a sword, but I'll be . . . if I can swallow a trumpet". Nitze in 1879, after solving the problems of illumination in his cystoscope, turned his attention to gastroscopy and was probably the first person to see recognisable gastric mucosa. A flexible instrument is needed for vision of the whole interior, and therefore has its own special problems of intricate lens sys-

Conclusion

We can now create the image of the "typical" Bart's prospective G.P.

He is the product of the Public School and Charterhouse Square with medical connections in the family but no opportunity to join a given practice. He has never seen a G.P. at work yet knows he wants to treat his patients from birth to grave in a country practice in the South of England. Good luck to him.

Reference:

Report of the Ministry of Health for year ended 31st December, 1958.

tems. The discovery by Schindler and Wolf in 1928, that it is possible to see through a curved tube with lenses of short focal length, finally saw the rigid tube discarded in favour of a flexible one; and their introduction in 1932 of the flexible gastroscope heralded a wave of popularity for gastroscopy. This instrument is still in use, though it has the disadvantage of possessing many blind spots. Hermon Taylor in 1941 introduced an instrument with a flexible tip which could be actively moved. This largely superseded the Schindler gastroscope in this country. But gastroscopic blind spots, coupled with the progressive increase in quality of diagnostic X-rays, and the undoubted necessity for skilled training as a gastroscojist, have held back general acceptance of the procedure.

The Instrument

The Wolf-Schindler gastroscope, 78 cms. in length, has a distal half (approx.) as a flexible steel coil with a rubber jacket terminating in a bulb and a solid rubber tip (see Fig. 1.) The proximal part is a rigid steel tube ending in an eyepiece with a balloon attachment and flex. The interior contains an optical lens system, surrounded by an air jacket. With this instrument, even when the eyepiece is introduced to the teeth, the junction of flexible with rigid parts is

still at least 3 cms. above the cardia. The Hermon Taylor instrument (see Fig. 1.) is similar in principle, but the flexible portion is sheathed by two concentric metal springs with left and right handed thread, and movement is controlled by two straight wires to a rack and pinion by a push-pull action. Although this affords controlled movement of the tip and thereby eliminates many blind spots, it means the flexible length has to be reduced, and this brings the flexible-rigid junction through the dangerous angle of the cardia. Both instruments have right-angled vision with an angle of vision of approximately 50 degrees.

Technique

As with all other medical investigations, it is essential that the patient has confidence in the gastroscopist, and one should always explain simply the reason for, and basic steps of, the procedure. Examination should be made of the teeth, and the possibility of kyphoscoliosis or cervical osteoarthritis should be considered. Other examinations for heart size, and possible oesophageal varices are made. Barium meal X-rays should be available for study before gastroscopy (though there are exceptions to this rule) in case there should be oesophageal or hiatal obstruction. The patient should have nothing to eat or drink since the previous evening, and with the out-patient it is desirable to pass an oesophageal tube immediately before gastroscopy to empty the stomach content. This procedure should also be carried out on a patient with pyloric stenosis or suspected carcinoma of the cardia. One hour before instrumentation, he is given a routine premedication, and half an hour before, half a tablet of Decicaine to suck. The patient is then brought into the darkened examination room. His position on the table is of great importance. The left lateral position with the knees drawn well up to the chest and the back rounded, is the correct one. The left hand is under the right axilla and the right arm is allowed to hang down over the edge of the table. The left shoulder should be at the top of the table so that the head rests over the top, in the palm of the assistant's left hand, and the patient should be encouraged to relax. The head should then be completely flaccid and moveable without any force by the assistant, who with his right hand on the right side

of the head has precise control.

The gastroscope is then introduced with three basic movements (see Figs. 2, 3). With the patient's head fully flexed on to the chest, the surgeon stands opposite the patient's chest, holding the gastroscope by its flexible portion in his right hand, a second assistant taking the weight at the eyepiece end. In the first movement the surgeon's left index and middle fingers are passed over the patient's tongue, the thumb sweeping the upper lip away from the upper teeth to prevent it being caught by the instrument. In the second movement, the rubber tip of the instrument is passed along the dorsal aspect of the index finger, the third finger is crooked over it, thereby angulating it sharply downwards. The gastroscope throughout this procedure is pointing upward in the direction of the naso-pharynx. In the third movement, two things are achieved as one combined movement. The tip of the instrument, protected by the third finger from the posterior pharyngeal wall, is advanced through the crico-pharyngeus, and at this precise moment the right hand is moved back to take the rigid portion of the instrument, and with it to describe an arc, bringing the eyepiece from a plane at right angles to the body into the axis of the oesophagus. Synchronously with this movement, the first assistant extends the head as the instrument is advanced swiftly but with meticulous gentleness into the stomach. The crico-pharyngeus may offer an obstruction, but if the patient is asked to swallow, this is easily overcome, and any use of force is absolutely contraindicated.

When the examination is completed, the patient is sat up for a few moments and encouraged to bring up wind before being moved to an adjacent room where he sleeps for an hour or two, after a brief question about any pain or dysphagia, and palpation of the root of the neck by the surgeon the patient is allowed to begin taking liquids and light foods, and then return to normal.

Orientation

The principal factors discouraging endoscopists are the difficulty of orientation in the stomach, and then the interpretation of the findings. Problems of orientation will here be presented as simply as possible, accepting the risk of inevitable oversimplification.

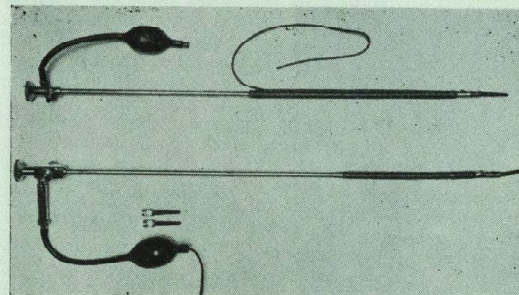


Fig. 1
Top: Schlinder Gastroscope
Bottom: Hermon Taylor
Gastroscope

If the instrument be passed to its full length and the button on the eyepiece turned to 10 o'clock, the angulus is seen as a curtain over the centre of the field, with the pylorus just visible beyond (see Fig. 4). This may be called Depth 1. Withdrawal to a point where the angulus is just vanishing, brings into view much of the lesser curve and is designated Depth 2. Further withdrawal, until the cardia appears at the opposite pole of the field, and with the button moved to 6 o'clock, is Depth 3. A brief glance at Figures 4, 5 and 6 will make this clear, and will also show that in all but Depth 3, moving the button through 180 deg. will show the corresponding area of the opposite curvature. It will also, however, indicate that there are blind spots as represented on the composite drawing Fig. 7. The blind areas a, b and c, will become visible with the Hermon Taylor instrument with the moveable tip, and the fornix is usually visualised on deep inspiration. Remembering too the fact that the place of the button on the field (usually designated 0 deg.) is proximal, or cephalad, and therefore the point at 180 deg. is distal or caudad, thus enabling one to plot the direction of a peristaltic wave, the first few basic steps in orientation should be achieved.

Indications

In spite of the quality of diagnostic X-rays, there is still a great place for gastroscopy. Generally one may say there are three broad groups of indications:

1. The presence of symptoms referable to the stomach in which X-rays are normal, e.g., gastritis and stomach neurosis, and haematemesis.

2. When barium meal reveals a lesion about which more information is needed, e.g., "cancer", a polyp, the possibility of a leiomyosarcoma.

3. In the post-operative stomach, e.g., recurrent ulcer, stomal ulcer, and silk erosions.

Gastroscopy is absolutely contraindicated in obstruction to the oesophagus or cardia, and aneurysm of the descending aorta; and should be performed under general anaesthesia in the un-cooperative patient. Pharyngeal inflammation, spinal deformity and achalasia represent contraindications in varying degree. Particularly should the beginner be gentle with the achlorhydric female over 45 years. Tanner has shown the morbidity of gastroscopy to be only 1 in 300 (unlike that of oesphagoscopy, which is 1 in 100) or 25 cases in 7,200. Avery Jones *et al.* report a morbidity of 75 in a collected series of 49,000. In most of these complicated cases, the patient was an elderly female, the stomach acid curve low, and in some, cervical osteoarthritis was also present.

The Normal Stomach

The normal mucosa is a uniform orange red colour, the highlights shining with mucus. The field is criss-crossed with folds and striations which cast shadows to confuse, but with the introduction of air, many of them flatten out and disappear. This is particularly true of the lesser curve and adjacent areas, but the greater curve retains many folds even when fully inflated, and at its most dependent part on the posterior wall in the fundus, there is to be seen the mucus lake. No folds exist to correlate with the well-known "magenstrasse" of the Physio-

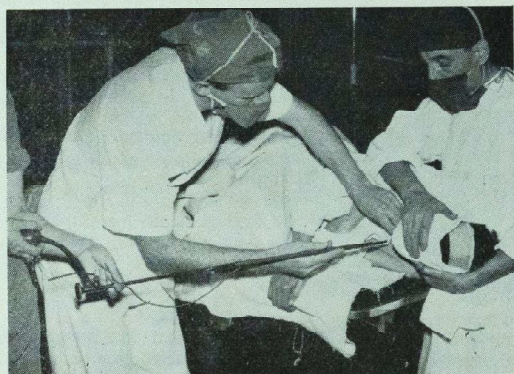


Fig. 2
Introduction of the gastro-
scope. First movement

logy Books. In the antrum, folds are absent, the demarcation with the body marked by the unmistakable angulus. This fold does not extend round the whole circumference, but tapers out near the greater curve, and from it extend a series of rhythmic waves spreading evenly down the antrum to abut on the pylorus, which closes at that moment with radial folds and often a pouting back of mucosa and a bubble of air from the duodenum escaping back. The wave recedes, and the pylorus again opens out like the opening of a flower, all this occurring in a gently flowing, beautifully graceful movement. The folds in the body are thickest on the posterior wall and greater curve, become a delicate network on the anterior wall, and largely disappear on the lesser curve. It is extremely rare to see peristalsis in the body.

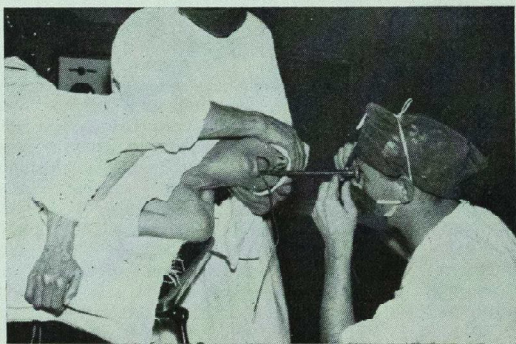


Fig. 3
Introduction of the gastro-
scope. Completion of third
movement

It is interesting that many of these findings are different from the radiological ones, and that each has something to contribute which to the other is denied.

The Abnormal Stomach

Gastroscopy reveals many and varied appearances in anaemia, varices, granulomata, benign tumours and polyps, foreign bodies, and other pathology, but its main value is in the field of gastric ulcer, cancer and the post-operative stomach.

1. Gastric ulcer

(a) In a case of chronic ulcer the history and site are already known from the textbooks, and emphasis here will be on only gastroscopic findings. The picture in the living is so different from the gastrectomy

specimen. The ulcer stands out as a white or greyish-white area in a bright orange-red field. The shape is usually round or oval but may on occasion be irregular, and the edge, which should all be seen, is sharply punched. The floor, usually white or greyish, may be brown with blood or contain food particles, and is smooth except when penetration of the pancreas has occurred, in which case it may be faintly lobulated. The depth of the ulcer, while at first difficult to estimate, is of importance. The mucosa around, though occasionally hyperaemic and oedematous, is usually quite normal, and the mucosal folds may show radiation either from spasm or after healing from fibrosis. Of value in diagnosis and in differentiation from cancer, gastroscopy is also of inestimable help in observing healing of an ulcer during medical treatment, and the picture of one ulcer through its phases of healing over several weeks is truly remarkable. It is more accurate than X-ray, it avoids irradiation, and is far cheaper.

(b) In case of bleeding from an acute gastric erosion in a superficial or atrophic (or even hypertrophic) gastritis, endoscopy is of supreme value. These erosions are often multiple, they heal very rapidly with treatment, and bleeding can be catastrophic. Barium meals taken after a few days are normal, and those who believe in X-ray studies in an emergency may be confused by the report "normal stomach", as erosions are rarely seen and gastritis is not a radiological diagnosis; although in this hospital cases of giant hypertrophic gastritis have been picked up by X-ray. Bleeding is recurrent, and the patients, often quite young females, and without a diagnosis, are sooner or later referred for unnecessary surgery. Gastrectomy has a place here only to save life, and the diagnosis should be made early, not only for subsequent management of bleeding episodes, but also for the interim symptoms and treatment of the gastritis. In Avery Jones's classic work on a series of 687 patients with haematemesis, personally treated, 217 had normal X-rays. Gastroscopy was undertaken in a selected number after the bleeding has stopped, usually the third to tenth day after admission. In 65 of these 116 an acute gastric ulcer was seen.

2. Carcinoma.

To the endoscopist, gastric carcinoma may be papilliferous, ulcerative, or infiltrative. The papilliferous growth is characteristic to

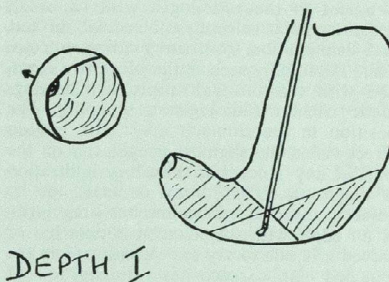


Fig. 4
Orientation in the stomach: at Depth 1, to show area visualised diagrammatically. Inset shows view with button at 10 o'clock, of incisura and antrum with pylorus.

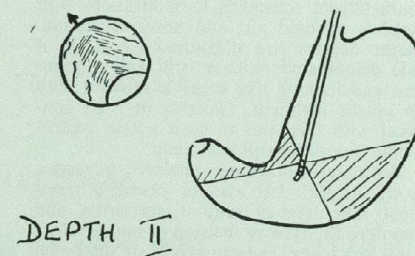


Fig. 5
Orientation in the stomach: at Depth 2, inset showing view of incisura and lesser curve.

him and to the radiologist with its broad base, irregular ulcerated bleeding surface, and demarcation from surrounding mucosa. More commonly seen is the ulcerative form, and with this the endoscopist can be dogmatic when a radiologist is in doubt. The position in the stomach may help, but on direct vision the slightest irregularity on the wall at any point with blending infiltration is diagnostic. There may or may not be adjacent mucosal infiltration, but irregularity of an edge, with suspicion of nodularity, or indeed it is safe to say any variation from the punched appearance is diagnostic of carcinoma, though the ingrowing of epithelium in the healing ulcer must be distinguished. Bleeding from the edge as opposed to the base, and the heaped edge, are also diagnostic signs. Most ulcer cancers are unmistakable, but it is the characteristic change in the edge which helps to diagnose even the rare cancer-ex-ulcere. The old adage "when in doubt X-ray again in one month" should never be allowed, any more than prevarication with a breast tumour. In diffuse non-ulcerative infiltrative lesions the case is more difficult. A complete "leather bottle" stomach can be diagnosed even before looking down the instrument by the characteristic resistance to infiltration, with inability to hold air, and noisy eructation. Lesser degrees are diagnosed by areas of pale demarcated mucosa, stiff and motionless, and looking like soggy cardboard with no mucus highlight. Gastritis may be confused with this, and in such a case gastroscopic biopsy forceps may help.

Not only in diagnosis, however, is gastroscopy helpful, but also in planning treatment. The type of tumour, its limits, and therefore the type of incision to make before a radical lower, radical upper, or total gastrectomy is undertaken, are all known, and in contrast to the radiological findings, the extent of surrounding submucosal spread is known with some accuracy. As everywhere else in the bowel, a 5 cm. minimum resection above and below the growth is needed (duodenum excepted) and a preoperative knowledge of the need for a thoraco-abdominal approach is of great value.

3. The post-operative stomach.

After gastrectomy or gastroenterostomy, carcinoma and recurrent gastric ulcer and haematemesis present the same problem as in the intact viscus. But the problem of stomal or anastomotic ulcer is peculiar, and

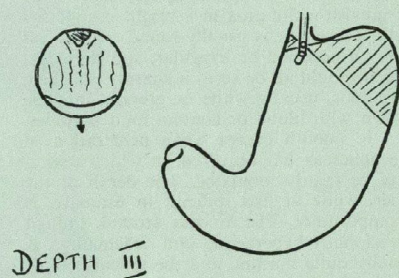


Fig. 6
Orientation in stomach: at Depth 3, inset showing view of incisura cardiaca and upper part of greater curve with the mucus lake, the button at 6 o'clock.

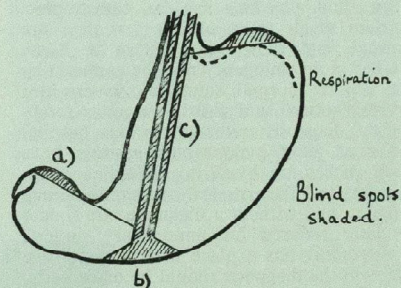


Fig. 7
Composite diagram of stomach showing blind areas of the Schlinder gastroscope. These are seen using the Taylor instrument.

X-rays in the diagnosis are notoriously difficult to interpret and may be misleading. While the history and sometimes the findings on fractional test meal are of great help, the ulcer is often diagnosed with certainty only by the gastroscope. These ulcers are frequently recurrent rather than chronic, and frequently bleed, and failure to diagnose by direct vision leads to delay before X-ray examination, and consequent healing during the interval. The practice, now almost universally abandoned, of using silk in the anastomosis led to many "silk" ulcers, and the threads of silk could be seen in the erosion. At one time these were so common that my former chief, Mr. Norman Tanner, invented an attachment like a biopsy forcep to the gastroscope for removal of the silk, healing then being rapidly achieved.

In conclusion one would like to say that the gastroscope is in no sense a rival to diagnostic X-rays. Each has a great part to play in the diagnosis and management of gastric disease, and with the increase in quality of X-ray practice the gastroscope has been

left a little in the shade of popular acclaim. However, the quality of X-rays varies a great deal in different hospitals, and even in the best there are a great many patients haunting clinics with "dyspepsia" as the diagnosis. Many of these could be labelled more accurately if the gastroscope were more widely used.

I should like to take the opportunity of expressing my thanks to three of my Chiefs: to Mr. Hosford for initiating me into the realm of gastroenterology; to Mr. Tanner for teaching me the way amid its intricacies; and to Mr. Hunt for his continued advice and encouragement in this field. I should also like to thank Mr. Harrison and the Photographic Department for their help with the diagrams and pictures.

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LETTER TO THE EDITOR

TO OLD BART'S MEN

Dear Sir,

May I appeal through your columns to any Bart's man who might wish to get rid of any old edition of *Rose and Carless's Manual of Surgery*? I am making a collection of these old editions, and those which I still hope to acquire are:—

1st—8th editions (1898-1911)
 12th edition (1927)
 16th edition (1940)

The very early ones are only likely to exist in the bookshelves of very early Bart's men, but the two later ones would be equally acceptable to me.

Yours faithfully
 MICHAEL HARMER

31, Queens Gate,
 London, S.W.7.

A review of Rose and Carless's Manual of Surgery appears on page 268. Ed.

BOOK REVIEWS

STROKE, A DIARY OF RECOVERY— by Douglas Ritchie. (Faber & Faber, 1960. 12s. 6d.)

It was the prospect of a long railway journey that made me agree to read Douglas Ritchie's book. As Colonel Britton he became a well-known broadcaster during the war. In the prime of life he sustained a cerebral vascular accident involving his dominant hemisphere. This book is the diary of his adaptation to aphasia and a hemiplegia. It takes about two hours to read.

From the security of our health we tend to obscurantism. We regard the introspective excursions of patients in publishing an account of their diseases with suspicion. Then we succeed in dispelling our alarm by thinking with distaste about self-pity or some similar quality. When I had completed this book I still felt it was off the same press as 'Living with Cancer'—and on the surface that impression is probably correct.

Even a rejected experience modifies our thought. From our self-protective isolation we too frequently fail to project ourselves into a patient's mind. Since I read this book my approach has altered. I used to pigeonhole a patient as having had a stroke, and thereafter I stopped thinking. I quailed at the prospect of trying to penetrate the hemiplegic's mind. I now find myself involuntarily recalling Ritchie's experience and endeavouring to apply it. Our knowledge of pathology is so small a part of what a disease means to the patient. It is in the hope that your insight into a common disorder may also be developed that I would recommend this book.

P.W.

CURRENT MEDICINE AND DRUGS. Vol 1. No. 1. Butterworths. Price 1s 3d.

Whether this journal has been produced as an aid to general practitioners or hospital staff or even both is not apparent but it falls below any of these objectives. The articles are too remote for general practice and are not well produced scientific papers that will tolerate exhaustive critical analysis or make any significant contribution to academic medicine. There is one excellent article written from extensive experience on the use of drugs in terminal neoplastic disease—a subject which concerns us all and in which most doctors are ill-informed. Professor Robb's article on anti-coagulants in surgical disorders can be of no real value in practice and is scarcely current news in surgical centres.

The other articles are neither helpful nor original since they reiterate well-known and universally practised measures. The section devoted to new drugs is entirely concerned with proprietary products and makes no mention of the pharmacological action, the mode of excretion, the price or the approved names, all of which are of real use in a journal of this sort.

M.L.P.

ROSE AND CARLESS, MANUAL OF SURGERY—pp. 1389. Published by Bailliere, Tindall & Cox. Price 84s.

This is the nineteenth edition of one of the oldest manuals of surgery which is in use today. This is itself a great tribute to the book. This edition is not merely one which has been brought up to date. The revision for it has entailed very extensive re-writing under a consulting editor (Sir Cecil Wakeley) and two editors (Michael Harner and Selwyn Taylor) who have called on 15 contributors—all experts in their own fields.

The seven sections are most conveniently arranged according to anatomical sites. In each section the subheadings are clearly set out for the student to follow. The completeness of the book leads to a good appreciation of the methods of examination, operative procedures and complications. The first section is an excellent study of general considerations which include very useful chapters on fluid balance, blood transfusion, and chemotherapy.

Many of the illustrations which have come to be known as "old favourites" are retained and in addition 370 new illustrations have been included. Throughout the book the illustrations (so important in a work of this kind) are of a very high standard and the diagrams are lucidly simple.

The scope is sufficient to attract those who are studying for the final F.R.C.S. The logical approach is excellent for a good grounding in a subject which is advancing rapidly. As an up-to-date book it is probably unsurpassed in its field and is a very sound investment.

"ON THE CAUSATION OF VARICOSE VEINS, THEIR PREVENTION AND ARREST BY NATURAL MEANS", by T. I. Cleave, M.R.C.P., Bristol: John Wright and Sons Ltd., 1960, 39 pp., price 7s. 6d.

Surgeon Captain Cleave argues that the body is built rightly, but is being used wrongly. "It must occur to anyone as highly significant that, except for those varices due to known specific causes (e.g. oesophageal varices in cirrhosis of the liver), all varices are confined to those limited areas of the body where pressure from the colonic contents can account for them." Westernized eating habits lead to an unnatural delay in the passage of the colonic contents, with water absorption leading to an unnatural increase in the weight of the contents. Varicose veins, varicocele, and femoral vein thrombosis, as well as piles, may then result. Colonic stasis can be corrected by the restitution of fibre to the food, such as the avoidance of white flour by eating true wholemeal flour, or by the addition of bran. Refined sugar should be substituted by fruits and vegetables.

HYPNOSIS — FACT and FICTION — by F. L. Marcuse. Published by Penguin Books Ltd. Price 3s. 6d.

This book was written in an attempt to answer the questions which more than 1000 people asked the author about hypnosis. This material, together with certain more specialised and less widely known problems have been combined into an excellent little book.

The author has covered topics ranging from historical attitudes to scientific theories; from methods of hypnosis induction to quackery; from its dangers to its therapeutic uses and potentialities. His terms are always clearly defined, but in a few instances, his arguments appear slightly obscure to the uninitiated.

In the preface Dr. Marcuse states that "the aim of this book is simply to separate fact from fiction in the field of hypnosis." This object has been fulfilled in a most comprehensive and convincing manner. It is a book which may be read with profit, both by students as a supplement to the course in psychiatry, and by the merely curious.

S.M.W.

BIOCHEMISTRY FOR MEDICAL STUDENTS — by W. V. Thorpe. Published by J. & A. Churchill Ltd. Seventh edition. pp. 552. Price 30s.

Previous editions of this book have been a standard for medical students for many years. It is a good introduction to the 2nd M.B. course and possibly adequate for passing the examination but the student wishing to see his name in lights would have to undertake a lot of supplementary reading. The author has attempted to include chemical pathology and some of the chemical aspects of physiology within this compact book so that it looks as if more ground is covered than is in fact the case. There are four photographic plates all dealing with chemical pathology including the famous photograph of the three types of osazone crystals whose shapes have to be memorised by the poor student so that he can distinguish glucose from lactose or maltose in the practical examination. He can draw consolation from the fact that this will be the first and last time he will ever have to identify sugars by that method. I have found no mention of chromatography anywhere in the book.

The earliest chapters introducing physical concepts in biochemistry are too brief and will probably not help students who have absorbed the elements of physical chemistry at school. The intermediate chapters on structure and metabolism in biochemistry have been more extensively revised since the last edition in 1955 though the interesting work on the synthesis of porphyrins is not mentioned, nor the discoveries on the pathway of cholesterol biosynthesis with its direct relevance to the formation of atheroma.

The presentation of the book is genial and it is written in a rather informal style which is easy to read and is punctuated by interesting though somewhat irrelevant information (p. 19. The water content of the mouse at different stages of development). This book will be used by many students for 2nd M.B. and is very reasonably priced but

other books of reference should be consulted at the same time.

J. C. C.

FRACTURES, DISLOCATIONS and SPRAINS. — by Philip Wiles. pp. 67. 519 illustrations. Published by J. & A. Churchill Ltd. Price 27s. 6d.

This book is an attempt to bring a series of display cards which the author has used in teaching at his own hospital to a wider audience. Although this is the first time that it has been published, the material of the book has been tested over a number of years. The form of the page is attractive. Each fracture is dealt with on a single page according to a fairly rigid formula. A representative series of X-rays is followed by illustrative line diagrams. The text considers the mechanism of the fracture, its treatment and complications under separate headings. Through the book there is a conservative rather than operative approach to treatment. Although the text is dogmatic (largely through its brevity) the student is given a sound framework. This naturally needs augmentation by further reading. There is a surprising lack of post-reduction films which would show the student the degree of displacement and mal-alignment which is acceptable. The book is very pleasingly arranged and has some well reproduced X-rays. It is to be recommended as an excellent approach to a new subject and the modern presentation will help the student to grasp the essentials of the subject with the minimum of effort.

PHYSICAL SIGNS IN CLINICAL SURGERY — by Hamilton Bailey. pp. 928. Published by John Wright & Sons Ltd. Price 75s.

Almost every medical student must have used "Physical Signs" and now we have the thirtieth edition. Originally published in 1927, this work has come to be an invaluable aid in examination and diagnosis. Until this edition the book has been much smaller, but now the scope has been increased. In some ways this is a pity for the student will perhaps be daunted by the length of the book in addition to a systematic manual which he will feel bound to read.

What cannot be denied, however, is the excellence of this edition. The book contains the most remarkable series of pictures which demonstrate the signs which are important in reaching a diagnosis. The present extended volume will undoubtedly appeal to many who have qualified.

In addition to the signs in general surgery, there is a very valuable demonstration of the signs which are important in the special branches. This means that within one cover the student can have a complete record of the signs which are important for him to know not only for his exams but for his proper practice of clinical surgery.

The book is well produced and is an excellent companion to both surgical manuals and clinical study. As in the past, students will find this book an essential aid to their studies in this field. The new edition is very complete and contains a very careful selection of important signs.

SPORTS NEWS

Viewpoint

IF the normal printing delay takes place, this Journal should be published soon after the new University year starts, and we will have amongst us many prospective athletes. We bid them all welcome, and hope that they will not consider their work at the Hospital is sufficient to stop them taking part in any activities. The staff in the Hospital departments both clinical and preclinical, on the whole, feel that all students should show an active interest in at least one Hospital sport, since no doubt a fit body leads to an active mind. Even when involved in the very strenuous and condensed 2nd M.B. course, it is considered that time should be found for athletic activities at least once a week.

The summer season is now almost over, at the time of writing. The Cricket Club has, unfortunately, lost its semi-final cup match v. St. Georges, after a replay. The batting appears to have let the side down, although the wicket was distinctly tricky early on. The Cricket Club's record this season has been much improved on past years, in fact the best since 1948. This is due to a large extent to the very able leadership of the captain, A. C. Warr, and to his batting. He scored three centuries during the season, with an average of 41, a very fine achievement. Three other players also scored centuries during the season.

Cricket Club

Sussex Tour, July 31st—August 5th.

For the first time for many years we were able to take a strong side on tour, and, as if to register approval the usually bashful English sun shone in her full glory for the whole week. Of the six games played, five were won and one lost. The cricket was always enjoyable and on occasions very amusing. Warr, Walker and Harvey all scored centuries, and most of the other batsmen got after runs. Of the bowlers Garrod and Harvey bowled very well in all the games, and Stoodley had a fine spell at Bancombe. The hospitality of our Sussex friends was as generous as ever, and the whole week was so enjoyed by everyone that it is difficult to single out the highlight of the tour. Was it Archie Warr's stroke-making or Hugh

Walker's whirlwind batting? Was it John Harvey's delightful century or perhaps the Rock'n'Roll session at the Deane Hotel at 2 a.m.? On further consideration it will be generally agreed that it was the moment when Padfield awoke from an alcoholic stupor to dismiss "Nobbie" Clarke, a former county batsman, with a brilliant one-handed catch on the fine leg boundary.

RESULTS:

Sunday, July 31st, v. Mariners. Won by 62 runs.
St. Bart's 251 for 4 dec. (Warr 103 not out; Davies 40; Walker 48).
Mariners 189 (Davies 4 for 42; Harvey 3 for 44; Walker 3 for 33).
Monday, August 1st, v. St. Andrews. Won by 83 runs.
St. Bart's 211 for 9 dec. (Davies 50; Pagan 38).
St. Andrews 128 (Stoodley 3 for 28).
Tuesday, August 2nd, v. Rottingdean. Lost by 7 wks.
St. Bart's 80 (Harvey 23).
Rottingdean 81 for 3 (Stoodley 2 for 23).
Wednesday, August 3rd, v. Ditchling. Won by 49 runs.
St. Bart's 122 for 8 dec. (Stoodley 23 not out; Jeffreys 21).
Ditchling 73 (Stoodley 3 for 30).
Thursday, August 4th, v. Bancombe. Won by 127 runs.
St. Bart's 249 for 8 dec. (Walker 104; Harvey 39).
Friday, August 5th, v. Newhaven. Won by 152 runs.
Bancombe 122 (Stoodley 4 for 17; Merry 3 for 28).
St. Bart's 234 for 6 dec. (Harvey 101 not out; Warr 62).
Newhaven 82 (Garrod 6 for 32; Harvey 2 for 6).

U. H. Cup Semi-final v. St. Georges, Friday, August 19.—Match Drawn.

Bart's were put into bat on an easy wicket and scored slowly but steadily. Warr scored his third century of the season for the Hospital, and even if this innings was not chanceless it contained many wonderful strokes. None of the other early batsmen made many, and it was left for the tail to add an air of respectability to the score. St. Georges were left 160 minutes in which to make the runs but soon fell behind the clock. Garrod and Stoodley provided a hostile opening attack, and Niven and Harvey also bowled very well, but were able to take only 6 wickets by the close.

St. Bart's 213 (A. C. Warr 112, B. J. Stoodley 25).
St. Georges 124 for 6 (J. Rankin 40; J. A. Garrod 2 for 18).

1st. XI v. Bromley, Sunday, August 14th. At Bromley.—Won by 4 wks.

On a dull damp day Bart's won the toss and took the field under the leadership of J. J. Davies. After two bad overs Garrod and Stoodley bowled steadily and four wickets fell for 48 runs; however, a slight recovery occurred and Bromley eventually reached 112. Bart's missed three "run outs" due to narcolepsy in some of the fielders.

Bart's had over two hours in which to bat but lost Davies early. Jeffreys batted well but was fourth out when the score was 59. Harvey and Savege then took the score to 85. At 94-6 Geach joined Harvey and this pair knocked off the runs. A word of thanks is due to A. R. Geach, our most regular scorer.

Bromley 112 (P. A. R. Niven 4 for 9; B. J. Stoodley 3 for 33).

St. Bart's 113 for 6 (R. V. Jeffreys 32; J. A. Harvey 48 not out).

1st XI v. Ferring, Saturday, August 20th. At Ferring, Sussex.—Lost by 3 wks.

After numerous adventures on our way down to Ferring, we won the toss and batted first. Having lost the first two wickets before a run had been scored, Jailler and Jeffreys both batted very well and almost repaired the situation. However, after these two were out no one else made many and we were eventually all out for 113. Ferring started

their innings shakily and, despite a notable lack of support from his fielders, Harvey bowled very well throughout the innings and with a little help from Merry at the other end managed to make them struggle hard for their victory.

St. Bart's 113 (J. M. Jailler 34; R. V. Jeffreys 20).

Ferring 114 for 7 (J. A. Harvey 4 for 36; R. T. E. Merry 3 for 53).

Cup Semi-final v. St. George's (Replay) Wednesday, August 24th.—Lost by 5 wks.

We were again put in to bat, but this time on a very green wicket which quickly became churned up. Warr once again batted very well, but apart from Jeffreys, who fought bravely, the rest of the side gave him little support. We were eventually dismissed for 106. Garrod and Niven opened the bowling and although the George's batsmen were in continual trouble on the treacherous pitch it was not until their total had reached 60 that we were able to break through. Garrod and Harvey then bowled very well and were supported by keen fielding; at one stage it looked as though they were going to run through the opposition, but 106 proved too small a total and we eventually lost by 5 wickets.

St. Bart's 106 (A. C. Warr 46).

St. George's 107 for 5 (J. A. Garrod 3 for 40).

BATTING AVERAGES

	Inns.	Runs	H.S.	Average
A. C. Warr ...	24	861	112	41.00
J. A. Harvey ...	26	616	101*	32.42
B. J. Stoodley	12	191	49*	31.83
H. R. J. Walker	14	309	104	30.90
W. H. Pagan ...	18	426	59	26.62
J. D. Davies ...	25	537	76	23.35
R. T. G. Merry	26	570	109	22.80
R. V. Jeffreys	26	461	46	19.21
J. M. Jailler ...	16	176	44	14.66
*Not out				
Played 30	Won 13	Lost 5	Drawn 12	

BOWLING AVERAGES

	Overs	Mds.	Runs	Wkts.	Ave.
J. A. Garrod ...	198.1	60	484	37	13.08
B. J. Stoodley	141.1	34	407	29	14.04
J. D. Davies ...	113.4	34	260	17	15.29
J. A. Harvey ...	340	72	963	61	15.78
P. A. R. Niven	203	31	731	35	20.88
R. G. T. Merry	131	22	443	21	21.09
H. R. J. Walker	53.5	6	259	10	25.90

INTER-FIRM SIX-A-SIDE

Saturday July 23

The rain held off, the day was warm, and everyone who was optimistic enough to come down to Chislehurst had a most enjoyable day. After some very close and exciting preliminary rounds in which a good deal of amusement was caused by the original tactics of certain teams, Kids and

Specials just managed to beat M.O.P.'s and S.O.P.'s in the final. In the evening a dance was held in the pavilion and proved as enjoyable as ever. Our deepest thanks to Mr. and Mrs. White for all the work they put in to ensure the success of the day.



The Amazons . . .

At the Six-a-Sides



The Americans . . .

Lawn Tennis Club

This season has of course been seriously affected by the continued adverse weather conditions, and in July matches against West Neath, Westminster Hospital, Stonyhurst Wanderers, and Roehampton had to be cancelled. For the same reason our second round Cup Match with St. George's was postponed so many times that they eventually sportingly conceded it to us, then the organisations threatened to scratch us both. This may seem strange to those who realise that they beat us 5-4 on June 18th. but on that occasion Peter Poore was the sole member of the first six playing.

Mixed Tournament, Sunday, June 26th.

Eight couples turned up and spent an enjoyable afternoon at Chislehurst playing a round robin system. David Latham and Pamela Aldis emerged clear winners.

v. Epsom College (A), Wednesday, July 6th.

On a dark windy day we just managed to avoid defeat by the college team weakened by examinations. Poore and Perry left one rubber at one set all to avoid holding up the match, and a late rally by Jennings and Dhagit from 2-8 down in the deciding set of the last match saved defeat. Drawn 4-4.

Team: M. C. Jennings (Capt.), B. Bhagit, D. Latham, R. Courtenay-Evans, P. D. Poore, M. Perry.

v. King's College Hospital (A), Saturday, July 16th.

Unfortunately Colin McNeill was misinformed that the match was cancelled and stayed up in Petersborough whilst the remaining five went down heavily to strong opposition. Lost 1-8.

Team: D. Latham, R. Courtenay-Evans, D. Prosser, R. Robertson, P. Poore, (C. A. McNeill).

v. St. Thomas's Hospital (H), Saturday, July 23rd.

Both sides had difficulty in scraping together six players, and the result of a sociable afternoon's tennis was 5-4 in our favour. McNeill and Prosser did well to beat their first pair.

Team: C. A. McNeill (Capt.), D. Prosser, M. C. Jennings, P. D. Poore, R. Robertson, D. Glover.

v. University College Hospital, Wednesday, July 27th.

We could only produce four players, and Bob Robertson was recruited straight from Theatre D. Our opponents arrived by car an hour before us, and Colin McNeill was further held up in some suede-boot shop. Eventually we started playing in a light drizzle which luckily soon stopped and the match ended in a draw. McNeill and Poore won both their rubbers in straight sets, while Jennings and Robertson lost both theirs in three sets.

Team: C. A. McNeill (Capt.), P. D. Poore, M. C. Jennings, R. Robertson.

Cup Match v. Guy's Hospital (H), Saturday, July 13th.

Unfortunately Trevor Seaton, who is a House physician at the Metropolitan Hospital, came all the way down to Chislehurst only to be called

straight back again to attend to a series of major crises. This gave three rubbers to Guy's and with their first pair on top form they were obviously unbeatable. Latham and Kohli did well to beat their second pair in three sets.

It was a great disappointment to be subdued so easily, because apart from their first pair they were not as good as in previous years. We wish them all the best for the final against St. Thomas's.

Team: A. T. Seaton, M. C. Jennings, C. A. McNeill (Capt.), P. D. Poore, D. Latham, S. Kohli.

v. Nurses, Saturday August 20th.

A very enjoyable match played against excellent opposition on the grass courts at Chislehurst with the men just emerging victorious by 3 rubbers to 1. The ladies were improving all the time and were getting very dangerous indeed when bad light stopped play.

Men's Team: M. C. Jennings, P. D. Poore, R. Courtenay-Evans, P. Butler.

Nurses' Team: Miss H. Jolly, Miss P. Roberts, Miss P. Willoughby, Miss D. Torhurst.

Ladies Lawn Tennis

This season we had been offered an unusually large number of fixtures extending into August and including quite a few for a second team. We looked forward to the season with mixed feelings; on the one hand we were losing half of our first team i.e. Jean Arnold, Jennifer Hartley and Janice Swallow, and on the other hand we waited expectantly for our newcomers. The trials had to be held on April 27th at College Hall as the Chislehurst courts were so heavily booked. This was unavoidably soon after the pre-clinicals returned from vacation, and probably accounted for the poor response. Only four new people arrived including two physiotherapists whom we were very pleased to welcome.

Sat. April 30th 1st VI v. U.C.H. (H) Won 5-3

Team: P. Kieley (Capt.), S. Whitaker, A. Vartan, P. Aldis, J. Clarke, J. Sykes.

This was our first outing on grass and the Chislehurst courts were really Wimbledonian! The match was very even throughout till Bart's achieved a 5-3 lead. Due to the late hours and failing light, the remaining game was halved. It was a most satisfying beginning to the season.

Wed. May 4th 1st VI v. U.C. (H) Won 8-1

Team: S. Whitaker, J. Hartley, J. Swallow, R. Murray, P. Kieley (Capt.), R. Watters.

The score is not quite a true indication of the play. All the games were very close, most of them going to three sets. Some very good tennis was played by both sides.

2nd VI v. St Mary's (A) Lost 4-5

Team: D. Layton (Capt.), P. Aldis, J. Clarke, J. Sykes, T. Lopez, W. Saunders.

We were very pleased to be able to put out such a strong team for this match, which was only just lost in the final set of the final game.

Sun. May 8th University of London Tournament. 1st Round. **1st VI v. King's College 2nd VI (H) Won 5-2**

Team: S. Whitaker, J. Hartley, P. Kiely (Capt.), J. Arnold, P. Aldis, D. Layton.

Unfortunately only two couples arrived from King's College, so Bart's had a 3-0 lead from the outset. The remaining four games that were played were very close and it was a pity that two complete teams could not have achieved a more satisfying result. The match was stopped when Bart's established a winning lead of 5-2.

Wed. May 18th **1st VI v. Guy's (H) Lost 3-6**

Team: P. Kiely (Capt.) A. M. Macdonald, J. Arnold, I. Tomkins, P. Aldis, J. Sykes.

The sunny weather inspired some good tennis from both teams. However we were unable to defeat a very good Guy's team and were left rather worried as to the outcome of our future match against them in the United Hospitals Tournament.

2nd VI v. Royal Holloway College (A) Lost 2-7

Team: R. Murray, F. Rose, D. Layton (Capt.) J. Clarke, T. Lopez, E. Ware.

We were quite pleased with this result as the opposition is always extremely strong at the Women's Colleges. The afternoon's play was unfortunately rather interrupted by rain.

Wednesday May 25th University of London Tournament, 2nd Round

1st VI v. Westfield College (A) Lost 1½-5½

Team: S. Whitaker, A. M. Macdonald, P. Kiely (Capt.) P. Aldis, D. Layton, J. Sykes.

This match was rather more exciting than the score suggests—the first couple had played 85 games and the second couple 66 games before Westfield established a winning lead. It was an extremely hot afternoon so we halved the remaining match in play and went thankfully for refreshments.

We wish Westfield luck in the rest of the Tournament.

2nd VI v. Bedford (A) Lost 2-7

Team: A. Vartan (Capt.), E. Knight, S. Cotton, J. Clarke, T. Lopez, S. Minns.

Though they did not win the second team enjoyed themselves in the glades of Regent's Park and had a pleasant afternoon's tennis. After the first three matches—they unfortunately only had time to decide the remaining sets in one long set each.

Wednesday June 1st United Hospitals Tournament. 2nd Round. **1st VI v. London (H) Won 7-2**

Team: S. Whitaker, J. Hartley, P. Kiely (Capt.), P. Aldis, D. Layton, J. Angell-James.

The first and second couples won their first two matches to give Bart's a comfortable lead of 4-2 at the tea interval. Afterwards this lead was increased to a final 7-2. As it was a very pleasant afternoon, all the matches were played off after the winning lead was established.

Saturday June 11th United Hospitals Tournament. Semi-Final. **1st VI v. Guy's (H) Lost 4-5**

Team: A. M. Macdonald, S. Whitaker, P. Kiely (Capt.), J. Swallow, D. Layton, A. Vartan.

This match was more keenly played than the previous friendly encounter in May. After the first round the score was 2-1 in Bart's favour then at the tea interval it was 3 all and very tense. However our first couple had lost to Guy's second couple, so it now required our second couple to defeat Guy's first couple after tea. As forecast this was the deciding match—a rather tired second couple lost in the final set 4-6, 7-1, 1-6, having played 80 games throughout the afternoon.

We wish Guy's all the best in the final!

On behalf of the team I should like to say how pleased we were to see our Vice-President Dr. Lehmann, on this occasion. He gave us no end of encouragement from the sidelines and a wonderful surprise of strawberries and cream for tea. Thank you very much, Sir!

Saturday July 2nd **1st VI v. London (A) Won 5½-3½**

Team: J. Swallow, J. Sykes, D. Layton, J. Clarke, A. Vartan (Capt.), A. Sinclair.

The London Hospital produced a team after some persuasion, as their normal players were not available so the match was a social occasion rather than a serious afternoon's tennis. The third couples abandoned their first match after two very long sets to avoid holding up the others and the final outcome was a win for Bart's.

Saturday July 16th **1st VI v. Royal Free (H) Lost 4-5**

Team: S. Whitaker, A. Vartan (Capt.), D. Layton, E. Ware, M. Goodchild, S. Watkins.

Bart's with a somewhat unorthodox team came very near to winning the match. The first couple were undefeated and the second couple beat the Royal Free third, but the Royal Free second couple proved their superiority in the decisive set by defeating Bart's third couple 8-6.

Wednesday August 3rd **1st VI v. West Heath L.T.C. (A) Lost 2-5**

Team: P. Kiely (Capt.), S. Whitaker, A. Vartan, E. Knight, D. Layton, M. Goodchild.

This was an evening match so it was decided to play two short sets against each couple. Bart's first and second couples managed 1 set all against their opposite numbers but all the other sets went to West Heath who had a very good team. The match was finished by twilight, then we were entertained to a marvellous supper.

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ST. BARTHOLOMEW'S HOSPITAL JOURNAL



Vol. LXIV, No. 10

OCTOBER, 1960

Calendar

November

- Sat. 5—On duty: Dr. G. W. Hayward
Mr. A. W. Badenoch
Mr. R. W. Ballantyne
R.U.F.C. Cornish Tour
- Mon. 7—Film Society: "High Society"
- Tues. 8—Squash v. Stonyhurst Wanderers (H) 6.30.
- Wed. 9—A.F.C. v. St. Thomas's Hospital (H)
- Thurs. 10—Abernethian Society: Professor Peart—"Hypotension"
- Sat. 12—On duty: Dr. E. R. Cullinan
Mr. E. G. Tuckwell
Mr. C. Langton
Hewer
R.U.F.C. v. Old Haberdashers (H)
A.F.C. v. Middlesex Hospital
- Tues. 15—C.U. Open meeting—Recreation Room, Charterhouse, at 5.45 p.m.
Squash—Cumberland Cup
- Wed. 16—A.F.C. v. St. Mary's Hospital (H)
- Sat. 19—On duty: Medical and Surgical Units
Mr. G. H. Ellis
R.U.F.C. v. Old Alleynians (H)
A.F.C. v. Warham Med. School (H)
- Mon. 21—Film Society: "Jour de Fête"—Jacques Tatis
- Tues. 22—Squash v. Middlesex Hospital (H) 6.30.
- Wed. 23—A.F.C. v. Westminster Hospital (H)
- Thurs. 24—S.U. Council Meeting & A.G.M.
- Sat. 26—On duty: Dr. R. Bodley Scott
Mr. A. H. Hunt
Mr. F. T. Evans
R.U.F.C. v. U.S. Chatham (H)
A.F.C. University Cup
- Tues. 29—Squash—Cumberland Cup
- Wed. 30—S.U. Council Meeting
- December
- Thurs. 1—Abernethian Society: Sir John Wolfenden—"Crime and Sin". College Hall at 5.45 p.m.
- Fri. 2—C.U. Service at St. Bartholomew-the-Less, 1.00 p.m.
R.U.F.C. Annual Ball
- Sat. 3—On duty: Dr. A. W. Spence
Mr. C. Naunton
Morgan
Mr. R. A. Bowen
R.U.F.C. v. Old Cranleighans (A)
- Mon. 5—Film Society: "Scott of the Antarctic"
- Tues. 6—Squash—Cumberland Cup
- Wed. 7—A.F.C. v. London Hospital (A)

Editorial

NOBODY is able to say what a hospital ought to look like. We are all very proud of the Square but in many ways the buildings which surround it are as unsuitable as any in the City for the practice of medicine. An aesthete (distinguished enough) has already suggested that the new L-block is almost devoid of architectural merit. Those who will use it may well find the lifts in the wrong place or the central heating inadequate. Of the standards by which a hospital can be judged, the most important are often those which are altering. The changing pattern of disease and morbidity alone, present the planners with a task which is hardly equalled elsewhere.

Modern design is influenced by space, neighbouring buildings (including churches!) and building materials in addition to the estimated requirements of the building. It is true that all these have been important in the past but the speed with which changes have occurred in medicine accentuate the importance of each. So much so that it seems that hospitals may not in future be designed in the traditional way as a single unit. Professor Llewelyn Davis goes so far as to say that "the hospital of the future may perhaps draw architectural inspiration from the size and shape of the functional units within it".

With this in mind and also the universal shadow of finance, Lord Taylor has suggested that a master-plan could be drawn up and consulted by hospital planners. Many, and especially those who believe that the modern ward will be replaced by acute, highly staffed, units and convalescent units and day treatment centres, think this plan impracticable. It does serve, however, to emphasize the need to study changing patterns of disease and morbidity in conjunction with design.

The ideal was perhaps experienced by us all when we were very young and were able to build with packs of cards. Not only was it easy to build up and pull down at will but the time between forming our plan and seeing our castle of cards was short enough to be reasonably certain that our mood had not changed. There was plenty of space too.

When we look around and see the extensive building programme being undertaken in the Hospital it is interesting to compare what we see with what we have come to expect of hospital buildings as a result of

recent writings. It would seem difficult to think of any of it in terms of a master-plan. Indeed in many ways freedom to experiment is more important than evolving a plan which might later slow our ability to meet changing needs. Those who have had their own ideas incorporated into a building will enjoy using it and also the freedom.

Fifty Years Ago

"The Surgical Side of the Hospital Fifty Years Ago" was the title of an article contributed to the Journal of 1910 by Alfred Willett F.R.C.S., who, at that time, was one of the Consulting Surgeons to the Hospital.

It was in October 1860 that Willett took up his appointment as house surgeon to Mr. Lloyd. In those days the house surgeon held office for a year, and worked single-handed, for it was not until 1882 that junior housemen came into being. For reasons of ill health, Mr. Lloyd retired early in 1861, and his place was taken by Mr. Wormald.

Thursday was admission day for in-patients, so at twelve the house surgeon had to hurry across to the Steward's Office to investigate the complaints of the surgical cases assembled, whilst Mr. Wood—the apothecary—did the same for medical cases. The office was usually fairly packed; few of the many patients were suitable for admission, their maladies being of the chronic type, ulcers of the leg predominating.

At 12.30 the physician and surgeon of the week would arrive. The surgeon would ask his house surgeon what cases he thought were suitable for admission, such as a tumour of the breast, a lipoma, or joint diseases. These being admitted, the remainder would be called up in turn, quickly examined, two or three more perhaps, looked upon with a more discerning and lenient eye by the surgeon, and passed for admission. The rest would be dismissed on one plea or another.

Each surgeon had five dressers, and though they were not required to take notes of the ward-patients assigned to them, they were, nevertheless, very fully engaged over the "dressings", for, practically speaking, all wounds of both operation and accident cases suppurated freely. Indeed it may be added that they were both expected and induced to heal by this method of "secondary intention" as it was called. That operation

wounds were bound to suppurate is proved by the routine in vogue.

To start with, each surgeon and assistant-surgeon had an operation coat, kept in a cupboard in the theatre: this in time became coated with dried blood and other discharges, and, like some tattered old flag, the more foul it became, the more honoured and treasured it was to its owner. Sponges were only casually cleansed by rinsing in water, and would do for a series of operations. Then, again, all bleeding vessels were tied with dry silk ligatures, unprepared, just as received from the manufactory, one end only being cut off, the other left long, so that when the wound was closed, a dozen or more threads were brought out between the sutures to "fall" as it was called when they became loosened by ulceration. After 48 hours the first dressing took place, and almost to a certainty either a bread or linseed poultice was ordered. Operation wounds would take from three weeks to three months in healing. Pyaemia too often marred the apparent well-doing. The advent of the tenth day was anxiously watched; despair settled on all at the dreaded summons: "Please sir, will you come to —, he has had a rigor." This, in about 48 hours would be followed by another, and then, in succession at short intervals, joint after joint would be found hot, swollen and painful, whilst cough and hurried breathing told, only too obviously, of the lungs being involved, and death usually supervened in about a week from the first rigor.

Excepting emergencies, all operations were performed on Saturday afternoons. A few incidents which happened are impressed on my memory. On one occasion Mr. Lloyd had a lithotomy, his plan for this operation being to plunge a bistoury from the centre of the perineum directly into the rectum and cut straight out along the middle line (not infrequently the operator would be deluged in a spray of liquid faeces); then, cutting into the groove on the s'aff, he reached the bladder in the usual way. On the occasion in question, the stone had been struck before commencing, but could not be found even after a prolonged search, and at length the boy was sent back to bed. The next morning, however, the nurse found the stone in the bed. It was surmised that the small calculus escaped from the bladder at the end of the first gush of urine, slipped unobserved into the rectum, getting caught in a fold of

mucous membrane where no one dreamt of looking for it.

It might be added here, that another surgeon, Mr. Skey held that no one should take more than half a minute for a lithotomy, which necessarily means that each stage of the operation had to be completed with the utmost rapidity.

The sisters of Abernethy or Lucas wards, according to the sex of the patient, attended the theatre at all operations. Sister Abernethy of the time was a really splendid character, immensely respected by all. Another noted sister on the surgical side was "Colston" to whom the nickname "Queen of Hell" was most unjustly given. The fact was she looked upon complaints by a patient as base ingratitude. Yet to see her every morning in the square, outside her ward, surrounded by a flock of city pigeons, which she regularly fed, settling on her head, shoulders or arms while she carressed them, showed she had at least one soft spot in her heart.

The article ends with a brief paragraph. "I fear the foregoing will not be so intelligible to many as I could wish, but without going into details, which would be tedious, it is difficult to compare the work and duties of past times with those of the present day. One characteristic of the past still remains, and will do so—I mean the affection which all connected with the hospital bear towards it."

News in Brief

It is with deep regret that we record the death of SIR HAROLD GILLIES. An obituary notice will appear in a subsequent issue.

SIR WILFRID LE GROS CLARK, F.R.S., has been elected president of the British Association for the Advancement of Science for the year 1961.

SIR JAMES PATERSON ROSS is to give the Thomas Percy Legg Lecture at King's College Hospital Medical School on Friday, Oct. 14, at 4.30 p.m. He will speak on the Principles of Surgery.

Professor M. de B. DALY has received the degree of Sc.D. from the University of Cambridge.

The Governors have approved an extension to the Radiotherapy Block. Plans are now being drawn.

Wessex Rahere

The Autumn Dinner of the above Club will take place on October 29th, 1960, at the Grand Spa Hotel, Clifton, Bristol, under the Chairmanship of Dr. Russell Grant, of Winchester. It is hoped that the Guest of Honour will be Dr. Heber Langston. Further details will be circulated or can be obtained by any Bart's graduates who are not already members from the Hon. Secretary, Mr. A. Daunt Bateman, F.R.C.S. 11 The Circus, Bath.

Births

BUTTERY.—On September 2, to Penelope and Dr. David Buttery, a second son (Jeremy David).

ELLISON.—On September 3, to Heather, wife of Dr. Anthony J. H. Ellison, a son Paul (Anthony Hereward).

Engagements

MCKINNA—FOREMAN.—The engagement is announced between Dr. Colin McKinna and Barbara Cynthia Foreman.

PARKES—WHATLEY-WHITE. — The engagement is announced between Dr. J. David Parkes and Elizabeth K. Whatley-White.

TRESSIDER—KARK.—The engagement is announced between Valentine C. Tressidder and M. R. Kark.

Deaths

FOSTER.—On September 3, Lt. Col. Raymond Leslie Vachel Foster, R.A.M.C. (retd.) aged 86. Qualified 1901.

GASKELL.—On September 11th, Dr. John Foster Gaskell, M.D., F.R.C.P., D.P.H., aged 82. Qualified 1907.

GILLIES.—On September 10th, Sir Harold Gillies, C.B.E., F.R.C.S., aged 78. Qualified 1908.

SEWELL.—On August 31, Col. Evelyn Pierce Sewell, C.M.G., D.S.O., M.B., aged 86. Qualified 1899.

Change of Address

Dr. L. J. Forman Ball, Bond's Cottage, New Street, Lydd, Kent.

"FIRST CATCH YOUR HARE"

by Malcolm Donaldson, F.R.C.S., F.R.C.O.G.

IN an old edition of Mrs. Beeton's cookery book there is a recipe for "Jugged Hare" which starts off, "First catch your hare". This advice is equally applicable to medical men or women who hope to cure patients of malignant disease. Every student realizes the importance of "early stage diagnosis" in the prognosis of cancer treatment, but may confuse this with "early diagnosis". It may be as well therefore to point out that "early diagnosis" means the discovery of the growth as soon as symptoms are noticed, but in some cases the growth is already in a "late stage" and disseminated. There is no doubt however that the more "early diagnoses" that are made the more likely it is that more "early stage tumours" will be found.

Accessible Cancers

The following are generally labelled the accessible cancers — breast, uterus, rectum,

bladder, mouth, larynx, lip and skin. These do as a rule show symptoms whilst in an "early stage" but alas are often neglected as is shown in figures from the Registrar General's Report 1957. The mean delay between a patient noticing a painless lump in the breast and seeking advice is 6.2 months and 17.3 per cent of all cases wait over two years, believing that if there is no pain or tenderness, it cannot be serious.

In cancer of the uterus (cervix) the mean delay is 5.7 months, but 8.4 per cent wait over two years. This of course is due to the fact that irregular bleeding between the periods and particularly during the menopause is so common and generally due to some endocrine disturbance. The dreadful phrase "only the change of life" is responsible for thousands of deaths. One woman discusses her trouble with a neighbour, who says "don't you worry my dear, it is only

the change, I had to go through it," and the younger woman being reassured by her foolish elderly neighbour neglects to take advice, possibly with disastrous results. In malignant disease of the rectum the delay is 5.4 months and 25 per cent wait over a year. This of course is due to the fact that the patient thinks it is "only a touch of the piles" and goes to the chemist week after week for "pile ointment".

Not only are these long delays due to ignorance but also to fear. It is not necessary to be a psychiatrist or a psychologist to realise this. Cancer is surrounded by a psychological atmosphere like no other disease. I call it "Cancer Smog".

It would seem that there are three types of this "Cancer Smog". First, true cancerphobia. This is probably rare in this country, and the diagnosis should only be made when a patient is so obsessed with the fear that it interferes with his or her way of life and should be treated by a psychiatrist. A few commit suicide; one was reported in Bedford recently and also in Reading.

In spite of the rarity of "cancerphobia", nearly 100 per cent of the adult population have a lesser or greater "cancer apprehension". This again is of two types.

(1) *Personal Apprehension*. By this is meant a person who has some symptom for which it is difficult to account, e.g. a woman with some pain in the breast, and she immediately thinks "can this be cancer?" Possibly she will speak to no one but worry for weeks or months until the pain disappears. She may go to the doctor but not mention her fears, and therefore gets no reassurance, and returns week after week, only to be considered a "neurasthenic" when the real diagnosis is a "cancer apprehensive".

Some do speak of their fears, only to be good naturedly laughed at. The patient goes away determined never to mention the word cancer again but goes on worrying. On more than one occasion at the end of a lay lecture I have been told "it is no good going to doctors about cancer, they won't tell you the truth". This lack of confidence in the G.P., but only in connection with cancer, has been increased recently, by a senior medical man writing to the lay press and saying doctors should deceive their patients.

During many years in the out-patients I used to manage such apprehensive patients by examining them carefully and then say-

ing, "I am glad to say there is nothing serious and no evidence of cancer emphasizing the word cancer. To which the reply was very frequently "Thank God, that is what I really came about". If this line was taken by more family doctors, and then a few words spoken about the early symptoms, the time spent would be refunded by such patients keeping away from the surgery. Of course, such patients are not so easy to spot in general practice as in gynaecological O.Ps.

(2) *Impersonal Apprehension*. By this is meant fear that by speaking to a person about cancer, will cause fear or increase fear in the person addressed. This type of apprehension is very common, and does a great deal of harm because it keeps up the "Hush Hush" and conspiracy of silence. This prevents patients from visiting a doctor at a time when the disease may be in an early stage. There is considerable evidence of this kind of apprehension.

When the C.I.A. was first started pamphlets in stamped envelopes were given to people to address and post to their friends, but they refused on the grounds that their "handwriting might be recognised". The same people however would give me the names and addresses of their friends, in one case 30, to send out.

How then can this fear be diminished? It can only be done by bringing the fear to the surface and encouraging people to face facts and to talk about cancer as they already talk about other serious disease, e.g. heart disease, which kills twice as many people per year as cancer, in fact the object should be as someone put it "to make cancer ordinary".

In this country a Cancer Education Campaign can best be organized by the Local Health Authorities, and indeed the 1946 Act puts the responsibility for "all medical education of the Public" on them. Every individual, however, can help by discussing the disease frankly and freely. "Knowledge is the antidote to fear" wrote Emerson, and he was correct.

Diagnostic Centres

Owing at present to the reluctance of some patients to visit their own doctor if they suspect the possibility of malignant disease, some people advocate centres to which anybody can go without symptoms. This is popular in the U.S.A. and the Strang Clinic

in New York is the best known of these. At one time they were common in Canada, but have now been given up. The arguments against such centres is overwhelming. The number of unsuspected cases without symptoms found is very small and requires a great many man and woman hours to discover them; this is more important than the money spent. It also means duplicating all the apparatus, X-rays, etc. Regular overhauls are ideal, as for motor cars, but at present not possible in this country under the N.H.S. It is true that such a centre would have the psychological advantage that the patient would be able to get an overhaul without having to face the family doctor, but it must be clearly understood that such an examination can only exclude some of the accessible cancers, breast, uterus, rectum, etc., with reasonable certainty. This at present can only be done by paying a fee.

For the present patients should be sufficiently informed so that they will go to their doctor if certain symptoms appear. The family doctor should be given better facilities for diagnosis, e.g. smears, etc., as they are in Edinburgh, and perhaps better post-graduate instruction on the diagnosis of "early stage" cancer. If the doctor has any doubt he should be able to send the patient to the hospital *next day*, where the patient should be seen by a *team* of consultants who *meet each day* except Sundays. Cancer is a greater emergency than an "appendix" because some of the latter do recover without treatment, cancer never.

The Profession and Cancer Education

In 1953 a questionnaire was sent by the B.E.C.C. to all family doctors (consultants for some unknown reason were not included), asking them if they believed in "cancer education" among the public, and they were to reply *Yes* or *No*; people were not allowed to have any doubts. As very few doctors had any experience of such education only 25.4 per cent replied and of these 14.1 per cent said *No*, and 11 per cent said *Yes*. Since 74.6 per cent abstained, the figures were statistically useless. Since that date the "Wind of Change" at present only a light breeze, has passed through the profession, and one well-known surgeon has published his conversion in the B.M.J. At present few are antagonistic, but many are apathetic.

What then are the arguments used against such an educational campaign. First the

psychological effects, i.e. the belief that it will create fear. At the International Cancer Conference 1958 in London, the representatives of every country who discussed this subject denied that it had increased fear or apprehension or that it had increased the work of the doctors or crowded the surgeries. This has been the experience in the Manchester area where out of 108 doctors asked whether the cancer talks ever caused them any additional work or brought patients to their surgeries without observable symptoms the answer was *No*, 105, and *Yes*, 3. My own figures collected during a pilot experiment in Yorkshire where the following printed ballot paper was distributed at the end of each lecture, pointed the same way.

Some people have suggested that lectures such as you have just heard do no good, and indeed may do harm. Please state quite frankly what effect it has had on you, by putting an X against the statement (i) if you think it has increased your worry and that such lectures should not be given; or against (ii) if it has helped you and you think more such lectures should be given. If you are doubtful put a ? instead of an X.

(i) *It has increased my worry and such lectures should not be given*

(ii) *It has relieved my mind and is helpful. More such lectures should be given*

Of 5,740 votes, 99.1 per cent were in favour, 0.2 per cent against and 0.7 were doubtful.

Statistical Objections. A definition of a statistician is "a man who takes great trouble to collect accurate figures for other people to misuse and to misquote". It has been said that statistics can be made to prove anything, but the truth is that without statistics nothing can be proved. The profession justifiably asks if it can be shown that it has affected the mortality figure or the five year survival rate. In this country the answer is *No* because hardly any cancer education has been carried out, but there are some suggestive figures in other countries. Every statistical table proves beyond doubt that clinical "early stage cases" have a better prognosis than late stage cases. It is therefore only necessary to prove that cancer education produces more "early stage" cases. There are suggestive figures from Manchester but at present the investigation has not been carried out on a large scale. It can be done as I showed in my report on the Yorkshire Pilot Experiment.

The following figures have been used to show that delay does not matter.

Delay in months after symptom noticed	Five-year Survival
0-3	44 per cent
4-6	39 per cent
7-12	41 per cent
24+	44 per cent

Such an argument is futile, a comparison is being made between entirely different types of growth. The cases treated in the first three months are mostly quickly growing early disseminating tumours, whereas those of two years' duration are entirely slow growing tumours, a selection by death. Between the two extremes there are all degrees of growth rate, and many of these 54 per cent who died in this series might have been saved by earlier treatment. Of course there are many individual cases who have to my knowledge consulted a doctor after hearing a lecture or reading a pamphlet. Sometimes it is said that doctors and nurses are the worst offenders about seeking advice concerning suspicious symptoms. Statistically this is not true, but any such case is remembered by a consultant, who never remembers the hundreds of delayed patients that pass through his hands, and possibly does not even ask how long the symptom has been present. When, however, a professional person does delay it is probably often due to fear lest they should be considered a case of "cancerphobia" or a "neurotic" by their colleagues.

Should the doctor tell?

Every student who takes up general practice will meet on the average about 15 new cases of cancer each year, but although small in number they will be the most worrying of all his or her cases. The problem of what to tell a patient is only *indirectly connected* with "cancer education" which is devoted to people who are *quite healthy*.

The present principle generally adopted is "Tell the relatives everything, the patient nothing". As a principle there are many arguments against such a procedure.

1. Every patient is not a mental defective, and when he or she realises that their condition is getting worse, it will be very difficult, if not impossible, to keep up the decep-

tion. Some may pretend to be deceived in order to comfort their relatives or doctor.

2. Having realised that he is dying of cancer, the patient will blame the doctor for not diagnosing the real condition earlier which has been camouflaged as "rheumatism" or some other disease.

3. If in later years a relative of the deceased thinks that he may have cancer, it will be difficult to convince him otherwise, because he knows the doctor deceived or tried to deceive his dead relative. This loss of confidence is very serious.

4. Aitken-Swan and Eason in 1959 stated that in a survey carried out in the Manchester area only 7 per cent resented being told that they were suffering from or had had cancer, so it is obvious that most patients prefer to know the truth rather than to remain in doubt. In hospital many patients, if they have not been given a definite diagnosis, assume that they have cancer.

5. If patients who have recovered from cancer are never told, the belief that no case is ever cured will persist, and any patient who suspects the possibility that he is suffering from cancer will consider that there is no object in going to a doctor.

For these reasons it is far better whenever possible, particularly when a patient has been cured, that the "doctor should tell". This can be done gently without causing much shock because the patient generally suspects it already. The prognosis given should be as optimistic as possible; *it is criminal to take away hope*. It is also foolish to give a poor prognosis, as on more than one occasion the patient has outlived the doctor who has given such a prognosis.

Far too many practitioners take a completely fatalistic view of the disease, and refuse even to attend a lay lecture in order to observe the reaction of the audience, on the grounds that they "have not got the time". Has not the time arrived when somebody should *find time to think about the "early stage" diagnosis of cancer?* The disease in this country kills 100,000 people per year, the greatest killing disease next to cardiovascular disease.

If cancer education could be carried out properly throughout the country, it would probably add 10,000, i.e. 10 per cent to the 30 per cent five year survival rate at present existing, and perhaps more important, would bring comfort to millions of people.

WILLIAM SMELLIE

by Elizabeth Knight

Part I of the Wix Prize Essay 1960, to be concluded.

His Time

IT was the beginning of the Age of Reason—so the eighteenth century has been described. The medical historian, Dr. Charles Singer, sees it as an Age of Consolidation in the evolution of the study of medicine. Much had happened in the two preceding centuries and methods of learning had altered. The study of science was itself becoming a science, not least through the influence of Isaac Newton.

This great man had proved that the Natural Law was universal and scientists were anxious to show its existence in every branch of learning. Progress was rapid and time was needed to sort out the wealth of material at hand.

Another desperate need in the field of medicine at this time was to improve medical education. Until the seventeenth century there had been little at any of the universities. Leyden in Holland was the first to establish a course, and in 1660, Sibbald, a student at Leyden, returned to his native Scotland and founded the Royal College of Physicians of Edinburgh. Thus Scotland, too, became a pioneer in the improvement of medical education.

This then was William Smellie's context, a century which marked a change in the scientific outlook, a country on the threshold of great cultural achievement, and a county, Lanark, which, within the short space of thirty years was to produce four great medical men, Smellie, Cullen, founder of the Glasgow University medical school, and the brothers William and John Hunter. It was certainly auspicious.

Youth and Education

The year of William Smellie's birth, 1697, is recorded only on his tombstone in the churchyard in Lanark where he was buried.

He was the son of Archibald and Sara Smellie. Archibald was made an Elder of the Parish church of Lanark at the Kirk Sessions of 1727. Elders of the Kirk were valued men who took their duties most seriously. Sara was related to a family of small landowners and must therefore have been quite well to do. From this one may deduce that William had a good Christian upbringing in a respected Lanark family.

Smellie went to the grammar school in Lanark which, at this time had a fine reputation. In a "letter of exculpation" written after his retirement to Dr. Pitcairn of St. Bartholomew's Hospital, he says of himself that he was "very idle and dull at school and was taken more up with carving and painting than books". However, he must have had an affection for his *alma mater*, because he left to the school his precious collection of books, which is still housed in Lanark.

Of his medical education little is known. At this time, however, there was no organised curriculum and the best education was to be had at Leyden or Paris, or by apprenticeship to a practitioner at home. As no formal qualification or degree was required this last was probably quite adequate.

McClintock, who edited the New Sydenham Society's edition of Smellie's works, says that "the registers of the Universities of Edinburgh, Glasgow, St. Andrew's, Leyden, Utrecht and Aberdeen have been examined with a negative result; but I have been informed that the registry of St. Andrew's is defective for some years about the time when Smellie's name would appear in it; so that he may have taken his medical degree in this University, and from not finding his name elsewhere, I am disposed to think that he did".

This, too, is somewhat negative evidence and Glaister, Smellie's first biographer, thinks it equally likely that Smellie in fact chose apprenticeship, under Dr. Gordon of

Glasgow. The evidence for this is that in later years the two were certainly close friends, and that Tobias Smollett, the novelist and friend of Smellie was indeed apprenticed to Gordon and might well have introduced the two men. Gordon was a Glasgow physician of some repute, who eventually became President of the faculty of Physicians and Surgeons. Later when writing of his debt to those who had helped him, Smellie says, "In particular I was obliged to Dr. Gordon of Glasgow, and Dr. Inglesh, of Lanark in Scotland; the first made me acquainted with the blunt hook, the other with the noose".

At all events, Smellie returned to practise in Lanark in 1720. Lanark, then, was a small town with a population of about two thousand, but it was also the county town, and an important centre of the wool trade.

The Lanark Doctor

Attempts were afterwards made by Sir James Young Simpson and others to belittle Smellie during his years at Lanark. At a meeting of the British Medical Association in Edinburgh in 1858, Sir James said of Smellie, "While settled at Lanark, he did not succeed, as we learn from one of his subsequents detractors, in getting above the position of second medical practitioner in that small community, and I have seen some of his accounts showing how miserably small his fees were. In fact he eked out his scanty income by keeping a shop as a village cloth merchant as well as by practising as a village doctor".

However, there is no evidence that this story was true, and a bill of 1723 in which "seven pound sterling" was named as the "agreed wages and fee for Amputation and Cure of your leg, performed by me in harvest last. Make thankfull pay^t and oblige your humble serv^t Wil. Smellie," belies the "scanty income" referred to by Simpson.

While in Lanark he read widely in the medical and obstetric literature of the day, and borrowed books on Medicine and Surgery from his friend William Cullen. In a letter to Cullen he says, "I have kept your book on Consumption too long, but I shall send it next week. Send me up Dr. Clifton's history of Medicine, I want to see something in him. I could not get that book from Glasgow or Edinburgh, but I have sent to London for it".

Smellie's was a "general" practice although this tends to be forgotten as only his notes on obstetric cases are extant. These he preserved until he wrote his great work, the "Treatise on the Theory and Practice of Midwifery". In case 186 he records some general notes on his methods at this time.

"During the first year of my practice when I was called to lingering cases, which were often occasioned by the imprudent methods used by unskilful midwives to hasten labour, such as directing the patient to walk about and bear down with all her strength at every trifling pain until she was quite exhausted, and opening the parts prematurely, so as to produce inflammations, and torture the woman unnecessarily; on such occasions, without knowing the steps that had been taken, I have been told that the patient had been in severe labour for many hours, and sometimes days, and that now I was called to prevent her from dying with the child in her belly. Thus solicited, if the head was at the upper part of the pelvis, I commonly turned the child and brought it by the feet; and thus if small, it was usually saved, provided it was not dead before my arrival; but when the head was large, or the pelvis narrow and distorted, the force necessary to extract it was often the occasion of its death.

"On the other hand, when the head was so low in the pelvis that I could not raise it into the uterus in order to be turned, I was obliged to dilate the cranium with my fingers, assisted by the blunt hook. This method, however, I never practised except when the head was low down and the patient so much exhausted that she could not be delivered by the pains; and not even then, until after I had tried Mauriceau's fillet which always failed, and another, introduced by my fingers in the form of a noose, which sometimes, though, very rarely, succeeded when the child was small."

Some time during his nineteen years in Lanark he married Eupham Borland, and everything suggests that the marriage was a happy one though without issue. They were the likely originals of Dr. and Mrs. S. in Tobias Smollett's novel "Peregrine Pickle".

In 1733 he was admitted to the faculty of Physicians and Surgeons of Glasgow—his first medical qualification after thirteen years of practice.

To London via Paris

In 1739, Smellie gave up his practice in Lanark and after a few months, settled in London. What led him to take this radical step? Again case 186 comes to our aid and hints at the answer. He says:

"In order to avoid this loss of children, which gave me great uneasiness, I procured a pair of French forceps, according to a draft published in the Medical Essays by Mr. Butterm, but found them so ill-contrived that they by no means answered the purposes for which they were intended. I afterwards perused the treatises of Chapman and Giffard, who had frequently saved children by a contrivance of this kind; and actually made a journey to London in order to acquire further information on this subject."

His intention in going to London was, then, to see if anyone there could instruct him in the use of forceps. While there he presumably listened to such teachers as there were, perhaps Sir Richard Manningham or John Maubray. But of London he says: "Here I saw nothing was to be learned: and I therefore proceeded to Paris, where courses on midwifery were at that time given by Grégoire."

There were in fact two Grégoire's, father and son. Smellie's biographer, Glaister, concludes that it was the younger to whom he went. Of Paris he says: "There likewise I was very much disappointed in my expectation." However, in Paris he did see the machines or "dummies" which were used in instruction. He became very interested in these and thought that he could better them. He says:

"Though his method might be useful to a young beginner, his machine was no other than a piece of basket-work, containing a real pelvis covered with black leather, upon which he could not clearly explain the difficulties that occur in turning, proceeding from the contractions of the uterus, os internum and os externum. And as for the forceps, he taught his pupils to introduce them at random and pull with great force, though he preferred Chapman's instrument to that used by the French, and recommended the improvement made upon Mauriceau's fillet, which can never be of any use.

Little satisfied with his manner of instructing, I considered that there was a possibility of forming machines which should so exactly imitate real women and children as to exhibit to the learner all the difficulties that

happen in midwifery; and such I actually contrived and made by dint of uncommon labour and application."

And so Smellie's path was finally directed to obstetrics and he returned to settle in London.

Teacher of Midwifery

Smellie set up first in Pall Mall as an apothecary and practitioner of midwifery. After some while, William Hunter came to live with him and studied under him. Smellie refers to him in some of his notes as having been present and assisted at certain deliveries. At this time, Smellie applied himself to his "machines" and to attending courses of lectures in various subjects. As he says:

"I endeavoured to reduce the art of midwifery to the principles of mechanics; ascertained the make and shape and situation of the pelvis, together with the form and dimensions of the child's head."

It was thus, into the mechanics of child bearing that Smellie enquired and it is significant that both critics and protagonists were united in their admiration of his ingenuity. A student described him as "an uncommon Genius in all sorts of mechanics, which after having shewed itself in many other improvements, he manifested in the machines which he has contrived for teaching the Art of Midwifery . . . They are composed of real bones, mounted and covered with artificial Ligaments, Muscles and Cuticle, to give them the true Motion, Shape and Beauty of natural Bodies, and the contents of the Abdomen are imitated with great Exactness". He also had several foetuses so that he was able to demonstrate all kinds of presentation and delivery.

On the other hand, Mrs. Nihell, a midwife, who delivered a bitter attack upon Smellie, is driven to admit that, "By this admirably ingenious piece of machinery were formed and started up an innumerable and formidable swarm of man midwives".

"On Monday, 14th June, at 5 p.m., will begin a course of lectures on the theory and practice of Midwifery at 11 a.m. for women, and 3 p.m. for men, by Mr. Smellie, at his house in the New Court, formerly the Key and Garter tavern over against St. Albans Street, Pall Mall." So runs the earliest advertisement of Smellie's classes, which appeared in the "London Evening Post" of June 1st, 1742.

The course comprised lectures and demonstrations on the models, and teaching on actual cases. Smellie offered free attendance on poor women on condition that he might bring his students with him.

The cost of a two months' course was seven guineas, that of a six months' course fifteen guineas. In addition, McClintock tells us, each student had to pay ten shillings for a case and six shillings into a common fund which Smellie dispensed to the more needy of his patients.

Dr. Peter Camper, the Dutch anatomist, who had graduated in philosophy and medicine at the University of Leyden in 1746, enrolled in Smellie's class in January 1749. He too, had been dissatisfied with the type of obstetric forceps then in use, and having heard of Smellie's teaching he came to London to see for himself. Camper made notes from Smellie's lectures, which are in accordance with what Smellie wrote later in the Treatise, and he gives a good account of Smellie's teaching.

"He (Smellie) explains the osteology of the pelvis in both a healthy and in a morbid and misshapen state. He explains both their external and internal parts by using the dead bodies of women but much more clearly in other exhibits specially prepared for the purpose.

"He demonstrated parturition in models of women of which the pelvis and spine of a well-modelled woman are the starting point. Both the abdominal and extra-abdominal parts have been made out of leather with such remarkable skill that not only is the structure as natural as possible but the necessary functions of parturition are performed by working models."

During a second visit to London, Camper makes a note on antenatal examination. This is of especial interest as there was very little clinical teaching during the antenatal period.

"I attended Smellie's lesson and examined twenty-one pregnant women between seven and nine months. I was always able to identify the head above the os pelvis, in the ninth month it was low in the pubis. The orifice of the uterus was in all cases turned back against the os sacrum, in some it was open, and it was easy to put one finger sometimes two in."

Camper's notes are invaluable for their own sake and because they show that what Smellie had to offer his pupils in 1750 can still be learned today in his great work, "The Treatise on the Theory and Practice of Midwifery", and in his "Sets of Anatomical Tables".

THE QUESTIONNAIRE

The Student and Emigration

by J. S. Price

IN the June *Journal* Mr. E. A. J. Alment presented a summary of the findings of the Questionnaire sponsored by the Journal Committee. This article is one of a series which deal in more detail with particular aspects of the findings, and which include the results of correlations calculated by the Tabulating Research Centre.

The Questionnaire was circulated to all Bart's students in December 1957, and was answered by 377 (85 per cent) of them. It was made clear at the time that the Questionnaire was anonymous, and that it was the basis of a serious study; in fact, only one of the answer papers included remarks which could be construed as amusing. The

validity of the Questionnaire as a research method will be discussed in another article; but as results are known to depend to a great extent on the way in which questions are asked, the full question and alternative answers provided will be given in each case.

In 1957 there was considerable interest among students in the subject of emigration, and the reasons for it are no less today. A large number of doctors were known to be emigrating, not a few of them being Registrars who found difficulty in getting Consultant posts in England. Therefore those who intended to go in for specialist work were liable to find a pressure on them to go abroad. Moreover the conditions of

General Practice had changed under the Health Service, and there was a possibility that the aspiring Family Doctor would look abroad to find a type of practice which he could no longer have here. Interest was further stimulated by a series of excellent articles in the *Journal* by practitioners overseas.

It was obvious that very few, if any, students would have already made definite plans for emigrating, or indeed would have very definite ideas on the subject. Therefore the object of the survey was to assess the extent to which students had considered emigration as a possibility, and to get from those who had in fact seriously considered it some idea of why and where they wanted to go, and to find out what sort of people they were.

We have left out the answers of the thirty-five foreign and Commonwealth students, which leaves a total of 343.

Interest in Emigration

The first two questions in the series on emigration (Nos. 41 and 42 of the Questionnaire) were designed to discover the main attitudes to the general prospect of emigration:

Have you considered seriously the possibility of emigrating?

	Total	%
Yes	231	67
No	112	33

If your answer to the last question is yes, have you . . .

	Total	%
Decided against emigrating	25	7
Decided to emigrate without or before obtaining specialist degrees	5	1
Decided to emigrate after obtaining specialist degrees	15	4
Remained undecided	60	18
Postponed your decision until after qualifying	102	30
Postponed your decision until after you have specialist degrees	24	7

Thus it appeared that a surprisingly large number of 231 students (67 per cent) had seriously considered the possibility of

emigrating. 25 of these had decided not to emigrate. 20 had decided to emigrate either before or after taking a specialist degree (17 men and 3 women). 60 had remained undecided about it and 126 had postponed the decision until later.

For the sake of simplicity these 231 students will be considered in three groups:

	No.	%
Group I: Decided not to emigrate	25	11
Group II: Decided to emigrate	20	9
Group III: Undecided or postponed the decision	186	80

The Country of choice

Only groups II and III are of interest in relation to the next question.

If you were to emigrate, to which country would you go?

	Group		Total %
	II	III	
Canada	6	57	30
Australia	2	20	10
New Zealand	3	32	17
Union of South Africa	0	5	2
British colony or protectorate in Africa	4	30	16
Other British colony or protectorate	1	7	4
Other Commonwealth country	0	4	2
U.S.A.	3	14	7
Other foreign country	2	21	11

Canada easily heads the list, with New Zealand and the African colonies a fair way behind.

Evaluation of prospects

The next question was intended as an objective assessment of the seriousness with which emigration had been considered; and also as a means of determining the sources of information used in making the appreciation.

Have you, concerning the country of your choice . . .

	Group		
	I	II	III
Talked to people with medical experience of the country	3	73	82
Visited it yourself	5	6	23
Sought information about it from an official body	1	5	32
Read articles about practice in the country	4	12	78
None of these	16	1	57

This shows that as many as 38 students had gone so far as to seek official information (and a further 5 who stated that they had not considered emigration seriously had also done this!). Personal contact with doctors from abroad was the main source of information, but articles on the subject were also of value.

It appears that an unsatisfactory investigation of prospects abroad was not a major reason for the decision not to emigrate.

Reasons for emigrating

The following are possible reasons for emigrating. Mark any of them which are important in influencing you to favour emigration.

	II III Total %		
	II	III	Total %
Better financial prospects and standard of living abroad	11	110	59
Better environment in which to bring up children	9	53	30
More private practice	3	28	15
Travel and adventure	10	90	49
Greater professional freedom	11	65	37
Greater possibility of combining specialist and general practice	7	56	31
Missionary work	2	24	13
Less overcrowding in the branch of medicine you wish to enter	9	73	40
Greater chance of becoming a consultant	3	27	15

What is the most important reason for which you would emigrate?

In answers to this question, the suggested reasons were given in the same proportions as for the previous question, and will not

be presented in detail. However, 61 students gave written answers, approximately as follows:

Too much red tape in Great Britain (7)
I would be more use abroad (5)
To escape from possible Socialism (4)
To join relations abroad (4)
More opportunity abroad (4)
Politics (3)
Overcrowding here (3)
Two gave each of the following:
This country is boring.
The weather.
The National Health Service.
To live in a free community.
Higher standard of living.
The potentiality of an underdeveloped race.
For a change.

And one each of the remainder:

To work with the W.H.O.,
I dislike conditions in G.B.,
Healthy environment,
Better facilities for research,
Angry young man,
To gain experience,
Security for wife and family,
To get a decent job,
Liking for other countries,
Uncertainty here,
To observe foreign methods,
To live in a young country,
Room to experiment in General Practice.

Financial considerations appeared to be the most cogent factor, with travel and adventure a close second (when the ladies are taken alone this order is reversed). Private practice did not seem to be much of a lure, while the mission field beckoned a small but significant group. Although none of the suggested answers expressed a primary dissatisfaction with Great Britain. 28 students gave this in written form in one way or another.

Who want to emigrate?

The main views on emigration were compared with a number of other answers, but on the whole results failed to show up any significant correlation. A slightly greater proportion of public school boys had seriously considered emigration (156 out of 221) than grammar school boys (66 out of 111). Four out of thirty-five students engaged to be married had decided to emigrate, and none not to emigrate, which suggests that

wedding plans and a desire to emigrate are in some way associated. Stage of training, university, political preference, or a medical parent did not appear to affect the issue, nor did the aspiration to any particular branch of medicine. As was expected, those who had never been abroad were less decided in their views.

Emigration statistics

To introduce a little reality into this analysis of aspiration, we will present a few figures on the actual number of doctors emigrating from this country. Unfortunately, these figures are extremely hard to come by, and the lack of information on this subject is perhaps one of the most surprising facts to be unearthed by this survey. The B.M.A. and the G.M.C. were unable to provide any statistics at all, and in fact the only document of any value is the Fifth Report of the Oversea Migration Board, published in March 1960.

This report quotes figures supplied by the Board of Trade for doctors emigrating by sea in 1958: a total of 984 doctors (838 men and 146 women) left this country by *long sea voyage* in 1958 with the intention of staying more than one year abroad. Since a fifth of all emigration takes place by air, and a larger proportion of professional men travel in this way, one might safely add a quarter to this figure making a rough total of 1,230. This, of course, includes many who intend to come back in a little over a year, and it also includes foreign doctors returning home after spending a few years here.

To which countries did these doctors go? We have no direct information on this point, but from a consideration of Commonwealth and Board of Trade statistics we can get a rough idea of the destination of emigrants as a whole:

	%
Canada	17.5
Australia	31.0
New Zealand	9.5
Federation of Rhodesia and Nyasaland	5.0
Other Commonwealth countries and British Colonial Territories and Protectorates	17.0
Foreign countries	16.5
	100.0

These figures relate to the year 1958 when there was a recession in Canada. In 1957 Canada had four times as many immigrants from the United Kingdom.

We do know that in 1958 the United Kingdom supplied 51 per cent of all Physicians and Surgeons immigrating to Canada (compared to 20 per cent of her total immigrants) but unfortunately we do not know the absolute figures.

The published figures give only a very rough idea of the number of British doctors emigrating, and of the countries to which they go.

Summary

In answer to the questions on emigration in the Questionnaire circulated to students in December 1957, 231 of them (67 per cent) said that they had seriously considered the possibility of emigrating. Of these 20 (9 per cent) had decided to emigrate, 25 (11 per cent) had decided not to emigrate, and 186 (80 per cent) had remained undecided or had postponed making a decision.

Canada was the most popular country to emigrate to, followed by New Zealand and the African colonies.

"Better financial prospects and standard of living abroad" was the most favoured reason for emigrating; the second was "travel and adventure".

Interest in emigration was slightly greater in ex-public schoolboys than in those who had been otherwise educated. 38 students had sought information about emigration from an official source.

The few available statistics on medical emigration are discussed; in 1958 about 1,230 doctors emigrated from the United Kingdom, and most of these probably went to Australia and Canada.

AN ADEN JOURNEY

by Alfred Flighswatt

ALL the best travel stories begin at home, with a scene on a bus in London, or a telegram received in the middle of a darts match in a country pub. This one begins on a chilly Sunday morning in September. I had been invited to lunch by a senior official from the Aden Protectorate, and we sat on faded leather upholstery and discussed my future programme. "I wouldn't advise that area", he said to one suggestion of mine. "I was shot at last time I was there." The object of my visit was to be a study of malaria and mosquitoes. There wasn't much we could fix at that range, so I sipped my sherry and left my plans unmade.

I left London a few days later in a Britannia, which flew us more speedily and more comfortably than any other plane I'd experienced. We landed at Khartoum at dawn, and later in the morning we got to our destination. That afternoon I was taken out swimming. It was pleasant to float around the buoyant waters of the Gulf of Aden and to remember that just 24 hours previously I had been drinking mild and bitter with the family in London.

On the 23rd we left to spend a night at a small station in the neighbouring state of Abiyan. The first thirty miles of the route lay along the shores of the gulf, and the road consisted of the top 20 yards below high water mark. The beach was littered with the bodies of dead fish, and the driver told us that this happened regularly at that time of year, which discouraged us from any further speculation on the effects of radioactive fallout in the depths of the Arabian Sea. On arrival at Abiyan we visited a hospital walled off from the desert, where I learnt that one in three of their in-patients were suffering from malaria. We inspected houses in the irrigated area that were festooned with gorged mosquitoes and we sat at night and caught them as they came in to bite.

A day or two later we flew to Mukheiras by the early morning plane. On the way we passed over the Upper Yafi territory, a country I would dearly like to have visited. However I was assured that no Englishman had ever been there, and that the chances of emerging alive were deplorably low. At

that time an outbreak of smallpox was known to be raging among the Yafi people, but the political authorities had firmly forbidden the enthusiastic young public health officer concerned from entertaining any ideas of personal intervention.

Mukheiras is only two miles from the Yemen border, and is one of the main bases from which intrusions by Yemeni tribesmen are repelled. It stands on a plateau which is a contrast of black rocky hills and shallow green wadis. The greenness is mostly due to fields of millet, which are watered by an ingenious system of irrigation from wells, using camels as a source of power. In a stream I found some Simulium (black flies), the first I think to be recorded in this otherwise arid country. In the evening I went out to a neighbouring village to see what mosquitoes could be caught as they came in to bite. In a very short time I was invited over to drink tea with one of the villagers, and since it wasn't dark yet I readily agreed. We passed through a hole in a mud wall, across a courtyard, up some rudimentary steps into one of the first storey chambers. After several cups of very sweet tea spiced with cinnamon I left and went off to do some catches outside. We caught nothing there, so we tried in one or two houses to which we were readily admitted. While this was going on, some Yemeni tribesmen loosed off a couple of shots in our direction, and when the time came to return, I was earnestly requested to put out my torch, and two armed village guards escorted me back to camp. From then on I abandoned night work in that district.

On the 26th we flew off in an R.A.F. Valetta to Attaq, about 100 miles to the east. Attaq boasts a fort standing in the middle of a sandy plain, built along the best Beau Geste lines. There is also a small tented army camp occupied by a detachment of Levies and a few odd British troops, clad in nothing but a pair of shorts and, like myself, dreaming of nothing but pints of mild and bitter. They had my sympathy.

We left Attaq in a battered old three-ton Bedford, and bumped and ground up a wide barren valley. After an uncomfortable couple

of hours, the road wound through a cleft in the hills, and we emerged into a narrow fertile valley, the Wadi Yeshbum, with the town Sa'id at its head. All the houses in Sa'id, as in all the towns and villages of the Aulahi country are simply mud sky-scrappers, tall square buildings with turrets on the roofs and three or four sets of rooms jammed one on top of the other. The rooms have high ceilings and narrow slits of windows, and the massive thickness of the walls evidently serves to protect the occupants both from the midday heat and from the chance of stray bullets.

On the first day we lunched with the Emir. The party included the young British Health Adviser, myself, the Arab political officer, our servants, the Emir and an aged African. "He is my slave", said the Emir "but I treat him like a brother". We left our shoes at the door and sat down on rugs arranged along the sides of the room. My companion had previously explained to me the two important conventions that must be observed; food must be eaten with the right hand only, and the soles of your feet must not be directed at anyone—in other words you may never stretch your legs out comfortably in front of you. The Emir served the food himself. There is quite a knack in eating, if not delicately, then at least efficiently, with one's hand. My first attempts were deplorably clumsy, but by the second meal I was spreading less of it over my face, my knees and the mat. From time to time our host would pass across some specially choice pieces of meat, which I had to accept even though they usually arrived when I had decided I had eaten enough and was attempting to withdraw from the fray. Tinned fruit was served—doubtless for our benefit—and this was followed by an awkward interval during which one was left wondering what on earth to do with a greasy right hand. However, soon afterwards, the slave, who by then was being treated as very much the younger brother, came round with a bowl and soap and water, and we were able to settle down more comfortably on our haunches. A curious brown liquid, described as coffee but tasting like a hot infusion of ginger, was then handed round, followed by several small cups of the usual spiced tea. The political officer then gave us the cue to go, and after he had made a little speech on our behalf, we replaced our shoes and left. At the door I produced my two words

of Arabic meaning, I hoped, "Thank you very much", to which the Emir replied, a little ambiguously I thought. "Please do not thank me. It was a duty".

The Protectorate is an incredible place. You are not permitted to walk around the country without an escort of two or three armed guards. One day I decided to cheat my jailers, and slipped off up the rocky hillside behind my quarters. For a time I enjoyed the solitude and barrenness of it all, but I was soon startled to see a ring of stealthy figures closing in on me. Their shouts soon proclaimed that they were my own guards calling to their officer that they had found me. On my return I received a respectful reprimand from him. "In this country", he explained, "people like to shoot at strangers, just for fun." I was perfectly prepared to believe it. The front of the rest house where I stayed was pitted with bullet holes, dating, so I was told, from the previous year when the opposing political faction had crossed the tenuous line that separated "loyal" from "dissident" tribesmen, and kept up a regular nightly sniping of the house whenever the British Political Adviser was there.

It is a wonder that, quite apart from the people, any bird or animal is left alive in the country. I was out another day with my escort who were more than usually boyish. A magnificent eagle escaped destruction by shifting off its perch while the first trigger pressure was being taken. Farther on, an eagle owl that had ventured out of hiding was pointed out to us by a passing stranger. The unfortunate bird sat blinking in the sunlight while bullets (at something like 2s. 6d. a time) smacked into the rocks around it. A glancing blow eventually brought it tumbling down the rocks to fall at our feet alive and still blinking. My escort then amused themselves by prodding and teasing it, much as small boys will play with something that is too fierce to handle.

I spent an energetic week up and down the sandy river bed of the Wadi Yeslibum. The main valley at that season was as dry as the desert itself, but up the gorges and side valleys there was always an abundance of pools and little streams that formed the foci from which malaria and bilharzia were contracted. I suggested once that I should take an escort with me and see what could be caught biting at night in one of these valleys. The plan was promptly vetoed by

the Arab Political Officer. The Chief Minister of State, when he heard about it, said it *could* be arranged but that guards would have to be sent to occupy the neighbouring peaks first; so I let the matter drop.

Another excursion took me to Beihan. This had been the centre of much recent skirmishing with the Yemenis, and at that time there was a battalion of Levies stationed there. The Levies produced a 3-ton truck for me and an escort, and sent me off to their outpost, Negd el Masr, 20 miles away. There was one British officer there and a number of Levies. There had been no shooting in the valley for a couple of weeks so I was told that, in the daytime, I could go anywhere I wanted provided I kept away from the border, which lay about half a mile beyond the camp. I visited it one morning ostensibly to do some catches, but in reality to have a good look across into the Yemen. Breakfast was laid on for me after which the guards described their prowess in recent actions; photographs were posed to show them shouting imaginary Yemenis, and only after considerable delays did I get any work done. The fighting at that time was an exaggeration of normal tribal feuds, instigated by the Yemenis on one side, and resisted by the Sultan of Beihan, with our support, on the other. It was rumoured that, when the Yemenis showed signs of losing heart in that sector, the local Protectorate tribes would fire over the top of the army camp to make sure that we did not evacuate the area.

The work in the valley was unusually profitable. At night the place hummed with mosquitoes, which proved to be of a little known variety. One evening I obtained permission from the C.O. to visit the nearest village after dark. We were about to depart when the senior Arab warrant officer came into the mess and said, "Sir, I think it is very unwise to proceed. They may see the lights of the car going out and lie in wait for its return". Eventually it was agreed that we could sally forth provided the lights of the car were put out. The moon was not yet up when we left, so we set off in the darkness.

Nothing happened, of course. In the village we were greeted with enthusiasm and led upstairs to a room full of old men sitting round smoking a hubble-bubble. I issued test tubes to the small boys of the house, and they hopped from crone to crone picking off anything that had six legs. After a

time one of the men got up and, taking a couple of tubes, announced that he would see what there was in the harem. Giggles from a neighbouring room suggested that he was actively engaged, but as he came back empty-handed I was left in doubt as to the single minded nature of his search. We returned to the camp in bright moonlight, feeling as conspicuous as a stage hand caught before the audience as the curtain goes up. Once near the camp the worry remained as to whether the guards would remember that we were out and would refrain from opening up on us.

The last of my visits was to Mukalla, the main port of the Eastern Protectorate or Hadhramaut. Eastern Aden is very different from the west. It is above all peaceful. Mukalla is an old Arab town with fine stone houses encircling a wide bay. Beyond the town the bay is fringed with sand dunes; behind, there are jagged red mountains which, with the intense blue of the sea and the white washed houses between, make a dazzling contrast in colour.

The four days I had in Hadhramaut were busy ones, beginning with breakfast at six, and ending with a race against time to get through the field work before it got dark soon after half-past five in the evening. Much of my time was spent in the brackish lagoons along the shore. Apart from these there was little to detain us apart from the pelicans paddling in the sea, the regiments of fiddler crabs that scuttled out of the way of the advancing car, and in one place the whitened bones of a whale and in another the battered skeleton of a plane. The lagoons are known to the few Englishmen in the country as profitable spots for shooting duck. To myself, they are memorable as the home, in little pools encrusted with salt, of a mosquito that somehow survived into the second half of the twentieth century without the dignity of a scientific name.

On my last evening in Mukalla we were invited out to dinner by the state customs officer, a Pakistani. The dinner proved to be an enormous affair. My English host insisted on issuing me with a *futa*—the long Arab sarong—and then added insult to injury by producing a pair of nylon underpants with all that implied as to my experience of squatting on the floor. I complied with his wishes and followed him into the house, trying not to trip over my skirt as we climbed upstairs. The party was held

on the roof. There must have been sixty people present, including the British Political Adviser, in the same attire as ourselves, the Prime Minister of the State (himself a Pakistani), the Sultan's 12-year old son representing his father, and three English women. We all sat down to dinner on Persian rugs with which the entire roof had been covered for the occasion. The food was laid out in rows of dishes spread on the floor on tablecloths 40 feet long, and when it had been served there was a dignified rush to get the best places. We plunged our hands into communal bowls in appropriate manner, and as soon as we had finished, our places were taken by the servants and hangers-on. And no doubt, if there was anything left after that, the remnants were gathered and sent down to the women and children.

Next day I flew off to Aden, clasping a precious bundle of live mosquitoes. My solicitude was in vain since they were all dead on arrival. Two days later I was back in Africa in the damp forested hills of the Tanganyika coast, a contrast as great as any I had experienced during the previous six weeks.

Epilogue

In the annual report of the Aden Protectorate Health Service for 1957 the following note appeared. I quote it in its entirety;

"Section 12. *Noxious Animal Life.*"

73. Dr. Flighswatt of the East African Institute of Malaria and Vector borne Diseases, Amani, Tanganyika, spent a month mostly in the West.

LETTER TO THE EDITOR

Dear Sir,

In the July issue of the *Journal* you have published a number of interesting statistical analyses of student opinion in relation to aspects of medical education.

With regard to teaching in particular, it is more than possible that the conclusions drawn or implied are fallacious. Student opinion is subjective rather than objective and invidious comparison between departments may be explained, partly at least, in terms of student attitude towards those departments and the subjects taught there.

In my experience it is unusual for a medical student, even in his final year, to have any appreciation of the value of a knowledge of pathology in relation to his over-all medical education. The realization that this subject is the key to clinical medicine only comes to him when he is faced

with his final examinations, or even in his next year when he is busy bridging the gap between his theoretical knowledge and the practical application of it.

In the departments of bacteriology and pathology there are individual members of the staff whose value as lecturers is well recognised in other parts of these islands and abroad, if not at St. Bartholomew's. Lectures and demonstrations in a medical school have no higher value than that of giving perspective and emphasis. The facts are available in text books.

In the final analysis the student is, in fact, *self-taught* and it is high time that the Bart's undergraduate recognised the difference between teaching and learning.

Yours Truly,
Donald Fraser

73, Harley Street, W.1.

BOOK REVIEWS

FURNEAUX'S HUMAN PHYSIOLOGY: The Nurses' Edition, by William A.M. Smart (1960). Published by Longman's. Price 13s. 6d. This textbook has been thoroughly revised and brought up to date, especially the sections on ligaments, cartilages and joints.

It is a book which makes interesting and informative reading especially to a nurse who has already a basic knowledge of Anatomy and Physiology. However, it is not an easy book for quick reference and contains more detail than is necessary for the Preliminary State Examination.

The illustrations and diagrams are clearly and easily understood. A number from the previous edition have been replaced by modern ones.

This book should be read by trained nurses who require more detailed information on physiology throughout their career.

J.G.

FAMILY PLANNING. J. F. Robinson, M.B., Ch.B. E. & S. Livingstone. Price 3s. 6d.

This sensible book gives concise and clear advice on modern methods of birth control. The illustrations are simple and good, the text not technical—and should be easy to understand by an intelligent layman. There are some rational arguments on the benefits of Family Planning and this book will provide adequate information to all those interested.

J.D.P.

AN APPROACH TO OCCUPATIONAL THERAPY—by Mary S. Jones. Butterworths. Price 42s. pp245.

To quote the author of "An Approach to Occupational Therapy", the work at Farnham Park is the specialised treatment of the short term patient with the expectancy of a quick return to a normal life in a professional or industrial capacity.

In this book Mrs. Jones has succeeded in showing the relationship and co-operation between the various departments concerned with the treatment of the patients at Farnham Park, whilst discussing in detail only the work carried out in the Occupational Therapy Department.

The author has shown us how each patient is approached and assessed both physically and mentally. She then gives detailed descriptions of the various pieces of equipment in use in the Occupational Therapy Department, together with excellent diagrams and photographs, besides clearly showing the movements involved in the use of the equipment and the subsequent therapeutic value. These descriptions also apply to the outdoor activities used, such as gardening, log sawing, etc.

This book will be of great value, not only to Occupational Therapists and those working in Physical Medicine Departments, but also to anyone who has interest in the complete rehabilitation of the patient after his discharge from hospital.

P.M.A.

LIFE'S LONG JOURNEY—by Kenneth Walker. Gollanz. Price 21s.

In this book a distinguished scientist and surgeon considers the effect of science and the "scientific" attitude to life on our understanding of man, his beliefs, and the moral, political and economic problems which confront him. Mr. Walker states in his preface, "this book is the story of the long journey made by life since it first appeared on this planet in the simplest single cell form, many millions of years ago". But the author does not give us another history of evolution; he is more concerned with the nature of life, as the quotation, from G. Lowes Dickinson (which appears twice in the text) indicates:

"Man is in the making, but henceforth he must make himself. To that point nature has led him out of the primaevae slime. She has given him limbs, she has given him brain, she has given him the rudiment of a soul. Now it is for him to make or mar that splendid torso. Let him look no more to her for aid; for it is her will to create one who has the power to create himself. If he fails, she fails; back again goes the metal to the pot, and the great process begins anew. If he succeeds, he succeeds alone. His fate is in his own hands."

In developing his thesis that mankind's future depends upon the primacy of personal religion *vis à vis* the 19th Century scientific attitude to life, the author quotes extensively and powerfully; this book obviously reflects a life-time's reading and research, followed by study and reflection. The author is not portentous, and has the gift (so often denied to philosophers and theologians) of writing on intellectual issues in a sober, matter-of-fact way, without solemnity or obscurity. His twelve chapters are almost miniature books, full of interesting facts, ideas and discussion.

After preliminary chapters in which he attempts to define the place of scientific thought in our thinking and the contributions to scientific method of Galileo, Frances Bacon and Locke, Mr. Walker deals with the assumption that the human mind is objective in its outlook, and arrives at its conclusions without being deflected from the truth by any innate bias, discussing (with support from G. M. Tyrell and Bergson) the conditioning to which man's mind is subject.

The chapters on evolution contain a masterly summary of the development of Charles Darwin's thought and the controversy which followed the publication of "The Origin of Species", and a fascinating survey of geology and pre-history. Passing glances at the psychologist Gurdieff whet the appetite for more.

Briefly, the author concludes that evolution cannot be explained or accounted for in terms only of chance, mechanism or natural selection: it is impossible to incorporate the wealth of thought which he displays in a brief summary.

For the layman (and Mr. Walker claims to be writing for the general reader rather than the specialist) the last three chapters are (perhaps) the

most valuable and stimulating; they are headed; "Man's Political Future"; "The Scientist's view of Man's Future"; and "Where will the Long Journey End?"

Among the topics in this section are the world wide shortage of food, the problems of the genetically unfit, the expansion of China—"According to reports of travellers returning from Communist China, maps predicting the future are to be found in Peking which place the limits of the Yellow Empire somewhere west of Moscow and east of Berlin, in approximately the same latitudes as the frontier marked out in the same latitudes as the frontier marked out in the thirteenth century by the Mongolian Conqueror Ghangis Khan."

We find the opinions of H. G. Wells (who never claimed to be a scientist but is included as being keenly interested in man's future) alongside William James, Julian Huxley and Alex Carrel.

Finally the author deals with the role of religion—in the wider sense of that much abused term—and suggests that it is to religion that "man will have to turn for help if he is to evolve any further, for religion affects the whole of man and not merely his reason". He is convinced of the validity of religious experience, and comments on the complete agreement between those who have used the methods prescribed by religion; "It matters little whether the person reporting on their use be a Christian, a Vedantist, a Buddhist, a Sufi or an ordinary Moslem for it is obvious that he has obtained from their employment similar results".

What is the cause of the rapid decline of religion in the West?

Mr. Walker states that one factor may be the long term rhythm in man's thinking, the swing between materialism and idealism noted by historians; another factor may be of a social nature (here the author quotes a writer in *Hibbert's Journal*)—the rift between institutional religion and the proletariat which goes back to the Industrial Revolution. It is certainly true that in the age of the affluent society organised Christianity has failed to engage with the most typical members of this society, the technologist and the industrial workers.

Arnold Toynbee's prediction that the Western World will adopt what he calls an "oriental religion" by which he means "the Christian religion that came to the Greeks and Romans from Palestine with one or two elements of traditional Christianity discarded or replaced by a new element from India" is quoted with approval.

Perhaps religion syncretism will regain ground in the future, but if it does we should not forget that such a viewpoint in effect denies the claim of certain religions, Christianity pre-eminently among them, that they stand on certain historical events—for the Christian, faith is a compelling divine gift—for the student of religions it is a matter for discussion.

In an epilogue Mr. Walker returns to Gurdieff's teaching as a further aid to man's evolution apart from those provided by religion. Because man's "knowing" has so distastefully outstripped his "being" it is necessary to achieve a higher level of consciousness.

In our contemporary situation concludes Mr. Walker we can derive comfort and a sense of perspective "by viewing all passing events under the aspects of eternity".

This same volume, disturbing and yet stimulating, written with authority deserves to be widely read, and should contribute to a new quality of life which our affluent society needs. It is a commentary on the words of the Frenchman, Pierre Teilhard de Chardin (p. 280 of "The Phenomenon of Man") "when mankind has once realised that its first function is to penetrate, intellectually unify, and harness the energies which surround it in order still further to understand and master them, there will no longer be any danger of running into an upper limit of its florescence".

R.H.A.

DeWEESE & SAUNDERS: TEXTBOOK OF OTOLARYNGOLOGY. (Henry Kimpton). Price 65s.

On opening this book the reader should remind himself that the American language is not the same as that spoken on this side of the Atlantic. Perhaps then the style would not appear to be "heavy going".

From the students' point of view (and the foreword recommends the text to students and general practitioners) its reading would be unwise as it could only be muddling; too many American methods in surgery differ from ours and treatments vary considerably.

Most of the diagrams and photographs, notably those by Dr. Hollinger, are excellent, and there are one or two hints that a trainee otolaryngologist could find "profitable"—in fact if such a man had time to spare and could overlook the verbose style, he would also find some American methods surprising (e.g. the recommendation of local anaesthesia as the best for tonsillectomy). But for students such clinical descriptions as "The patient recovered without treatment, except reassurance, and then relapsed. He had no symptoms." could surely not help to gain an M.B.

A.F.

CHRISTMAS CARDS

Journal Christmas Cards will be printed again this year. Cards depicting the Henry VIII window in the Great Hall will be sold at 4½d. each (including envelopes) Orders will be taken by the Manager of the Journal. Please write placing an order as early as possible.

SPORTS NEWS

Viewpoint

Although this is not the number in which the Hospital pays tribute to Sir James Paterson Ross on his retirement, it is better late than never to mention the great interest Sir James has always shown in the sporting activities of the Hospital.

He has been both President and Vice-president of a great number of clubs, and this has been more than a mere nominal interest. In spite of what must have been overpowering commitments from the Hospital and the Royal College of Surgeons, he often went to great lengths to keep himself up to date with events in the clubs with which he was connected. The Cricket Club, in particular, is very grateful for the great help and attention he has given, in the 12 years in which he has been a Vice-President.

One of the clubs which has been having a remarkably successful year in a very unobtrusive manner, is the Sailing Club. During this summer, it has won a great number of trophies, the reports of which appear in this issue. These have not all been in United Hospital events. Perhaps the greatest achievement of all was the Ariel Cup, which was an event open to the country, won during Burnham week recently. Most of the successes have been due to Bill Fischer, and the club is lucky indeed to have a helmsman of his class. But credit must also be given to all others who have taken part.

Sailing Club 1959-1960

Under the auspices of our Commodore, Mr. Alment, to whom we are grateful for his active participation while still with us, and his good wishes, now that has left London, the club has had a successful year—success, that is, not only in competition, but in consolidation.

Since it is customary to direct attention to the least spectacular—that is not to say the least important—first, and thence through events of more immediate charm to a final apocalyptic event, thus hoping to instil a sense of impending climax to the reader, we will first consider what consolidation has taken place.

Surely one of the tests of the health of a club, like that of a gentleman, is to observe how it, or he, behaves when on its own. Admirable opportunity of this was afforded by the annual regatta held early in the year at the United Hospital's Club in Burnham. In spite of the strong N.E. wind which paradoxically brought sailing to a standstill on the second day, enough races were held to decide who should hold the various cups for the year. Races, that is, characterised by a gay disregard for the international rules and conventions.

The occasion of the regatta coincided with the annual dinner held in the Royal Burnham Yacht Club at which the cups were distributed.

Open Race—R. C. Birt
1960 Cup—D. M. Howells
Ladies' Race—Miss J. Hartley

In view of the support received at the regatta, it was decided that the time was ripe for a major attempt to spread the cult of yachting in the Hospital. Expeditions of novices have therefore been taken to the Welsh Harp by club missionaries, and it is hoped to continue these throughout the winter. In preparation for this the Club Firefly—Rahere—has been re-fitted in Charterhouse Square.

The winter series on the Welsh Harp has already been referred to in a previous issue of the Journal, but the ill-luck which followed us there was dispelled by the stronger winds of Burnham-on-Crouch, where, thanks to the superb helmsmanship of W. A. Fischer, the club has excelled itself, and swept the board, winning:

The Sherren Cup—held at Whitsun—
The Banister Cup—Inter Hospital series—
The Harvey-Wright Gold Bowl—on September 3rd.

Not content with this, W. G. Fischer went on to win the Ariel Cup—an open event for Sharpies—during Burnham Week.

Finally, the club would like to express its grateful thanks to the Students' Union for a capital grant to buy a new boat. A National Enterprise dinghy has been decided upon, and, complete with trailer it is hoped to enter a new class of racing.

D.H.O.

Rifle Club

St. Bartholomew's Hospital Prize Meeting

The Prize Meeting and the annual match for the E. B. T'Anson Staff v. Students Challenge Cup were held at Bisley on June 26th. Weather conditions were good, with only a moderate wind, and good light. The Benetfinck Challenge Cup was awarded this year on a dropped points handicap basis, the competitors being grouped according to their capabilities and experience. The staff team was strengthened by the addition of two past members of the Club.

H. J. Waring		
Challenge Cup:	A. M. Pollock	96
runner up:	A. A. Lewis	92
Benetfinck Challenge Cup:	A. M. Pollock	96
runner up:	Miss J. G. Stephan	94.8
Donegal Badge:	P. N. Riddle	91
E. B. T'Anson Challenge Cup:	The Students	

The Students	The Staff
A. M. Pollock 96	Mr. J. D. Hobday 96
P. N. Riddle 91	Mr. J. Elgood 91
A. M. Ward 91	Mr. G. L. Bourne 89
	Dr. F. T. J. Hobday 88
F. I. R. Hardy 90	Mr. G. R. Hobday 87
Miss Z. Gardner 87	Mr. H. Jackson
M. T. Barton 79	Burrows 68
534	519

N.R.A. United Hospitals Cup

The Hospitals Cup at the Imperial Meeting was shot for on Friday, July 4th. in heavy rain. Conditions were not easy but scores in general were high. The Hospital "A" team were unfortunate to be placed only third, behind The London and Guy's "A". The "B" team was placed fifth.

London Hospital "A"	379
Guy's Hospital "A"	376
St. Bartholomew's "A"	374
	200 500 600
A. M. Pollock ...	35 33 32 100
P. N. Riddle ...	33 34 31 98
Miss Z. Gardner	32 31 33 96
A. M. Ward ...	30 20 30 80

The full-bore season was finally closed with another match against the Staff, the match being held at Bisley on September 4th. Weather conditions for this, the last

match, were good, and the only rain came at the luncheon interval, and after shooting had finished for the day. The match, which consisted of 2 sighters and 10 to count at 200, and 2 sighters and 15 to count at 500, resulted in a narrow victory for the Students.

The Students	The Staff
P. N. Riddle 116	Mr. G. L. Bourne 113
	Mr. G. F. Abercrombie 113
M. T. Barton 109	Mr. R. P. Ellis 113
A. M. Ward 108	Mr. H. Jackson
A. M. Pollock 106	Burrows 103
Miss A. M. Holloway 102	Mr. R. C. Farrow 91
541	533

The Small-bore Season 1960-61

With the loss of the rifle range in the Hospital after December of this year, it has been decided that the number of teams run by the Club will have to be reduced. Both Standing and Kneeling teams have been dropped, as has one of the Pistol teams, and a Lloyd Cup team.

The following teams are being entered this season:

- United Hospitals Lloyd Cup: One team.
- United Hospitals Tyro League: Two teams.
- University of London Pistol League: One team.
- National Short Range League: One team.
- Browne Martin Competition: One team.

Chess Club

The Chess Club has had a fairly successful season. We have retained the Hospitals Cup and managed to stay in the 1st division of the University of London Chess League. Few people seem to realise that, apart from the invincible Ladies Hockey Club, we are the only club in the Hospital to have the Cup for the second year running.

In the league, after a poor start, the 1st team improved and made certain of its place in the league by defeating U.C.H. at the close of the season. In the Cup, we reached the final by beating St. George's easily and the London with difficulty. The final was contested with Guy's.

A good meal and a display of the Cup were calculated to rouse the fighting spirit of the teams and a very good match it turned out to be.

Bart's: D. J. P. Gray; G. Gardos (Capt.); P. M. Perry; R. Harrison; A. MacFarlane; R. Zeegan; were soon in trouble. In spite of Perry's spectacular win, which he achieved in excellent attacking style, quite early on. Bart's were 2-1 down after 1½ hours play. Then Gardos won though after a very exciting game to make the score 2-2, but the prospects in the remaining games were gloomy for Bart's MacFarlane was struggling

against a strong attack and eventually succumbed. Gray, though attacking well, had already used up nearly all of the allowed 1½ hours and found himself in a very complicated position, but, with seconds to spare, Gray managed to get out of time trouble, avoiding disqualification, and went on to win.

The final result was 3-3. By eliminating the result of the bottom board, Bart's won the match and thus retained the Cup.

About 30 gentlemen have joined the Chess Club this year and special mention must be made of T. Harcup for his continued good play during the season.

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- *KOK, D'Almero (and Wild, F.) Serum iron determination. *J. Clin. Path.*, 13, May, 1960, pp. 241-5.
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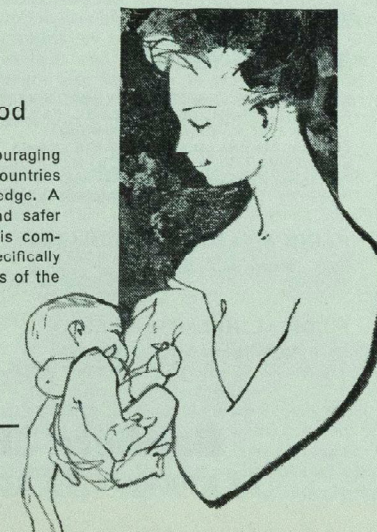
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ST. BARTHOLOMEW'S
HOSPITAL JOURNAL

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NOVEMBER, 1960

Calendar

DECEMBER

- Thurs. 8—Squash v. Jeu de Paume (H) 6-30 p.m.
Sat. 10—On duty: Dr. G. W. Hayward
Mr. A. W. Badenoch
Mr. R. W. Ballentine
R.U.F.C. v. Rugby (H)
Tues. 13—Squash—Cumberland Cup
Wed. 14—A.F.C. v. U.C.H.
Thurs. 15—Squash v. Aspro (A) 6-30 p.m.
Sat. 17—On duty: Dr. E. R. Cullinan
Mr. E. G. Tuckwell
Mr. C. Langton Hewer
R.U.F.C. v. K.C.S. Old Boys (H)
A.F.C. v. King George's House
Y.M.C.A. (H)
Sat. 24—On duty: Medical and Surgical
Units
Mr. George Ellis
Sun. 25—Christmas Day
Mon. 26—Ward Shows
Tues. 27—Ward Shows
Wed. 28—Pot Pourri
Thurs. 29—Pot Pourri
Fri. 30—Pot Pourri and Party
Sat. 31—On duty: Dr. R. Bodley Scott
Mr. A. H. Hunt
Mr. F. T. Evans
R.U.F.C. v. Old Rutlishians

Editorial

THERE have been several inconclusive discussions about the structure of pre-registration appointments. The suggestion of having an extra pre-registration year was, for example, discussed in 1959 by the B.M.S.A. For those who favour the idea, the course seems clear. Knowledge has increased and experience must go hand in hand. The obvious solution lies in further training. And nobody is able to deny the advantages of progressing to obstetrics and paediatrics after medical and surgical jobs. A clever M.P. might also be quick to realise how some of the problems of staffing hospitals at a junior level could be overcome in this way.

On the other hand is the student who is forced to proceed through a long and, in so many ways, outdated medical training. At the end of this time he emerges from his final examinations with registration only a year away. When registered some will choose to do a further house appointment, some may decide to spend a year as a trainee in a general practice.

If there is to be a change, two important things must be remembered. The first is that if the time before registration is to be lengthened, there must be an honest effort to shorten and change the course before the final examinations. The second point of importance is that any deliberations about the changes must be conducted openly with

full representation from hospital staff and Ministry Officials.

It would be very unfortunate for any government to link a change in the structure of house appointments with, for example, an increase in salary. The connection would appear almost intentional instead of a coincidence resulting from an honest wish to increase salaries, an appreciation of a need for further experience and a problem of staffing hospitals.

However, it has been reported that the Government have plans to increase the pre-registration period from one to two years, at the same time increasing the salary to £820. On October 28th, the *Evening Standard* described the Government's behaviour on the matter as "furtive." On the same day there was an official denial from both the Ministry of Health and the General Medical Council. It is very reassuring to think that all these rumours have been officially denied. But until the matter is settled there will be some who are suspicious of what might follow the rise in salary.

Quidquid id est, timeo Danaos et dona ferentis.

Fifty Years Ago

A Case of Loss of Memory.

The following case may be of interest to readers of the *Journal*.

While on duty as house-physician in the surgery in 19—, a patient was brought in at 5-30 p.m. complaining that she had completely lost her memory. The patient was obviously an educated girl, about twenty-three years of age. The patient, who spoke with a slight American accent, stated that about midday she found herself in Lincoln's Inn Fields without the slightest idea who she was; she looked in her pockets and found her name on her handkerchief, and a small piece of paper with a number written on it, together with the names of several towns in England, and on the opposite side the surname of a person, B——.

Being rather busy I asked the patient to sit down for half-an-hour. At the end of this time the patient was getting very anxious but was not at all desirous for me to communicate with the police. This made one think that the case was possibly not genuine.

The patient was then left for two hours, and at the end of this time she could remem-

ber that she had had an operation on her knee by a surgeon in Harley Street, and that she had been to America.

I rang up the surgeon on the telephone and he remembered the case perfectly, and was able to say to whom the name B—— on the paper referred.

Thinking by this time that the case must be genuine I decided to try a method that had been successful in somewhat similar cases before. The method, shortly, is this—first to get the patient to think of some piece of furniture in a room in which she has slept. In this case I suggested the wardrobe. Having got this point in memory, the next thing to do is to make up a probable story of what the patient did. The patient is then often able to contradict it and say what did happen. In this way it is possible to advance from one point to another. In this particular case my object was to try and make the patient's memory travel from the room in which she slept to the dining-room and then out into the street, and then to remember the number on the door as she left the house, but in this I was unsuccessful; she could only remember the colour of the door. I will not put in all the stages which eventually led to the complete recovery of her memory, but will quote one of the "probable stories." The patient's memory had got so far as to remember that she was at one time in Birmingham.

So I said, "Then you came by train to Paddington?" She replied, "No, I came to Euston." "You then took a cab and paid him?" "No, I took a taxi, the fare was 4s. 6d." "You then told him to drive to —?" "But here the memory was blank: The patient remembered passing a big hospital supported by voluntary contributions, after passing "Jay's" in a park. This was obviously St. George's.

In this way it took two and a half hours solid conversation of the above description to get the patient's memory back to the address she was staying at, and the name of her relations who owned the house.

Most people who read the above case will possibly be inclined to think that it was not genuine. I can only say that all the nurses and people who saw the case believed it genuine; and in my mind there is not a shadow of doubt, as I have seen the patient once or twice since, and am indebted to her for permission to publish the case.

News in Brief

SIR JAMES PATERSON ROSS gave his last lecture, as a member of the staff, at Charterhouse. Although it was primarily intended for the new pre-clinical entry, the hall was packed with all members of the hospital.

SIR GEOFFREY KEYNES, at the first British Congress on the History of Medicine and Pharmacy, was awarded an Honorary Fellowship.

SIR GEORGE AYLWYN has retired from the presidency of the Medical College. Our next issue will have a report on the ceremony in which Sir George was installed as an Honorary Perpetual Student of the Hospital in appreciation for all his work.

MR. M. W. PERRIN of the Wellcome Foundation is the newly elected President of the College.

MR. H. B. STALLARD has been elected an Hunterian Professor of the Royal College of Surgeons, 1960-61.

THE NEW PATHOLOGY Lecture Hall and Class Room are nearly completed. A short trial of the seats has shown that they are very much more comfortable than the new seats in the Clinical Lecture Theatre!

A NEW DINING ROOM for the House was opened on November 14th. It is situated in the basement of the hospital between the medical and surgical wings.

TWO COPIES of a new manual for official visitors to hospitals are being sent to every Hospital Management Committee in the United Kingdom. Committee members are advised that their own powers of observation may often be a surer guide than answers to questions. Later there is a note of caution, "It is inadvisable that matters of policy should be discussed, or promises made to members of the staff, while going around the hospital."

Students' Union

Finance was the main subject of discussion at the Council meeting held on September 14th. The president, Mr. A. H. Hunt, took the chair. Following discussion on a Financial Committee recommendation, the Council decided that future club tours would be financed from a separate tour fund. This fund would be distributed amongst the clubs on a man-per-day basis, allowing for a reasonable number of players and reserves. To avoid interference with tours previously arranged it was decided that of the £189 available this year the Rugby Club should receive £100. The remainder, plus £50 from either the 1959-60 budget surplus or from the contingencies fund, would be allocated to the other clubs for tours on the man per day basis.

A copy of Standing Orders on Procedure at Meetings of St. Bartholomew's Hospital Students' Union was considered and approved by the Council.

As there was a strong desire within the student body to mark the retirement of Professor Sir James Paterson Ross and to show their appreciation to him, the Council decided to organise a presentation to which all students were invited to subscribe.

Mr. Hood reported that dances for the remainder of this year had been allocated as follows:

October: Boat Club.
November: Soccer Club.
December: Rugby Club (Ball).

This was at the rate of one dance per calendar month which was in accordance with the last instructions received from the Warden of College Hall.

Rifle Club: (a) Honours Colours were awarded to two members of the Club; Miss A. M. Holloway and Mr. A. M. Ward.

(b) Mr. Waid pointed out that since the Club had been unable to use the miniature range at the Hospital, the G.P.O. had kindly offered the use of their range every Wednesday afternoon. Any student wishing to avail himself of such facilities should apply to the Rifle Club for the necessary permit.

Mr. Hunt also presided at a Meeting of the Students' Union Council held on Wednesday, October 12th in the Recreation Room at Charterhouse Square.

Mr. Hood reported that he had obtained a William IV sugar basin (1834) for the presentation to Professor Sir James Paterson Ross on the occasion of his retirement.

Mr. Howes explained that the Medical College had decided to institute parking rules at Charterhouse Square. This was necessitated by the building development due to start this term on the present car park. Students had been granted the use of the car park behind College Hall. Short term parking of up to two hours would be allowed throughout the day in certain areas of the square. The Council decided that the car park allotted to students should be reserved for residents but hoped that future development plans would include facilities for student parking.

Mr. Hood reported that Mr. Ellis, the Warden of the College, had decided that one dance per month would be allowed for the time being and in due course the position would be reviewed. The Sub-Committee on Dances set up in June was thus disbanded.

The Council agreed to send three student representatives to the forthcoming Annual General Meeting of the B.M.S.A. to be held at Whitley Bay on November 11th, 12th and 13th. A grant was allocated to these representatives, who would be empowered to speak on behalf of all Bart's students.

Mr. Thomas informed the Council that stricter fire and seating arrangements would have to be enforced at the next Pot Pourri to be held on December 28th, 29th and 30th, at the Cripplegate Theatre. All scenery had to be fire-proofed and no standing would be allowed in the balcony. Regarding Ward Shows Mr. Thomas stated that they would not be held on Christmas Day this year, it being a Sunday.

Abernethian Society

On October 13th, the Society was addressed by Lord Cohen of Birkenhead. He took as his subject, "Straight Thinking in Medicine." He commenced by stressing that to apply logic to medicine, it was necessary to start with facts and that these should be clearly distinguished from opinions. He also compared the physical examination of the patient with a painting which could be excellent but there could still be various interpretations of what was seen unless the previous events were known. Lord Cohen then went on to describe and illustrate eight of the possible errors of logic that were frequently per-

petrated once the facts and the history were known. One of the first errors was generalisation from inadequate data. This was at times inevitable in medicine and such aphorisms as "commonest things are commonest" had their value, though the concept of all symptoms being covered by one diagnosis was erroneous. In fact, more than one diagnosis was possible providing that there was not an unnecessary elaboration of diagnosis.

Premature extrapolation from inadequate data was a common fault as was also the "*post hoc ergo propter hoc*" type of fallacy. It was often observed that a patient improved after treatment though his rate of recovery without treatment might have been as rapid. Argument by false analogy and complete faith in authoritative statements also led to error. When Vesalius examined the intraventricular septum, he found no channels as required by the Galenic theory, but was satisfied by the comment that "We are driven to wonder at the handiwork of the Almighty that blood can sweat from the left to the right side of the heart without there being visible pores." He thought that in modern times, no work could be done without accepting authoritative statements but if these clashed with observation they should be challenged. Allied to this was the "*argumentum ad hominum*" and finally the fallacy of figures which had been aptly exposed by Schiller who had said that "Nothing has a greater effect on the human mind than nonsense supported by technicalities." Lord Cohen concluded by wishing success to the freshmen present at the meeting and an entertaining vote of thanks was proposed by Dr. Cullinan. The meeting was held in the Great Hall which was warmed by enormous fires in the grates and provided a delightful setting for the occasion.

January—December, 1960

President: Miss J. E. Angell James

Secretary: Dr. J. C. Crawhall

Treasurer: P. J. Watkins

Committee: H. White, R. J. Wilson, T. Hudson

Charterhouse Representative: M. Lipsedge

Presidents of the Abernethian Society have been made Honorary Life Members of the Students Clinical Society, University College Hospital, Ibadan, Nigeria.

XIV Decennial Club

The fifth Annual Meeting is to be held this year in the White Hart on Saturday, December 10th from 6-30 p.m. to 11-30 p.m.

There will be a running buffet and drinks available at bar prices. Subscription for those attending is 10s.

All those who entered the Medical College either in Charterhouse or the Hospital direct between 1945 and 1955 and who are now qualified are eligible as members.

The Hon. Secretaries would be grateful to receive notification of any changes of address.

Medical Staff

SURGICAL PROFESSORIAL UNIT.—Director: Professor G. W. Taylor, October 1st, (succeeds Professor Sir James Paterson Ross).

MR. TUCKWELL'S FIRM (from October 1st).—Registrar (Chief Assistant): Mr. Harvey Ross, October 1st (succeeds R. V. Fiddian).

DEPT. OF PSYCHOLOGICAL MEDICINE.—Consultant: Dr. C. M. B. Pare, September 19th.

EYE DEPARTMENT.—Registrar, part-time: Mr. J. E. Cairns, October 1st (succeeds M. S. Wilson).

NEUROLOGY DEPARTMENT.—Senior Registrar (Chief Assistant): Dr. F. Lees, October 1st (succeeds K. W. G. Heathfield).

E.N.T. DEPARTMENT.—G.P. Assistant: Dr. A. Ross, October 1st (succeeds S. Shere).

DEPARTMENT OF DIAGNOSTIC RADIOLOGY.—Registrar: Dr. P. McDonald, October 1st.

MR. NAUNTON MORGAN'S FIRM.—Senior Registrar (Chief Assistant): Mr. J. D. Griffiths, October 1st (succeeds W. M. Keynes). Junior Registrar: Mr. P. J. G. Smart, November 1st.

MR. HUNT'S FIRM.—Senior Registrar (Chief Assistant): Mr. T. Early, September 5th (in place of Mr. Knipe who is in America for one year).

DR. CULLINAN'S FIRM.—Junior Registrar: Mr. J. T. Silverstone, October 1st.

MEDICAL UNIT.—Junior Registrar: Mr. B. P. Harrold, September 1st.

DR. BODLEY SCOTT'S FIRM.—Junior Registrar: Mr. J. S. Malpas, November 1st.

DR. HAYWARD'S FIRM.—Junior Registrar: Mr. T. W. Gibson, November 1st.

Engagements

BONN—GOULD.—The engagement is announced between John Anthony Bonn and Audrey Ann Gould.

SIMS—HARTLEY.—The engagement is announced between Dr. Robin Owen Stroud Sims and Dr. Jennifer Ann Hartley.

STANTON-ELLIS—FOALE.—The engagement is announced between Dr. Charles Michael Stanton-Ellis and Glenda Elizabeth Foale.

STEPHENSON—GARNHAM.—The engagement is announced between Dr. Charles Graham Stephenson and Carolyn Ismea Garnham.

VISICK—PATTINSON.—The engagement is announced between James Hedley Visick and Angela Kaye Pattinson.

WHITE—WRIGHT.—The engagement is announced between Dr. Roger G. White and Susie Wright.

WINCE—MORRIS.—The engagement is announced between Dr. Walter Hugh Dowling Wince and Muriel Beatrice Morris.

Births

BLOMFIELD.—On September 15th, to Joan, wife of Dr. Douglas Miles Blomfield, a son.

BROOKS.—On September 29th, to Mary and Dr. W. V. Brooks, a son (Clive William), brother to Robert and Mary Anne.

CAIRNS.—On October 1st, to Mary and Dr. John David Cairns, in Toronto, a daughter (Patricia Davidson).

ELLIOTT.—On September 29th, to June Margaret, wife of Dr. David Hallen Elliott, a daughter (Joanna Ruth).

FARROW.—On September 9th, to Ann and Lewis Farrow, a daughter (Katherine Louise).

HAIGH.—On October 5th, to Sanda and Dr. Adrian Haigh, a daughter (Sarah), sister for Joanna, Amanda and Andrew.

JONES.—On September 22nd, to June and Dr. John M. Jones, a son, a brother for Richard.

OGDEN.—On September 15th, to Barbara and Dr. William S. Ogden, a son (Christopher William), brother for Susan.

TUCKWELL.—On September 29th, to Sally and Barry Tuckwell, a son.

Deaths

BEIT.—On September 13th, Francis Victor Owen Beit, Lt. Col., I.M.S. (Rtd.), aged 86. Qualified 1897.

COATES.—On October 8th, Miriam Darcus Coates, formerly Ward Sister of St. Bartholomew's Hospital.

EVANS.—On October 4th, Dr. William Burnett Evans, aged 53. Qualified 1932.

PINKERTON.—On October 9th, suddenly at sea returning from New Zealand, Major John McLean Pinkerton, M.C., F.R.C.S., Qualified 1914.

TATE.—On October 5th, Dr. James Tate. Qualified 1914.

TERRY.—On October 3rd, at Evanstown, Illinois, Dr. Richard Barratt Terry. Qualified 1946.

WALMSLEY.—On September 12th, Dr. Nicholas Walmsley, in his 91st year. Qualified 1900.

Examination Results

UNIVERSITY OF LONDON SPECIAL FIRST EXAMINATION FOR MEDICAL DEGREES

June, 1960

Pass:

Brown, M. E. A.
Campbell-Smith, S.
Crawley, P.S.
Goodall, D.
Hamilton, G. R. S. A.
Hardy, F. J. R.
Jones, D. V.

The Early Life of Sir Thomas Dunhill

Note: This account of Sir Thomas Dunhill's early life was sent in response to a request for some account of him when I was preparing the Dunhill Memorial Lecture for the Fourth International Goitre Conference in London, July 1960. It was written by Dunhill's cousin, Miss Jean Peel, of Inverleigh, Victoria, Australia, with the help of his

youngest uncle, Mr. Charles Herbert Peel, now aged 88. I was able to use only a part of the account in my lecture, and Miss Peel has kindly agreed to its being printed in full in the St. Bartholomew's Hospital Journal.

Geoffrey Keynes

IN the year 1852 George Peel brought his bride—both of Grantham, England, out to Australia. After sailing for 13 weeks they landed at Point Henry, near Geelong, having £1 which had been slipped into the bride's hand on leaving, and his kit of tools. Sickness had prevented them from coming a year earlier. George Peel had contracted typhoid fever and had used up all his savings, but the shipping agents said they would take them when they were better, as they had paid their passage. They had to pay 6s. for a barrel of water as soon as they landed. George Peel was a stone mason and immediately obtained work in Geelong.

After two or three years he moved to Inverleigh, 20 miles west, camping on the bank of the Barwon River. He soon obtained land near the Leigh and Barwon Rivers and there built a home, which is still the home of Charles Herbert, the youngest of their family. It was in September 24th, 1856, that Mary Elizabeth was born, and a new room was added to their home.

At the age of 19 years, Mary married John Webster Dunhill, who had come from Yorkshire, and was an overseer on a Cattle Station at Tragowel near Kerang in northern Victoria. It was summer time, during a heat wave a year later, with the temperature at 110 degrees in the shade, and without medical aid, on December 3rd, 1876, that their first boy Thomas Peel Dunhill was born.

The nearest railway was 80 miles away and from there everything had to be brought by waggon. A number of Aboriginal Tribes still lived in those northern areas.

When Tom was a little more than a year and 4 months old and before his brother was born, his father contracted typhoid fever, again there was no Doctor to consult and after a brief illness, he died at the age of 26 years. Mrs. Dunhill returned to her mother and father at Inverleigh, and there at Tower Hill, John Webster was born. After a year or two her father built her a home in close proximity to the old home.

When Tom and John were old enough they went to school at the Inverleigh State School. His mother's youngest brother, Charles Herbert, who is the only surviving member of their family, and who was just 5 years older than Tom, took young Tom on his first day to school, and the master asked him his name and he said, "Thomas Peel Dunhill Esquire", and the master asked if he had any spurs?

The two boys were great mates with their uncles Will, Fred and Bert, and did most things healthy country boys do.

It was a good mile to walk to school and for their lunch they had a solid, but wholesome, home-made yeast bun. On his last visit to "Tower Hill", he still had vivid memories of being taken to school, walking past Mrs. Close's house, through the quarry, over the Leigh River bridge and could name the people who then lived in homes they passed. He also remembered a very big flood when Will had to carry the fowls up from the stockyard holding them in his hands high above the water.

When Tom was 12 years old his mother married again, to William Laury, a mine manager of Daylesford. Gold mining was in full swing by then. The boys continued their education at Daylesford Grammar School. "Paradise Lost" was a prize presented to Tom in 1890.

Tom wanted to become a chemist, so he became an apprentice to a chemist at Daylesford, as well as winning scholarships which enabled him to attend the Ballarat School of Mines for lectures.

When reminiscing in a letter of November 28th, 1956, he wrote, "when I was doing my course as a chemist, I used to catch a train from Daylesford to Ballarat after a day's work, to attend my lectures, get up at 2.30 a.m. next morning, walk two miles to Ballarat station to catch the train at 3.30 a.m. Spend three hours in the train, reach Daylesford at 6.30 still almost an hour before daylight in the winter and be ready to open the chemist's shop at 8 o'clock. In my first year at the University John and I used to get lunch in Melbourne for sixpence each, and by buying a dozen tickets at a time, we got it for fivepence halfpenny. One of my happiest memories is the drives with you (Bert) when you were delivering bread around Shelford and Dorog (neighbouring townships) and you would give me a tart made of that crisp pastry. I can remember

the songs you used to sing—I could even now, sing them back to you, but strangely I have no musical voice and cannot sing a note.

"I suppose some people would say that I was ambitious, I was not, and never consciously had a scrap of ambition, something just pushed me on. I have never asked for anything that I have got, never applied for any position. They just came. I was staying with Edith in Carlisle, 250 miles away, when I saw in the "London Times" that I had been appointed Surgeon to the Royal Household. I was in France when I received a cable from Lord Dawson asking me if I would accept promotion as surgeon to King George V, and years later, I was in Norway when I received a cable asking if I would accept the position of Sergeant Surgeon to George VI. That is just how it all happened, my pen just ran away with me."

While at Daylesford he and John built a canvas canoe and tried it out on the lake there. The skeleton or ribs of that canoe are still in the roof of our barn at "Tower Hill", and one of his cousin's sons last year used it as a pattern to build his canoe.

Canoeing and fishing were his favourite hobbies. Many holidays were spent at "Tower Hill", and each summer the "Peel" family would rent a house at Lorne for a month, and often during that time Mr. and Mrs. Laury, Tom and John would join the parties and go too. Once when they were walking around the rocks Tom happened to drop his pocket knife down a big crevasse in the rocks and when the waves receded he made an attempt to retrieve it. After several unsuccessful attempts he said, "I am going to get that knife next time. You (Bert) hold on to my legs and keep me down," but he never found his knife. He and the party enjoyed many days fishing and he wrote in 1957, when recalling those days at home, "I can smell the frying "Mullet" and occasionally "Sweep" as well as if it had been yesterday".

He loved the deep firm gullies and beautiful pink heath and asked "were there still black cockatoos in the clumps of gum trees near the beach? and I remember the day when Fred, John and I were all swept off the rocky end of the ledge into the bay beyond. I know from that experience and others when canoeing down the Snowy river, that drowning is not painful".

As soon as he qualified as a chemist, he opened a pharmacy shop at Rochester, a remote up country town in the North of Victoria.

It was while there, that he got the urge to take up medicine, and as soon as he had sufficient money he went to "Ormond College", Melbourne University, as a medical student. He was very successful in his studies, winning many scholarships, and taking first class honours in many exams.

It was while he was at "Ormond" that he became ambitious to help people suffering from goitre.

An Inverleigh lady, a Mrs. Alderson, was a goitre sufferer and under Tom's instruction she kept goats, which he used to experiment on.

Later on she let him operate on her. This was his first goitre operation, which proved successful as Mrs. Alderson lived to be 89 years of age.

His brother John became a dentist, and then he too studied Medicine, but at "Queen's College". During their University days he and John with different parties undertook several hazardous trips down the Snowy River. We have a photo taken on top of Mt. Thoscinko in 1901, and several of Colonel Bridges, Professor Parnell, and Mr. Cornwall (registrar of the University) and Tom in 1904. The first time they bought two folding Canadian canoes for easy transport, these had a watertight compartment where they kept their food, etc.

They went to Dalgety in New South Wales, where on two horses they transported

the canoes to the Snowy River, "across the open end of the big horseshoe curve which the Snowy takes below Dalgety, we launched and started from there, before the river enters the gorges through the Snowy ranges. It drops continuously from its rise above Jindabyne to the neighbourhood of Buchan". "Three of us on a long rope frequently used to get the bow of the canoe at the right angle to make it possible to enter the rapids". (The above is a description taken from the back of some of the photos taken on those trips.) Another shows "how rocks submerged and half submerged create a difficult problem and the swiftness with which the steersman has to react to prevent capsizing and perhaps wrecking the canoe", yet another shows their tent, "the one and only night they put it up, showing Cornwall, Dunhill, Parnell and Bridges taking the photo".

The Snowy was a wild treacherous swift-flowing river with many hazardous rapids to negotiate and many times they were thrown out and their canoes wrecked, but they patched them up and off again to explore more river. Arriving at Buchan, the first man they met was an old school mate from Inverleigh. They did not know each other at first, but after talking for awhile they recognised each other, Dan Neve (for that was his name) said he had an appendicitis, and Tom said he was a qualified doctor, so later on in Melbourne he performed the operation.

Tom was one of the top eight to qualify for a doctor in 1903 and this enabled him to practice at the Melbourne Hospital. He took his M.D. in 1906.

Belly Laugh

by R. N. W. Price

The air was electric, the atmosphere tense;
The patients were gripped by an air of suspense;
Nobody uttered or dared make a sound,
For the Chief was beginning his surgical round.

He stood in thought at the head of the ward,
His students behind him, all seemingly bored—
Who was he going to teach on today,
And whose naked torso was up for display?

The houseman suggested in reverent awe
His humble opinion that bed number four
Was probably quite the best case one could find,
And a good exercise for the medical mind.

The Chief, in agreement, just nodded his head,
And straightway approached the aforementioned bed
Whilst the dresser concerned, quietly cursing his luck,
Slowly emerged with his notes from the rack.

The patients relaxed once again, save this man,
Who nervously peeled back his sheets and began
To expose for the students his pendulous girth,
Which, rightly or wrongly, caused no end of mirth.

For there stamped in letters an inch or two high
Was written a warning for all to espy;
And the words on his abdomen set for display? . . .

NOT TO BE OPENED BEFORE CHRISTMAS
DAY!

BLADDER SHADOWS

by C. N. Hudson

EXCRETION urography or intravenous pyelography, as it is commonly called, has long been recognised as a leading diagnostic aid in urology. The older title of I.V.P., familiar as it is, is misleading in that it focuses attention exclusively on the pyelogram. It is true that this may be the most important part of the investigation. It is also true that the descending ureterogram may not be satisfactory as one or both ureters may never be demonstrated on any of the films. The dye which collects in the bladder, however, almost always produces a descending cystogram, which in many cases may provide useful information.

It is the practice in this hospital now to include a view of the bladder in the 20 minute or later film, if there is satisfactory concentration, in all patients over the age of 40. It is also the practice to take an AM or "after-micturating" film in the same patients. These pictures are not as a rule taken in patients under this age unless there is some special reason as, particularly in women, it involves irradiation of the gonads. For the same reason, if an I.V.P. has to be taken in pregnancy, it is usual now to take only one exposure at 20 minutes.

It is profitable to consider whether any or all of the information provided by an excretion cystogram may be provided equally well or better by cystoscopy. It is also possible that it may be better to pro-

vide this information by cystography rather than cystoscopy.

Cystography, like any opaque medium radiography, produces both positive and negative images, the latter being commonly termed "filling defects". The positive shadows are produced by dye in places where there should normally be none. Briefly, these are likely to be diverticula, fistulae, and residual urine.

Diverticula of the bladder are usually of the pulsion type, and commonly occur when

there is obstruction to the outflow of urine from the bladder. They may be diagnosed on cystoscopy, but it is very easy to miss one. Their importance lies in the fact that, if they do not drain, it will never be possible to clear an infection, such as may well follow instrumentation or prostatectomy. If a diverticulum with stasis is not removed at the time of the latter operation, trouble can ensue. Diverticula often arise in the neighbourhood of one or other ureteric orifice and as such may be hidden by

the bladder shadow in a postero-anterior cystogram. They may show up in the AM film if they do not empty, or even as an area of increased density in a cystogram. If one is suspected it is usual to take oblique views, which often demonstrate them better. A carcinoma may arise in a diverticulum and, if a cystoscope cannot pass the mouth, a cystogram may give the clue by showing a filling defect in the diverticulum. Fig. 1

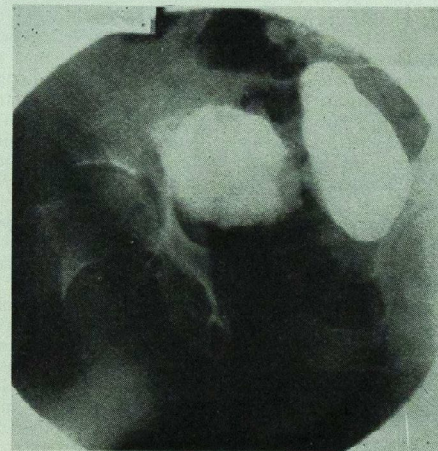


Fig. 1. Trabeculation of the bladder with a large diverticulum.

shows a diverticulum of the bladder and a heavily trabeculated bladder.

Fistulae are not easily demonstrated by I.V.P. and, in any case, the diagnosis is made more easily clinically.

It is in the demonstration of residual urine that excretion cystography really comes into its own. The only other ways of doing this are by instrumentation and bimanual palpation. The latter is insensitive and difficult in fat patients. Catheterisation is studiously to be avoided in chronic retention as it invariably leads to infection (often ascending) if the bladder is allowed to fill again afterwards. The I.V.P. cystogram is therefore the safest and best way of determining the ability of the bladder to empty itself.

Filling defects of the bladder may be classified as extramural, intramural and intraluminal. Extramural filling defects arise from other objects in the pelvis, particularly gynaecological swellings. Fig. 2 shows a smooth filling defect due to an uterine fibroid. It may be said that there are easier ways of discovering fibroids, but only by this picture may the effect of the fibroid on micturition be demonstrated. This patient's urinary frequency was cured by myomectomy.

Intramural filling defects are various. Heavy trabeculation may show up in this way, but its diagnosis by this method is not important.

Fig. 3. Papillary tumour of the bladder, producing a filling defect without distortion of the bladder outline.

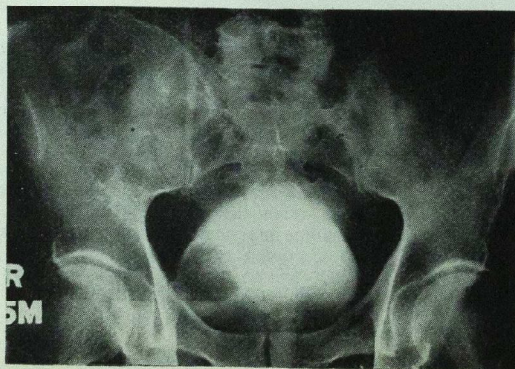


Fig. 2. Filling defect produced by uterine fibroid.

Most filling defects of the wall of the bladder are caused by new growths. The type of defect may be of help in establishing the stage of spread of growth. In general it may be said that if the outline of the bladder is not distorted by the defect, the growth is more likely to be benign, or still in the mucosal layer. On the other hand if the defect has an obvious indentation, as though a piece had been bitten out of the shadow, this is highly suggestive of an infiltrating carcinoma.

Fig. 3 is the appearance of papillary tumour of the bladder, and Fig. 4 is the appearance of a carcinoma infiltrating the wall.

Finally, an intravesical enlargement of the prostate may produce an intramural filling defect on cystography. Enlargement of the prostate of a size sufficient to show in this way is almost always more readily detected by other clinical means. In one particular instance, however, excretion cystography may be useful. This is in the investigation of prostatic symptoms after removal of the rectum for some other reason.

Fig. 5 shows a defect from an enlarged prostate.

In conclusion, the intraluminal defects are not important. These are either due to stone or foreign bodies, and are more readily seen on cystoscopy. Most vesical calculi, also, are radio-opaque and visible on plain film.

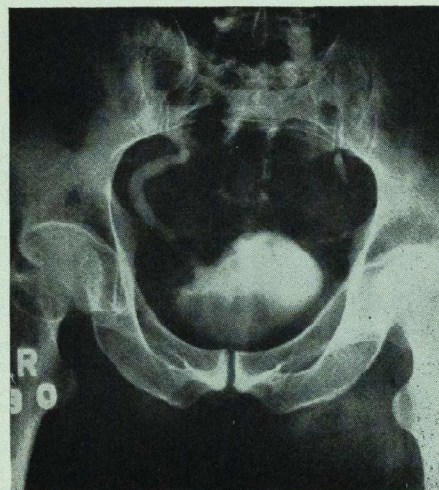


Fig. 4. Invasive carcinoma of the bladder with early ureteric obstruction.

Summary

The cystogram is an important part of excretion urography. It may provide information complementary to that obtained at cystoscopy, and may demonstrate some conditions not easily defined at the latter examination.

It is the method of choice in demonstrating residual urine in patients suspected of having a persistent inability to empty their bladders.

Acknowledgments

I thank Mr. A. W. Badenoch for advice and help in the preparation of this paper. The photographs are reproductions by the Photographic Department from the Demonstration produced for the recent Open Day at the Hospital and Medical College. The originals were provided by Mr. Badenoch and the Department of Radiology.

Fig. 5. Intra-vesical projection in benign senile hyperplasia of the prostate.



WILLIAM SMELLIE

by Elizabeth Knight

Concluding the Wix Prize Essay, 1960

His Work—The Treatise

The Treatise was published in three separate volumes and these at intervals. The first volume appeared in 1751/2 and contains the main substance of Smellie's teaching. It is the result of eleven hundred and fifty deliveries in the presence of his students as well as his considerable private practice. This volume is subdivided into chapters and sections. These are preceded by a preface and introduction in which Smellie sketches a brief history of his subject up to that time. He begins with Hippocrates and, coming nearer to his own time, he assesses Mauriceau who "published a treatise on midwifery, which exceeded everything before made public on that subject." Smellie continues, "Contemporary with Mauriceau were Dr. Chamberlen and his three sons, who practised midwifery in London with great reputation. One of these three sons, father to the late Dr. Hugh Chamberlen, translated the first volume of Mauriceau into English; and in a note upon that author's method of extracting the child by the help of the crotchet and tire-tête, affirms that his father, brothers and himself were in possession of a much better contrivance for that purpose.

"This was no other than the forceps, which they kept as a nostrum, and was not generally known till the year 1733, when a description of the instrument was published by Chapman. Long before that period indeed, several different kinds of forceps or extractors, different from those mentioned by the Arabians, were used in France, Germany and other places; but all of them fell short of the instrument used by the Chamberlens."

Smellie says that he originally had every intention of following the teachings of his predecessors—"but having by these means lost several children, and sometimes the mother, I began to alter my opinion, and consult my own reason."

Book I of this first volume gives an account of the anatomy of the pelvis with measurements, and then goes on to describe the mechanism of parturition. Sir Fielding Ould of the Dublin Lying-in Hospital was the first to doubt the current teachings that

the occiput of the foetus was towards the front of the pelvis of the mother throughout labour. Ould established that the foetal head engaged with its antero posterior diameter in the transverse axis of the pelvis. "But", says Glaister, "he complicated and obscured the problem by suggesting that in order that the head should occupy this position, the chin should be turned to one or other shoulder".

Smellie clarifies this in a revolutionary passage which expresses new ideas based entirely on his own observation, and which represents, perhaps, his greatest contribution to the science of obstetrics.

"When the head presents itself at the brim of the pelvis, the forehead is to one side, and the hindhead to the other, and sometimes it is placed diagonal in the cavity: thus the widest part of the head is turned to the widest part of the pelvis, and the narrow part of the head, from ear to ear, applied to the narrow part of the pelvis between the pubes and the sacrum. The head, being squeezed along, the vertex descends to the lower part of the ischium, where, the pelvis becoming narrower at the sides, the wide part of the head can proceed no farther in the same line of direction: but the ischium being much lower than the os pubis, the hindhead is forced in below this last bone, where there is least resistance. The forehead then turns into the hollow at the lower end of the sacrum and now again the narrow part of the head is turned to the narrow part of the pelvis. The os pubis being only two inches deep, the vertex and hindhead rise upwards from below it; the forehead presses back the coccyx, and the head, rising upwards by degrees, comes out with a half-round turn from below the sacrum: the wide part of the head being now betwixt the os pubis and the coccyx, which being pushed backwards, opens the widest space below, and allows the forehead to rise up also with a half-round turn from the under part of the os externum."

As Camper says, this was "an entirely new theory" and stresses, in Professor Johnstone's phrase "the mechanical relationships existing between the passenger and the passage".



Rymsdyk's drawing for Plate XXXV in the "Anatomical Tables", showing the use of the long curved forceps in the delivery of the after-coming head.

The rest of the book deals with a further note on anatomy and has some theories on the physiology of birth.

Book II considers the pathology of pregnancy. Smellie discusses nausea and vomiting, difficulty in making water and concludes with some theories on the causes of haemorrhage.

In Book III Smellie begins by discussing presentation. He was the first to contradict the Hippocratic theory when he avowed that the child's head is usually downwards throughout pregnancy.

There follows a note on vaginal examination. Smellie preferred the upright posture because "the weight of the uterus is more sensible to the touch than when the woman reclines."

Smellie then classifies labours thus—"I call a natural labour in which the head presents and the woman is delivered by her pains and the assistance commonly given; but should the case be so tedious and lingering that we are obliged to use extraordinary force in stretching the parts, extracting with the forceps, or (to save the mother's life) in opening the head and delivering with the crotchet, I distinguish it by the appellation of laborious; and in the preternatural I comprehend all those cases in which the child is brought by the feet, or the body delivered before the head."

In this book, too, he talks of the delivery of the placenta, showing more caution than was customary at the time—"I at first swam with the stream of general practice, till finding by repeated observation that violence ought not to be done to nature . . . I resolved to change my method, and act with less precipitancy in extracting the placenta."

Smellie's "General Rules for using the Forceps", are also included in this book.

Book IV deals with the management and after care of mother and child in the immediate post natal period. It concludes with a note on the qualifications required by the perfect midwife, one of which was undoubtedly near to Smellie's heart—"She ought to avoid all reflections upon men practitioners, and when she finds herself at a loss candidly have recourse to their assistance."

Volumes II and III are the record of five hundred and thirty-one cases, the more interesting and instructive of all that Smellie attended. They are divided into forty-nine groups illustrating the points made by Smellie in Volume I. Volume II contains

mainly the laborious, and Volume III the preternatural labours of Smellie's classification. They make absorbing reading and illustrate well Smellie's integrity. Mistakes and successes alike are recorded so that his readers may learn and profit from his great experience.

The Anatomical Tables

Smellie sets out the purpose of these in his preface . . . "finding that most of the representations hitherto given of the parts subservient to uterine gestation and parturition were in many respects deficient, I have been induced to undertake the following Tables with a view to supply in some measure the defects of others, and at the same time to illustrate what I have taught and written".

He goes on to say that Dr. Camper was responsible for eleven of the Tables and that the rest were done by Mr. Rymsdyke with the exception of two by "another hand", probably Smellie's own.

Camper confirms his part in the Tables in an entry in his journal in July 1752.

"Friday 21st, I drew for Dr. Smellie and with the forceps delivered from a corpse a head in the transverse position wedged with the ear against the os pubis—Thursday 27th, I again experimented with Dr. Smellie on a corpse, delivered with forceps and made careful drawings and profiles."

The Tables illustrate in forty plates the female generative organs, the pregnant uterus at different stages, the progress of a normal labour, and many abnormal circumstances. These include the different presentations encountered and the use of forceps and the curved crotchet.

The Tables make, therefore, what Smellie intended them to be, an illustrated accompaniment to his teaching set down in the Treatise.

Smellie's Forceps

Smellie was the true pioneer in the successful use of forceps in obstetrics. It was in search of an efficient pair of forceps that he left Lanark. The pair referred to in Case 281 were "so long, and so ill-contrived, that they by no means answered the purposes for which they were intended."

London and Paris both disappointed him, and so he "began to consider the whole in a mechanical view, and reduce the extraction of the child to the rules of moving

bodies in different directions. In consequence of this plan I more accurately surveyed the dimensions and form of the pelvis, together with the figure of the child's head and manner in which it passed along in natural labours; and from the knowledge of these things. . . I have been led to alter the form and dimensions of the forceps, so as to avoid the inconveniences that attend the use of the former kind."

The main improvements which Smellie made to the design of obstetric forceps were by shortening and lightening the instrument, by inventing the "lock" and by introducing the pelvic curve. Denman describes them as "simple in their construction, applicable without difficulty, and equal to the management of every case in which forceps ought to be used".

Smellie was often criticised for using the forceps too much, but this charge cannot be supported. He himself says in his preface to Vol. II of the Treatise, "if these expedients are used prematurely, when the nature of the case does not absolutely require such assistance, the mischief that may ensue will often overbalance the service for which they were intended; and this consideration is one of my principal motives for publishing this second volume".

In the Treatise, too, are to be found his "Rules for the Safe Application of Forceps", many of which still apply in the practice of obstetrics. The forceps were used secretly at this time for, in Smellie's own words, "As women are commonly frightened at the very name of an instrument, it is advisable to conceal them as much as possible, until the character of the operator is fully established".

So his wise caution is yet again apparent.

Retirement

Smellie taught in London until the middle of 1759, when, "having made over his class, museum and teaching appliances to Dr. John Harvie, he left London and retired to his native country". So McClintock tells us.

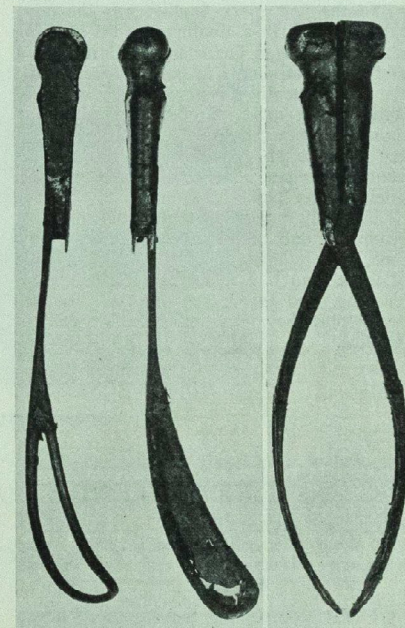
Dr. John Harvie had married Mrs. Smellie's niece and was his heir. It is likely, then, that Smellie left London feeling that his practice and collection were in good hands and that he could enjoy the years that remained to him with an easy mind.

In fact he lived only four years more and died, according to a note on William Hunter's copy of the "Treatise", of "an

Asthma and Lethargy at his Home by Lanark in Scotland on March 5th, 1763". He was buried in the grave of his parents in the churchyard of St. Kenigern.

Epitaph

During his life Smellie evoked much controversy. He was criticised by the midwives, one of whom, Mrs. Nihell made a scurrilous attack on him. The original of Dr. Slop, in Sterne's novel "Tristram Shandy", who was Dr. Burton of York, wrote "A Letter to Dr. William Smellie, M.D., containing critical and practical Remarks upon his Treatise on the Theory and Practice of Midwifery. By



Smellie's forceps, showing the pelvic curve, in the Obstetrical Museum of the University of Edinburgh.

John Burton, M.D. Wherein the various gross Mistakes and dangerous Methods of Practice mentioned and recommended by that writer are fully demonstrated and generally corrected."

This letter ran to two hundred and thirty-three pages and was almost certainly occasioned by professional jealousy. Whatever

Smellie thought of it, he was wise enough to say nothing.

Giles Watts defended Smellie against Burton in these words.

"Dr. Smellie has made great Improvements in Midwifery, his Doctrines are judicious, and his general Method of Practice unexceptionable; and this I am well satisfied may be fully demonstrated to impartial judges notwithstanding anything that Dr. Burton has, or can, advance to the contrary: And surely he has been too unmercifully severe on a few faults."

Why did Smellie have these critics who hurled such bitter abuse at him? Glaister, in his biography of Smellie, explained it thus.

"In the first place Smellie was the chief exponent of man-midwifery and his teaching was a very large factor in the introduction of male practitioners to the practice of that art. Consequently he incurred the wrath of some, if not most of the midwives and of those who thought with them that the ordinary practice of midwifery should still remain as it had done for centuries before, solely in the hands of women.

"Secondly Smellie was probably the most prominent and best equipped teacher of his time, and in consequence invited the envy of those who felt themselves left behind in teaching, and the malice of some who believed that they were being out-stripped in practice.

"In the third place, Smellie was unquestionably the first teacher to demonstrate on correct mechanical principles, the processes of parturition and to inculcate, generally, sounder principles in obstetric practice.

"He therefore called forth the criticism of those who believed and taught the traditional doctrines chiefly by quotation from the writings of the Ancients."

But let the unknown author of a pamphlet written in 1773 on "The Present Practice of Midwifery Considered", be pressed into service to write Smellie's epitaph.

"I knew him well and he was an honest man, and not only a faithful compiler of the doctrines and sentiments of other writers on the subject, but whatever he advanced as new and properly his own was founded on real facts and observation; and what ought still more to recommend him and enforce his authority with those of his fraternity—he was an enthusiast in his profession—man-midwifery was the idol of his heart, he believed in his forceps as firmly as he did in his Bible."

Acknowledgments

I am much indebted to Messrs. E. & S. Livingstone who have most generously allowed the reproduction of the two plates. These are taken from Professor R. W. Johnstone's "William Smellie", which, together with Glaister's "Dr. William Smellie and His Contemporaries", provided much material for this essay. To them I am duly grateful.

EXPERIENCES IN BASUTOLAND

by R. C. Whalley

AFTER completing three junior house appointments I became liable for National Service and decided, for several reasons, to do a tour with Her Majesty's Overseas Service. By chance I was posted to Basutoland.

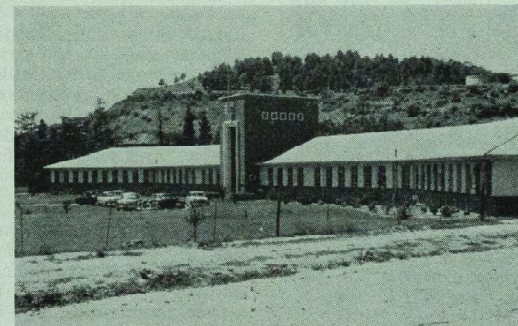
Basutoland is a mountainous country, about the size of Belgium, contained wholly within the Union of South Africa. About one quarter in the west is lowlands (5,000-6,000 ft.), the rest being highlands rising to 11,000 ft. in the Drakensberg Mountain

range. The Union's two largest rivers, the Orange and the Tugela, have their sources in this high plateau. The climate is temperate and healthy. The total population is 793,639 (1956 census) of which 1,926 are Europeans. The majority of the Africans live in the lowlands, giving a greater population density there than anywhere else in rural South Africa. The main tribe is the Basuto but, especially in the south, there are many of the Thembu tribe. These two tribes are a great contrast; the Basuto wear brightly coloured

blankets and conical grass hats, speak Sesuto and most of the men ride Basuto ponies. The Thembu, on the other hand, smear their bodies with red ochre; their clothes are simple and of the same colour. They speak a type of Xhosa and in most respects are more primitive than the Basuto.

There is a large central hospital at Maseru, the capital of Basutoland, and eight district hospitals. Each hospital supervises its own outlying clinics. The majority of the district hospitals have only one Medical Officer.

It is difficult to summarise accurately the common diseases despite annual statistics. The majority of those seen are of course coughs, colds, infectious diseases, dyspepsias and other vague aches and pains. Of the individual diseases the following are common:



Queen Elizabeth II hospital, Maseru.

malnutrition, presenting as pellagra, kwashiorkor and ariboflavinosis. This group is produced by a primitive culture, difficult farming conditions and by the fact that sixty per cent of the able-bodied men are working in the Union. Goitre is endemic in Basutoland due to lack of iodine in the soil. It is seen in forty-one per cent of the population. uterine fibromyomata, being easy to diagnose clinically, are commonly found, as also are vesico-vaginal fistulae.

Venereal diseases are common together with their textbook complications. Typhoid, diphtheria and tuberculosis are also frequently seen. There are no tropical diseases in Basutoland.

We arrived in South Africa at Capetown having called at Las Palmas, Ascension Island and St. Helena en route and travelled by

car to Maseru where we spent our first year. During this year I worked with four other doctors, before being transferred to Quthing district where we are at present.

Quthing hospital has forty beds, but there are usually between ten and twenty extra patients sleeping on the floor or on mattresses. The staff is African, consisting of three Staff Nurses assisted by ward attendants. In addition the district has three mountain dispensaries, each run by a Staff Nurse. These dispensaries are only accessible on horseback or by jeep. In some districts similar dispensaries are visited by air, either in a single engine Dornier or Piper Tripacer. Magnificent views of the mountains and valleys of the interior are obtained on these flights. Some of the district hospitals have

no X-ray units and there is no pathological laboratory in Basutoland. All specimens requiring laboratory investigation have to be sent to the Union. Therefore the majority of diagnoses is made on clinical grounds only, and so few cases of gall bladder, renal and alimentary tract diseases are diagnosed.

To give some idea of the work involved, this is the diary of a typical week:

Monday, 8.30 a.m. Urethral dilatation followed by ward rounds. On the round there would be, for example, the following cases:—fractured scaphoid with dislocation of the wrist, tuberculosis of the spine, chronic ulcer on the thigh of unknown aetiology, typhoid, compound fracture of the tibia, a P.U.O., a diabetic for stabilisation, a ruptured patellar tendon, an extra-uterine pregnancy, a tuberculous knee, a

P.I.V.D., puerperal sepsis, rheumatic fever, a caesarian section for placenta praevia, acute nephritis, lobar pneumonia, diphtheria, kwashiorkor, a fibroid uterus and a congestive cardiac failure. The other ward patients comprise pulmonary tuberculosis, maternity, infected skin lesions and lacerations, etc. After the round I go to the dispensary to see anything from thirty to one hundred and fifty patients. History is taken through interpretation. In the afternoon I see the remainder of the dispensary patients, cope with the days administrative work and do the evening ward round.

Tuesday. The same routine, but in the afternoon there are two cases from the morning's dispensary. A breast abscess for incision and drainage followed by a reduction of a supracondylar fracture of the left humerus. (This fracture is common in young boys and is often due to the boy falling off his donkey—hence locally known as “donkey fracture.”)

Wednesday. A post-mortem in the afternoon. We have much medico-legal work to do, including medical examinations in cases of rape and assault. I have also had to witness eleven executions and have had one fatal case of arsenic poisoning.

Thursday. Operation list in the morning, which in the summer starts at 6-30 a.m. (1) Hysterectomy for fibromyomata; (2) Excision of prepatellar bursa; (3) Excision of ganglion of wrist; (4) D & C; (5) Tonsillectomy; (6) Reduction of fractured radius. Theatre facilities are primitive. At the time of writing there is no theatre lamp and no sucker. All anaesthetics are “open ether,” given by the African dispenser. Instruments are sterilised by boiling over a primus burner. Operating sometimes becomes quite complicated, trying to remember what the textbook said, supervising the anaesthetic and keeping an eye on the drip!

Friday. A visit to a Mountain dispensary twenty-two miles away. The dispensary is on the other side of the Orange river which is crossed in a rowing boat. There may be between thirty and one hundred patients to be seen and I usually take back a car full who need hospitalisation. For example, a case of diphtheria and a compound fracture of the tibia on this particular visit. The majority of mountain dispensaries are situated near a Trader's store from whom the medical officer receives generous hospitality.

Saturday. There is usually a smaller dispensary in the morning and the afternoon is spent playing tennis at the Club—for my wife, while I baby-sit! Emergencies, of course, have to be dealt with, but these are few as the patient may often travel for as many as three days before reaching the hospital. Also the people fear to go out at night and so even patients within walking distance of the hospital seldom come in until the next morning. This applies to the district as opposed to Maseru where night calls were quite frequent. Our only true emergencies arise in maternity cases already in hospital.

Another week may be completely different. A visit to more distant dispensaries will mean six to eight hours of very steep and rough tracks in a Land Rover or five to six hours on horseback. We go up on Monday, to see patients all day Tuesday (sometimes as many as two hundred) and come half-way home on Wednesday. On Thursday morning we do another smaller clinic and return home in the afternoon. These “treks” provide a pleasant break from hospital routine. The scenery is fascinating and I usually find an hour or two to do some trout fishing.

Living conditions form a strong contrast with those in England. Before we left we had a 1935 Morris 8 Tourer, whereas we now have a new Ford Zephyr. We have a house servant and a garden-boy. The cost of living is low. However, shopping facilities are limited and many things have to come by post. There is little in the way of cultural entertainment. The work is interesting and rewarding, but the conditions are primitive (by modern standards) and difficult due to the very limited funds available for the medical work in this territory. The recent constitutional development in Basutoland and the fact that Her Majesty's Government is unable to accept a greater degree of responsibility for medical officers overseas who return to the United Kingdom on account of political change make it impossible to recommend this as a permanent career, but as a temporary career for the man or woman seeking experience, responsibility and the opportunity for service where it is often desperately needed, it can be strongly recommended.

* * *

LISTER AND CATGUT

by J. Ind

EVERY student of medicine is familiar with the name of Lister in connection with antiseptic surgery, but few associate the name with the modern catgut ligature which we take so much for granted.

Catgut has been known for many hundreds of years and its name is supposedly derived from the word kitgut. A kit is a fiddle, and a confusion between the words kit and cat probably resulted in the modern term catgut. The gut is prepared from the sheep's intestine by stripping off the mucous and submucous coats, scraping them free of fat and soaking them in water until they can be readily separated from one another. The submucosa is then twisted to form the finished catgut. The best fiddle strings come from Italy (Roman strings), the ill-fed, hardy sheep presumably having the toughest intestines.

In the days prior to antiseptic surgery, it was common practice to have the ends of ligatures long and hanging from the wound after tying off the larger arteries. This enabled the ligature to be pulled out after it had ulcerated through the artery. Sepsis was an almost inevitable companion to the ligature. It had long been noticed, however, that smooth metal objects and glass could remain embedded in the tissues for years with no apparent ill effects. The case of Lieutenant Gerard Fretz who lived for eight years with a large fragment from the breach of his fowling piece embedded in his ethmoid and sphenoid bones was a widely quoted illustration of this point.

Lord Lister had considered this fact and wrote, “A foreign body amongst the tissues does not exert any disturbing influence unless it be either mechanically or chemically irritating.” Therefore, he reasoned, “how could silk or linen thread composed of materials of soft consistence and as un-simulating chemically as glass or steel,” occasion any irritation? He was not long to realise that micro-organisms lay in the meshes of the ligatures and multiplied readily in the excellent culture medium of blood and serum in which they were bathed. He therefore

determined to experiment with sterilised ligature material and his first attempt was made on December 12th, 1867. The subject of the experiment was an old horse, the carotid artery of which was ligated with unwaxed purse silk prepared by soaking it in a saturated aqueous solution of carbolic acid for several hours. The ends were cut short, and healing was by first intention, the horse continuing in excellent health. Some six weeks later however, the horse died of exhaustion “from struggling ineffectually to rise from the recumbent posture.” On dissecting the animal Lister was delighted to find the ligature unchanged but surrounded by fibrous tissue.

Lister now felt justified in using the sterilised ligature on a human subject and did so when tying the external iliac artery on a lady of 51 with a femoral aneurysm. The patient made a perfect recovery but died some ten months later after rupture of an aneurysm of the abdominal aorta. At *post mortem*, Lister found some signs of irritation caused by the silk not having been completely absorbed, and he began to cast around for a suitable material more readily absorbed.

Catgut was Lister's first substitute, and during the Christmas of 1868 he operated on a calf, tying the carotid artery in two places. One ligature was of commercial catgut and the other, home-made from ox peritoneum. A month later the calf was killed and dissected; the results delighted Lister, for both the ligatures were almost completely absorbed and their place taken by fibrous tissue.

For nearly two years after this event Lister devoted himself to experiments in order to perfect the catgut ligature. He soon realised that unprepared catgut was too readily absorbed and the knots tended to slip when the catgut was moistened by body fluids. By a strange stroke of fortune however, his problem was solved for him when he overheard a fiddler, who had come into the wards to amuse the patients, complain that his fiddle would not play well as the strings were not properly seasoned. Lister

confirmed by experiment that the catgut improved with age and further experiments led to preparation of the gut with chromic sulphate and corrosive sublimate. This was the very close forerunner of the modern chromic catgut.

Although Lister himself used catgut with absolute confidence and perfect results, some surgeons were not as successful and often obtained disastrous results. It is probably fair to say that the bad results obtained were due to either faulty technique or, more often, incorrect preparation of the gut.

BOOK REVIEWS

ANATOMY AND PHYSIOLOGY FOR RADIOGRAPHERS—J. E. Blewett and A. M. Rackow. (Butterworths). 37/6. 322 pages, plus index and plates.

For some years there has been no text book of anatomy and physiology suitable for student radiographers. Some works, intended for medical students, are too large, detailed and costly. Others, such as books intended for nurses, have given insufficient detail concerning the special aspects of anatomy of importance to radiographers, for example, the anatomy of the skull and surface markings. Now, at long last, a book specially written for radiographers has been published and it is most welcome. Its text is comprehensive and clear. It is well illustrated with helpful line diagrams in the text and 22 plates, showing reproductions of radiographs, are included at the end of the book.

There is more than enough on nearly every subject to enable students to pass the M.S.R. examination. A more comprehensive index would have been helpful. For example, there is no mention in it of "blood" or "sinuses," although both subjects are dealt with in the text. A more detailed treatment of the para-nasal sinuses would be advantageous to students of diagnostic radiology, together with diagrams and a better illustration than plate VII (preferably the standard occipito-mental view).

Two unfortunate mistakes were noted in the text. Myeloid leukaemia (pp. 219) is said to be an overgrowth of the red cell series, whereas in fact it involves the granulocytic white cells. The function of the parathyroids (pp. 321) is described as being excretion of calcium. While it is true that urinary calcium loss may be higher than normal, the primary action of the parathyroids is to cause phosphate excretion by the kidneys (phosphate is not retained until renal failure sets in), the calcium changes being secondary.

When the next edition appears, as it is much to be hoped that it will, these and a number of very minor errors can be corrected and some parts revised to make a truly admirable all-in-one volume for the M.S.R. candidate. The authors are to be congratulated for their service to radiology in producing this book which will meet an urgent need.

D.H.T.

Whatever the cause, however, these instances of failure using catgut, and the opposition of many eminent medical men such as Sir James Y. Simpson did much to retard the acceptance of prepared catgut as a standard form of ligature.

Nowadays catgut is used universally with the utmost confidence but it is worth bearing in mind that this modern material differs only in detail from that prepared by Lister, and also that this latter was the product of nearly five years leisure time devoted to research.

THE HOSPITAL GAZETEER, 1960. London, British Medical Association, viii, 163 pp. 5s.

The British Medical Association has performed an invaluable service to young doctors in compiling and publishing this booklet. It will prove useful to applicants for junior hospital appointments at any hospital in Great Britain, and records information regarding numbers of beds, special departments, staff, accommodation and amenities, noting the posts recognised for the various professional examinations.

Amenities include facilities for swimming, tennis, archery, golf, badminton, chess, etc. and the possession—or otherwise—of a library. Too many record "no library," and one hospital provides darts but no books!

This guide will require frequent revision, and new editions will obviously be called for. It is worth five shillings to any medical man.

J.L.T.

DOCTOR AGNES BENNETT. Cecil and Celia Manson. Foreword by J. C. Beaglehole. Epilogue by Agnes Bennett. London, Michael Joseph (1960). xv, 189 pp., 18s.

Biographies of living persons can be boring in the extreme, and those of doctors in particular, with few exceptions, have seldom proved successful. This must be one of the exceptions.

Dr. Agnes Bennett, O.B.E., is now eighty-eight years young, and is studying nuclear physics! Born in 1872 in Australia she took a B.Sc. at Sydney University, and having decided to study medicine, went to Edinburgh. Constantly fighting the prejudice against educated women, she practised in Wellington and at the St. Helens Hospitals.

In 1915 Dr. Bennett decided to volunteer for war service, and found herself in Salonika. The Second World War brought her back to England, still, of course, in a useful capacity. But a brief survey cannot do justice to the activities of this remarkable woman, which embrace several journeys across the world, and a career as varied as it must have been exciting.

This biography of a great lady cannot fail to inspire potential women doctors, for it was the struggles against prejudice by women such as she that have made their paths so much easier.

J.L.T.

DOCTORS AND DISEASE IN TUDOR TIMES. By W. S. C. Copeman. Dawson's of Pall Mall, 1960. xiv, 186 pp. 42s.

The Fitzpatrick Lectures delivered at the Royal College of Physicians have provided some significant studies in the history of medicine, and this survey of medicine in Tudor times is no exception. The period has been much neglected, and there still remains room for a more extensive study, although this book provides most interesting reading. Chapters are devoted to "The evolution of the profession"; "Medical education"; "The Scientific basis of Tudor medicine"; "The Art of diagnosis"; "Diseases", including the plague, small-pox, syphilis, leprosy, etc.

The book is illustrated with carefully chosen plates, but one cannot help comparing the price of this work with that of a similar work on the history of surgery, published almost simultaneously at less than half the price!

Familiar names are encountered throughout the text, including Andrew Boorde, Timothy (not Thomas!) Bright, John Caus, William Clowes, Jean Fernel, and Thomas Linacre. The book contains a useful select bibliography.

J.L.T.

AN INTRODUCTION TO PHYSICAL CHEMISTRY FOR BIOLOGISTS AND MEDICAL STUDENTS, by H. R. Kruyt and J. T. G. Overbeck, translated by A. J. Mee. Heinemann, 25s.

This book, like the curate's egg, is good—very good—in parts. Unfortunately, the overall impression it leaves is also the same as that which the egg must have left.

The authors are distinguished experts in the field of colloid science, and have written a book which, according to the Preface, "deals with those aspects of physical chemistry which are necessary for the understanding of colloid science, and with elementary colloid science itself."

There is no doubt that colloid science is deserving of considerably more attention than it receives in the majority of text books of physical chemistry, particularly those books intended for students of biology and medicine. This book devotes approximately thirty per cent of its space to colloid science and closely related phenomena, and on the whole this section of the book would well repay study by any student of biology or medicine. With few exceptions the style is clear and lucid, and much of the subject matter is presented in an original fashion. Important aspects of colloid science, such as the behaviour of macromolecules and the effects of electrolytes and dehydrating agents on sols are dealt with in much more detail than is common in a book of this size. The only serious criticisms to be levelled at this part of the book are that once again too much emphasis is placed on lyophobic colloids, and not sufficient on lyophilic ones, since the latter are far the more important to the biologist.

If the colloid section had been expanded to fill the whole book, this might have been a very valuable book indeed. As it is, however, it would have been better if the rest of the book had never been written.

It is difficult to see what class of student might obtain some benefit from the rest of this book. Familiarity with an elementary science course is assumed, and specialised scientific terms are frequently introduced without any explanation, yet at the same time many aspects of physical chemistry are dealt with at a level which should not be necessary if any previous knowledge of science is assumed. On

the other hand, many biologists and medical students have little or no familiarity with the physical sciences before starting their courses, and these would be completely lost with such a book. Everywhere compression is carried on to such an extent that very important subjects receive dismissal in a few lines. Subjects such as pH, buffer solutions, oxidation-reduction potential, to name but a few, are very inadequately dealt with, and in far too many cases clarity has been sacrificed to brevity to such an extent that statements are made which the average student will find positively misleading, even if he can understand them at all.

Looseness of phraseology abounds. Statements such as "the concentration of the cell sap is normally greater than that of the soil solution" are quite unobjectionable; in this case, which is only one of many, there is no attempt to distinguish between the vague term "concentration" and the accurate term "osmolarity"—a term, incidentally, which does not appear at all! The statement of le Chatelier's principle is also particularly bad, and there is an unfortunate tendency to use phrases such as "it is obvious that", or "it follows from the above", when it is very far from obvious, or where the connection with any preceding statement is very obscure. In one case I was completely unable to see how it followed at all; in others it certainly did not.

Many readers will also be deterred by a semi-mathematical treatment which in many cases is quite unnecessary and not in the least helpful. It certainly seems quite pointless to give what purports to be a deduction of a mathematical relationship if it is necessary in the course of the deduction to assume equations which are far more complicated than the final result, without any attempt to justify them. Since, in most cases their justification would be far beyond the capability of the reader to follow, the final results might just as well be given with no deduction at all, or simply omitted. In the deduction of the gas laws from the kinetic theory, in particular, it is unforgivable to assume that "as we know from experiment, $PV=RT$!"

It is also very annoying to find graphs and diagrams which carry no descriptive legends, and which cannot be understood without frequent searching in the text for the relevant information. In some cases also, these diagrams are quite misleading; Figure 14 shows an ordinate simply labelled "temperature", with no indication that it is freezing point which is meant; Figure 48 contradicts itself and also the table of sizes of particles on the previous page.

It is difficult to decide whether the authors, the translator, or the proof readers are responsible for the fact that the section on order of reaction on page 29 is completely nonsensical, and the accompanying table is meaningless. Certainly there are a number of cases where clumsiness of expression could be due to poor translation, and there are also a few misprints—several in mathematical expressions, which are particularly non-obvious to the casual reader, but it is difficult to understand why this book should have run to fifteen editions in Holland unless the Dutch editions are superior to the English edition in this kind of thing.

The Index is very inadequate, but this is a minor fault in comparison with all those faults which make this a book not to be recommended to anyone other than a knowledgeable physical chemist who wishes to learn a little more of colloid science.

At the same time, it must be admitted that it is refreshing to find, in such a small book—under 200

pages in all—at least a brief mention of many aspects of physical chemistry not normally met except in advanced treatises. The authors would have done far better to write an introductory book along these lines not aimed at the elementary student at all, and to have been far more careful in the matter of accuracy and clarity of expression and illustration.

G.E.F.

CLINICAL MEDICINE: The Modern Approach.

A. E. Clarke-Kennedy and C. W. Bartley. Pitman Medical Publishing Co. Ltd. 25 s.

For the clinical student, knowledge comes most easily and surely from the study of the patients he meets, and is supplemented and amplified by reading and by some of the lectures he attends. But this method of learning is haphazard, and final examinations tend to be upon him before he can attempt a synthesis of the facts and outlook he has acquired. To be able to take a broad view of medicine early in the clinical course is a much felt need, not to be met by the reading of text-books, or books on "Signs and Symptoms". This present book—Clinical Medicine—written with the intention of supplying this need and using a fresh approach, certainly succeeds.

To dip in more detail into its construction is, not surprisingly, to find some grounds for criticism. Here and there some of the sentences display hasty construction that makes meaning uncertain, but as a whole it is easy to read, a point of importance when considering the intention for the book. To meet, in inverted commas, many expressions used by patients to illuminate their symptoms is refreshing, but the very liberal scattering of slang and colloquial expressions in other contexts is to your reviewer, an annoyance, and their continued presence must seriously limit the value of the book in other countries. Even a yachtsman and an airman might interpret differently the sentence in which bacteria "bale out".

It could further be criticised that, for an introductory book, some concepts, e.g., osteomalacia, epilepsy, are introduced without adequate description, while one might certainly quibble with the definition of a drug of addiction.

A still broader view, a world view, of some aspects, e.g., the changing incidence of bronchial carcinoma, or of atheroma with thrombosis, could well be expected, while the section dealing with antibiotics is far from satisfactory. "Antibiotic cover" is very frequently mentioned, but its limitations hardly hinted at. There is insufficient guide concerning those diseases where bactericidal treatment is essential, or those where bacteriostasis is adequate, and the broad statement that antibiotics "must always be given in the highest possible dose devoid of risk" is untrue.

The amplifications called for might limit the space for treatment details, but this could be advantageous in that editions would less frequently go out of date.

The expressed hope that this book may be invaluable to the post-graduate student is not likely to be realised, but it will be very useful to the student starting his clinical training, and at 25s. the book is indeed very reasonably priced.

A.E.D.

BLOOD FLOW IN ARTERIES, by D. A. McDonald. Edward Arnold (Publishers). 40s. net.

The author's aim in writing his masterly account of arterial haemodynamics is to "advance our methods of objective quantitative analysis of arterial pressure and flow". Consequently the treatment of his subject is predominantly mathematical, and that to a degree which necessarily restricts the appeal to a few specialists. This trend is becoming pretty general and undoubtedly inevitable, because of our dissatisfaction with much inaccurate observation in the past, and with the development of instruments which now, for the first time, allow more critical quantitation.

A wealth of experimental technique and know-how obviously underlies the mathematical generalisations drawn in the text; and if any criticism can be made it is merely that in a monograph of such authority the description of experimental arrangements would give the non-specialist a more practical insight. Those who have been fortunate enough to see some of the cinematographic observations on blood flow made by the author, comprehend the better the fascinating subject which he has made his own, and of which there is no more authoritative exposition than can be found in these pages.

F.E.W.

AIDS TO GYNAECOLOGY (12th Edition). W. R.

Winterton, M.A., M.B., B.Ch., F.R.C.S., F.R.C.O.G. Bailliere, Tindall and Cox. Price 10/6.

A new edition of this invaluable book, which was first published in 1885. It is an excellent, up-to-date synopsis of Gynaecology; of great use to students in conjunction with their clinical teaching, and with additional reference to larger text-books.

J.P.A.P.

BODY FLUIDS IN SURGERY, by A. M. Wilkinson, Ch.M., F.R.C.S.E., F.R.C.S., London: E. and S. Livingstone Ltd., 1960, 2nd Ed., pp. 276. 21s.

This excellent book can be strongly recommended. This revised edition incorporates new material and diagrams, and the descriptions of acid-base balance, acidosis, and alkalosis have been largely re-written. The book gives a clear account of the "content and distribution of water, sodium and potassium in the body", chapters on "sodium", "potassium", "the maintenance of chemical neutrality in the body", and an account of the metabolic effects of injury, shock, loss of gastro-intestinal secretions, and the influence of associated disease, on fluid and electrolyte balance. The diagnosis and treatment of fluid and electrolyte imbalance, with special emphasis on the problems of infancy and childhood, are ably considered. This readable, informative book gives good understanding of surgical biochemical problems, and is written by the first Nuffield Professor of Paediatric Surgery at the Institute of Child Health of the University of London.

W.M.K.

LETTER TO THE EDITOR

Sir,

An old controversy has arisen here about the origin of the sign R, which doctors affix to the beginning of a prescription. I am told that the Oxford English Dictionary maintains that it is the first letter of the Latin verb *Recipe* (take). One immediately asks why not then the plain R without the stroke through the right leg.

Sir William Osler affirms in his *Evolution of Modern Medicine* that the history of this sign goes back to Egyptian Mythology. Horus, the youthful son of Osiris and Isis, lost his one eye in a fight with Seth (either his uncle or brother), who had murdered Osiris. This eye, the symbol of sacrifice, became next to the sacred beetle the most common talisman of the country. Osler then quotes John D. Comrie in the *Edinburgh Medical Journal*, 1909, who wrote: "When Alchemy, which had its cradle in Egypt,

passed to the hands of the Greeks and later of the Arabs this sign passed with it. In a cursive form it is found in mediaeval translations of the works of Ptolemy, the astrologer, as the sign of the planet Jupiter. As such it was placed on horoscopes and upon formulae containing drugs for the administration to the body, so that the harmful properties of these drugs might be removed under the influence of the lucky planet. At present in a slightly modified form it still figures at the top of prescriptions written daily in Great Britain."

I shall be glad if a Bart's scholar can throw light on this controversial subject.

Yours sincerely,

J. van Schalkwijk.

P.O. Box 42,

Graaf-Reinet,
Union of South Africa.**SPORTS NEWS****Viewpoint**

The new season has now been in swing for about a month, and most clubs which are active in the winter know how much talent they have at their disposal. The results of the Rugby Club have not been inspiring so far, though perhaps better than last year. The Soccer Club started off the season in fine form, but since then their skill has deserted them. It is to be feared that the Ladies' Hockey Club will not be the "tour de force" this year that it normally is. Many players have been lost, who have been the backbone of the side for the past few years.

One of the disadvantages of Hospital athletic activities has always been the fact that within four to five years, the membership of a club is completely changed. The standard of performance of a club can change drastically from one year to the next, while one's opponents, which are not student bodies, have approximately the same standard year after year. "Team building" can never be done with an eye to the future.

Ladies' Hockey Club

The officials for the 1960-61 season are:—

President:	Professor A. Wormald
Vice-Presidents:	D. H. Lehmann Mr. D. F. Ellison Nash
Captain:	Miss S. Minns
Vice-Captain:	Miss S. Cotton
Hon.-Secretary:	Miss E. Knight
Match Secretary:	Miss A. Coates
Treasurer:	Miss J. Thoroughgood
Committee Member:	Miss E. Clements

Bart's v. King's College, at Mitcham, on Saturday, October 15th, at 2-30 p.m. Lost 2-7.

The first match of the season was played against King's College, and we were very pleased to have several new members in our team. This was a hard match to start a new season, especially with a much-changed team since last year. King's attacked strongly from the start and our defences were hard pressed, whilst our forwards had little to do. King's opened the scoring early, and had little difficulty penetrating our defence, who did not mark their opponents, and did not

recover quickly. Our forwards made little headway when given an opportunity, until our first goal was scored; then Bart's settled down better as a team and things looked more promising. The half-time score was 1-4.

In the second half Bart's had more of the play, and in spite of several corners, only managed to score once more. Our defence improved, especially the halves, but King's still made numerous attacks in the circle. Had it not been for the excellent play of our goalkeeper, the score against us would have been still higher. Goals: S. Minns (2).

Team: C. Lloyd, J. Thoroughgood, C. Foot, M. Childe, J. Evans, E. Knight, S. Lewis, N. Harker, P. Kumar, S. Minns, J. Swallow.

October 19th. —Match v. Queen Mary College, at Chislehurst, Result: Lost 13-0.

This was annihilation! Q.M.C. had a very good team, well-knit together and they opened the scoring from the first whistle and scored four goals in the first ten minutes, whilst Bart's could only field 10 players. After this Bart's fought back and held them off for a while but more goals came inevitably, and at half-time the score was 7-0. In the second half Bart's were somewhat improved. The half-backs fought desperately in defence, led by the tireless Miss Knight, and the forwards moved better together and had a few near misses. However the forwards must find much more thrust and the backs more determination in the tackle if we are to beat teams such as Q.M.C.

Team: S. Cotterell; G. Turner, C. Foot; J. Thoroughgood, E. Knight, T. Coates; R. Walters, N. Harker, E. Clements, P. Kumar, S. Cotton.

Rifle Club

At the Annual General Meeting of the Rifle Club, held on October 13th, the following officers were elected for the year 1960-1961:—

President:	Mr. H. Jackson Burrows
Vice-Presidents:	Dr. G. E. Francis Dr. Aumonier Mr. G. L. Bourne Mr. R. Farrow

Captain:	A. M. Ward
Hon. Sec., Fullbore:	A. M. Pollock
Hon. Sec., Smallbore:	F. J. R. Hardy
Hon. Treasurer:	Miss Z. N. C. Gardner
Committee Members:	P. N. Riddle R. S. Thompson

Soccer

1st XI v. St. Mary's Hospital on October 1st (H).

Bart's 2, St. Mary's 1.
This match proved a very encouraging start to the season. Bart's, inspired by the fine leadership of J. Jailler, were just a little too strong for St. Mary's.

The Hospital fought back from a 1-0 deficit, and equalised through D. Prosser. The winning goal was scored by L. Iregbulem after a fine midfield passing movement. This latter goal illustrated well the possibilities of the Hospital XI this season, and further, it showed that even in inter-hospital football brain can triumph over brawn.

Team:—J. Spivey; G. Haig, A. Howes; J. Jailler, (Capt.) B. Hore, G. Gardos; P. Stanley, H. Phillips, L. Iregbulem, D. Prosser, B. Dodd.

1st XI v. Swiss Mercantile College on October 8th (H)

Bart's 2, Swiss Mercantile College 2.
Bart's might well have won this game had a little more skill been substituted for abundant enthusiasm.

The strength of Bart's lay at half-back where Jailler, Hore and freshman Hudson played consistently. The Swiss team gained an early lead, but scores were levelled when a Swiss defender placed an admirable lob over his own goalkeeper's head.

Iregbulem scored a magnificent goal from 20 yards to give Bart's the lead, which however, was soon to be lost.

This result was very encouraging for all concerned.

1st XI v. City of London College, on October 15th (A)

City of London College 4, Bart's 2.
Bart's should not have lost this game. The opposition consisted of players that were at their best perhaps 10 or 20 years ago. The Hospital took the lead through Herbert, but were fairly soon to be 3-1 down.

Phillips reduced the lead but the "old campaigners" retained their lead till the end.

Rugby Football

1st XV v. Reading on September 26th (A).

Result: Reading 3 pts., Bart's 5 pts.
Conditions were ideal for the first game of the season and Bart's kicked off, uphill into the sun on a springy pitch.

The first half produced some good probing three-quarter movements on both sides and M. Britz drew some appreciative applause with his tackling. Reading achieved a slight superiority in the lines-out and half-time came with them leading by a penalty goal to nil.

Early in the second half there were some tense moments and Bart's twice lost their chance to equalise when P. A. R. Niven failed to kick penalty goals from relatively easy positions. However, following a loose scrum M. C. Jennings picked up and went over near the posts. Niven converted.

J. E. Stevens' vigorous pre-season training sessions now paid off and with tails up and superior fitness telling, the Bart's team spent the last fifteen minutes attacking strongly, but no further score resulted.

Team: P. A. R. Niven, J. E. Stevens, M. Britz, P. M. Perry, R. V. Jeffreys, R. R. Davies, I. M. Peek, A. J. S. Knox, M. C. Jennings, J. A. Harvey, M. M. Orr, B. R. H. Doran, R. P. Davies, P. D. Moynagh, D. Goodall.

1st XV v. Trojans on October 1st at Chislehurst.

Result: Bart's nil, Trojans 6 pts.
This was a very disappointing performance indeed for, despite an almost embarrassing amount of the ball from both scrums and lines-out, and a clear territorial advantage in both halves, Bart's contrived to lose this game by a try and a penalty goal to nil. Weakness in the centre and some unintelligent play among the backs as a whole largely contributed to the outcome and at the end the Hospital had only a series of near misses to set against 6 pts.

Trojans took their opportunities with a penalty goal in the first half and a try in the second, following a scrum on the Bart's line during a rare excursion into the home twenty-five. They defended well throughout and displayed much enthusiasm, particularly in the loose. Summarising then, this was not an impressive display and one which the 1st XV might do well to forget rather quickly.

Team: Niven, Stevens, J. K. Bamford, Jeffreys, G. J. Hails, Davies (R. R.), Peek, Knox, B. H. Gurry, J. W. Hamilton, Orr, Doran, Davies (R. P.), Jennings, Goodall.

1st XV v. Woodford on October 8th (A).

Result: Woodford 5 pts., Bart's nil.
On a very wet and dull day the Hospital went down by a goal to nil. The pack, well led by M. C. Jennings, fought hard against their heavier opponents and were only dominated for a brief period just after the interval during which time Woodford scored, following a blind-side break by their scrum-half, Hooker B. H. Gurry, striking very fast gained several scrums against the loose head but with the half-backs playing together for the first-time and the slippery ball, the outsiders were not able to take advantage of this.

Bart's came close to scoring in the second half when first M. M. Orr and then D. Goodall were hauled down just short of the line and a short penalty for the Hospital, taken from under their opponent's posts only just failed to bear fruit in the closing stages.

A game played in bad conditions that served to emphasise the defensive ability but lack of attacking power of the Bart's team.

Team: Niven, Stevens, Bamford, A. T. Letchworth, Jeffreys, Britz, Peek, Knox, Gurry, Hamilton, Orr, Doran, Jennings, C. J. Smart, Goodall.

1st XV v. Cambridge University LX Club on October 12th (at Chislehurst).

Result: Bart's 3 pts., C.U. LX Club 9 pts.
In a fast, open, and often exciting game at Chislehurst, Cambridge LX Club beat Bart's by two tries and a penalty goal to one penalty goal, a margin that was only prevented from being greater by the LX Club's poor finishing and the predatory tackling and covering of the Bart's team as a whole. The heavier LX forwards completely dominated the lines-out, gained a majority in the tight and were responsible for their side's opening score—an unconverted pushover try. This was followed quickly by a well-taken penalty goal and just after half-time, LX Club's opportunist right wing dashed twenty yards to the corner to complete a good handling movement. In reply J. E. Stevens kicked a penalty goal from 35 yards close on time. For Bart's, Stevens and Jeffreys ran well, and although the Hospital matched the undergraduates for fitness, they could not match the ingenuity and creative efforts of their opponents.

Team: Niven, Stevens, Letchworth, Bamford, Jeffreys, Britz, Peek, Knox, Gurry, Hamilton, Doran, Orr, Jennings, Smart, Goodall.

1st XV v. United Industries on October 15th (A)

Result: United Industries 12pts., Bart's 19 pts.
United Industries, a new venture, comprising representatives from several London major industrial concerns, made their debut at Southgate on Saturday in losing to Bart's Hospital by three penalty goals and a try to two goals, two tries and a penalty goal. Conspicuous for their enthusiasm rather than their ability the Industries opened the scoring with a penalty goal through their admirable full-back T. Frith. However, aided by a majority of the ball from the set pieces and loose tackling by their opponents, the Hospital backs were able to put in several strong runs and steadily establish a clear lead. In this respect, mention should be made of M. Britz, who scored one try and made another for M. M. Orr. The Bart's pack pushed over for a further score and then A. T. Letchworth and R. R. Davies contrived a clean break for the latter to ground under the posts. J. E. Stevens converted two tries and kicked a penalty goal. Meanwhile Frith had increased the Industries' tally with two more penalty goals and just on time, M. Hulley, on the right wing, crossed after a quick heel from the loose on the left to complete the scoring.

Team: Niven, Stevens, Britz, Letchworth, Jeffreys, Davies, Peek, Knox, Gurry, Hamilton, Doran, Orr, Jennings, Smart, Goodall.

1st XV v. Old Blues on October 22nd (A)

Result: Old Blues 25 pts., Bart's nil.
In murk and drizzle and on a pitch abounding with puddles, Bart's took on the unbeaten Old Blues at Fairtop and went down by five goals to nil. From the outset it was a forward battle with the ball rarely going beyond the stand-off halves both of whom kicked to advantage.

For the Hospital, Gurry hooked well, Orr jumped high and effectively in the lines-out and Peek toiled bravely at the base of the scrum. Half-time came with Old Blues one goal up scored after a neat movement by their back row, but Bart's were still very much in the game. However, after the interval the home side ever dangerous with the ball at their feet, helped themselves to a further twenty points. Among the factors contributing to this final rout were astute tactics from the Blues' stand-off, the pulled hamstring of his opposite number, a place-kicker who achieved all but perfect accuracy, and indecisive tackling and poor covering by the Bart's team as a whole.

Summarising, this was a disappointing Bart's performance with the team showing little adaptation to the conditions, and one in which the defence, hitherto outstanding, displayed gross inadequacies.

Team: Niven, Stevens, Bamford, Letchworth, Jeffreys, Britz, Peek, R. J. Shearer, Gurry, Hamilton, Doran, Orr, Jennings, Smart, Goodall.

Bridge Club

The Bridge Club has retained the Hospital's Cup for the third year running, this time, however, it was far from being easy.

In the first round the Bart's second team: A. Stewart—R. England, P. Evison—R. Harrison went down to King's I and Bart's III: J. Scobie—J. Bamford, D. Abell—A. Geach lost to St. Thomas's C. The first team had a bye and met King's I, last year's defeated finalists in the semi-final. The Bart's team: D. Gray—A. Garrod, R. England—G. Gardos, finished 2 match points up after 28 boards being 11 down at the half-way stage. Since the four extra boards did not produce the required winning margin of 5 match-points the match was drawn and had to be replayed. This resulted in an easy win for us (+27 match points), putting us into the final, where we met St. Mary's.

The Bart's team: D. Gray—A. Garrod, F. Abercrombie—G. Gardos, started well and were 9 match points up after 14 boards. In the second half of the match, however, disaster struck and owing to some bad mistakes our team finished the 28 boards one match point down. The first three of the four extra boards did not alter the position when good fortune, or perhaps divine justice, came to our aid and at game all the following hands were dealt:

S. Q x x				S. K J 10 x x x
H. J 10 x x x x	W	E	H. Q x x	
D. x x		S	D. K Q	
C. x x			C. K x	
				S. A x
				H. A
				D. A J x x
				C. A x x x x x

At the table where Abercrombie and Gardos were sitting North and South, the bidding went:

S	W	N	E
—	No	No	1S
3C	No	3D	No
5D	No	No	No

Abercrombie's 3D bid is imaginative, if his suit is not supported by South there are still good prospects for game in Clubs. East led a heart taken by the Ace in dummy, followed by Ace and another trump. The trumps splitting 2-2 and the King of Clubs successfully finessed later North made his contract with an over-trick. Against an opening spade lead North cannot make the over-trick because it is impossible to get rid of the spade loser in time.

At the other table the diamond suit was not bid and the Mary's N—S pair went to 5 Clubs, Gray sitting East having opened the bidding with 1S. Garrod, sitting West led a low Spade taken by the Ace in the closed hand. The situation is now entirely different from the other table. Playing in Clubs instead of Diamonds South could not see any way of entering into dummy to take the Club finesse. He played the Ace of trumps trying to drop a singleton King, but as the King was guarded he lost a trump, a Spade and a Diamond and was one down. Garrod's Spade lead is excellent, for the safe trump lead or a Diamond lead would be disastrous here. But even against a Spade lead there is an ingenious way of making the contract. South takes the Spade lead with the Ace, cashes the Ace of Hearts, the Ace of Diamonds and plays a low Diamond to East's King. East thrown in, because after cashing in his good Spade K he cannot prevent North from getting in with the HK or a ruff and take the Club finesse, losing only two tricks. This is not a "double dummy" problem, for the chances of the 2-2 split in Diamonds and

ST. BARTHOLOMEW'S HOSPITAL JOURNAL



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EDITORIAL

WHEN Osler said that "book-worms were rare in Oxford" he was happily referring to the insect bookworms. It would be sad to imagine shelves of un-thumbed volumes waiting to have their dust disturbed by scholars who never appeared. What a disillusionment, however, for scholars to be eager to chase Robert Hooke's "small silver-colour'd Book-worms . . . to some lurking cranny" and to be unable to get at the precious volumes!

Fortunately, it is not likely that book-worms are methodically and destructively eating their way through the back numbers of the Hospital Reports (regrettably no longer published) for Osler found that "recent ravages (of book-worms) were rare" even in "one of the least used collections." Most of us, also, would be offended to think of our library as one of the least-used collections.

Until recently, however, it has been difficult to find much time after the day's clinical commitments for reading.

When most clinics and ward rounds finish (about 4 o'clock), there follows that strange forty-five minutes. Hardly is this time to settle in the library but longer than is necessary to fortify oneself with doughnuts for the ensuing lecture. After the lecture the library was shut. But now it is excellent to be able to read until 10 o'clock on three evenings a week, encouraged to stay by a cheap supper and a warm evening in the library. The new hours seem to be popular. Those who, deservedly, benefit most are those who live some way from the Hospital. In addition there is always the encouraging knowledge that "*La bibliothèque des savants laborieux n'est jamais attaquée des vers!*"

Fifty Years Ago

The views of Oliver Wendell Holmes on the medical profession as published in his obituary in the *Journal* of 1910 bear repeating more than once in these days of chemotherapy, especially as Mr. Holmes was medically qualified himself and indeed, at one time, held the Chair of Anatomy in the medical department at Harvard University.

The obituary quotes a lengthy passage from the first conversation of "The Professor at the Breakfast Table."

"Now when a civilisation or a civilised custom falls into senile dementia, there is commonly a judgment ripe for it, and it comes as plagues come, from a breath, as fire comes from a spark.

"Here, look at Medicine. Bigwigs, gold headed canes, Latin prescriptions, shops full of abominations, recipes a yard long, 'curing' patients by drugging as sailors bring a wind by whistling, selling lies at a guinea a piece—a routine, in short, of giving unfortunate sick people a mess of things either too odious to swallow or too acrid to hold, or, if that were possible, both at once.

". . . Now mark how the great plague came on the generation of drugging doctors, and in what form they fell.

"A scheming drug vendor (inventive genius) an utterly unworthy and incompetent observer (profound searcher of Nature) a shallow dabbler in crudition (sagacious scholar) started the monstrous fiction (founded the immortal system) of homeopathy. I am very fair you see: you can help yourself to either of these sets of phrases.

"All the reason in the world would not have had so rapid and general an effect on the public mind to disabuse it of the idea that a drug is a good thing in itself, instead of being, as it is, a bad thing, as was produced by the trick (system) of this German charlatan (theorist). Not that the wiser part of the profession needed him to teach them, but the routinists and their employers, the 'general practitioners, who lived by selling pills and mixtures, and their drug-consuming customers, had to recognise that people could get well unpoisoned. These dumb cattle would not learn it of themselves, and so the murrain of homeopathy fell on them . . . Not only out of the mouths of babes and sucklings, but out of the mouths of fools and cheats, we may often get our truest lessons."

Some Medical Aphorisms

"God and the doctor are the last to be remembered."—*Dr. Mathews Duncan.*

"The best thing for the inside of a man is the outside of a horse."—*Sydenham.*

"Going upstairs is good for the heart, coming down for the liver; remember this when the lift is full."—*Sir Dyce Duckworth.*

"God heals; the doctor takes the fee"—*Benj. Franklin.*

"There being no doctor in the village, I soon got better."—"Gil Blas."

"I do no more than my duty as an honest and conscientious physician when I do nothing at all."—*Sydenham.*

"If a man is ill enough to say he is ill when he is not ill he must be very ill indeed."—*Dr. Sutton.*

"Use the eyes first and much; the touch second; and the tongue least and last."—*Geo. Humphrey.*

"Never tell a woman she is neurotic or hysterical, she never is."—*N. Leonard.*

"Life is a pause between two bad quarters of an hour."—*Monkswood.*

"A big voice and a big presence are two-thirds of the necessities of success in the medical profession."—*Anon.*

"All sick men are scoundrels."—*Dr. Johnson.*

"No man can be spoken of as healthy until after his *post mortem.*"—*Anon.*

Calendar

JANUARY, 1961

Sat. 7—On duty: Dr. A. W. Spence
Mr. C. Naunton Morgan
Mr. R. A. Bowen

R.U.F.C. v. Noits (a.m.) (H)
A.F.C. v. City of London College (H)

Wed. 11—A.F.C. v. Royal Naval College (H)

Sat. 14—On duty: Dr. G. W. Hayward
Mr. A. W. Badenoch
Mr. R. W. Ballentine

R.U.F.C. v. Taunton (A)
A.F.C. v. Old Chigwellians 2nd XI (H)

Sat. 21—On duty: Dr. E. R. Cullinan
Mr. E. G. Tuckwell
Mr. C. Langton Hewer

R.U.F.C. v. Cheltenham (A)
A.F.C. v. King George's House
Y.M.C.A. "A" XI (A)

Sir George Aylwen, Bart.

On the retirement of Sir George Aylwen from the position of Treasurer to the Hospital, and President of the Medical College, he was elected to the status of Perpetual Student, an honour which he now shares with a small and distinguished band of men (printed below). The ceremony took place on October 5th, in the presence of some of the governors, the senior staff and a few senior students. The Dean welcomed him as a member of the Medical College, and warned him that he should abide by its rules, saying also that he felt that an honour of this kind was of greater value than some more material presentation. Sir George replied, thanking the staff and students for this evidence of their appreciation, and outlining some of the trials of the position of the Treasurer. Mr. Christopher Hood, representing the students, presented him with the tie of the Students' Union, and proposed his health. We wish him a long and happy retirement.

Honorary Perpetual Students

- 1922 Professor Harvey Cushing
- 1926 Professor H. Cabot
- 1927 The Rt. Hon. Lord Moynihan
- 1929 Professor G. Grey Turner
- 1929 H.R.H. The Prince of Wales (Duke of Windsor)
- 1931 Professor D. P. D. Wilkie
- 1933 Professor A. H. Burgess
- 1935 Professor C. Max Page
- 1937 Professor R. E. Kelly
- 1937 H.R.H. The Duke of Gloucester
- 1939 Dr. Everts A. Graham
- 1940 Dr. J. A. Venn
- 1951 Professor E. Holman
- 1956 Dr. Howard Means
- 1956 Dr. F. A. Simone
- 1956 Dr. Frank Gerbode
- 1958 Professor H. Rocke Robertson
- 1959 Professor Walter MacKenzie
- 1960 Professor John Loewenthal
- 1960 Sir George Aylwen, Bart.

News in Brief

UNIVERSITY OF CAMBRIDGE. Lord Adrian, Master of Trinity College, has been appointed a Deputy Vice-Chancellor of the University for the academic year 1960-61.

HARVEIAN ORATION. Sir Francis Fraser delivered the Harveian Oration at the Royal College of Physicians on October 18th.

COLLEGE OF GENERAL PRACTITIONERS. Dr. G. F. Abercrombie has been re-elected President of the College.

UNIVERSITY COLLEGE OF GHANA. Professor H. V. Morgan, Dean and Professor of Medicine, Khartoum University, has been appointed Professor of Medicine in the University College of Ghana.

MR. P. H. JAYES has been appointed civil consultant in plastic surgery to the Royal Air Force

Medical Film

The first showing of a film entitled "Appointment Systems in General Practice" was given in October, in the Apothecaries Hall. This was the second of a series of films made by Lloyd-Hamol Ltd., for the Medical World, discussing medical problems of topical interest.

In this film, two general practitioners (together with a housewife to state the patient's point of view), discussed the relative merits and demerits of making closely scheduled appointments for patients. The problems debated included the obvious difficulties of assessing how long to allow for each patient; and whether the system is really as economical, in terms of time and energy, as it is claimed to be.

One was left to draw one's own conclusions from the debate; there seemed, on the whole, to be more in favour of the system than against it. However, there remains one important factor, which was not sufficiently stressed in the film; that the success, or even the desirability of such a system depends largely on the personality of the doctor, and on the type of practice concerned.

Announcements

Medical Staff

Mr. M. A. BIRNSTINGL, M.S., F.R.C.S., was appointed part-time Consultant Surgeon to the Hospital from October 1st, 1960 (Mr. Tuckwell's Firm).

Casualty Physicians

From November 1st, 1960, Casualty Physicians in the Surgery will be on duty as follows:—

	Morning	Afternoon
Mon.	Dr. Weitzman	Dr. de Mowbray
Tues.	Dr. Galbraith	Dr. de Mowbray
Wed.	Dr. de Mowbray	Dr. Weitzman
Thurs.	Dr. Galbraith	Dr. Galbraith
Fri.	Dr. Weitzman	Dr. Weitzman
Sat.	Dr. Galbraith	

Department of Anaesthesia

Registrar, Mr. I. S. Paterson, from 1-10-60.

Department of Pathology

Registrars, Dr. M. J. Lefford, from 1-11-60; Dr. G. W. Marsh, from 26-10-60.

Mr. Badenoch's Firm

Junior Registrar, Mr. M. A. Pugh, from 1-12-60 (in place of Mr. Hudson).

Department of Diagnostic Radiology

Senior Registrar, Dr. A. R. Crispin, from 1-10-60.

Engagements

EVISON—WILLIAMSON.—The engagement is announced between Dr. Peter Raymond Holloway Evison and Elizabeth Mabel Williamson.

JUNIPER—GRIFFITHS.—The engagement is announced between Dr. Colin Pudan Juniper and Dr. Jane Margaret Blair Griffiths.

MISSEN—STEPHAN.—The engagement is announced between John Missen and Janet Stephan.

Deaths

DOWLING.—On October 31st, Dr. Stanislaus Marcus Dowling, aged 94. Qualified 1905.

FURBER.—On October 17th, Dr. Lionel G. H. Furger, aged 82. Qualified 1908.

WOODROW.—On October 13th, Dr. Cyril Erskine Woodrow. Qualified 1927.



Mr. Jackson Burrows, the President of the Rifle Club, is seen receiving a presentation model service rifle as a gift from the Club. During the convalescence from his recent illness Mr. Jackson Burrows shot in the Queens Prize and the Club hope that he will be seen often at Bisley in the future.

Births

BROWSE.—On October 19th, to Jeanne and Norman Browse, F.R.C.S., a daughter.

BURROWS.—On November 18th, to Ann and Dr. Peter Burrows, a sister (Sarah Robin) for Jane, Mark and Susan.

DAVIS.—On November 17th, to Elizabeth and Dr. Peter Davis, a son.

DINGLE.—On October 23rd, to Marion and Dr. Hugh Dingle, a son (Geoffrey Trehane) brother for Alison and Jacqueline.

DOHERTY.—On November 11th, to Helen and Surg. Lieut. Roger Doherty, R.N., a daughter (Charlotte Frances).

GAWNE.—On November 9th, to Jill and Dr. Edwin Gawne, a daughter (Sarah Frances).

GILBERT.—On November 22nd, to Paddy and Dr. Roger Gilbert, a daughter.

GREEN.—On November 10th, to Joy, wife of Dr. Henry Green, a daughter (Jane Penelope Harrison).

PRANKERD.—On October 22nd, to Peggy, wife of Dr. T. A. J. Pranker, a brother for Richard, Henry and Nicole.

REISS.—On October 15th, to Margaret, wife of Dr. Bernard Reiss, a son, a brother for Stephen.

TRAPNELL.—On November 2nd, to Elizabeth and Dr. David Trapnell, a son (Simon Hallam).

Marriages

BELL—LONG.—On October 22nd, Dr. Thomas John Cranston Bell to Dr. Daphne Nevill Long.

MCCOLL—MCNAIR.—On August 27th, Dr. Ian McColl to Dr. Jean Lennox McNair.

Examinations

The following General Certificate of Education Candidates have qualified for exemption from the First Medical:—

James, T. E.	Nicolson, I. C.
Jones, H. G.	Revill, M. G.
Lindo, F. C.	Sanders, W. M.
Merrill, J. F.	Whittaker, M.
Muktarsingh, W.	

PERCIVALL POTT ON HEAD INJURIES, 1760

by John M. Potter

Based on a paper read to the Society of British Neurological Surgeons, November 25th, 1960.

IT seems appropriate to record in this Journal that this year sees the two-hundredth anniversary of Pott's book, "Observations on the Nature and Consequences of Wounds and Contusions of the Head, Fractures of the Skull, Concussions of the Brain, etc." It is a remarkable book, not only for the literary accomplishment of its author, but for its lucid and useful information; and for the picture it creates of Pott himself as an observant, logical, humane and, above all, a humble surgeon, anxious and able to simplify a difficult subject.

The first edition comprised 182 pages only, and was dedicated, acknowledging his "polite and friendly treatment" to John Darker, Treasurer of St. Bartholomew's Hospital. There may be a moral in the fact that this kind of gesture is no longer made, but Pott worked in what social historians call "the age of enlightenment", during which, over the period of more than a century, an average of one new hospital a year was built by co-ordinated voluntary effort, and he was very conscious of the significance and merit of this change. A second and enlarged edition was published eight years later, under the less cumbersome title, "Observations of the Nature and Consequences of those Injuries to which the Head is liable from External Violence", which also contained 43 case histories. This is the edition to which I shall refer. There were two further editions, and the treatise was incorporated subsequently into Pott's Collected Works, of which there were five English editions, two French, one German and one American between the years 1771 and 1819. During his lifetime this work appears to have been the most valued of his publications which were read throughout the civilised world, and Sir D'Arcy Power regarded it as one of the classical writings of English Surgery.

The book is in six sections, the first of which is devoted to injuries of the scalp, and of these he observes what is not always remembered today, that they "become of much more consequence than the same kind of ills can prove when inflicted on the common teguments of the rest of the body".

It is a most useful account, which draws attention to the vascular communications "between all parts without and within the head" and emphasises the importance of always attempting preservation of the scalp. When Pott goes on later to say that he is aware that "the very mention of a suture in a wound of the scalp, particularly a lacerated one, will startle some of my readers", he is already treading new ground, and he is painstaking in giving his reasons for taking this path. He observes that piercing or penetrating wounds "are in general more apt to become inflamed, and to give trouble, than those which are larger". He warns about the "fingers of an unadvised or inattentive examiner" making the well-known mistake of regarding a cephalhaematoma as a depressed fracture.

Section 2 is entitled "Effects of Contusion on the Dura Mater, and Parts within the Skull", but it is really concerned with infection. It will make strange reading to medical students and to many younger practitioners of today, so unusual is it now to see cases of intracranial infection like the ones Pott describes. He distinguishes between the early symptoms of cerebral compression due to extradural haemorrhage and the later symptoms "all of the febrile kind", seldom occurring until some days are past, that indicate infection and usually extradural pus formation which only later still causes pressure symptoms. He gives his classical description of osteitis of the skull with extradural abscess of which his "puffy tumour" is localising evidence. In its pure form, this infection occurred, presumably from the bloodstream, at the site of the contusion and beneath an intact, or relatively intact scalp. The swelling did not appear until a week or two after the injury and might not be discovered if the existing febrile illness and the earlier head injury were not connected in the mind of the medical attendant. This complication of a head injury is now extremely rare in this country, but one does sometimes see the same puffy swelling over the forehead in cases where suppurative frontal sinusitis has proceeded

to osteitis of the frontal bone and extradural abscess formation, and the same sort of localised, pitting oedema of the scalp occurs directly over an extradural haematoma, even though there is no infection present.

Pott emphasises that when these symptoms and signs of infection occur, recovery can never take place without trephining. He was able by this means to save seven out of the 17 patients he describes, in whom the infection had apparently spread no deeper than the dura mater. Several openings, he says, may be required in order to find the pus and to give free exit to it. General measures (in those days chiefly phlebotomy and purging) must supplement the evacuation of pus and the relief of intracranial pressure. "This being all our art is capable of doing in these melancholy cases, I wish I could say that it was more frequently successful . . . some have been saved by it, none can escape without it". In cases where the subdural space had been reached by the infection, presumably generalised leptomeningitis also followed, for all such cases that he described died.

Pott's successful results were surprising, and even, one infers, unbelievable to an evidently experienced writer in a textbook 100 years later who knew of no such success, indeed of any success, among his contemporaries. But is it difficult to doubt Pott's honesty, and Abernethy, his pupil, who was a most critical person and no blind admirer of his master, assures us that "Mr. Pott was a man on whose veracity I could rely". It seems likely that the nature of the infection, the patients' susceptibility to it or the facility with which organisms entered the bloodstream may have altered during the century which followed Pott, and up to recent times even before the advent of chemotherapy and antibiotics.

Section 3 is a short one on osteitis and sequestrum formation in the skull following trauma. Four examples are given and the process is compared with that associated with "old and neglected venereal disorders".

Section 4 is entitled "Fissures, and fractures of the cranium, without depression". It starts with a sensible observation which might still be heeded. "Fractures of the cranium were, by the ancient writers, divided into many different sorts . . . These are to be found in most of the old books: but as they merely load the memory, without informing the understanding, or assisting

the practitioner, modern authors have generally laid them aside". Pott is content to divide fractures simply into those with and those without depression, and he recognises that the fractures in themselves do not produce symptoms. He was one of the first to emphasise their relative unimportance in a head injury. He was an energetic advocate of trephining as a prophylactic measure about which there was much controversy, but he argues his case most persuasively and is by no means indiscriminate. One is left with the feeling that Abernethy, O'Halloran (in Ireland), Astley Cooper and others who later opposed his views on this matter, may well have lost patients unperforated whom Pott might have saved.

He objects to the inefficient and unnecessarily diverse instruments employed by those practising cranial surgery, particularly in earlier times. They were "irksome to the patient, tedious to the operator, and unequal to the end proposed". He settles, very simply, for a sizeable trephine with a light wooden handle and an elevator, and "perhaps, now and then, a pair of forceps".

Section 5 is concerned with depressed fractures. He knows that the depression of the bone is only one part of the trouble in many cases, and that all the usual complications must still be anticipated. Every practitioner, he says, should know this, and the friends of the patient should also be told. (This is only one of several instances of Pott's concern for the friends and relatives of the patient. Elsewhere, he says, "Friends and relatives have a right to be informed of the motives of a surgeon's conduct".)

He mentions bandages. Those usually described are "on paper . . . neat and elegant . . . and when applied nicely may impose on the ignorant, and on those who have not reflected much on their inconvenience. They press, heat, and painfully confine the head, even when applied in the best and most ingenious manner; and when put on awkwardly or negligently are still more troublesome, and less serviceable". The keeping of the dressings comfortably in place "will always be better accomplished by a loose cotton or yarn night-cap". He is pleased to find the "antient", Oribasius to be of the same opinion.

The sixth and final section is on "Extravasation and Commotion". Pott comments that many of "our ancestors" were too content in talking about concussion, "and

although they had no very precise idea annexed to the term, yet they seldom went farther for a solution; like teeth and worms in infants, or like nerves in women, it satisfied ignorant inquirers. The cranium was not broken, the mischief was out of sight, most probably out of reach, and they had not often the curiosity or the anatomical judgment to examine after death into the real state of the case".

Pott does not use the word concussion in quite the limited way that Wilfred Trotter defined it, and as it is usually employed today. His use of the word, stunning is nearer to our meaning, but this subject will always be bedevilled by semantics.

He describes the lucid interval in extradural haemorrhage which had been recognised by contemporary French writers, but emphasises that it may be entirely lacking owing either to the rapidity with which the haemorrhage occurs or to the overlap of the effects of the initial commotion of the brain and of the haemorrhage itself. He operated successfully on two of the four

cases of extradural haemorrhage that he described, but he found it difficult to locate subdural haematomas, although he describes both these and the allied condition of subdural hygroma.

It is altogether a remarkable book, full of interest, observation and common sense. It needs to be read several times in order that the atmosphere of the time may be appreciated, and with each reading one's respect for its author increases. It is easy to forget that he had no neurology, no knowledge of the true nature of infection, little insight into the complications of coma, and no inkling of the deviations of metabolism which must have complicated, particularly, his cases of infection, with the bleeding and purging that went on. How should we have measured up to him, I wonder? His humility is perhaps best illustrated by this passage, "Our fathers thought themselves a great deal nearer to perfection than we have found them to be; and I am much mistaken if our successors do not, in more instances than one, wonder both at our inattention and our ignorance".

LETTER FROM LAOS

by R. H. Herniman

THIS letter is a difficult task for me. A description of what this country is like, and what has been happening here recently, will be very incomplete coming, as it does, from one who has suffered since birth from a severe reluctance to write letters. You will wonder what I am supposed to be doing here and why; where Laos finds itself on the map; whether there is a registrar problem; and whether Oriental girls are always as submissive as they are alleged to be in novels. Some of these and other details I will attempt to give, though in a rather haphazard fashion I am afraid.

There are two of us, both doctors, who have been sent to this country by the Foreign Office as part of Colombo Plan aid. We are rather vaguely called the Colombo Plan Medical Team in Laos and it has been our business so far to try and discover exactly what this means in terms of work.

The village where we do a daily clinic is about 20 kilometres and four military road blocks from Vientiane. The journey is done in our Land Rover.

The road is of tarmac for a short distance and then becomes mud and water—the latter predominating as it is the end of the rainy season. The mornings are bright and sunny however and everything is brightness and colour. The people at the roadside wave and shout encouragement (probably anti-American slogans if one did but know). As we drive on we may be stopped very politely by a group of saffron robed monks who wish to be transported to the local temple. This we do and are thus bombarded with quite incomprehensible remarks for a few miles. Absolute incapability of understanding seems to be no barrier to them for they grin and chuckle in the most delightful way and seem grateful when their destination is reached.

Shortly we reach our own village and turning off the road we lurch across a sort of field and squelch to a halt in front of the village dispensary. This is a wood and bamboo house built in the Lao style on stilts. The Lao medical orderly (equivalent of a district nurse in England perhaps) lives here and as he has a large family there is only one room set aside for medical purposes. It is here that we do the clinic. Let me try and capture the scene for you—it has much in common with an East End surgery though the similarities are not immediately obvious.

Outside the house three dogs fight noisily over some rotten but no doubt delectable morsel. The sun is high and hot and pours into the crowded room. Here I sit at the table sweating, and swear at the shop in London that assured me that khaki drill was really very cool. The first patient is a strong child of two years who, determined, fights against the stethoscope while his giggling mother bares her betel stained teeth with pleasure at the foreign doctor. Eventually the child tires of the struggle and with a competence that will stand him in good stead later he undoes his mother's brassiere and starts to feed. In the comparative silence that ensues, the Lao orderly questions the mother and translates into French for my benefit (a language which is popular out here since the days when the French colonised the country). A few words of reassurance and some cough mixture and the next patient appears. He is a solemn child who sadly looks at his toes while we look sadly at his head and neck which are covered in a mass of purulent scabs. He stands patiently while we wash him in Dettol and anoint him with antibiotic cream and his silence and dignity are so commendable in the surrounding bedlam that we give him a marron glace that for some extraordinary reason we have with us. Then his brother picks him up, carries him down the steps and places him on the carrier of a bicycle. They ride away the child still silent, dignified, naked, and clinging desperately to his brother.

The morning goes on and we see mostly children; children with ear infections, bronchopneumonia, worms, dysentery, scabies, malnourishment and all the other ills attendant on poor hygiene and ignorance. It seems that if you can possibly survive childhood then you have made it, for the adults seem fit and have good physiques. The room gradually empties of bystanders

and one can see little pools on the floor made by the children whose mothers were far too busy staring at the doctor and wondering what he would be like as a husband.

When all is done we sit and drink tea and grumble about the situation—no drugs, no doctors, no buildings, complains the Lao orderly; what can he do? He has in any case only two years medical training and badly needs more qualified encouragement. Small wonder is it that most patients try the traditional medicine first and only come to the clinic when the dung and incantations have manifestly failed. This is often too late as in the case of an eight-year-old boy who had measles and then bronchopneumonia—the parents waited for a week before calling us and then it was too late.

The kingdom of Laos, the land of a Million Elephants and the White Parasol, has been sheltered from progress by its geography, its climate, its religion and the benevolent but inactive colonisation by the French. Now it has woken from its tranquillity to find itself the centre of an international political struggle.

In a harassed South East Asia, Laos has not escaped—any country bordering on China finds itself courted by powerful friends and soon learns that these do not always have altruistic motives. Since Laos gained independence it has carried the uneasy burden of American aid and influence, both being used at times to prosecute the cause of anti-communism. The only result, to a casual observer, has been to throw the initiative slightly in favour of the left.

Laos is politically immature in democratic ways, and its three million inhabitants have had vulnerable governments and poor leadership. American aid has been misused by corrupt officials so that Vientiane is a mass of modern (and uncomfortable) villas and Mercedes-Benz cars. As one American said rather ruefully "I did not realise how much we were giving aid to Western Germany until I saw the cars in Vientiane."

It is a difficult land in which to introduce progress; communications are impossible except by air—there are few roads, no railways, administration in the countryside is rudimentary. The Lao people are in a minority in their own country for there are many different tribes and groups, the remnants of many migrations from the north. Over these groups the government has virtually no influence, indeed it is doubtful if

some of the hill tribes are even aware of the king and his government. The Laotians themselves prefer to live in valleys by the rivers in villages which still retain a feudal atmosphere. They are a gentle, cheerful and friendly people and as yet unaware of the dubious benefits of Westernisation. It is in many ways their tragedy that they cannot now be left alone.

Hard work is considered not quite the thing and fêtes or BOUNS are celebrated wherever possible. It is a tranquil philosophy of life stemming from the Buddhism that is the official religion. In spite of this, animism or the worship of spirits is very common and the two beliefs seem quite compatible. Recent events have shown all too clearly the advantages of such characteristics for the Lao army is endowed with a wholly commendable reluctance to fight their fellow Lao, with the result that the civil war that is dragging on at the moment is being conducted practically without bloodshed.

The French pride themselves on having bequeathed to Laos some of their culture, and this is true in the better educated circles and in the civil service where French is the administrative language. It is true also that there is very little resentment of the French and they still enjoy much influence—a tribute to the gentleness of their administration when in occupation. Otherwise culture is at a village level and learning resides in the monasteries. The Lao language is a simpler version of Thai with a most elegant rounded script. To learn it is the most exasperating mixture of simple grammar and complex tone values. Unlike those who try to learn their language, the Lao people seem to learn languages quickly and well, and I suppose this is hardly surprising with the multiplicity of languages and dialects that exist side by side.

To judge by Western standards of progress, one is forced to the conclusion that Laos is a hundred years behind any other country in the Far East. This may or may not have been a good thing for them, but now the country is trying to adapt itself to a modern world and in so doing leaving a trail of comedy and tragedy behind all its efforts.

The medical field is extremely interesting—there is no registrar problem by the way because there are no registrars. There is one Lao doctor who is qualified by English standards. The others have had brief courses of anything from two to four years at Hanoi or Saigon. There is a form of medical

administration set up by French army doctors and this consists of small dispensaries in the larger villages.

These are staffed by a Lao orderly or "infirmier". Obviously the scope of medicine practised is very limited and any enthusiasm is frustrated by lack of facilities and further instruction.

Superimposed on this skeleton administration are the efforts of the various aid programmes. The United States concentrates most of its forty-six million dollars per annum in the army which is thus enormous, well equipped, and dare I say it, relatively ineffective. However, the Americans are in charge of the malaria eradication campaign which has been going on for several years but has run into difficulties with the political situation—for a long time now it has been difficult to travel freely in the countryside. The main burden of medical aid falls on a charitable Filipino organisation called Operation Brotherhood. These excellent people have one very good hospital in Vientiane itself and send field teams into the country to form small village hospitals and dispensaries. Although their main rôle has been that of providing clinical treatment they have started now a teaching programme for Lao nurses and auxiliaries.

Medico, an independent American organisation started by Dr. Dooley, has received much clever publicity in the U.S.A. in order to raise funds but in fact in Laos has only two small hospitals going at the moment (they do have many programmes in countries elsewhere).

It is with this background that the Lao government asked the British government to supply fully equipped medical teams to work in the countryside in order to provide some sort of medical service to the more inaccessible regions. The teams would be sent as part of Britain's contribution to the Colombo Plan—that rather vague plan that seems to embrace topics as diverse as hydrographic surveys and teaching English.

Once the idea was accepted the Foreign Office moved slowly and gingerly to implement it. They had no experience of organising such a thing and so other government departments were called in to advise (and in addition make for rather unwieldy administration). The appropriate department then advertised for two doctors to form the first team and eventually after a series of

coincidences obtained myself and a friend of mine from St. Thomas's.

We had a three months training period in England when we drew up lists of equipment—mostly on an empirical basis, for we had little idea of the conditions out here. We also tried to learn some tropical medicine, and spent much time frightening ourselves in the Burroughs-Wellcome Museum which surely has the most horrifying collection of unpleasant things in London. At the same time we tried to brush up our French which was an excellent excuse for seeing as many French films as possible.

We also visited the School of African and Asian studies to find out something of the language and customs of the country we were going to live in for two years.

Finally we ended up having a working holiday doing a maintenance course on the Land Rover; this being at that well known holiday resort Solihull. By this time our brand new Land-Rover with the decorous Union Jacks had been forwarded to Bangkok to await our arrival. Being inexperienced travellers we also sent five trunks full of hilariously unsuitable clothes (no one told us that it got cold in winter), and an incredible amount of toothpaste, soap and other household goods. I don't know quite where we thought we were going, but when our baggage did arrive I was amazed to find one of my trunks nearly half full of Tide—a commodity which is sold in the most inaccessible village in the country.

On July 4th after several rather hectic sessions saying goodbye we climbed into a Comet and after a short doze and a few snacks found ourselves in Bangkok.

Here we wallowed for a few days in the luxury of air-conditioned hotels and the verbal caresses of innumerable people who said that we were mad to go to Laos and that any pretence at civilisation ended at Bangkok (this is quite untrue though all things are relative). Incidentally the British Embassy at Bangkok is a sight which would set the Plasmodia warming the blood of any die-hard imperialist; it is a huge compound with gracious lawns and buildings surrounding a hideous, squat, Buddha-like statue of Queen Victoria that not even the Japanese had the courage to remove. During the war they merely boxed her in and later cut holes in the box so that she could see out. This after the fearsome old lady had appeared to the Japanese commander in a dream saying, as

she seems to have said so often: "We are not amused".

Having seen as many of the sights as possible we climbed into the Land-Rover, donned our sunglasses and (figuratively speaking) our sun helmets and set out for the great unknown.

Two days later a rather bedraggled Land-Rover could be seen in the streets of Vientiane determinedly chasing an enormous American Cadillac. We were in fact lost and hoped, successfully, that eventually the Cadillac would stop and we could ask the occupants the way to the British Embassy.

After this we were well looked after, for the British Embassy fell over themselves to help us and to entertain us and to introduce us to all the right people.

With such backing, our plans to move out into the country seemed to be going very well. In our splendid ignorance we did not realise that nothing goes well in Laos—it's something to do with the climate—and sure enough four days before we were due to leave by barge for the South, we came down to breakfast to find a revolution in full swing.

Vientiane can best be described as follows. Take a mediaeval village and superimpose on it a French provincial town. Ask the French to leave and build a few new government buildings and masses of "Chinese ranch" villas. To the Lao population add representatives of all the Asian countries, a fair number of cows, horses and water buffalo, and thousands of dogs. The last mentioned are wild and very anti-social, being deafeningly vocal at night.

History does not relate whether they were especially vocal on the early morning of August 9th, but it was then that Captain Kong Lac turned left instead of right and with 800 paratroopers behind him entered Vientiane and took control.

He had cleverly chosen the time when the government were all out of town in the old Royal capital of Luang Prabang. Here they were consulting astrologers as to the most favourable time to bury the ex-king, who had been dead nearly a year. The revolution proceeded quietly and without bloodshed. The next morning we found plenty of grinning soldiers everywhere and the radio-spouting anti-American propaganda.

The revolutionaries are dedicated to a policy of neutralism and stamping out corruption in the government (where have

we heard that one before?). They are in fact now the legal government with Captain Kong Lac's nominee Prince Souvannaphouma as premier.

That, you might think, is that, with fair shares for all, but in fact things have become rather worse if anything. The ex-minister of Defence, General Phoumi, took umbrage at being deposed by a mere captain, and so the general decamped to the South with a sizeable chunk of the army and a dissatisfied member of the royal family to add tone. General Phoumi and Prince Boun Oum have thus set up a new revolutionary group and the two sides are still sorting things out—not very satisfactorily.

Meanwhile, there are several other complicating factors; firstly the quasi-Communist Pathet Lao organisation, which has a fair number of badly organised troops in the countryside. These are quite possibly supplied and advised by the Viet Minh.

The Pathet Lao are at the moment supporting the government of Souphannapouma, which of course does not endear the premier to the Americans. Secondly, there are the

Thais who seem to be in favour of General Phoumi (Marshal Sarit, Premier of Thailand is General Phoumi's uncle) and are blockading Laos, thus cutting off a main supply line.

Laos is landlocked I should explain and is supplied either via Bangkok or Saigon.

At the moment, therefore, we are quite unable to stir from Vientiane except to do a daily clinic in a village about 20 Kilometres away. Travel is virtually impossible in the rest of the country and the region where we had planned to work is in fact the line between the two opposing factions. We have made several abortive attempts to get out but as soon as things get organised something always seems to happen. Last week we were all set to go to a village near Luang Prabang, but now, alas Luang Prabang is a trouble spot. So all we do is sit and wait and obey the curfew at night. We learn Lao and try to stop ourselves from going to the dogs. Miss Lotus Blossom is quite obliging they say, but her state of health is never reliable. So what's to do?

Does anyone know the address of a good opium den?

John Hosford

To mark Mr. Hosford's retirement from the Surgical Staff we are printing an abbreviated version of a valedictory address by Reginald S. Murley.

Mr. Hosford's former house surgeons and registrars entertained him at the Junior Carlton Club on the 9 September 1960.

I AM greatly privileged at being invited to give this appreciation of John Hosford. It is a task which is at once as onerous as it is honourable, and I feel rather like the writer of an obituary notice who is compelled to deliver his praise and panegyrics in the presence of the corpse! However, if I may parody Mark Anthony, I come, thank heaven, to praise Caesar, not to bury him.

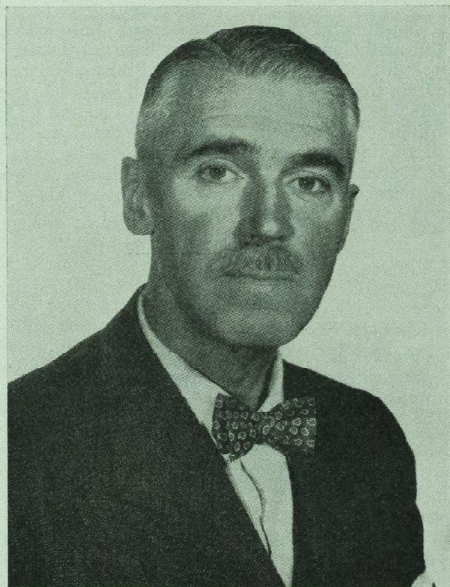
John Hosford had the good fortune to be brought up in a medical household, the second of four sons of a highly respected family doctor in Highgate. All four sons read medicine and achieved considerable success, the eldest following in the father's practice until his retirement some seven years ago; and of the two younger brothers, Bryan is a physician at Tunbridge Wells, and

Maurice, the youngest, is a much respected anaesthetist at Bedford. John apart, it is plain that the family has been both an ornament to our profession and of singular service to the public.

It has not been easy to find out much about his student days or extra-mural activities, but he is described by one of his contemporaries as "always equable, pleasant, helpful and co-operative"; and others speak of him as a man of tremendous integrity, something which all of us know only too well. His brilliant academic record is well known and I shall say no more about it. I find that he was honorary secretary to the Abernethian Society and the first record in his handwriting minutes a meeting in June, 1922. On that occasion, George Bernard Shaw

addressed a packed house on "The Advantages of being Unregistered". So far as John Hosford was concerned, Shaw's advice seems to have fallen on stony ground, for a few months later, the *Bart's Journal* records that he had completed his examination for the M.R.C.S., L.R.C.P.

The next issue of the *Bart's Journal*, for November, 1922, records his appointment as house surgeon to McAdam Eccles and Girling Ball. From this period dates his celebrated story of how, during the repair of an inguinal hernia, Eccles' dressers were required to file slowly past the operation



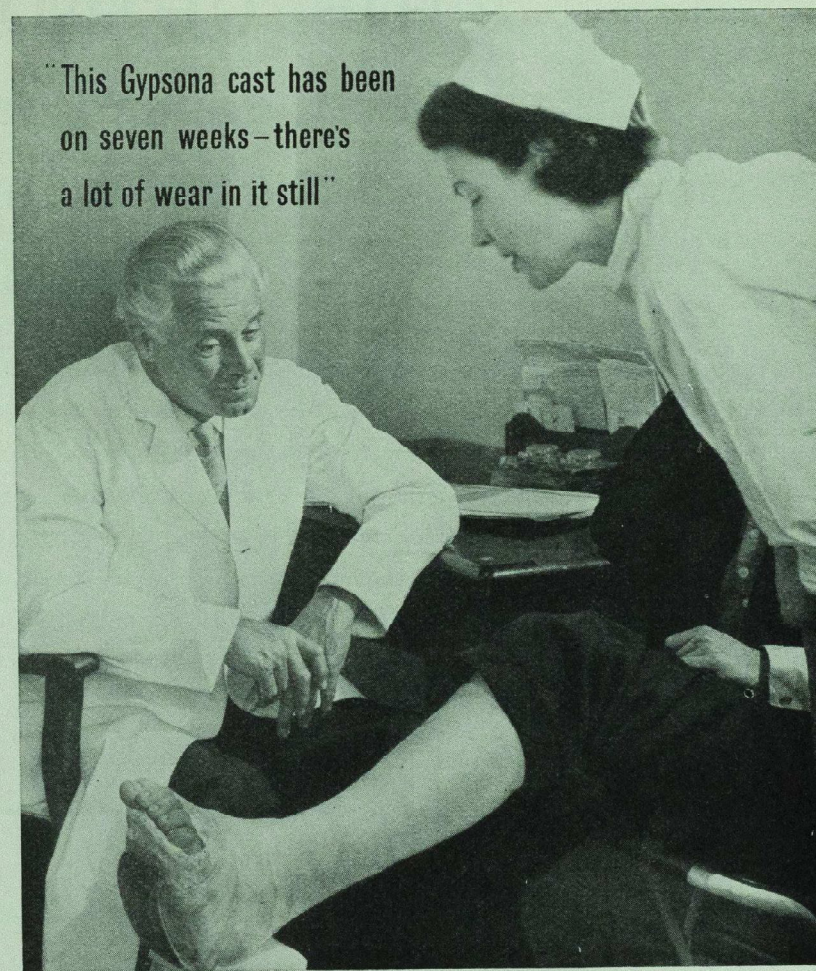
table, gazing intently in the direction of the internal ring, while solemnly chanting "good-bye sac". Thank goodness this never became part of his own technique, but only an interesting story for dressers and assistants.

After the first house job, John Hosford went on from strength to strength. He was house surgeon in the ophthalmic department, followed by chief assistant to Eccles and Ball, chief assistant to the orthopaedic department and then chief assistant, first assistant and temporary assistant director to the surgical professorial unit. During this time he had

the great fortune to act as a private assistant to Lord Moynihan—an altogether first-class surgical training. Once established on the staff, his superb technical skill, combined with the most equable of temperaments, has justly earned him a unique position at Bart's and a tremendous reputation outside. He has been an excellent teacher of both undergraduates and post graduates, but his modesty has sometimes led him to suppose that he was not a success with the senior men. I can well remember one day before an F.R.C.S. class when he seemed a trifle depressed and said that he feared his teaching

was not of much value to them. I was constrained to say "rubbish" and to tell him how his classes were widely regarded as among the best given.

Though many know him well as a chief, few know him really well as a man. I have never known him speak unkindly or unjustly of others and rarely have I heard an unkind word spoken of him. Though I fancy that he does not suffer fools gladly, he shows little of this in his face and is indeed slow to anger. Nevertheless, the physical signs of his displeasure are easily recognised by those



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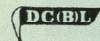
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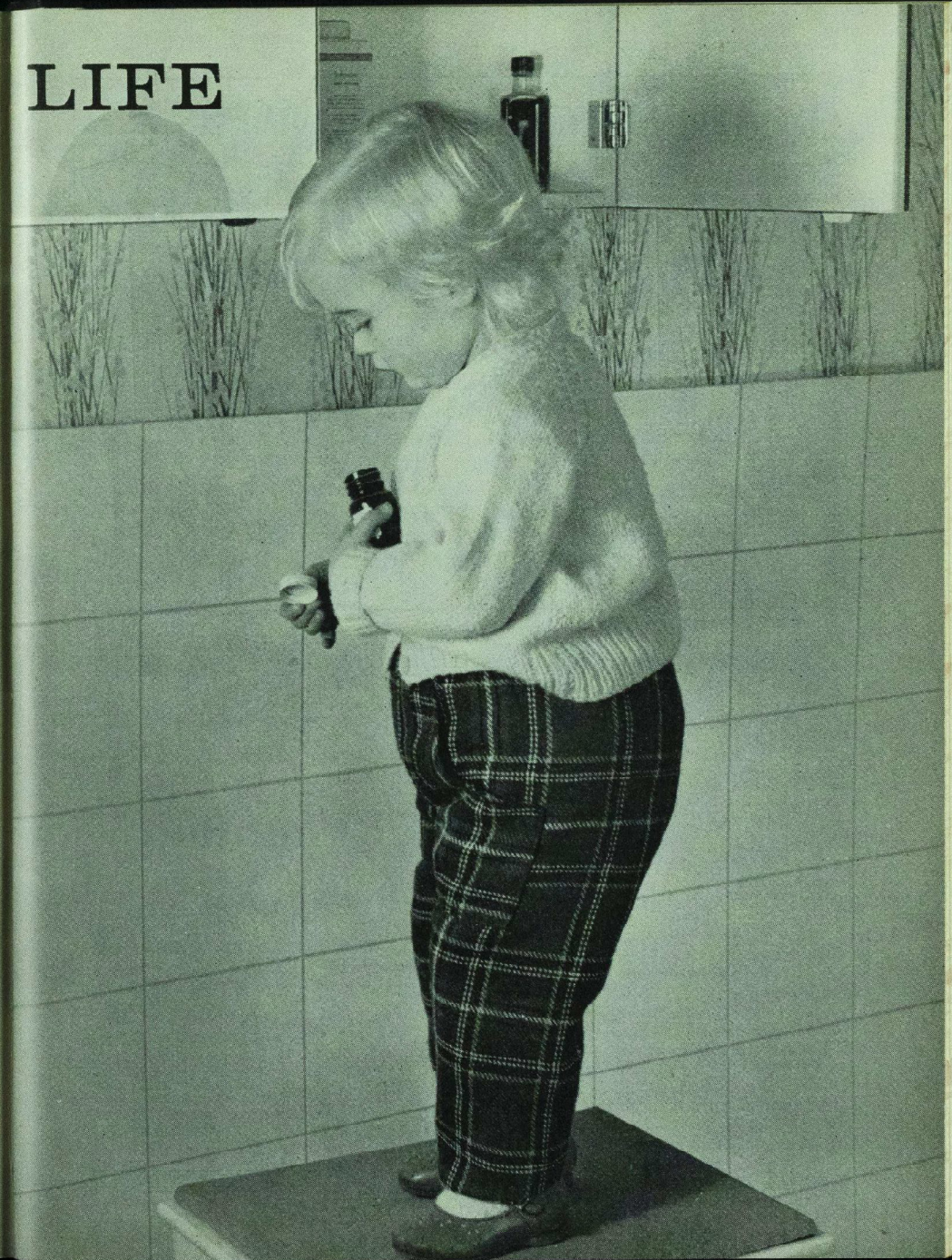
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who know him well. I can think of nobody with such a remarkable ability to disengage himself from an awkward conversation; or to proceed to more important business. His extraordinary reserve is at once the admiration of some and the exasperation of others.

Of the lesser known aspects of his life and character, I think it worthwhile mentioning that in his time, John Hosford has caused a certain amount of flutter among the nursing staff. When special theatre sisters were first established in 1929, the then theatre superintendent, Miss Hayes, went to considerable trouble in selecting her first three "pinks"—the Misses Grice, Briggs and Edwards. Alas, within a short space of time the late Wilfred Shaw had married Miss Grice; Alex Roche snapped up Miss Briggs, and John Hosford completed the decimation of the theatre staff by carrying off Miss Edwards, to whom he has remained happily married ever since.

His good looks have, of course, been the talk of the nurses' home and of fashionable salons for many years, but we cannot let him run off with all the physical honours. Though he has never been mocked with that modern appellation, "Big-Head", he was once celebrated for his big feet. Indeed his feet are referred to in the *Bart's Journals* for 1930, 1933 and 1934. They featured in a number of posters for the Christmas shows and one poster consisted solely of a picture of two huge feet. The *Journal* for 1934 is rather reminiscent of recent discussion about the "yeti", or abominable snowman, in that it contains several veiled references and innuendos about his alleged "spoor" in the Hospital square. Lest anyone should feel that here, at last, is his weak point, let me say that he put those big feet to very good use when, in May, 1923, the Bart's octocentenary year, he won the Hospital 120 yards hurdles in 19.4 seconds. He then went on to triumph in the United Hospitals 120 yards hurdles a month later.

John Hosford has always affected a somewhat casual form of dress, but though he has never adhered slavishly to the Harley Street pin stripe tradition, I think we may justly claim that he usually strikes a note of some sartorial elegance. Since the war, he has often sported a bow-tie which is now as much a part of Bart's as were Sir Geoffrey Keynes' celebrated suede shoes. I can recall one rather fine group of dressers (most of whom

were ex-service men), all of whom attended their last round immaculately decorated with bow ties. That they feared Mr. Hosford's displeasure was shown by the anxious way in which the ringleaders had consulted me a few days before. I listened to their plans with ill-concealed glee and, in reply to their enquiry as to whether he would be angry, I thought it best to say rather brusquely that men who had hunted U-boats and bombed Germany would look a bit soft if they were fearful of their Chief.

John Hosford has always been a keen motorist, and when a chief assistant drove from Highgate to John O'Groats in one day. So far as I can tell, he has no criminal record. The only offences with which he has been charged have concerned minor motoring misdemeanours. In this connection I recall a time when I chanced to mention that I had been stopped for speeding. He confessed that he had recently been in a similar predicament and told me how, on being consulted by a learned judge on a surgical matter he was emboldened to ask the Judge's advice as to whether he should attend court for his latest offence. The judge seemed horrified that so eminent a consultant should suggest a certain lack of professional success by finding time to attend a mere magistrates' court. He duly penned a letter addressed to "their honours" and couched in the most elegant and contrite language. The case was dismissed, and John Hosford very kindly lent me a copy of this letter with like success.

I must now return to a more sober note. I want to say what a tremendous pleasure and privilege it was to work for him and with him. By his example I learned many things that have proved of immense value, not the least of which is a calm, unruffled and conservative approach to surgery.

That John Hosford has chosen to retire five years before his allotted time has given rise to much speculation. I doubt, however, whether we need look far for his motives. On his father's side he is descended from farming stock, and I think that he is inspired by a basic saneness and simplicity of character which is as rich as it is rare amid the turmoil of Metropolitan consultant practice. His retirement to cultivate his land in Portugal now seems to be Mother Nature's way of reclaiming a prodigal son of the soil whom she must regard as a distinguished if delinquent peasant.

CARCINOID TUMOURS OF THE ALIMENTARY TRACT

by J. C. Crawhall

“Vielleicht könnte man sie als Karzinome bezeichnen.” (Oberndorfer, 1907).

The term “carcinoid” was first introduced by Oberndorfer (1907) to describe a rare tumour of the intestinal tract which was of carcinomatous nature but differed from the more common carcinomas in several vital respects. He said that the cells were mostly undifferentiated, though there was some evidence of glandular structure; they were circumscribed with no tendency to infiltrate the underlying structures; they did not metastasise; they grew slowly and did not reach a large size and finally, multiple tumours were sometimes found.

Gosset and Masson (1914) investigated the histological properties of these tumours and noted their argentaffin character and their similarity to endocrine cells. In 1928 Masson reviewed all the evidence that carcinoid tumours arose from the Kulitschitzky cells in the Crypts of Lieberkühn. In view of their argentaffin properties he renamed them argentaffinomas but in fact, as in one of the cases at Bart's Hospital, not all of these tumours are argentaffin so the old terminology will be retained in this essay.

The appearance of these tumours only in the alimentary tract “*dal cardias all 'ano*” (Steiger & Avancini, 1954) is in agreement with their being derived from special cells in the intestinal wall, though true carcinoids have been observed in teratomas of the testis and ovaries (Thorson *et al.* 1958). The most common site for carcinoid tumours is the appendix but these quickly occlude the lumen of the appendix leading to appendicitis which is treated by surgical removal before any metastases develop.

Very little advance was made in the study of carcinoid tumours after Gosset and Masson (1914) demonstrated the chromaffin and argentaffin character of the cells and their endocrine nature, until the early 1950's. At this time the existence of a new hormonal substance was recognised. Erspamer in 1933 showed the presence of a highly active pharmacological substance which he called enteramine. He showed its presence in the enterochromaffin cells of the alimentary

tract but was not able to isolate it from this source as the enterochromaffin cells are so few and widely scattered. He was able to isolate it from the salivary glands of the octopus. It was not until 1952 (Erspamer & Asero, 1952) that he was able to characterise this substance as 5-hydroxytryptamine. In 1953 Lembeck showed that 5HT could be isolated from a carcinoid tumour removed at operation.

At the same time as these properties of 5HT were being discovered a clinical condition of carcinoidosis was being described (Thorson *et al.* 1954; Waldenstrom, 1954). This is characterised by:

- (a) A malignant carcinoid of the bowel of slow progression and metastases in other organs.
- (b) Generalised widening of the cutaneous vessels of the skin, in some cases telangiectasis. Pellagra-like cutaneous lesions may be present.
- (c) Dependent oedema, frequent watery stools, borborygmi and abdominal pain are common. Ascites and pleural effusion may occur.
- (d) Plethoric colouration, cyanosis in the absence of polycythaemia and peculiar patchy flushing of the skin in some cases combined with pilomotor symptoms, may occur.
- (e) Pulmonary stenosis and tricuspid regurgitation.
- (f) Attacks of bronchial asthma of a rather unusual type.

I would like to present a case of carcinoid of the ileum that was in this hospital in 1959 and also, briefly, other cases of carcinoid tumour and carcinoidosis that have been treated in this hospital since 1952.

Case Report

Mr. R. S., aged 70, was a retired store-keeper. He was sent to the hospital by his doctor complaining of pains in his abdomen. For 5 months he had had lower abdominal pains with distension of his abdomen and

borborygmi. These had occurred one hour after meals, once or twice a day at first and now much more frequently. The pains were of a stabbing character but were not severe. He had anorexia, was eating soft foods only and had lost half a stone in weight over the last five months. Five days ago there had been an increase in the severity of his symptoms. He had no nausea, vomiting or jaundice. His bowels were opened regularly each day and the stools were of normal consistency. In his other systems: C.V.S. He had had mild exertional dyspnoea for many years. He had no palpitations or flushing and no ankle oedema. C.N.S. He slept normally, had no headaches, dizziness, or paraesthesiae. He had no mental disturbances. R.S. He had no cough or chest pain. U.G.S. D/N: 5/0-1. There was no pain on micturition, no difficulty in passing his water, no dysuria and the stream was good.

In his previous history, he had nephritis 41 years ago, a left inguinal hernia repaired 31 years ago, he had a peptic ulcer diagnosed six years ago, which was treated medically and had not recurred. He was divorced and lived with his sister-in-law. He smoked six cigarettes a day and did not drink alcohol.

O/E, he looked as if he had lost weight but was not in severe pain. There were no abnormal physical findings in the head, neck or chest. The apex beat was palpable (not heaving) $\frac{1}{2}$ in. outside the M.C.L. in the 5th I.C.S. The 1st and 2nd sounds were heard normally and there were no added sounds. The pulse was regular (80), the radial artery wall was thickened, B.P. 180/110.

His abdomen showed marked visible peristalsis, accentuated by drinking a glass of water. The peristalsis was not of a central step-ladder pattern, but commenced in the left iliac fossa and moved up to the left hypochondrium. There were dilated veins on the epigastrium. No enlargement of the liver, kidneys or spleen could be felt and there were no additional masses. The abdomen was very resonant all over. There was a marked succussion splash. The sign of shifting dullness could not be elicited. On auscultation there were vigorous bowel sounds. There was a small direct inguinal hernia. Investigations were carried out after his admission showed his Hb was 74 per cent and his W.B.C. was 4,600. A plain X-ray of his abdomen showed multiple fluid levels in his small bowel.

At operation three days later a tumour

was found obstructing the terminal ileum, $\frac{1}{2}$ in. from the ileo-caecal valve. There were no metastases in the liver. There was stenosis of the pylorus, probably from the old gastric ulcer. There was cholelithiasis and mild ascites. A right hemi-colectomy was carried out, with removal of the attached mesentery and mesenteric lymph glands. This was followed by an ileo-transverse colostomy. Post-operative recovery was complicated by the development of urinary retention. This failed to respond to catheterisation and 12 days later, cystoscopy and trans-urethral resection of the prostate was carried out for enlargement of the median and left lateral lobe of the prostate (This had not been detected previously p.r.). Recovery after this was uneventful and he was discharged 10 days later.

Histologically, the tumour was yellowish, ill-defined and measured 4:3.5:1 cm. lying in the sub-mucosal layer of the ileum and obstructing the lumen. The ileum proximal to the obstruction had become dilated and hypertrophied. The tumour was infiltrating the muscle layers and three out of six lymph nodes were involved with neoplastic tissue. A section of the tumour showed it to be argentaffin and typically carcinoid in appearance. No measurement of the 5-hydroxy indole acetic acid was carried out.

Discussion

The case of R.S. illustrates one of the ways in which carcinoid of the alimentary tract may present if the diagnosis of an intestinal neoplasm can be made whilst the growth is contained in a localised region. This type of case must have led Oberndorfer to believe these tumours to be benign. R.S. had a five-months history of abdominal pain but at operation there were no distant metastases though local lymph nodes were infiltrated. As these were removed at operation with the primary growth it is probable that R.S. will have no recurrence of his symptoms. R.S. showed some signs of the carcinoid syndrome such as increased peristaltic action and borborygmi. He had no cardio-vascular symptoms and no clinical oedema or ascites though some ascites were demonstrated at operation. It is thought that the reason why these localised carcinoid tumours do not give rise to the carcinoid syndrome is that the 5HT is drained by the portal venous system to the liver where it is metabolised

to 5-hydroxy indole acetic acid (5HIAA) which is pharmacologically inactive. In patients with the carcinoid syndrome liver metastases are present so that 5HT may be secreted by them straight into the inferior vena cava and thence to the peripheral circulation.

The other seven cases confirmed at Bart's from 1952-59 were not known personally by the author but details of their case histories have been obtained from their

notes and some general picture of carcinoid tumours and carcinoidosis will be drawn from these patients seen at this hospital. The P.M. report on F.S. was not available until the rest of this article had been written and the findings are not included in this discussion.

Lembeck (1958) has analysed 51 cases of carcinoidosis showing the incidence of the various possible symptoms originally described by Thorson *et al* (1954).

TABLE I

Symptoms	Number Investigated	Symptoms		Symptoms Questionable	No Comment Made
		+ve	-ve		
Flushing ..	49	41	7	1	2
Cardiac Lesion ..	30	20	9	1	21
Dyspnoea ..	24	12	12	0	27
Renal Symp. ..	16	0	10	6	35
Oedema ..	27	16	11	0	24
Mental Symp. ..	21	4	16	1	30
Diarrhoea ..	51	43	4	4	0

It can be seen from Table I that diarrhoea and flushing are very common symptoms. Oedema and cardiac signs are quite common and the latter might contribute to the

dyspnoea seen in some cases. The cases observed at Bart's are summarised in the following similar table. Renal and mental symptoms were not observed in these cases.

TABLE 2

Symptom or Sign	+ve	-ve
Flushing ..	F.S., W.K., G.B.	E.F., G.B., R.S.
Oedema ..	F.S., A.A., G.B.	W.K., R.S.
Cardiac Disease ..	A.A., F.S.	E.F., S.B., W.K., R.S.
Dyspnoea ..	A.A., E.F.	S.B., R.S.
Intestinal Disorder ..	S.B., A.A., R.S., W.K. E.F., F.S., G.B.	
Increased 5-HIAA Excretion ..	F.S.	S.B.

Symptoms of carcinoidosis found in Bart's patients with carcinoid tumours (1952-59).

Occurrence and aetiology of the symptoms

Intestinal symptoms: These may take the form of small bowel obstruction, which may present as abdominal pain or borborygmi, sometimes as visible peristalsis. This occurred in two of the Bart's patients (S.B. and R.S.). In the case of S.B. definite kinking of the ileum was observed and with R.S. the growth was sufficiently close to the ileocaecal valve to cause obstruction. Both patients had multiple fluid levels in the small bowel but had well formed stools so that water resorption must have taken place normally in the large bowel. If obstruction does not occur the patients may present with looseness of stools. This occurred in five of the Bart's patients (G.B., A.A., W.K., E.F., F.S.) and it is significant that four of these patients died within one year and the fifth three years later after the appearance of another tumour in the ileum (W.K.). In this series, therefore, intestinal symptoms were invariably present but if obstruction did not occur the symptoms were either overlooked by the patient or treated conservatively by the physician until widespread metastases rendered the patient severely ill.

5-HT is secreted by the enterochromaffin cells of the alimentary tract and it can be demonstrated pharmacologically that one of its actions is to stimulate peristalsis (Rocha e Silva *et al* 1953). It is probable that this is not the sole initiator of peristalsis as it is known that peristalsis is controlled neurologically via the plexuses of Auerbach and Meissner, but perfusion of isolated loops of guinea-pig ileum with 5HT does lead to increased peristalsis. Bean, Olch and Weinberg (1955) suggest that the peristalsis is induced by the neoplasm *per se* and not the secretions from it. However Thorson *et al.* (1958) reported a case of a woman (J.J.) with full carcinoid syndrome with intractable diarrhoea in whom it was found at operation that she had a teratoma of the ovary containing carcinoid tissue. The venous drainage of this teratoma was not via the liver and hence she had the symptoms of carcinoidosis without liver metastases. It seems from that example that hyperperistalsis can be initiated by 5HT or some analogous substance.

Oedema: Dependent oedema of the limbs is quite frequently present with carcinoid tumours, sometimes accompanied by ascites. Three patients in this series had extensive

dependent oedema (G.B., A.A., F.S.), one had transient ankle oedema (E.F.) and one had clinical evidence of ascites only (S.B.). Various theories have been proposed for the genesis of this oedema. In the presence of extensive hepatic metastases, oedema may arise from liver failure. If serious heart lesions are present the oedema may arise from heart failure. However evidence from other cases reported in the literature suggest that the oedema may be the direct result of 5HT secretion. Erspamer and Ottolenghi (1953) have shown that 5HT has a powerful antidiuretic effect in the rat but this may be a species specific effect (cf. Packthorn in Lewis, 1958). The evidence from man is contradictory as Smith *et al.* (1957) noticed a reduced urinary output (800 ml.) in two patients with carcinoidosis with no oedema and one of our patients had extensive oedema and nocturia (x2 or x3).

Flushing: This is one of the cardinal signs of carcinoidosis but is probably only present at the one stage of the disease and is superseded by permanent telangiectasis and pigmentation of the skin. This may lead to a permanent but often blotchy rubor or else to cyanosis in the absence of polycythaemia. In our series these cutaneous phenomena took various forms. G.B. complained of her blue colour and on examination she had general erythrodermia of her body with blotchy cyanosis of her face and hands. On her first admission A.A. had pigmented areas on her hands, the back of her forearms and on her face. She was readmitted three years later with a recurrence of her condition and this time had marked flushing. F.S. had had flushing of the face for four years before admission. A.A. had a malar flush but also had rheumatic heart disease.

It was originally suggested that flushing was a direct result of a sudden release of 5HT in the vascular system but Snow *et al.* (1955) showed that intravenous injection of 5HT in man did not cause a similar flushing. Flushing is also initiated by histamine which is also raised in carcinoidosis (Smith *et al.* 1957) Peart *et al.* (1959) showed that intravenous 5HT caused hyperpnoea and a relatively slight flush whereas adrenaline and noradrenaline cause considerable flush without hyperpnoea, which is more characteristic of carcinoidosis. Adrenaline could be the initiator for the release of 5HT from the tumour but blood withdrawn from the I.V.C. and portal vein of a patient who was flushing

as the result of adrenaline administration, did not have a raised 5HT level. He deduced from this that 5HT is not the chemical mediator in flushing. Initial flushing followed by telangiectasia is one of the features of rosacea and it is possible that there is a related hormonal basis for this condition.

Cardiac symptoms: A right sided endocarditis leading to pulmonary stenosis and tricuspid incompetence is one of the features of carcinoidosis. A.A. was found at post-mortem to have endocardial changes involving all the valves of her heart. These were regarded at P.M. as being of rheumatic origin although it is generally believed that pulmonary stenosis is never of rheumatic origin. In view of this, it is possible that A.A. had both carcinoid endocardial lesions of the right side of the heart and rheumatic lesions on the left or that all the lesions were of carcinoid origin. In other cases reported in the literature the endocardial lesions of carcinoidosis were restricted to the right side of the heart. It is believed that 5HT is the cause of this endocardial inflammation and it has been shown by cardiac catheterisation that the concentration of 5HT on the right side of the heart is three times greater than the left in a patient with carcinoidosis (Goble *et al.* 1956). The lung contains a high concentration of amine oxidase (Weissbach *et al.* 1957) which is responsible for the degradation of 5HT to 5-hydroxy indole acetic acid (5-HIAA) which is pharmacologically inactive.

At *post-mortem* W.K. had thickening of the pulmonary and tricuspid valves. F.S. also had a systolic thrill below the left clavicle and a systolic ejection murmur at the left sternal border

Dyspnoea: this has been regarded as a primary symptom (see Table 1) and was present in two of these cases (A.A., E.F.) and may have been present in others. In view of the liver and heart disease of these patients, dyspnoea seems a likely complication and no evidence has been provided that is a primary symptom.

5-HIAA excretion in the urine: As the metabolism of 5HT gives rise to 5-HIAA, this is likely to be raised in patients with a secreting carcinoid tumour. The urine of only two patients in this series was examined, in one of which it was raised (F.S.) and in one the other it was not (S.B.). After the removal of the primary growth some idea of the development of secondary growths can

be obtained from periodic analysis of the urine for 5-HIAA. This may rise to 100 mg.-800 mg./24 hours compared with an upper limit of normal of 13 mg./24 hours. 5HT excretion in the urine may not be elevated, as free 5HT is rapidly metabolised in the body except in the rare example of kidney metastases (Smith *et al.* 1957) but histamine excretion may be raised (Smith *loc. cit.*) Neither 5HT nor histamine excretion were measured in the Bart's patients.

Treatment

If the primary growth is localised, excision of the affected section of gut with the accompanying lymph nodes may be carried out, followed by an end-to-end anastomosis of the free ends. A careful search should be made to see whether multiple tumours are present. If there is a solitary metastasis in the liver, this should be removed also. If more extensive metastases are present it may not be possible to remove them all but as they are slow growing the patient may survive for a long time in spite of them. Two such cases of extensive metastases in the Bart's patients were treated with DXR but both died within six months. Recently attempts have been made to find an antagonist to 5HT and although these are effective *in vitro*, no clinical benefit has been observed in patients receiving these drugs (Gaddum *et al.* 1955). Recently Sandler *et al.* (1959) have demonstrated that administration of phenylacetic acid reduced the 5HIAA excretion of a patient with carcinoidosis without any noticeable improvement in their condition.

Prognosis

Although Oberndorfer (1907) described carcinoid tumours as benign, four out of seven of the Bart's patients died within one year of diagnosis and another patient died after three years. On the other hand the two patients successfully treated presented with small bowel obstruction so the discrepancy between this position and that observed at the beginning of the century may be explained in the following way. The patients observed by Oberndorfer either presented with obstruction and were quickly operated on or else the tumour was found at post-mortem as an additional finding. It is unlikely that the disease has changed its character in 50 years so it is probable that

patients with carcinoidosis did appear at that time, but in view of the extensive metastases, the presence of a small tumour in the ileum was either overlooked or else not recognised as being a primary tumour. In the case of A.A. the primary growth in the ileum was described as a minute hard submucous nodule and such a primary tumour may easily be overlooked in the examination of the ileum. In Cooke's (1931) exhaustive review of the literature to that time, out of 104 cases only 8 had liver metastases and 10 had lymph node metastases.

On the basis of the patients who have been treated at Bart's, it seems that those who present early with small bowel obstruction have the tumour removed at an early stage and the prognosis is good for an effectively complete cure. This is in accord with the prognosis for carcinoid of the appendix, where appendicitis rapidly brings the patient to hospital and the tumour is removed and no cases of metastases have been reported. If, on the other hand, obstruction does not occur, the patient will probably exist for many years with indefinite symptoms until a recognisable picture of carcinoidosis appears. This probably corresponds to extensive liver metastases and cardiac involvement and at that point the prognosis is bad because the metastases will continue to secrete 5HT after the primary growth has been removed. This will further aggravate the cardiac lesion leading to right sided heart failure unless an effective 5HT antagonist is found. Without this, the prognosis may be for only one or two years of life but this would be completely transformed if an antagonist could be found, as the metastases

grow very slowly, are restricted to the abdomen and it would take many years to reduce liver function to fatal levels.

This essay is an abbreviated form of the essay which was awarded the Bentley Prize 1960. I would like to thank Mr. Curwen, the Hospital Statistician, for his assistance in collecting this inclusive list of cases of carcinoid disease treated in this hospital since 1952.

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Love Specific

I met my love in the S.T.C. ;—
 She was all I wished my love to be ;
 The warmth behind her opaque eyes,
 Her pupils of unequal size,
 So adoring and attractive,
 To light were totally non-reactive.
 Her nasal bridge was well depressed,
 And as my stethoscope I pressed
 To auscultate, I thought I caught a
 Song of love from her aorta ;
 An air melodiously pathetic

Plaved by cusps long since luetic.
 And yet, despite her W.R.,
 (A positive without a par),
 Her peg-shaped teeth were matched by none
 And soon enough my heart she'd won ;
 So casting cares and doubt aside
 I asked if she would be my bride,
 Which shows, although it may sound stupid,
 The spirochaete can oft play cupid.

IVOR GUMMER

Obituary

RICHARD BARRATT TERRY died in Chicago in October, 1960, after an illness lasting three months. He was 46 years old.

He came to St. Bartholomew's Hospital from Malvern College in 1934, and qualified in 1939 shortly before the outbreak of war. As a territorial officer, he was called to the colours in August of that year while still holding the post of junior house physician to Dr. Gow and Dr. Bourne. His service was mainly in the Middle East and he reached the acting rank of lieutenant-colonel before he returned to the hospital in 1946 to become a supernumerary chief assistant. Within a few months he had obtained the M.R.C.P. and the M.D. London and was appointed Chief Assistant to Dr. Bourne and Dr. Bodley Scott. At the end of his term, he was awarded a research scholarship to Cook County Hospital, Chicago, returning at the end of a year to this country as registrar to the follow-up department at St. Bartholomew's and physician to the Seamen's Hospital at Greenwich.

The six years spent in the Army at the start of his career put him behind in the race for appointments and, although he was runner-up for the post of assistant physician at two teaching hospitals in London, younger men were successful on each occasion. He had made such a favourable impression at Cook County Hospital that before he left he had been offered the post of assistant director of medical education. With great courage he decided at the age of 39 years to emigrate to the United States with his wife and two children. He served a year's internship at Cook County Hospital and passed the examination of the State medical boards. Within a few years he had built up a busy consulting practice in Chicago and at the time of his death he was an assistant professor of medicine at Northwestern University and

Richard Barratt Terry

a member of the staff of Passavant Memorial Hospital.

This recital of the bare outlines of his professional career gives an indication of Richard Terry's determination and application. It is not an easy task to pass the examinations for M.R.C.P. and the M.D. London within 12 months of release from six years in the Army, spent mostly in forward units: it is not easy at the age of 39 years with a wife and two children to turn one's back on secure mediocrity and start afresh in a foreign country; and the life of an interne at Cook County Hospital, with more than 3,000 beds and a resident staff always below strength, is far from easy for a man of 40 years.

When a Chief Assistant he married Miss Elizabeth Greenaway who was then working at the hospital as a physiotherapist. Those who were fortunate enough to know them both realise what great happiness he enjoyed in his marriage and in his family. In the difficult decisions which faced him he was able to draw strength from his wife's courage and from the unwavering support she gave him. She and their four children have the sympathy of us all.

His adopted country in no way diminished his essential English-ness, although he did his best to remember to use the short "a" when speaking to his patients in Chicago. His friends will recall the tall, elegant figure, the kindness and the irresistible charm. In his last letter he wrote: "It is remarkable how completely one is accepted and how well the methods learned at Bart's go over with the local patients". His teachers may draw some consolation from the second part of this comment, but the first will appear remarkable to none who knew him. No man was more generously endowed with the attributes which make a good doctor than Richard Terry.

R.B.S.

LETTERS TO THE EDITOR

Pathology

Dear Sir,

The results of a "one-word answer" questionnaire are bound to be misleading, and the report in your July issue on Aspects of Medical Education contained some provocative nonsense. Mr. D. Fraser had no choice but to pounce upon it in his letter last month. But imprisoned in the "fallacious conclusions" of the summary was a *cri de coeur* from a student body as unhappy about our education as our teachers, represented by Mr. Fraser, obviously are about our sense of responsibility. His last sentence sums up the situation, "in the final analysis the student is, in fact, *self taught* and it is high time that the Bart's undergraduate recognised the difference between teaching and learning." Or between teaching and education he might have said. The deficiency at Bart's is not in the teaching, which is usually adequate and often excellent, the deficiency, where it exists, is in the *opportunities for learning*, a wider and very much more important concept.

A practitioner differs from a student in being able to *try out* his knowledge and learn by his endeavours, a chance worth more to him than all the facts that have ever "passed from the notes of the lecturer to those of the student without going through the mind of either" in all the history of medical education. This is the priceless gift that every serious student hankers after more than any other when he contemplates the delights of qualification. And it is one, I suggest, whose worth is soonest forgotten by those who possess it.

Another medical son of Canada and Oxford wrote of his clinical students "They should be in the hospital as part of its equipment, as an essential part, without which the work cannot be of the best." (William Osler, *The Hospital as a College*.) But a great teaching hospital, such as St. Bartholomew's, is right in protecting its patients against the inept malpractice of its students. Clearly trying out knowledge and learning by mistakes cannot be extended unreasonably in this direction. How then can *opportunities for learning* be found?

I believe in two ways, both suggested by the answers to the questionnaire. Firstly, the unpopularity of pathology is a major

curricular disaster which the Department and Medical College have a responsibility to put right quite apart from any defence of the teaching staff. Here again it is not the teaching that is at fault but the opportunities for learning. The one opportunity that we have of relating practical pathology to our patients is in the *post-mortem* demonstrations, and these are deservedly popular. In the wards we are expected to take histories and examine our patients, and woe betide the student who copies the houseman's notes. The third stage of diagnosis, however, is represented in our minds by pilgrimages to the Path. Lab. with handfuls of W.R. tubes and the subsequent appearance of slips of green and yellow paper. Pathological investigations are a real and growing part of medical practice and the journals resound with the cry of the practitioner who has to send his patients up to hospital for a haemoglobin estimation or a urine culture. Surely we should be asked on ward rounds, what cells did *you* see in the urine? What did *you* find the blood group to be? and what did *you* think of the histology of the endometrial curettings? Here surely is the answer to "dead" pathology practicals, if these techniques are worth learning at all they are worth learning to *use*. It would need some new facilities of course, a few microscopes, some chemical and bacteriological apparatus, but nothing that could not be fitted (dare I suggest it?) into a corner of the new and spacious teaching laboratory.

Secondly, might we not test our knowledge in tutorials? More than three-quarters of the questionnaire replies were in favour of these. I believe that this is not an attempt to badger more teaching out of a wearied staff but an expression of the need to present our knowledge to a mentor, as essays or short talks (the Psychiatric Department gives us an only chance of this kind) to be criticised and to *discover what we do not know*. Surely the stimulus to this discovery is the essence of education.

Yours truly,

DAVID GARDNER-MEDWIN

The Abernethian Room

Dear Sir,

It is true, as Mr. Fraser points out in his letter in the October *Journal*, that the student attitude to teaching is largely subjective; but the aim of the Questionnaire was surely to determine this subjective attitude; and if a large number of students share the same opinion regarding the teaching of a particular subject, this finding is significant and one must attempt to analyse the reasons for it. This I attempted to do *objectively* in my commentary on the results of the Questionnaire in the July *Journal*.

With regard to pathology, on which Mr. Fraser makes further comment in his letter, it is probably true to say that students are not fully aware of its value, but I would like to point out that many students feel that a longer and less intensive course which is rather more integrated with clinical medicine would be of both greater value and greater interest. This viewpoint is confirmed by the very considerable popularity of the daily *post mortem* demonstrations at which pathology and clinical medicine are studied concurrently, or in other words are fully integrated. Such "integration" was strongly recommended in 1948 by the B.M.A. Committee's Report on the Medical Curriculum which said: "The divorce of pathology from clinical medicine is one of the most serious defects of the present medical curriculum . . . The Committee therefore recommends that the teaching of pathology should be spread over the whole of the clinical years and that the pathologist and the clinical teachers should co-operate in the instruction given in the lecture room, the wards, the laboratory, and the *post mortem* room". I am suggesting that if the pathology course is given a different *emphasis*, it could become one of the most "popular" subjects, and an integral part of the more practical study of medicine and surgery.

The opinions I have expressed here are the result of considerable discussion with my student colleagues. It would certainly be most interesting to see the views of the other members of staff and of other students in these columns of the *Journal*.

Yours faithfully,

P. J. WATKINS

The Abernethian Room,
St. Bartholomew's Hospital,
London, E.C.1
November, 1960

Profile

Dear Sir,

I write somewhat belatedly to thank you for the article on Professor Taylor which appeared in your July issue and to express the hope that its publication marks what would be a very welcome change in editorial policy.

While very properly singing the valedictory praises of each retiring member of the staff, the *Journal* has, in the past, rarely done more to welcome the man appointed to fill the resulting gap than to announce his name. This is no doubt sufficient for those of your readers (a minority, I believe) who work within the hospital and to whom the newcomer will soon be, if he is not already, a familiar figure. But there must be many old members of the hospital—especially those who have occasion to refer their patients to Barts for consultation or treatment—who would be grateful for a little more information as to who and what the new man is, where he comes from, and what he has accomplished in the past.

The "Profile" technique adopted by your contributor—a judicious blending of *curriculum vitae* and character sketch—has come to be accepted in even the most august journalistic circles as the best way of introducing Top People to Top People. May we have more articles of this sort in the *Journal*—starting, perhaps, with Professor Taylor's successor as Assistant Director?

Yours faithfully,

DONALD CROWTHER

27 Lansdowne Road, W.11

Gastroscopy

Dear Sir,

I enjoyed reading Mr. Peter Knipe's article on Gastroscopy in the current issue of the *Journal*, but would like to remind you that Mr. Hermon Taylor, whose design of gastroscopy is in common use, is also a Bart's man.

Yours sincerely,

W. RADCLIFFE

"Ten Acres," Wivernoe,
Essex

Cyril Morgan Pearce

Dear Sir,

I was very shocked and sorry to see the notice of the death of Cyril Morgan Pearce in your last issue.

We both went to Charterhouse (at Godalming) within a few months of each other.

Then came the 1914-18 war, when he served with the Royal Artillery and was wounded in 1918.

We met again at Barts in 1923, when he was H.S. to Mr. Rawling, and later Senior Resident after Franter Evans. After leaving Barts he became a surgeon at Blackburn, when I regret to say I lost sight of him.

He was always kind and unassuming, though inwardly he had great drive, determination, and powers of leadership.

He had a first-class brain, which he devoted entirely to surgery, and considerable personality.

With these qualities he never lost his kindly spirit, and was always helpful and kind to those not so brilliant as himself.

There will be many men of our generation who will miss him, and remember him as a good surgeon, a true friend, and a staunch and pleasant companion.

Yours sincerely,

T. A. DODD

(Bart's, 1923-26).

Tyneham House, Christchurch,
Hants

Medical Society

Dear Sir,

There has recently been formed in the University of London a Medical and Dental Society. As treasurer of the Society and a Student at Bart's I would appreciate the opportunity of bringing its existence to the notice of your readers.

The idea behind the formation of such a Society was not to replace the College Medical and Dental Societies, but to present to students in the Faculty of Medicine a common meeting ground. Mixing with students of other hospitals is an anathema to some, but thought to need encouragement by others.

We are at present in process of being recognised as an official society of the Union, but several successful meetings have already taken place—subjects have included "Forensic Medicine" by Dr. F. Camps, and "W.H.O. in Formosa." In the future we have, among other events: Dr. Eustace Chesser on "Marriage," Prof. Rotblat on "Nuclear Physics in Medicine," and a Dental Topic. This gives an idea of our scope. At the recent Fresher's Evenings we enrolled 100 new members.

Our doors are wide open to Bart's Students.

Yours sincerely,

BRIAN J. DONEY

Malet Street, London, W.1

BOOK REVIEWS

BOOKS RECEIVED

ANIMAL EXPERIMENTS IN THE DIAGNOSIS OF HUMAN DISEASE, Research Defence Society, Conquest Pamphlet No. 12. Price 6d.

VACCINATION AGAINST WHOOPING-COUGH, DIPHTHERIA AND TETANUS, Research Defence Society, Conquest Pamphlet No. 11. Price 6d.

MISCELLANEOUS NOTES (Eighth Series), by F. Parkes Weber. Published by H. K. Lewis & Co. Ltd. Price 3s.

THE NEWLY BORN INFANT, by Andrew Bogdan. Published by Austick's Medical Bookshop, Leeds. Price 3s.

AN ATLAS OF HUMAN BRAIN AND SPINAL CORD SECTIONS, by W. Hewitt. Published by Pitman's. Price 5s.

ANAESTHETICS FOR MEDICAL STUDENTS,

by Gordon Ostlere and Roger Bryce-Smith. Fourth Edition. Published by Churchill. Pp. 116. Price 12s.

There is no joy in owning this little black sheep of Richard Gordon's flock. Its featureless pages, bound in soft green cloth, contain nothing to stimulate interest or imagination. Nor has it enough facts to be worth anything as a reference book. But there is no doubt that between its wearisome succession of lists and its self-consciously readable style "the little green book" does somehow manage to present the useful essence of anaesthesia, with a healthy emphasis on safety. With its help you can devour the subject in a couple of days—even hours if you are really famished. It is worth doing so, two or three times if you like. But the book is rather expensive.

D.G.M.

MEDICINE FOR NURSES, by W. Gordon Sears, M.D., M.R.C.P. Published by Edward Arnold Ltd. Eighth Edition. Price 20s.

This latest edition has a complete range of subjects covering the Syllabus of the General Nursing Council. These subjects are clearly stated with sufficient information without confusing the reader with too many details.

The nursing care of the patients is well emphasised—a point which is lacking in many other books of medicine for nurses. There is, however, a lack of photographs and good clear diagrams which most nurses find helpful when studying.

The short chapters at the end, particularly the one on drugs, offer concise facts, good for quick reference. The summaries on the various subjects and the examination questions make this book ideal for revision.

I have found the book very useful and would recommend it to nurses wishing to further their knowledge in this subject.

W.M.M.

AIDS TO MEDICINE, Seventh Edition, by J. H. Bunce. Published by Bailliere, Tindall and Cox. Pp. 391. Price 12s. 6d.

Although it is no simple task to include as vast a subject as medicine into so few pages, this little book achieves reasonable success in tackling the subject in a concise, if too brief, form. However, only the more common conditions are described in any detail, and this tends to be inadequate, while several conditions of academic importance are barely mentioned. Treatment is discussed only very briefly and, in most instances, no mention is made of the advantages or otherwise of the various therapy recommended. While most sections are definitely inadequate, that on dermatology is recommendable even for normal study.

This book is intended mainly for the new clinical student venturing on to the wards for the first time, its value lying in the fact that it readily fits the pocket and the concise manner in which it is divided into the various systems. However, on no account should this book be used other than for quick reference, and one would be hesitant in recommending it to more senior students for revision as its brevity and omissions are likely to lead yet further confusion to the already muddled mind.

R.G.M.

SPORTS NEWS

Viewpoint

A THIRD of the winter sporting season is gone—and what is there to show for it? Apart from two of the wettest months for this time of year in living (admittedly short) memory, there has been a great deal of activity with some good results. However, to start at the beginning and back to August . . .

The Rugger Club, in a determined effort to improve on last season's rather poor showing,

THE RELUCTANT SURGEON: THE LIFE OF JOHN HUNTER, by John Kobler. London (etc.), 1960. Published by Heinemann. Pp. 359. Price 21s.

There have been several studies of the lives of William and John Hunter in recent years, most of which add little to our knowledge of these two eminent men, and some of which are unworthy to be called biographies. The best-documented study of the two brothers was that privately published by George C. Peachey in 1924, and this has hitherto been our primary source of information.

This present life is written by an American, was first published in the States (although there is no indication of the fact in this reprint), and is here reproduced in a somewhat cheaper format. It is remarkably cheap at one guinea, which is considerably less than the price of the American edition.

Without fear of contradiction, we state that this is the best biography of John Hunter that has been produced so far. It reveals an intensive study of his life and times, is well-documented, and contains an extensive bibliography.

John Hunter (1728-1793) remains one of the greatest figures in the history of surgery without having made any one epoch-making discovery. Comparatively uneducated, he was ill-equipped to study the writings of his predecessors, which was probably one of the main reasons for his success. He looked for himself, conducted experiments, dissected everything he could lay his hands on, and added greatly to our knowledge of anatomy, surgery and natural history. His writings, and his museum at the Royal College of Surgeons of England are our inheritance, and one can only marvel at the industry that achieved so much. We will not even attempt to provide a summary of John Hunter's career. Readers will be better served by being advised to read this book.

J.L.T.

started training on the lawn in front of College Hall—much to the amused amazement of the inmates who sat in their little cells (unpadded) and looked rather like battery hens clucking away, well fed on stodge and locked in their cages at a set time by a well-meaning martyr. Need we take the analogy any further!

The Rugger enthusiasts were joined by equally keen members of the Hockey and Football teams, and the training programme

was stepped up in intensity. By the start everyone felt, and looked, fit. However, for a while the 1st XV seemed unable to make the best possible use of this; but with increasing experience from some good games, tactics have changed from defence to attack, with the result that it has won three of the last five matches. Special mention should be made firstly of the "A" XV who have won five of their last six games; and secondly of the splendid spirit that exists throughout the Club—partly fostered by a highly successful social evening in October, consisting of the pleasant mixture of films and beer.

The Football Club made a good start, but since then have been greatly hampered by a series of injuries to several 1st XI players. Anyway, they had a good tour in Cambridge and have drawn their first three league games in the interesting arithmetical progression: 1-1, 2-2, 3-3. They have seven more games—so perhaps the final game should be especially worth watching!

Gloom was the accent on the prospects of the Hockey Club at the beginning of the season. This has been dispelled to reveal a team much improved on last year. It won, quite comfortably, its first round cup match and looks forward with some optimism to the next.

The Ladies, not to be outdone in spite of the weather, have been energetic, and the Lacrosse and Hockey teams have both been doing well. There is not enough space to measure all the other teams, though mention must be made of the Golf Club, who did very well to reach the final of the U.H. Cup, only to lose to an exceptionally fine team.

Over all, one can see an all round enthusiasm which is a healthy sign that the members of the various teams are making useful contributions to the community, and through this helping themselves.

RUGBY

Bart's v Harlequin Wanderers. Away. Saturday, October 29th. Lost 0-11.

Despite rain and a damp pitch, both sides contrived to handle and the home team's superiority and greater experience in this respect is reflected in their win by a goal and two tries to nil. Bart's forwards achieved a majority of the ball in the tight only to see chances frittered away by a threequarter line which, although usually effective in defence, was sluggish and impotent in attack.

Mistakes on the Hospital line twice let in opportunist Harlequin scores, but the best try followed a multiple handling movements initiated in the home twenty-five which not even the vigorous covering of Jennings and Smart could contain. In the last fifteen minutes high up-and-under kicks several times

forced the Wanderers' defence into error, but at no-side their line remained undefield.

Team: Niven; Stevens, Bamford, Letchworth, Jeffreys; Davies, Peek; Hamilton, Gurry, Knox, Orr, Doran, Jennings, Smart and Goodall.

WEST COUNTRY TOUR

Bart's v Penzance and Newlyn. Saturday, November 5th. Lost 0-24.

Bart's v Paignton. Monday, November 7th. Won 21-6.

Bart's v Brixham. Wednesday, November 9th. Lost 0-11.

This season's tour opened, as in former years, at Penzance, where the Hospital forwards were gradually worn down by one of the heaviest packs in club rugby, the annihilation becoming complete when Smart had to be withdrawn to replace the injured Britz at half-time. Encouraged by this front line domination the elusive Penzance backs were able to add three goals and a try to their two first-half tries against a plucky but often ineffectual defence. Mention should, however, be made of Stevens and Peek, both of whom defended stalwartly.

The Paignton game, however, produced a welcome recovery of form and, although down at half-time, the forwards, with Davies outstanding, guided Bart's to victory, assisted by the determined running of Jeffreys and the incisive kicking of Stevens. Tries came from Jeffreys, Halls, Davies and Stevens, and the last-named converted three and kicked a penalty goal.

On the pultaceous Brixham pitch Bart's went down by a goal, a try and a penalty goal after a scoreless first half. Poor Chesney making his 1st XV debut at scrum-half had to cope with appalling conditions, an unfamiliar outside-half and a fast, hostile back row, and although he did not always get the line going he displayed Jeeptian resolution and courage in defence. The pack fought hard, but failure to make use of good opportunities in the first half, and defensive lapses in the second, resulted in defeat.

Off the field the tour went with a bang socially and pyrotechnically; and during the few quiet moments, golf proved a popular mode of relaxation under sunny autumnal skies.

Tour Party: Niven, Ross; Stevens, Harris, Letchworth, Bamford, Jeffreys; Britz, Peek, Chesney; Harvey, Gurry, Knox, Orr, Doran, Smart, Davies, R. P., Goodall, Jennings and Halls.

Bart's v Old Haberdashers. Home. Saturday, November 12th. Drew 6-6.

This game only livened up in the last quarter of an hour, when all the scoring came. Before this, both sides made frequent mistakes in a scrappy game with the heavier Haberdashers' forwards gaining a clear advantage in the scrums and lines-out. The Hospital scored first when Peek ran round the blind side after an attempted pushover try. This was neutralised almost immediately when Haberdashers' strong-running right wing galloped 70 yards after a break in his own "25." Neither try was converted. Next, Niven charged down a kick, dribbled over and touched down, but with the last kick of the match, Haberdashers drew level with a penalty goal from 30 yards. **Team:** Ross; Harris, Stevens, Niven, Jeffreys; Bamford, Peek; Hamilton, M. G. Revill, Knox, Orr, Smart, Davies, R. P., Jennings and Halls.

Bart's v Old Alleynians. Saturday, November 19th. Won 12-0.

The Hospital pack playing superbly together sowed the seeds of victory early in this game by not only achieving more than their fair share of the ball in the set pieces, but also by being noticeably a yard or so faster than their opponents on to the loose ball: in this latter respect Smart and Davies distinguished themselves and Cripps made a notable debut. Outside, the wings both ran determinedly and the defence always proved sound. Tries came from Orr, after a good handling movement among the forwards, and Bamford who jinked through on the right following a cross-kick from the left. Between these scores Stevens and Harris kicked penalty goals.

Team: Ross; Harris, Stevens, Niven, Jeffreys, Bamford, Peck, Hamilton, Gurry, Knox, Orr, Smart, Davies, R. P., C. M. Cripps and Jennings.

Bart's v U.S. Chatham. Home. Saturday, November 26th. Won 6-3.

The Hospital beat U.S. Chatham by a penalty goal and a try to a penalty goal in a fast game at Chislehurst. The Services scored first, but Bart's drew level almost immediately when J. E. Stevens kicked a penalty goal almost under the posts. Thereafter the Hospital had much of the game territorially, but it was not until close on no-side that Peck and Bamford contrived an opening through which Niven ran very strongly to score one of the best tries of the season.

Bart's pack came close to scoring push-over tries on several occasions and gained a majority of the ball from the tight, but this advantage was often nullified by the effective spoiling of the opposing back row.

Team: Ross; Harris, Stevens, Niven, Jeffreys; Bamford, Peck; Hamilton, Gurry, Knox, Orr, Smart, Davies, R. P., Jennings and Halls.

HOCKEY

First Round, U.H. Cup. Bart's v King's College Hospital. Home. Thursday, November 17th. Won 5-2.

It had been raining continuously since the previous evening at Chislehurst, and the pitch was—to say the least—very wet. But Bart's started well, using the advantage (one of the opposing team arrived late). Mastering the conditions, the forwards and halves pressed the opposing defence. Several attacks came down the right wing where P. Caine was in his usual marauding mood. It was not long before H. da Silva drew first blood by scoring from an attempted clearance following a short corner. Soon after, D. Glover, inside left, scored from the back of the circle off a perfect square pass from M. Hessian at inside right. R. Jeffreys at centre half, playing his second game of the season, being on loan from the Rugger XV, commanded the centre of the field with quick interceptions and accurate passes. By half time Bart's were 3-0 up.

K.C.H. then started to come together, their play was much quicker and they started some fierce tackling. The Bart's defence was now put to the test and stood up well; at times they relied upon the King's forwards overeagerness by coming up and invariably putting them offside.

Occasionally a mêlée started in our circle, the defence not taking the first opportunity to clear the ball away out of danger.

From two such mêlées the King's centre forward scored but, on many occasions, S. Campbell-Smith in goal cleared most effectively.

H. Walker and M. Smith-Walker, the backs, sent up some very good 16 yard hits, but the forwards and wing halves had lost the co-ordination they had in the first half. Nevertheless, Bart's continued to get the ball near the K.C.H. goal, and on one occasion M. Hessian netted the ball after a short corner had been blown for by the umpire. P. Kingsley scored soon after to make the score 4-2. P. Caine, taking a good pass from R. Courtenay Evans at right half, finished off a very nice run down the right wing with a gentle push which completely beat the K.C.H. goal-keeper. The final minutes soon passed, with Bart's still pressing—the final whistle and victory—the first Cup match the Hockey Club has won since 1956.

In the next round, to be played in January, we meet Charing Cross Hospital.

Team: S. Campbell-Smith, H. Walker, M. Smith-Walker, R. Courtenay-Evans, R. Jeffreys, A. Robertson, P. Caine, M. Hessian, P. Kingsley, D. Glover (Capt.). H. da Silva.

SOCCER

United Hospitals' Cup, First Round. 1st XI v St. Mary's. Wednesday, November 16th. Away. Lost 1-5.

Bart's have once again been eliminated in the early stages of this competition. The Hospital XI were beaten quite comfortably by St. Mary's, the current cup-holders. The score, however, gives no indication of the standard of football we achieved.

Mary's took a three-goal lead in the first half. This did not deter Bart's, and Iregbulem scored well to make it 3-1. The cup-holders confirmed their superiority by scoring two more goals in the second half without reply. Bart's played well, but not really well enough to achieve anything in this competition. **Team:** J. Spivey, G. Ilaig, M. J. Noble, J. Jailler (Capt.), D. Delaney, M. Hudson, E. Manson, L. Iregbulem, H. Phillips and N. Davies.

LACROSSE CLUB

1st XII v St. Mary's Hospital. Wednesday, October 19th. Regents Park. Won 7-4.

This was the first game of the season, and although the pace of the game was fast at first, the game as a whole was rather slow. St. Bart's shot the first goal, but Mary's fought back and we managed, with difficulty, to hold them at three goals each by half-time. Our throwing was a little out of touch and the defences were not marking closely. S. Ducker and D. Layton shot six of the goals between them, although Mary's defences were crowding in front of the goal.

Team: J. Pitt (Capt.), J. Anderson, T. Anderson, R. Benison, E. Bohn, J. Clarke, S. Ducker, S. James, A. Kark, D. Layton, C. Lloyd and E. Webb.

1st XII v The Royal Free Hospital. Wednesday, November 2nd. At Chislehurst. Won 19-10.

The Cup Match arranged for this date was postponed as the Royal Free were unable to raise a full team. The Bart's attacks play a good game and the passing was more accurate, in spite of the high wind. Our defences had a hard game marking the Royal Free attacks, who were very fast.

Team: J. Pitt (Capt.), J. Anderson, T. Anderson, J. Clarke, S. Ducker, J. Hazeldine, D. Layton, C. Lloyd and C. Telfer.

R. Bewson and E. Bohn played for the Royal Free.

December, 1960

United Hospitals' Regatta

All crews entered for this Regatta started training six and a half weeks before the event and, with the exception of the scullers and pair, arranged two or three outings a week. Both IV's and the Junior VIII went out about ten times in the last fortnight. The considerable keenness shown by the VIII was particularly encouraging—few Bart's Junior VIII's can have had so many outings. Great tenacity was shown by all crews throughout training in the face of continually bad conditions, most crews having no more than a couple of rainless trips. Since the Junior VIII and Senior IV A moved up to London Rowing Club at Putney a month ago the flood waters rose so high on two occasions that the boats were almost floated off the racks in the boathouses! The Senior VI A are indebted to G. D. Benet and H. Ward for the benefits of their coaching early on in training.

Results

Senior IV A. *Bow* (steers), A. H. Knight (U.C.S.); 2, D. C. Dunn (Forrest and L.M.B.C.); 3, H. Coleridge (Moncton Combe); *Stroke*, N. E. Dudley (Bedford).

Semi-final: Rowed on dead water and with little wind a very indifferent piece of rowing was done in which a clash of blades necessitated a restart further down the course. In unconvincing style the Bart's Senior IV B was beaten by 3 lengths.

Final: v. St. Thomas's Hospital. Bart's in one of the best starts produced by the crew, shot rapidly into the lead, and at Beverley Brook were half to three-quarters of a length in the lead. A clash of blades without infringement of either water drew Thomas's level, and then started a ding-dong battle right over the mile long course, with neither crew ever more than half a length in the lead. The verdict of a canvas (canvas in light IV's is approximately 6 feet) was awarded to St. Thomas's as judged by the interval between the bow lights, dusk having fallen. In view of the fact that Thomas's crewed two of their successful Wyfold IV Bart's acquitted themselves well.

Senior IV B

Bow (steers), M. Frnst; 2, T. Hudson; 3, I. Wilson; *Stroke*, J. Diamond.

It was unfortunate that this crew, which trained hard and had numerous outings, should meet the other Bart's IV in a race which lacked fire.

Junior VIII

Bow, J. Anderson; 2, J. Merrill; 3, J. Wilson; 4, D. V. Jones; 5, B. Bennett; 6, M. Stewartson; 7, D. Hunter; *Stroke*, N. Whyatt (Capt.); *Cox*, R. Weller.

First Heat: v. St. Mary's Hospital. Following a poor start due to stroke breaking his jost straps, Bart's on the Middlesex station, trailed over half a length down. Then in a magnificently judged race the Hospital caught their opponents and, with a devastating spring for "home," beat them by one and three-quarter lengths.

Semi-final: v. St. Thomas's Hospital. On a tide that had already started to turn, Bart's were unfortunate to have the Surrey station. Try as they might the crew found the half a length lead by Thomas's irreducible under the conditions, but hung on gallantly only to lose by three-quarters of a length.

N.B. It is probably true to say that Bart's were the second best crew entered for this event, having beaten the other finalists, Westminster Hospital, in practice, who were beaten by Thomas's easily.

Junior IV A

Bow, R. Blake-James; 2, J. D. Hardy; 3, J. Pusey; *Stroke*, J. Wan Ping; *Cox*, N. Laughnan.

First Heat: v. Westminster Hospital. In a paddle full of style and confidence, Bart's came in with a verdict "easily," rating at a leisurely 24.

Second Heat: v. Guy's Hospital. The eventual winners of the event with the most entries, showed Bart's who was master, and beat them convincingly by two and a half lengths.

Junior IV B

Bow, D. Robins; 2, C. Anderson; 3, W. Garson; *Stroke*, M. Aveline; *Cox*, I. Cole.

First Heat: v. London Hospital. This novices boat, which was entered primarily to give them racing was unfortunate to meet the eventual semi-finalists, who beat them easily.

Rugger IV

Bow, A. C. Howes; 2, M. Waterworth; 3, T. D. V. Cooke; *Stroke*, P. Scriven; *Cox*, G. Renn.

v. St. Thomas's R.F.C. The Bart's crew were impressed by the rowing style of the Thomas's oarsmen who, in turn, were not impressed with the rugger style of the Bart's rugger players and beat them easily.

Pair

E. M. C. Ernst and J. G. Diamond.

v. St. Mary's Hospital. Against a crew containing last year's Cambridge bow man and another oar of distinction, the Bart's pair did remarkably well to lead them to the Black buoy. Thereafter, experience and fitness told to the extent of three lengths in Mary's favour.

Double Sculls

A. H. Huight and A. I. Wilson.

v. St. Mary's Hospital. Considering this crew was entered merely to keep the event alive, the two Bart's scullers, without practice, gave Bartlett and White, of Mary's, as close a race as that distinguished pair are ever likely to get in the U.H. Regatta. Bart's lost by only one and a half lengths in a race whose outset was always in doubt.

Junior Sculls

Vane-Tempest

v. J. G. Scott (St. Mary's) and A. N. Other (St. Mary's). After being kept waiting on the start for three-quarters of an hour by his opponents, the Bart's sculler was struck by an allergic reaction of unknown aetiology which kept him at quarantine distance away from his nearest rival.

TO LET

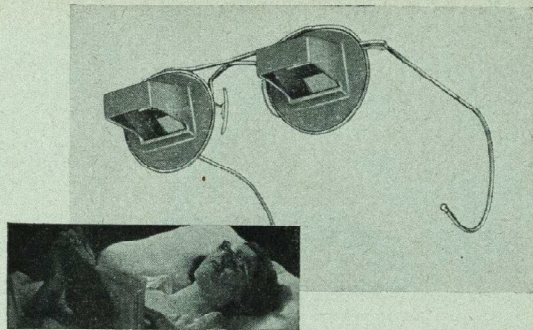
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