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ST. BARTHOLOMEW'S HOSPITAL JOURNAL

Vol. LXV, No. 1 **JANUARY, 1961**

Calendar

JANUARY
Sat. 7—On duty: Dr. A. W. Spence
Mr. C. Naunton Morgan
Mr. R. A. Bowen
Sat. 14—On duty: Dr. G. W. Hayward
Mr. A. W. Badenoch
Mr. R. W. Ballantine
Sat. 21—On Duty: Dr. E. R. Cullinan
Mr. E. G. Tuckwell
Mr. C. Langton Hewer
Mon. 23—Film Society: "Hiroshima mon Amour".
Thurs. 26—Abernethian Society: Dr. Carstairs.
Sat. 28—On Duty: Medical and Surgical Units
Mr. George Ellis

FEBRUARY
Sat. 4—On Duty: Dr. R. Bodley Scott
Mr. A. H. Hunt
Mr. F. T. Evans
Mon. 6—Film Society: "The Naked Truth".
Sat. 11—On Duty: Dr. A. W. Spence
Mr. C. Naunton Morgan
Mr. R. A. Bowen

Editorial

THERE ARE A great many views, held individually, on what the Journal is, and what it should be; and yet few of our critics, when questioned, seem fully to understand the purpose of this publication.

It has been suggested that these pages could carry a little more humour, but the Journal is no medical equivalent of *Punch*, and it is certainly not part of our policy to swamp it with the various forms of humour which may be gathered from the resources at our disposal. Humorous articles and poems, however, do appear in sensibly balanced proportion, and either pertain to a matter of domestic interest, or are submitted for publication by some very welcome contributor.

A second suggestion is "that we include more articles of educational value", yet just as we do not wish to upset the balance by overloading the Journal with humour, so neither do we wish to tip it the other way. The articles published are of general medical interest, and although they will further our knowledge, they are not primarily intended to assist the examination candidate.

The final suggestion is that the Journal broadens its scope, but here it is necessary to

mention one or two points of policy. The principal aims of the Journal are: firstly to cover the domestic affairs of the Hospital and Medical College, secondly to provide articles on topics of general interest to us all, and thirdly to serve as a link with the Hospital for those who have left. These functions are accomplished by the Journal as it is, and a further broadening of scope would inevitably mean the introduction of material irrelevant to the Hospital and ourselves, and it is over questions like this that the Journal must maintain an adequate sense of proportion.

Great use has been made recently of the phrase "A wind of change" and the blasts and hurricanes of Africa and the Far East have been matched in this country by a gentle zephyr rustling the scattered papers in the Journal Office. In short it has been decided to change the printers. As a result of this change, it is hoped to bring the Journal up to date so that it is published during the month for which it is current. The Editor would like to take this opportunity to apologise to contributors and readers alike for the unfortunate delays which have so marred our publication in the past. *A propos* of this, it would greatly assist the editorial staff if all who contribute reports on club and social activities ensured that these reports are forwarded in good time for publication.

Fifty years ago

ON MONDAY, DECEMBER 5th, 1910, a General Meeting of the Students' Union was held for the purpose of discussing a question which was of vital importance to the continued prosperity of the British Empire. A large number of members were present, and Mr. Waring, President of the Students' Union, kindly consented to take the chair. The subject of the discussion was: "That in the opinion of this meeting the continuance of the present Liberal policy will lead to the ruin of the Empire".

It may be remarked that, although gentlemen of conflicting opinions on this academic topic sat upon different sides of the room, the proceedings throughout were conducted with a mild and broad-minded bon-homie, and that the party spirit that might easily have been much in evidence during a general election seemed to be remote from the thoughts of the various speakers, whose wholesome probing after truth showed that they, at least, had not been drawn into the vortex of Party politics.

Mr. Morse, in opening, said that greatness was thrust upon him. He could not go into details, but the combined "Liberal-Radical-Socialist-what-not" policy was disruptive and almost anarchy. If all were equal today, all would be as before tomorrow. Socialism, an impossibility, must end in dictatorship.

Mr. Barrow, in seconding, said that the lower classes did not hate the upper classes and were polite to him. Single chamber is impossible, as any government could pass any law it liked, which could be reversed by the opposition when in power. United States had a strong second chamber.

Mr. Baynes, the opposer, spoke of the agile change of the Unionist front, and quoted the Referendum. Democracy is an important thing, to be trusted and not to be exploited by the House of Lords. Free Trade and Home Rule were necessarily fundamental propositions to the Liberal policy.

Mr. Molony, who seconded Mr. Baynes, deplored the mistrust of Ireland by England after one hundred years of union. He said that the Government of Ireland was wasteful in police and judiciary, and parsimonious in education and public health.

Mr. Hill, a historian, stated that England was greatest when England was drunk.

Mr. Snowdon said that theoretically, Socialism was excellent; practically an impossibility.

Mr. Strahan quoted Referendum, House of Lords, Bills (various), trams and gas (municipal).

Mr. Russell attempted to address the meeting, became "political", and sat down.

Mr. Wedd assured us that the whole Liberal policy was destructive and non-imperial. "Unity (and Tory Government) is strength."

Mr. Nicholson, our railway expert, quoted statistics. There were a number of other speakers.

Mr. Baynes, in replying, became poetical and mystic, and talked of "the great stream of Socialism flowing through a dam of Peers."

Mr. Morse, in replying, said that democracy cannot govern; "it's breeding" that counts. He ended with a few verses of Kipling.

On a show of hands the motion was found to be carried. The meeting then adjourned.

Abernethian Society

ON OCTOBER 25TH, 1960, Prof. R. A. McCance, F.R.S., Prof., Experimental Medicine, Cambridge University, addressed the society on: "Thermal Stability in the Neonate and Adult".

He introduced his subject with a summary of the physiology of heat production and loss. Heat production results from muscular activity, basal metabolic rate and thermo-regulatory heat production. It is, in fact, a result of cellular activity, derived from wastage in the synthesis of adenosine triphosphate. Heat loss in human beings occurs through the lungs and direct from the skin—we rely mainly on our subcutaneous fat for conservation of heat.

Recent experiments on mice and pigs were explained. Heat production is at a minimum at the critical temperature but it increases as the temperature is lowered. Nor-adrenaline may mediate this response. It was observed that the oxygen consumption increased during cooling and that injections of nor-adrenaline had the same effect only during cooling.

Piglets when cooled, use up their glycogen stores because hypoglycaemic fits will result if they are warmed up while in this state. We are to deduce from this, therefore, that cold newborn infants are also hypoglycaemic. A well meaning nurse would endeavour to warm them up and thus unwittingly induce convulsions. It would be better, first, to treat the hypoglycaemia and acidosis, and then, the neonate will be better able to return to a normal temperature.

T. G. H.

ON NOVEMBER 10TH, Prof. W. S. Peart, Prof. of Medicine at St. Mary's Hospital, addressed the society on: "Hypertension". His talk, illustrated by slides, included many interesting experiments, but he found it difficult to assess their significance:—

A rise of blood pressure is caused more by an increase in peripheral resistance than by the cardiac output. Referring to his recent work on hypertension due to atheromatous renal artery stenosis, he suggests all loins should be stamped: "Kidneys not to be sacrificed"—an arterial graft gives better results. Histology reveals the arterial obstruction within the kidneys often leaves the glomeruli intact and damaging only the tubules. Removal of a Phaeochromacytoma is not so good in lowering blood pressure. The I.V.P. of a diseased kidney in hypertension is often deceptive. It will excrete the dye less effectively than its normal partner, thus exhibiting a much greater concentration of the dye. Usually, one is tempted to assume that the kidney showing less dye is at fault, but in this instance it is not. Work on the carotid sinus showed it to be adaptable to the general blood pressure. It is effective in lowering small increments of pressure and this property remains, however high the general pressure may be.

Prof. Peart thought hypertension was a phenomenon of the body resulting because there was no mechanism to stop it. After all his work on the kidney, he remains sure that this organ secretes the hormone primarily concerned in changes of general blood pressure—though it has still not yet been identified satisfactorily.

T.G.H.

The result of the elections for the coming season were as follows:

President	J. C. CRAWHALL
Secretary	P. J. WATKINS
Treasurer	H. WHITE
Committee	M. BALL
	T. G. HUDSON
	A. J. B. MISSEN
Pre-Clinical Representative	M. LIPSEDGE

Film Society

The Film Society's Spring programme will be—

9th Jan.—Hamlet.

23rd Jan.—Hiroshima mon Amour.

6th Feb.—The Naked Truth.

20th Feb.—The Third Man.

6th March.—The Importance of being Ernest.

Dramatic Society Nursery Productions

IT WAS WITH great interest that a large audience gathered in the recreation room of College Hall on the evening of November 23rd to see the Nursery Productions of the Dramatic Society. Three one act plays were performed offering ample scope for detecting talent amongst the newer members of the Society who had never before had opportunity to exhibit their skills before a Bart's audience. The idea was a novel one, and as such succeeded. There should now be little doubt, in the mind of the producer, who is likely to merit the distinction of appearing in the cast of the main production of the Society at the Cripplegate Theatre on February 20th and 21st, 1961. Not only did the Nursery Productions offer opportunity for the actors to shine, but talent was exhibited in many other directions contributing to the total success of the evening. Congratulations should go to all those who worked behind the scenes, to the providers of the most adaptable scenery and in particular to those who made the most of the necessarily limited facilities offered for such a production at College Hall. Mechanical difficulties were dealt with skilfully and those less capable of being overcome were accepted by a cheerfully tolerant audience.

The first play "Try it again" by J. B. Priestley was performed by a group of preclinical students who enthusiastically tackled something which they and the audience found somewhat oppressive. It is essential that a One Act play must hold the attention of the audience constantly within its grasp, but the acting, though vigorous, was ineffectual in conveying the meaning of the play as one assumes the author intended. Credit must go to Bruno Kastelitz who gave a convincing performance as Kramer, the stranger who endeavoured to disentangle the oh so familiar problems of domestic life as seen through the eyes of the playwrights. Rachael Fisher gave a promising performance as Helen, the intonations of her voice singling her out from the other members of the cast who unfortunately showed little variation in manner of speech and in gesture. The limitations of the stage may well have caused the poor positioning in the play, but could hardly be blamed for the self-conscious attitudes and mannerisms of the cast apparent to some extent throughout the evening. The choice of play was ambitious and was a welcome feature of this domestic trilogy in that it was a play with some purpose.

"The Birds of Prey", a comedy by Mabel Constanduros and Howard Agg, was received with great appreciation by the audience. Susan Williams exercised considerable talent in the portrayal of Mrs. Wiffin, the central character in the play, and one feels sure that she will soon become a familiar figure on the stage of the Cripplegate. John Graham Pole, though having only a small part to perform, did so well. All praise to the producer, Nicholas Lochlan, for this polished presentation.

"Love in a Suburb" by Philip Johnson, did not quite achieve the high standard promised by the previous play. Unfortunately the cast, composed this time of clinical students and members of the nursing staff, succumbed to one of the perils of clinical existence and the show went on despite the recent illness of three members of the cast. Diana Clark gave a brilliant performance as Queenie Tremayne and one found it hard to believe that she was not originally intended for the part, her gestures rarely failing to inspire laughter from the audience. Patrick Kingsley as the eager Tony Mortimer gave us some insight into his experience as an actor and Mike Stewardson tacked a difficult character study with imagination and zest, carrying with him sympathetic attention throughout his appearance. Despite this, the production on the whole appeared stilted and much of the acting wooden and unimaginative.

The evening passed quickly and pleasantly for those present and there is no doubt that as a social and constructive occasion it was a great success, although at times of doubtful artistic merit. The Dramatic Society is fortunate to have so many enterprising members and the success of the evening should be a great source of encouragement to those responsible for the main production next year. It was gratifying to see so many members of both the medical and nursing Staff present, and one feels sure that future productions of this kind will find little difficulty in attracting a similar response.

A. C.

The Guinness Luncheon 1960

ON NOVEMBER 7TH, thirty students from Bart's walked through the gates of Guinness's brewery at Park Royal with somewhat greater alacrity than they had shown on entering the gates of Brighton six months earlier. This was the third day on which Guinness had entertained successful competitors of the 1960 Inter Hospitals London to Brighton Stroll.

Their pace quickened as they were directed to the Toucan Inn and on arriving there, those who had not already drunk their morning draught were surprised to be met by a rather large talking toucan, however, on closer examination, it became apparent that Mr. Alfie Howard, the Guinness Majordomo, was inside.

Once inside, all were soon draining the glasses of Guinness thrust repeatedly into their hands, but eventually the majority of the guests were persuaded to leave for a tour after the guide had promised a speedy return to the Inn.

The tour of the brewery was an impressive and extremely interesting experience for everybody and much surprise was expressed generally at the enormous scale on which Guinness is brewed and the "dairy cleanliness" of the whole factory.

Their palates thoroughly prepared by the sight of so much Guinness the party returned to the Toucan Inn, where they slaked their thirsts with quantities of assorted liquid refreshment.

The colourful menu, proclaiming such dishes as Weary Calf Steak with Blister sauce and Assorted Brighton Rock, hardly paid justice to the splendid meal which followed. Later in a flow of postprandial eloquence, no doubt enhanced by the excellent Port and during which Mr. E. Wood and Mr. G. Baker exploded the notion that brewers do not know any good stories; Professor Hazelwood of Guys, himself a successful competitor, said how impressed he had been whilst walking, by the tremendous spirit of camaraderie amongst students, who, in any context would have been the keenest rivals.

Late that afternoon the numbers in the Toucan Inn had hardly decreased and the general opinion was that it had been worthwhile walking to Brighton. Our hearty thanks must go to Arthur Guinness Ltd. for their splendid and unstinted hospitality. Next year I suspect they will see many familiar faces and I hope, many more new ones.

News in Brief

Sir Geoffrey Keynes will be giving the second Grey Turner Memorial Lecture for Durham University at Newcastle on 22nd February. The subject of the lecture will be "The History of Myaesthenia Gravis".

On May 3rd, Sir Geoffrey Keynes will also give the Gideon de Laune lecture at the Apothecaries Hall. Subject: Dr. Timothy Bright, Physician to St. Bartholomew's Hospital.

Change of Address

MR. & MRS. JOHN HOSFORD'S only address will be: Carril, Reguengo, Portalegre, Portugal.

DR. A. GEOFFREY DAWRANT, 26 Boltons Court, 216-222 Old Brompton Road, London, S.W.5.

DR. R. KNIGHT, c/o Morwell Medical Clinic, Morwell, Victoria, Australia.

BRIG. J. E. SNOW, O.B.E., Echo Barn, Echo Barn Lane, Wrecclesham, Farnham, Surrey. (Farnham 460.)

Births

MACADAM.—On December 1st, in Buenos Aires, to Diana, wife of Dr. F. I. Macadam, a daughter (Margaret Mary).

MIDDLETON.—On November 23rd, to Jeanne and Dr. George Middleton, a daughter.

PHILIP.—On December 5th, to Julia and Philip Paton Philip, a son (Charles).

KIMMINGTON.—On December 3rd, to Peggy and Dr. Kenneth E. Rimmington, a son (Thomas Oliver Rahere), a brother for Noëlle and Robin.

Deaths

HAMILL.—On November 29th, John Molyneux Hamill, M.A., M.D., D.Sc., O.B.E., aged 80. Qualified 1904.

HAYES.—On December 10th, Dr. William Edward Hayes. Qualified 1921.

PATON.—On December 7th, Florence Paton, S.R.N., late of St. Bartholomew's Hospital.

SEYMOUR.—On November 28th, Dr. James Croley Seymour, aged 39. Qualified 1945.

SOME OF THE ADVANTAGES OF A VISIT TO A G.P.

by M. Millington

IT IS NOT generally known in the Hospital that facilities exist whereby students can spend a week or two with a general practitioner. The desirability of such a scheme would seem obvious, for although during student and pre-registration years it is possible to gain a fairly accurate picture of the various aspects of hospital practice, most gain only secondhand information, usually prejudiced, regarding general practice. Since the majority of medical graduates eventually enter general practice, it is strange how they can feel themselves capable of making such a decision, whilst so lacking in accurate information. Viewed this way, if medical education is to realise its aim of preparing students for the work of later life, there is obviously need for the inclusion of specific instruction in general practice in the medical course.

Much is written nowadays about the importance of treating the patient as a person, and not a collection of organs, each considered as a separate entity in itself. Indeed, like every reaction, over-emphasis tends in this direction at the present time, rather than the opposite of a few years ago, so that much otherwise good advice becomes platitudinous and hackneyed. Nevertheless, the psychological and social concomitants of physicall ilness are real problems, and a period in general practice helps one to appreciate them.

Another very useful feature is that a stay in general practice can serve to indicate to the prospective general practitioner those aspects of his undergraduate education which will be of most use to him later. A true picture of the incidence of disease may be obtained, in contrast to the artificial selection imposed by hospital entry. For instance, in the practice I visited, Weil's disease occurred as frequently as rheumatic fever, and although this may not be generally applicable throughout the country, one questions the brief mention of the former, to the exhausting teaching of the latter in hospital, as being not quite in true perspective.

Students tend to view Public Health and the administrative aspect of medicine, together with medico-legal matters, as not "real" medicine worthy of their attention. Yet, a considerable amount of a general practitioner's time is taken by these matters, so that again such a visit results in a change of emphasis, and the student thereafter may take account of them in his medical training.

Although not the main purpose of these visits, an appreciable amount of medicine is learnt, useful for the more immediate worries of examinations. Similarly, the opportunity of discussing all branches of medicine, as presented by the patient, in a short space of time with a knowledgeable and amenable person is one that does not occur during hospital training. Housemen are usually so busy, consultants too remote and unapproachable for really thrashing out a subject individually, and registrars a combination of both, that such discussion becomes especially profitable. In fact this was the nearest approach to an individual tutorial system I have met in clinical medicine, even though such a system would obviously be of great value should it exist in the hospital.

I have tried to show a few of the advantages of a brief visit to a general practice, but have not described the details of my visit, nor of the particular practice I visited, because they will obviously differ with each practice, but have tried to indicate the broader principles which are more widely applicable. It is for this reason that a week to a fortnight is the most advantageous length of time to stay, because the principles of general practice which emerge during this time, and whose impartation is the object of such visits, would later tend to be obscured in the mass of detail acquired by a more prolonged stay.

Finally, I should like to thank those who made my visit possible, and if all practitioners practice as high a standard of medicine as the one I visited I think there will be few students disillusioned by general practice.

A CASE OF AMYLOID DISEASE

By S. M. Watkins

AMYLOID DEGENERATION OF the kidney was first described by Rokitansky in 1842 as "Speckniere" or "bacon kidney". It is fairly uncommon as a clinical syndrome: only four victims were reported in this Hospital in 1959. All four were cases of amyloid secondary to chronic infection. One of them was of particular interest because of the multiple pathology and symptomatology, and the development of a rare complication.

Case History

Mrs. B., a housewife, sustained a fracture of the sacrum at the age of 12. The wound became infected, and the resultant abscess took 14 months to heal. The osteomyelitis recurred several times during adolescence and early adult life, with general malaise, fever, sacral pain, and pus draining from the rectum. She had two pregnancies: both children were normal.

In 1952 at the age of 32, she developed polymenorrhoea and menorrhagia. In 1957 she was seen again suffering from malaise, with headaches, anorexia, dyspnoea, and palpitations on exertion. On examination, the liver was just palpable; there was bilateral ankle oedema; and there was an erosion in the posterior wall of the rectum. Investigations revealed a severe anaemia, proteinuria, and azotaemia, with a fall in alkali reserve. A renal biopsy confirmed a diagnosis of amyloidosis. The treatment was an increase of protein and fluid intake, together with 40 m Eq. of sodium lactate daily. In May 1958, she had a radium menopause to stop the loss of blood.

One year later she was re-admitted, complaining of nausea, vomiting, headache, pruritus, and "misty vision". She had impaired powers of concentration. The blood pressure was raised, and there was bilateral Grade IV hypertensive retinopathy; left ventricular hypertrophy, oedema and a raised jugular venous pulse were also present. There was severe anaemia (which was treated by transfusions of packed cells), and acidosis (shown by the low alkali reserve). Her condition deteriorated rapidly and three weeks after admission she had a series of short convulsions lasting about a minute each, followed by a massive retinal haemorrhage. She died the same day.

Post mortem examination showed that death had been caused by the intracerebral and pontine haemorrhages. Other pathological findings were: old osteomyelitis of the sacrum, with fibrous adhesions to the rectum; left ventricular hypertrophy, with mild atheroma of the coronary vessels; a foraminal pressure cone in the brain, oedema of the legs and serous effusions of the pleurae and peritoneum. The kidneys were contracted (40 and 45 grams) and showed ischaemic scarring; the cortex was reduced in thickness, and the vessels and Malpighian bodies were prominent; iodine staining for amyloid was positive. Microscopically there was exten-

Summary of Pathological Tests

	Age	*Blood Urea mg %*	*ESR mm/hr*	*Hb %*	*W Bc /cu mm*	*BP*	*Serum Proteins Gm %*	*Urine Proteins Gm %*	*Serum Cholesterol*	*Alkali Reserve m Eq/l.*	*Serum Sodium m Eq/l.*	*Serum Cl m Eq/l.*	*Serum K m Eq/l*
	21	32	43	60	30,800	108/80							
First Pregnancy	22		64	96		122/84							
Second Pregnancy	27			70	6,900	110/70							
At Time Of Diagnosing Amyloid	37	220	46	46	11,000	150/80	A. 3.3 G. 2.0	4.8	280	16.3	133	105	5.9
Last Admission	38	300	52	36	4,500	230/130				25.7	130	103	4.5
On Day Of Death	38	256				220/140				17.2	117	83	4.7
(Normal Range of Values)		15–40	4–7	82 105	4,000 –10,000		A.4–6.7 G.1.2–2.9	0	200-300	24–34	137-152	96–106	3.9-5.6

sive amyloid infiltration, which in places had formed large focal collections which were gradually obliterating the renal architecture. The spleen was congested and contained amyloid infiltration, as did the adrenals. The ovaries had similar deposits in the vessel walls; there were also some follicular cysts, and an old haemorrhagic corpus luteum. The lungs were congested and oedematous.

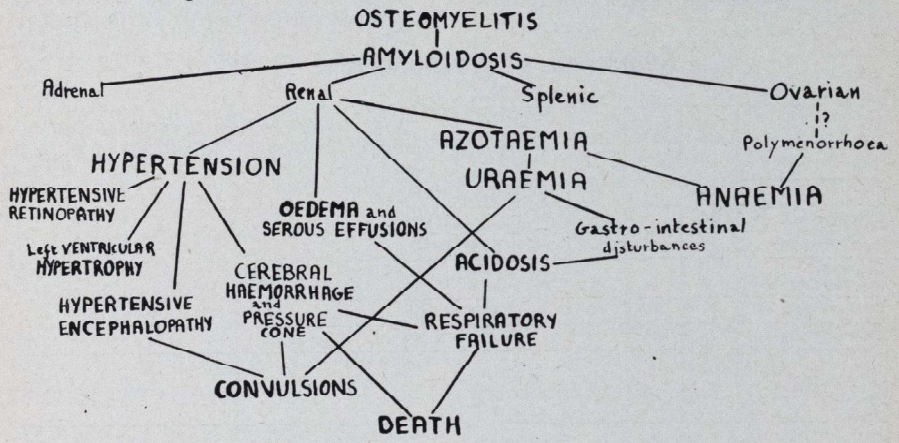
This, then, is a case of amyloidosis secondary to osteomyelitis. Hypertension, which occurred in this patient is an uncommon complication of renal amyloid (in 1950, Leard and Jaques could find descriptions in the medical literature of only 40 cases, all of whom, like Mrs. B., had contracted, ischaemic kidneys). The nature of the relation between the two conditions is uncertain. The hypertension in its turn, caused Grade IV retinopathy (with misty vision), and left ventricular hypertrophy. Finally it contributed to the convulsions and to the terminal cerebral haemorrhage.

body fats, in an attempt to restore the osmotic pressure of the blood, which has fallen as a result of the urinary protein loss.

The azotaemia depressed the marrow function, contributing to the patient's severe anaemia; another contributory factor was the polymenorrhoea (which may perhaps have been in some way related to the ovarian amyloidosis). Later, there developed the full clinical picture of uraemia, with weakness, nausea, anorexia, vomiting, headache and pruritus. The gastro-intestinal disturbances, together with renal failure eventually caused a metabolic acidosis.

The terminal convulsions were probably due to a combination of uraemia and hypertension, precipitated by the cerebral haemorrhage. Finally, death was due to a combination of these latter factors, together with respiratory failure.

The clinical and pathological history is summarised in the following diagram.



The renal damage in due course gave rise to proteinuria and azotaemia, with mild hypoproteinaemia (especially albumin), and a slightly raised blood cholesterol. "The loss of protein in the urine . . . is probably a major factor in the accompanying hypoproteinaemia, the reversal of the albumin/globulin ratio, and probably, by mechanisms as yet unknown, the hypercholesterolaemia (Allen). With respect to the latter, Fishberg has ingeniously suggested that the raised blood cholesterol (which is far more marked in fat patients), represents the mobilisation of

The Problem of Diagnosis

The diagnosis of renal amyloidosis from other forms of nephrotic syndrome is often difficult, for in the early stages, the conditions are clinically identical. Congo red tests and tissue biopsies are, of course, diagnostic, but they are rarely performed in the early stages of any renal disease. As in Mrs. B.'s case, the most valuable early clue is a history of chronic infection preceding the renal signs, though it is not present in every case.

The first differentiating symptom is often polyuria. For in nephrosis, increasing glo-

merular damage leads to a decrease in GFR (and hence a tendency to oliguria and diminishing proteinuria) whilst in amyloid degeneration of the glomeruli, the GFR and proteinuria are progressively raised. At the time of diagnosis, Mrs. B.'s daily urinary output varied between $1\frac{1}{4}$ and $2\frac{1}{2}$ litres, which was certainly suggestive of amyloid rather than other types of nephrotic syndrome. Another clue is the urinary albumin level, which is relatively lower in amyloidosis than in other nephroses. Geill noticed that the urinary albumin fraction falls further still in the terminal stages of amyloid disease, and that a level of less than 60 per cent of the total urinary protein indicates a poor prognosis.

These few differentiating features are mainly of academic interest, for the treatment and prognosis of all forms of nephrotic syndrome (including amyloid disease) are the same. However, the importance of early diagnosis of amyloid disease has often been stressed in the interest of those rare cases in whom intensive treatment of the underlying condition may lead to a regression of the amyloid. Mrs. B. on the other hand, is an illustration of the vast unfortunate majority in whom the amyloidosis, though fairly easy to recognise, appears only when the chronic infection has been present for many years and has failed to respond to treatment.

As yet, there is no treatment for amyloid disease. Prophylaxis is surely the answer to the problem; and to this object a study of the pathogenesis of the disease is no doubt an important approach.

The Pathogenesis of Amyloid Disease

(a) Circulating Globulins

The aetiology of amyloid disease is a matter of controversy, and is complicated by the fact that, although most cases are secondary to infective and other conditions, a small number are apparently primary or "idiopathic". The commonest underlying conditions are chronic suppuration, tuberculosis and syphilis, but it occurs also in a small proportion of cases of multiple myelomatosis, Hodgkin's disease, leukaemia, gout and rheumatoid arthritis.

In early experiments it was found that repeated injections of living or dead bacteria, or bacterial toxins, produced amyloid disease in mice; and that prolonged feeding of cholesterol to rabbits caused hyperglobulinaemia, and sometimes amyloidosis. In 1923, Kuczynski produced hyperglobulinaemia and amyloid in mice by repeated injections of sodium caseinate, and concluded that the amyloid deposition was in some way the direct result of increased amounts of circulating breakdown products. However, in 1936, Jaffé showed that the amyloid changes were proportional to the number of the first few injections only, after which there was no quantitative relationship. He concluded that the amyloid changes are the result of an acquired hypersensitivity to the foreign protein; excess circulating antibodies could indeed favour the deposition of complexes containing globulin (e.g. amyloid material) and recent experiments have shown that this process is accelerated by gamma-irradiation (Lesher et al.). The amyloidosis secondary to chronic infection may thus be explained in terms of acquired hypersensitivity to the organism (or to one of its derivatives). Similarly, this could account for the amyloidosis associated with rheumatoid arthritis, for as Glynn says: "haemolytic streptococci are capable of adsorbing minute amounts of non-antigenic polysaccharides, and converting them to complete antigens". He suggests that this may be the immunological basis of the rheumatic lesions, in which, a tissue component constitutes the non-antigenic hapten. It is possible that the same immune reaction could also be responsible for the amyloidosis. If this were true, it would be a case of two different degenerative lesions resulting from a single immunological factor, rather than one lesion being secondary to the other. In this case one might expect that any agent which produces a cure or remission of one condition should do likewise in the other. Parkins and Bywaters have observed precisely that: in cases of amyloid with rheumatoid arthritis, remission of the latter during steroid therapy was accompanied by regression of most of the clinical signs of amyloid, although the Congo red test remained abnormal. Relapse of the arthritis was associated with a rapid return of the splenomegaly and proteinuria, and the presence of amyloid was confirmed by biopsy. The temporary symptomatic improvement of both conditions is certainly not a cure; it may be a combination of the specific action of steroids in rheumatism, together with a non-specific

effect on glomerular filtration (it has been shown that urinary fluid and protein loss could be diminished by steroids, which decrease glomerular permeability). However, the complete disappearance of the hepato splenomegaly as well as the proteinuria suggests that something more has happened: perhaps the remission of both conditions represents an attack by the steroids on the common underlying cause, thereby allowing temporary improvement of the structure and function of both the rheumatic joints, and the amyloid viscera. The fact that steroids are beneficial in so many types of immunological disorders would lend support to such an idea.

What, then, of primary amyloidosis? Jaffé, firmly convinced by his explanation of an immune response, suggested that it might be due to a pathological hypersensitivity to the foreign proteins, which result from abnormal intestinal permeability, abnormal liver function, or other disturbances of protein metabolism. This could be true, though he offers no evidence to support his theory. One could well suggest other causes: for example, an immune response of the rheumatic type (outlined above), without the associated rheumatism; for, by this theory of a common underlying cause, one could expect amyloid disease without rheumatism, just as one so often sees rheumatism without amyloidosis. Another possible source of antigen for an immunological reaction could be from extensive tissue damage: for example, the young man described by Muerhke *et al.* had been severely burnt in childhood: could his amyloid degeneration have been initiated already at that time, when his body was reacting to the denatured proteins? Or perhaps it may be possible for amyloid to develop in an organ which has suffered a prolonged, low-grade, symptomless infection (a combination of direct toxic effects with local hypersensitivity). However, these are but unsupported suggestions. In any case, the multiplicity of the known conditions underlying amyloid, suggests that several different antigen-antibody reactions may lead to the same pathology.

(*b*) *Tissue changes*

The ground substance of connective tissue is composed largely of hyaluronic acid and chondroitin sulphate, and, according to some workers, it constitutes the "metachromatic pool" from which elastic and fibrous structuser are formed and to which they eventually return in the course of ageing. It has been suggested that the amyloid material arises from connective tissues. Is it possible then, that in response to an antigen-antibody reaction, amyloid (i.e. chondroitin-sulphate-protein complex) deposition is an abnormal, exaggerated and accelerated form of the normal degenerative process of ageing, in which the elastic tissue is gradually replaced by ground substance (or "returned to the metachromatic pool")? Lesher *et al.* whilst agreeing with the principle of amyloid formation from connective tissue, have pointed out that the kidney has very little connective tissue, and therefore the amyloid must be synthesised in numerous organs, and carried from the more productive areas to other sites by the plasma. Indeed, a rise in serum chondroitin sulphate has been found in amyloidosis. (However, this rise occurs also in other types of renal disease, so that this non-specific change could perhaps be the result, rather than the cause of renal damage.) Recently (1955), Block *et al.* have found a relation between an electrophoretically abnormal circulating protein-polysaccharide, and amyloidosis.

It is possible that a combination of abnormal circulating materials and tissue changes is required for amyloid deposition. The long continued stimulus of abnormal substances would cause a large increase in circulating globulins (antibodies) or, as Pépin describes it in his excellent review "une vague d'hyperglobulinémie". The globulins would readily be precipitated in the deranged connective tissues and attract other substances from the circulation, notably lipids, cholesterol and chondroitin sulphate.

One last consideration: why do some animals develop amyloid disease, whilst others, under the same conditions, do not? Krawkow, in 1896, produced amyloid in rabbits by the injection of Staphylococcus aureus, but found that some of the rabbits failed to develop amyloid, although during life they had similar symptoms and died just as quickly as those that did develop it. He concluded that the difference in reaction was due to "toute une série de conditions individuelles". Just what those individual, constitutional conditions are is still unknown. However, recently, Peräsalo *et al.*, experimenting with sodium caseinate injections in animals, found that various "stress" conditions (heat stress, infection, cortisone and ACTH injections etc.) accelerated the appearance of amyloid, and concluded that there may well be a relation between "stress" and amyloid deposition. Further investigations are required in this field.

These experiments and theories are mere searchings in a most confusing field of facts and figures. Yet they are of great importance, for only in the understanding of the actiology is there hope for the prevention and cure of this fatal disease.

Acknowledgments

I should like to thank Dr. Bodley Scott for permission to publish this case and for his interest in the work; and Dr. Matthias, Dr. Lehmann and Dr. Stansfeld for their encouragement and assistance.

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EXTRACTS FROM A REPORT ON AN UPJOHN FELLOWSHIP 1960

By J. B. Bamford, M.R.C.S. (Eng.), L.R.C.P. (Lond.), D.A.

IN THE EARLY part of 1960, Dr. Bamford was awarded an Upjohn Travelling Fellowship, in the course of which he was able to spend two weeks at his old Hospital. Of the four subjects which Dr. Bamford selected for his attention, and on the basis of which he was awarded the Fellowship, the last is:

"To do my part in meeting as many of the young doctors as well as my contemporaries who are now on the senior staff, and to persuade them that the ART of medicine must not be forgotten in this great advance of scientific medicine. To entertain them and encourage the young ones to WANT to become good General Practitioners. . . ."

I had a wonderful opportunity not only of talking to consultants, but also to registrars and housemen, especially over lunch and tea. They all welcomed one and were not only prepared to help one by answering questions, but were also very keen to hear about General Practice.

I was most impressed when sitting in with one surgeon seeing his follow-up cases, some of whom he had not seen for many months. No patient was allowed in until he had looked through his notes and refreshed his memory of the case. Every patient was welcomed, not only by name, but by a shake of the hand across the desk. The pleasure this efficiency and friendliness gave to the patient was obvious. It made me think of times when I am rushed and call out crossly "Next please" in my surgery. A salutary lesson.

I know bad doctors can shake hands with patients. I also know that some doctors think they are so clever and can get to the top without politeness, and some do. But why not combine both. I was delighted to see the art of medicine was still considered important.

When sitting in with a physician, another point was brought out. I noticed he was signing a patient up for three different kinds of Tablets. I enquired, "Do you tell the General Practitioner what tablets you have given the patient?" His reply was, "Yes, usually". Then he asked me, "Do you always tell the Consultant, when you refer a patient to hospital, what tablets the patient is having, or has had recently?"

The next patient came in and her opening remarks were: "The tablets my own doctor gave me last week have made me so *much* better!" She had no idea what they were, nor had the consultant. It made me think.

From the above notes, it may look as if I did no real work on research. I think that is probably true, but I have never had such a stimulating fortnight, and except for a little reminiscing, I talked shop most of the time, until bedtime, helped of course by good Claret and Cockburn's '27!

I now add a few notes on a few subjects that are of interest to many General Practitioners.

Post-graduate Study for General Practitioners

I would like to see a Scheme, in addition to all that is arranged now, of Senior Registrars spending one week, every three or four years with a General Practitioner who would be willing to entertain them. The registrar would have to be prepared to talk shop and, I feel, would be able to help one to keep up to date and, at the same time, see several cases of medical interest, and see what the General Practitioner "wants" from a consultant or hospital. All registrars to whom I spoke were greatly in favour of the Scheme. The only people who might object would be the Consultants who would lose their Right hand man for seven days! I still think that General Practitioners' courses and "get-togethers" are important, and should be continued.

General Practitioners and Teaching Hospitals

I feel that the Student and young Houseman still do not have a high opinion of the average General Practitioner. I think their experience in this field is limited, and often coloured by a very few bad General Practitioners who refer many cases to hospital without examining them!

I feel that it is imperative for the welfare of the whole profession that this state of affairs should be improved.

I have never had anything but the greatest courtesy and help from Consultants, even when I have "missed" an obvious diagnosis.

I suggest that all teaching hospitals should appoint a good General Practitioner to each of their eight or ten Clinical firms.

The General Practitioner should be prepared to be at the hospital for one half day each month. He should go on a round and be allowed to talk to the Registrars and Housemen and Students for 10–15 minutes at the end of the round. He would provide the personal link with the firm and general practice. Registrars, housemen, and students would probably then welcome an invitation to see general practice at first hand.

I fully realise that the Dean of my old Medical College is conscious that the curriculum is already over full, but those of us who have sons, or know sons of friends doing medicine feel that 15 minutes a month could easily be fitted in, and that an odd half day during their holidays would be welcomed, if the opportunity was offered and organised. I feel that the advantages of this simple scheme are enormous, and would help to raise the standard of medicine, and help to narrow the gap between the General Practitioner's services and the Hospital services.

General Practitioners and Hospital Beds

I feel that this is a very difficult problem. Personally, I feel that it would be wrong, at the moment, for a General Practitioner to be in charge of beds in General Teaching Hospitals. I do, however, feel strongly that a start should be made for General Practitioners to be in charge of hospital beds for the Chronic sick. The following is a short memorandum on the subject.

MEMORANDUM

on General Practitioners being in charge of Patients in Hospitals for the Chronic Sick.

General

I feel that a wonderful opportunity to improve the N.H.S. in every way would be to allow more G.Ps. to be in charge of Beds in those hospitals which care for the Elderly Chronic Sick (i.e. the old workhouses and Infirmaries now converted to Hospitals). In large towns where there are wards (or blocks) of large hospitals devoted to the Elderly Chronic Sick, local G.Ps. should be encouraged to be in charge of these wards. There are many hospitals for Chronic Sick where one G.P. looks after over 200 beds, surely too many for one man.

Advantages

A. To Patients

1. It would lessen "the shock" to a number of old ill people if they knew their own doctor (or a doctor of their choice) would continue to look after them when admitted to Hospital.

2. In some cases where one knows the background at home, it might be easier to get them home after they are over the critical period of their illness.

3. Usually it is easier and better for a Doctor who has known his patients for a number of years to treat what is possibly their last illness.

4. I feel that it is wrong that because a patient is poor or ill that he should be deprived of his or her Doctor of choice. This is the only category of patient (except those in the Services) which cannot choose its medical advisers.

B. To the Service as a whole

1. G.Ps. have been clamouring for years for more G.P. beds. Surely this is one way of implementing it.

2. The Nursing Staff would benefit by meeting different doctors with different but equally good methods. Anything to improve the "nurses' lot" in this type of hospital is worth-while.

3. There would be a quicker turn-over of patients which would tend to cut down the appallingly long waiting lists, as doctors would do their best to discharge their patients home to admit more of their urgent cases.

C. To the General Practitioner

It would bring G.Ps. into contact with one another and with consultants, thereby raising the standard of medicine. It would help to develop The Cottage Hospital attitude for patients and staff, although it is for the Chronic Elderly Sick, and help to remove the stigma of Workhouse, Infirmary, etc.

Disadvantages

I presume that these would be purely administrative, but I feel could quite easily be overcome. If each G.P. was given, say, 25 beds, the number of G.Ps. on the staff limited to this proportion, it would give every keen and good G.P. something to work for to be appointed to the Staff. I suggest payment on the Cottage Hospital Scale, if payment is considered necessary.

Merit Awards for General Practitioners

I feel that a Scheme could be worked out on the following lines. That age and experience all help to make a good doctor, and over a period of twenty years, the patients have a very good idea of who is a GOOD General Practitioner.

Bearing in mind the above points, I suggest that Merit Awards should be given for 5 years and only considered for those General Practitioners who have been in practice for 20 years, and aged between 55 and 60 years and whose lists are average or above the average for the neighbourhood.

I think General Practitioners should be asked to apply for them in the same way as they apply to become a Trainer, in the present Trainee Assistant Scheme. In spite of talk of abuse of the Trainee Assistant Scheme, there are very few people who can quote actual cases of any number where it has been abused.

Sir Will Spens, who personally suggested the Trainee Scheme, meant it as a Merit Award for General Practitioners, and that for six months the trainer should train a young doctor, passing on useful information etc., and then the final six months having more time off himself and leaving his Trainee to take some of the work off his shoulders. I do not mean going off on holiday and leaving the Trainee single handed. I have met many Trainees and have yet to meet one who was dissatisfied with his or her Trainer.

QUOTE

Transactions of the 19th Conference on the Chemotherapy of Tuberculosis, Cincinnati

THE SECOND ANNOUNCEMENT I would like to make, pertains to a mouse who was taken out of the laboratory at Cape Canaveral and tested for radiation, had electrocardiographic tracing, had his urine tested, his blood checked, and his fur checked. He was then put into the nose cone of a missile, and he had electrodes strapped on to him, and a movie camera was turned on him, and a recording device was put on, and the missile was then shot 5,000 miles down the Atlantic about 200 miles up. The nose cone separated and fell into the Atlantic Ocean, and the destroyer went out, "frogmen" dived in and recovered the nose cone. The nose cone was put on the destroyer. The destroyer raced back to Cape Canaveral. The mouse was taken out of the nose cone, was taken back to the laboratory. His recordings were all analyzed. His blood was again checked. The urine was again checked. The radiation was checked. His fur was checked. And finally he was put back in the cage. At which point, all the other mice raised up and asked him how it was. And he looked at them and said, "Well it was pretty bad, but it sure beats cancer".

BOOK REVIEWS

MACKIE AND McCARTNEY'S HANDBOOK OF BACTERIOLOGY. A Guide to the Laboratory Diagnosis and Control of Infection. Edited by Robert Cruickshank, M.D., F.R.C.P., D.P.H., F.R.S.E., and Members of the Staff of the Bacteriology Department, University of Edinburgh. Tenth Edition. pp. xi + 980. 40s. **E. and S. Livingstone, Ltd.,** Edinburgh and London.

For many years, Mackie and McCartney has been the standard manual in bacteriological laboratories, and has been chiefly concerned with practical methods and not a great deal with theory. This new edition has undergone a change. It has new authors, being compiled by Professor Cruickshank and seven others from the Department of Bacteriology, University of Edinburgh. It has been extensively re-written and includes much new material. Viruses, for instance, now occupy eight chapters instead of one as in the last edition. The test is somewhat less arbitrary and the theoretical background is more fully stated. There is no doubt that pathologists will welcome this edition as warmly as its predecessors. Because of its wider scope it should be of greater service to others. R.S.A.

SOCRATES ON THE HEALTH SERVICE. Published by the Lancet. 5s.

Collections of articles that have appeared in Journals, when reprinted in book form, are always intimidating to anyone who approaches them fresh. The cautious reader might well fear the worst from this collection of dialogues which first appeared in the *Lancet Dialogues* with too much wit, too much intellect, and by an anonymous author, who the editor assures us is well known: the whole conjures up the thought of reading something like an anthology of the more esoteric of the *Spectator* competitions. But once the Socratic method has been braved, such fears prove unfounded. Should the reader persevere, he will find enough wit and intellect to stimulate his own thoughts, enough wisdom to satisfy and arguments to arm him for discussions on a number of controversial subjects concerning both doctors and laymen. Among the subjects dealt with in this collection are nuclear warfare, medical education, committees, birth control, punishment and crime. To those who already know these dialogues, this little book provides a useful collection so that they may be read again, and enjoyed, at leisure. R. S. D.

MARY, QUEEN OF SCOTS: THE DAUGHTER OF DEBATE by Sir Arthur Salusbury MacNalty. London, **Christopher Johnson,** 1960. 247 pp. 21s.

The tragic story of Mary, Queen of Scots has been the subject of numerous biographical studies, and Sir Arthur MacNalty here stresses the medical aspects of her hectic but brief career. A chronic sufferer from gastric ulcer and rheumatism, the subject of several severe mental disturbances, in addition to numerous other illnesses, she would appear to have been the victim of circumstances in a very turbulent period.

Sir Arthur has previously given us remarkable studies of Henry VIII, Queen Elizabeth, and the Princes in the Tower. In this well-documented survey of the life of a queen who was executed at the age of forty-four, we trace the fast-moving details from the time of her birth to her execution. Sir Arthur's researches throw fresh light on the events of the sixteenth century, and we will now have even greater sympathy for Mary, Queen of Scots, the tool of ambitious men. J. L. T.

LEWIS'S MEDICAL, SCIENTIFIC AND TECHNICAL LENDING LIBRARY, including a classified index of subjects. Supplement 1957–1959. London, **H. K. Lewis,** 1960. 306 pp. 10s. 6d. (Subscribers, 5s.).

This latest supplement to Lewis's main *Catalogue*, which covers the period up to the end of 1956, includes additions up to the end of 1959. An invaluable reference tool for users of the Lending Library, it also provides details of latest editions, including prices. The main body of the supplement is arranged alphabetically by authors, but there is a useful index of subjects. J. L. T.

POCKET PRESCRIBER. Published by Cruickshank. 6s. 17th Edition.

For its size, this book contains a remarkable amount of Therapeutic Information.

The first section of General Prescriptions contains many interesting old mixtures, a considerable number of them must be of doubtful value except, perhaps, that they satisfy the patient's demand for "a bottle". The emphasis given to remedies for some conditions is often unusual, e.g. Parredilych and Barbitone head the list of treatment for insomnia. Gold is discussed in detail for the treatment of Rheumatoid Arthritis, while aspirin gets only a passing mention. The treatment of vomiting with small repeated doses of iced Champagne is an attractive idea, but must be rarely practicable.

There is a useful section consisting of an abbreviated list of drugs for the National Formulary, followed by a list of proprietary drugs giving their official names, instructions and dosages, and finally various tables.

It is unfortunate that the relative points, side effects and tonic effects of the various drugs have not received more attention.

This may well be a useful pocket reference book for a busy General Practioner, but it cannot be recommended as a short cut to Therapeutics for Students. T.W.G.

REALLY NURSE by Roger Brook. **Published by Souvenir.** 6s.

This is a light-hearted book for casual reading. The classified headings just save it from being a list of howlers made by student nurses in examination papers. It should have a wide appeal in the nursing profession, nostalgic and reminiscent for the veteran, stimulating and mirth provoking for the newly qualified and to the student a cheerful warning of pitfalls to be avoided. Its appeal will extend beyond the hospital walls to anyone seeking an inexpensive gift. It could be an entertaining addition to any bookshelf. The illustrations by T. Birdsall are clever and amusing. M. S. S.

SPORTS NEWS

SPORTS FIXTURES, FEBRUARY, 1961

Date	*Men*	*Ladies*
February 1st	A.F.C. v. Royal Dental Hospital (A)	Lacrosse v. Guy's Hospital (A) Hockey v. Guy's Hospital (A)
February 4th	R.U.F.C. v. O.M.T. (H) H.C. on Cambridge Tour A.F.C. v. St. George's Hospital (A)	Hockey v. Wimbledon (A)
February 8th		Lacrosse v. Queen Mary College and University College (H) (Cup)
February 11th	R.U.F.C. v. Esher (H) H.C. v. Kings College, Cambridge (H) A.F.C. v. Old Cholmelians 2nd XI (H)	Hockey v. Goldsmith's College (A)
February 15th		Lacrosse v. Reading University (A)
February 18th	R.U.F.C. v. Metropolitan Police (H) H.C. v. Orpington (H) A.F.C. v. Trinity Hall, Cambridge (H)	Hockey v. St. Mary's Hospital (H)
February 22nd		Hockey v. Reading University (A) Lacrosse v. Royal Holloway College (A)
February 25th	R.U.F.C. v. Oxford University Greyhounds a.m. (H) H.C. v. St. Mary's Hospital (H) A.F.C. v. Guy's Hospital (H)	Hockey v. Royal Holloway College (H)
February 26th	H.C. v. Bandits (H)	

Sports View-point

"Thoughts of a Left Wing"

AS I STAND here—in the driving rain, temperature just, and only just above freezing—soaked, muddy (watch those spots in my eye—"Cast not out the beam in thy brother's eye etc."), the water slowly oozing over, and into, my expensive boots made in the other "Ancient Univarsity" and . . . wait . . . oh a movement, the ball is heeled (after sixteen successive attempts to get the ball past the prop have failed) scrum-half to fly-half and . . . but no—he's kicked back into touch . . .

Sorry where was I? . . . Oh yes . . . waiting. Well I wonder why am I here. My thoughts wander to another very gallant gentleman Sir Nigel Molesworth, who has written on the same subject:

"Headmasters hav to hav some sort of excuse for games so that they can drive all boys and masters out into the foul and filthy air while they stir the coals into a blaze and settle down with one of the gangster books they have confiskated. In the last five minits they appear on the touchline and shout GET INTO HIM MOLESWORTH, GET INTO HIM it is all very well i am cold and covered with mud, the only thing i want to get into is a bath ha-ha!"

Now, unlike brave Sir Nigel, I've only myself to blame—or have I? Let's keep in line with my contemporaries and blame someone, something else—commonest things first of course. Freud—ah, now there's a possibility—what about my intra-uterine existence (ugh! what a sordid idea—perish the thought of me as a foetus). Think again . . . oh no hang on a moment . . .

Some silly fool in the opponents (by now they look exactly the same as us) has kicked ahead and the ball has gone and landed straight in the wettest part of this bog—and I shall have to be heroic (ha!) and fall on it . . . oh . . . How foul! And the mud smells just like the Roman Baths (at Bath of course) or like sewage—perhaps they manured the field with human . . . no they only do that sort of thing in uncivilised countries (to whom we used to send gun-boats regularly). And we are civilised aren't we (Welfare State and Tommy Steele!)?

To return to my monologue. Why exactly am I here? God may know the number of hairs on my head, but I bet he doesn't know why I am here (though since I haven't counted recently, and he presumably has, he is obviously in a better position to judge). Let's be fair! After all remember I'm British and all that (gun-boats again).

Perhaps that's why I'm here . . . No that won't do. We are a logical nation (that's why we say how wicked the unions are, and

then promptly go on strike with some bolsky —yea Brothers I use the word deliberately— capitalist says Mr. Cousens is a wicked man).

Why the . . . (can't use the word now— its so vulgar, everyone has been using it since the trial) am I here? . . .

Sorry for the delay, stupid full-back (ours) went and threw me a pass across the field— nearly dropped the damned greasy object— then moment of glory, I caught it and rooted it into touch; and all but eviscerated the President standing on the touch line (just to cap his afternoon!).

To return . . . no it's finished. Sorry. I shake my opposite number by the hand, "Good game—well played you deserved your win" (liar—that penalty was no more "foot-up" than the gymnasium over at Charterhouse is clean?).

Ah well—there's always the shower . . .

Sat., Dec. 3rd

1st XV v. Old Cranleighans. Lost 0–3.

Old Cranleighans won this game by the only score, a penalty goal, kicked early in the first half when they were playing with the wind and the slope. For the rest, the appalling conditions ruled out any constructive back play with the result that the match developed into a series of forward skirmishes between the twenty-fives. Jennings and Smart, with vigour undiminished by the previous night's Rugger Ball, toiled hard in the loose and Peek at scrum half handled and passed the very slippery ball with extreme skill.

Team. Ross, Burbridge, Letchworth, Niven, Jeffreys, R. R. Davies, Peek, Shearer, Gurry, Knox, Doran, Smart, R. P. Davies, Jennings, Halls.

Sat., Dec. 10th

1st XV v. Rugby. Lost 0–6.

Rugby came to Chislehurst on a dull, but dry afternoon and proceeded to score two forward tries without reply. However, it was not until late in the second half that their powerful pack achieved all-round domination. Both the Rugby scores followed forward rushes in the home twenty-five and indeed there seemed to be a premium on tackling and falling amongst the Hospital pack at times.

Outside, R. R. Davies frequently ran or kicked Bart's out of trouble and his tackle of the largest Rugby forward at the corner flag was particularly memorable. The three-quarter line contrived an overlap on occasions but lack of real speed prevented these opportunities being converted into tries.

Team. Ross, Burbridge, Letchworth, Niven, Jeffreys, R. R. Davies, Peek, Shearer, Gurry, Knox, Orr, Smart, R. P. Davies, Jennings, Halls.

Wed., Nov. 30th at Chislehurst

Bart's 2nd XI 4 Guy's 2nd XI 3.

This was a memorable game, deservedly won by Bart's. Despite the fact that they had only ten players, Guy's went into an early 1–0 lead. However, Walker soon equalled the score with a good goal. Guy's fought back and eventually went into a 3–2 lead, but goals by Choonoo (2) and Phillips ensured victory for the hospital. Gardos and Beecham, the latter wearing boots at least three sizes to large for him, played very well throughout. Further, the dislike for the opposing goalkeeper shown by Chant was noteworthy. In all, a very enjoyable game against more experienced, but less persistent opposition.

Team. N. Jones, A. C. Howes, I. R. Smith, J. Cannan, G. Gardos, H. Beecham, P. Stanley, R. Choonoo, H. Phillips, H. Walker, A. D. B. Chant.

Sat., Dec. 10th at Chislehurst

Bart's. 1st XI 4 Old Josephians 5.

Bart's were handicapped again by only having ten men. However, with a little more persistence, they might well have won this game.

At half-time, the score was 5 1. Two of the opposition goals had been virtually scored by Bart's players, for which only one of those players apologised to his team-mates.

In the second half, the hospital fought back well with goals from Choonoo (2) and Davies. Unfortunately, this effort on the part of Bart's came just a little late. Phillips scored Bart's other goal, and Hudson was a tower of strength at half-back.

Team. J. Spivey, G. Haig, T. Herbert, J. Davies, P. Savage, M. Hudson, E. Manson, R. Choonoo, H. Phillips, N. Davies.

Swimming Club

THE AMBITIONS WITH which the club started this season have not been realised. Two teams entered the United Hospitals' Water Polo Leagues, one in each division. With all last year's players and a few promising freshers it seemed that Barts had a good chance of winning both divisions. However, this was not to be, and although the first team did lose two matches which could have been won, St. Mary's Hospital, much strengthened this year, did deserve to win two well fought matches by the narrow margin of two goals each time.

The second team, when all are present, are certainly among the best in the second division.

On December 5th and 6th, a swimming team was entered for the University Swimming Championships and in January 1961, the University Water Polo League commences. Two teams will be entered for the first time. The first team defend the high reputation which it earned by finishing third in the first division, and is determined to beat St. Mary's as it did last year.

RESULTS

United Hospitals' Water Polo League

	Played	*Won*	*Lost*	*Drawn*	*Goals For*	*Goals Against*
Division I						
Barts I	10	6	4	0	82	59
Division II						
Barts II	8	4	3	1	17	9

(Time: Saturday 3.30 p.m. —
Place: Some wet and windy environ of London)

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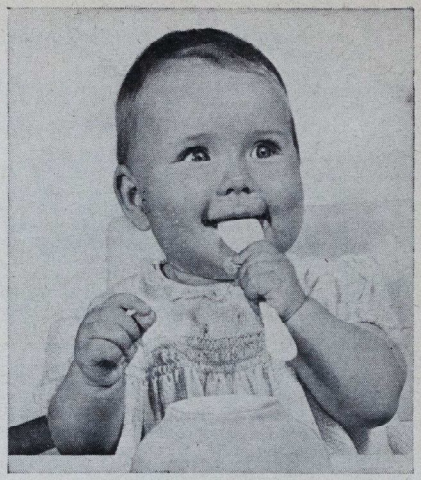

ST. BARTHOLOMEW'S HOSPITAL JOURNAL

Vol. LXV, No. 2 FEBRUARY, 1961

Editorial

" This being so, the patient will appreciate the oncoming nausea and express vomitus to the exterior."

There are many of us guilty, at some time time or other, of putting out answers to questions asked on the wards or in examinations, in this florid, pretentious and utterly undesirable manner, without perhaps realising the scorn and sometimes utter disregard with which they are treated.

Many previous pleas have passed unheeded and this over pedantic manner is still too commonly employed. The many and various committees, admittedly essential for the organisation of the student body of the Hospital, appear to be a productive breeding ground for this type of phraseology, and one's ears are only too often assailed by such words as " I feel it incumbent on me to interject at this juncture," and other abysmal examples.

Apart from being less time consuming and easier to write, plainer English conveys its meaning with a minimum of ambiguity. The longer and rarer words of the English language, in the hands of the unskilled, are prostituted with monotonous regularity, sometimes being used with no relation to their true meaning and sometimes being subject to the most ludicrous malapropism. There are one or two amongst us who are able to employ these words to advantage and it is to these " Masters " that such words should be left, for, when all is taken into consideration, medicine is an exact and complicated science which demands clear and concise expression. That which is already somewhat murky should not be viewed through the tinted glasses of ambiguity.

We commiserate with the Hospital rugby XV who, after so long and gallant a fight, lost to Guys in the cup match. Rather less, however is our sympathy for those valiant warriors, who, armed with bags of flour and other impedimenta, waged war upon the field before and after the match. We strongly recommend these intrepid souls not to let their enthusiasm and zeal cloud their judgment, and to confine their attentions, if fight they must, to members of other hospitals. The Editor is still trying to remove Barts flour from his coat.

Fifty years ago

AN ARTICLE APPEARED in the February edition of the Journal of 1911, entitled "Psychological and Physiological Presuppositions of 'Mind' and its disorders," by Sir Robert Armstrong-Jones, F.R.C.S., F.R.C.P. Sir Robert, at the time, had recently been elected Lecturer on Mental Diseases in the Medical School, which appointment he held for fifteen years. During this period he held demonstrations for students in the wards and laboratory at Claybury, near Woodford, Essex, at which he was the medical superintendent. Claybury was the first new asylum of the first London County Council. Sir Robert had a remarkably distinguished career in the field of mental disease. He contributed no less than eight articles to the Journal, all on psychiatric subjects, between 1911 and 1929.

In this, his first article in the Journal, he welcomes the invitation to contribute, writing "how much satisfaction is afforded me as a lecturer to know that my efforts to make clear a subject so obscure, so debatable, and elusive as the study of mental diseases have met with the approval and appreciation of my audience." He continues by recalling his own difficulties as a student "and, indeed, oftentimes since, to apprehend the meaning of abstractions, to trace their various relations in mental experiences, and to understand the nature of such terms as 'perception' and 'ideation', to know the meaning of 'cognition', 'emotion'; of 'conation' and 'volition', terms which, although familiar, are used by mental experts with specialised meanings, and which when precisely understood lend a new interest and a new power to the student and the teacher."

Sir Robert continues by attempting to clarify his own conception of the term 'mind'. "It took a long time before I was able to throw off the quasi-philosophic attitude as to the nature and essence of mind, and only after considerable experience in the wards, in the laboratory, and in the post-mortem room was I able to look upon 'mind' as implying only states of conciousness dependent upon matter, and known exclusively through, and by means of matter." He goes on to distinguish between philosophy and psychology, and then having detached the metaphysical he develops the theme of the dependence of consciousness upon the nervous system, and the processes occurring within it. He illustrates this with a number of examples. He concludes his argument by stating that "without a knowledge of psychology and of physiology in regard to the mind and the senses, the prevention of insanity is not possible, for we would be unable to teach the value of temperance, prudence, thrift and self-restraint; or the benefit of cleanliness, good habits, and regularity of conduct. Without such knowledge it would be impossible for us to understand the nature of mental alienation, which, as an illness, excites terror beyond all others. Again, it would be impossible without such knowledge to realise the nature of the classification of mental diseases, the extent, duration, or termination, omitting altogether any attempts at their proper and adequate treatment."

The paper ends on a rather more mundane note with an outline of the opportunities for specialising in Lunacy as a branch of general medicine, and a scale of remuneration thereunto. Sir Robert finishes: "The practice of men in this department is often very trying, and to many is actually repellent, but in order to be successful this work must be started early in professional life. It is a practice relating to the highest attribute of man, and the only attribute which distinguishes man from the animal, and which allies man to his Creator."

Calendar

FEBRUARY

Sat. 18—On duty: Dr. G. W. Hayward
Mr. A. W. Badenoch
Mr. R. W. Ballantine
Mon. 20—Film Society. "The Third Man."
Dramatic Society Main Production.
Tue. 21—Dramatic Society Main Production.
Sat. 25—On duty: Dr. E. R. Cullinan
Mr. E. G. Tuckwell
Mr. C. Langton Hewer

MARCH

Fri. 3—Operatic Society—"H.M.S. Pinafore."
Sat. 4—On duty: Medical and Surgical Units. Mr. G. H. Ellis.
Mon. 6—Film Society. "The Importance of being Earnest."
Thu. 9—Abernethian Society. Dr. D. Stafford Clark—"Psychiatry and the Criminal."

The Abernethian Society

ON DECEMBER 1ST, 1960, Sir John Wolfenden, Kt., O.B.E., addressed the Society on "Crime and Sin". Sir John commenced with a description of the now famous committee of which he had been chairman. He emphasised that they had not been asked to comment on the moral implications of homosexuality or prostitution, but to investigate the relation between these practices and the law. It was a departmental committee and not a Royal Commission and hence detailed evidence of the witnesses did not have to be published. Although such a committee was smaller than a Royal Commission it had to contain lawyers from England and Scotland, theologians of various denominations, members of Parliament, both Commons and Lords, doctors and women. Some of these requirements could be met with in one person such doctors who were women or women who were doctors. Difficulties in definition were encountered as on the occasion when he asked Lord Goddard what sort of actions ought to be crimes. Lord Goddard was not prepared to answer the question in that form, but thought that no form of behaviour was in itself criminal. It only became criminal when it was a transgression of the law. Sir John said that in addition to this, there were actions that were morally reprehensible within the moral code prevalent in that society. Actions considered in the context of morality or criminality should not be placed in antithesis, only in disjunction. The most difficult question to answer was "how far should morality be enshrined in the criminal law?" There were four different types of extramarital relationships, fornication, adultery, homosexuality between consenting males and homosexuality between consenting females. In addition, there were various other recherché operations. Although all these would probably be considered morally reprehensible only one was criminal, i.e. male homosexuality.

It might be thought that adultery was potentially more socially destructive, but it was unlikely that it would be made a crime. In general, many sins were not crimes and vice versa and it was difficult for criminal law, which was in theory absolute, to replace moral law, some aspects of which were modified with each succeeding generation. Sir John thought that the less legislation there was on matters of personal behaviour the better. Human behaviour was dependent on moral concepts and the exercise of these should be encouraged and not become the responsibility of the legislature.

We would like to offer our congratulations to Dr. C. H. Andrews, F.R.S., Deputy Director of the National Institute for Medical Research, a graduate of this Hospital, past President of the Abernethian Society (1921–2) and twice a speaker to the Society, on his award of a knighthood (K.C.V.O.).

11th Decennial Club

THE TWENTY-SIXTH ANNUAL DINNER of the 11th Decennial Club will be held at Simpson's-in-the-Strand, on Thursday, 20th April, 1961, at 7 for 7.30 p.m. Dr. Stanley Ward Barber, M.B.E., T.D., J.P., a general practitioner, will be in the Chair, and we are hoping for a good attendance. All Members now on the lists should be in possession of a list of names and addresses of those who have joined the Club, and it is suggested they go through these and try and stimulate their friends to come with them. A list of those who have since been added will be circularised next year.

For many years the Annual Dinner has been held on the third Friday after Easter, but it has long been realised that many general practitioners make Thursday their half day, and as an experiment we are trying this as the day of the Dinner this year.

The list of Members has recently been revised and made up-to-date, but if there is anyone who joined the Hospital between January 1st, 1915, and December 31st, 1925, and has since qualified, who does not get a notice and would like to join, will he please communicate with the Honorary Secretaries: F. C. W. Capps, 16 Park Square East, N.W.1, or M. L. Maley, 15 Victoria Avenue, Southend-on-Sea, Essex. The price of the Dinner will be 23s. to include tips but exclusive of wine.

POT POURRI — 1960

SOMEBODY HAD BLENDED astringent herbs into the sweet fragrance of Pot Pourri this year. The perfume which resulted was essentially "joie de vivre" plus a generous dollop of "My Sin"—and possibly a bit of beer too. In any event it was a best seller, a delightful concoction of the remains of the Ward Shows, put on by people, mostly quite untheatrical, but blessed with unbounded enthusiasm. It is this that makes Pot Pourri, as ever, easier to commend than to criticise and this year's show is in places hilariously funny, witty and slick and never dull.

The thankless job of uniting the severed members of the Ward Shows was well done by David Gibson, an amiable and successful Frankenstein. His use of the spotlight was generally most effective, though perhaps not ideally suited to some numbers. Backstage, the master, Bert, was tireless at making up, and put a good face on many of the cast. Before the curtain, the compères, those excellent sugar daddies, sweetened the audience, especially one, who farrowed a whole litter of splendid stories.

Now down to the shows. There was so much good here that I want to get some criticism of technique out of the way first. The management of a chorus is notoriously difficult. The most effective and seemingly most spontaneous movements on stage are those which have been most carefully rehearsed. Sloppy jiggling around is out. To make a song successful, no matter how good the words and tune, the cast must look up, sing up to the front row of the balcony, and look cheerful. It's a sad song that comes from a row of stern, glum faces.

An obvious exception to these criticisms was the Outpatients Show. Here was enthusiasm, vitality and first rate production, a crop of good songs and real talent. An Oscar must go to Jillian Turner for her perfect performance of sweet innocence in "Johnny's got a Yo-Yo", another to Kerry Davies and his clarinet, while their version of "Nicotine and Alcohol" was put over by the cast as a good song should be. And, shucks goddam me, I mustn't forget those hips!

Another well produced show, the kids' suffered in the translation from ward to stage, which made some of the numbers and characters appear out of place. But of all the songs about Wolfenden Ladies this year, their "Curzon Street", well sung by Liz Knight as the main tart, was easily the best, perhaps because it so movingly caught the wistfulness of this unfortunate profession.

"Preparation"

From the Clerks and Dressers show, Patrick Kingsley's fine singing of "Waggon Train" proved that there is obviously a place in revue for serious songs, and there could well be more of them in Pot Pourri; even then, I would not for all the world have missed those inspired Porters in his other number.

Is it gynaecology or the gynaecologists that sharpen the wits of medical students? Which ever it may be, the Midder Show was far and away the cleverest show this year. Their lyrics, each one original, bristled with good invention and topicality. David Orrell and Pat Kielty put over difficult songs well. Chris Hood's splendid voice told us neither the Hospital, nor, my darlings, its leading lights, are sacred, whilst a most comely charwoman brought her welcome genius back for another farewell performance.

Perhaps this year's finalists thought it better not to risk comparison with the excellence of last years. Anyway they didn't even try.

And so to the House who, traditionally incapable of determining what six it prefers, treated the classics and consultants alike with scant respect. Assured that others would enjoy it as much as they evidently did, they romped through Shakespeare in glorious technicolor, using, of course, a quite unbowdlerized edition. If Covent Garden does not go wild over their clever version of the Miserere, nor Stratford blench at such competition, the Cripplegate thought it fun, and that, I'm happy to say, goes for the whole of Pot Pourri 1960.

"Exultation"

"Dissipation"

News in Brief

Mr. J. B. Hume, M.S., F.R.C.S., has been appointed an Associate Lecturer in the Department of Anatomy. During the many years that Mr. Hume has served the Medical College he has for two periods been in full charge of the Department of Anatomy and has always maintained his interest in the academic and practical aspects of this subject. Mr. Hume's vitality as a Teacher has been called upon by the College to help once again in this Department, and it is perhaps a sign of the increasing need of integration of pre-clinical and clinical teaching that this step has been taken. The presence of one who has so recently been Senior Surgeon to the Hospital in the dissecting rooms is a stimulus and a challenge welcomed by all.

Dr. R. A. Hunter has been appointed Assistant Physician to the Department of Psychological Medicine, National Hospital for Nervous Diseases, Queen Square.

View Day Ball 1961

The Students' Union annual View Day Ball is to be held this year at the Dorchester Hotel, Park Lane. The date of the Ball has been fixed for Thursday, June 1st, and it will commence at 9 p.m., lasting until 3 a.m.

As this year marks another milestone in the history of the Hospital, the organisers of the Ball hope that all associates of Barts, past and present, will make a special effort to be present on this occasion.

Table reservations with seating for 8, 10 and 12 only, must be made with applications for tickets. Double tickets, price £3 10s. will be limited and may be obtained from:

Guy T. Sharp,
Abernethian Room,
St. Bartholomew's Hospital,
E.C.1.

Cheques should be made payable to St. Bartholomew's Hospital Students' Union, and crossed "Ball A/C." Please mark envelopes "View Day Ball".

CHANGE OF ADDRESS

Miss A. G. Dunn, S.R.N., S.C.M.,
Pear Tree House,
Great Bedwyn,
Nr. Marlborough,
Wilts.

HONOURS

The following honours were awarded in the New Year's Honours List:—
Dr. C. H. Andrews—Knighthood.
Mr. J. C. Hogg—C.V.O.
Professor C. H. Stuart-Harris—C.B.E.
Surg.-Lieut. J. S. P. Rawlins—O.B.E.
Dr. R. G. Gibson—O.B.E.

ROYAL COLLEGE OF SURGEONS. Mr. G. T. Hankey has been presented with the John Tomes Prize for the period 1957–9 for clinical research.

ENGAGEMENTS

ROSS—BRIGGS.—The engagement is announced between Alexander Patrick (Paddy) Ross and Anne Sinclair Briggs.

EMINSON—MACINTYRE.—The engagement is announced between Dr. B. Ian Eminson and Moira MacIntyre.

GOMPERTZ—WATERSTON.—The engagement is anannounced between Dr. R. Michael Gompertz and Jean M. Waterston.

LANGHAM—EDWARDS.—The engagement is announced between Dr. David Langham and Ann Valerie Edwards.

LEWIS—HALL.—The engagement is announced between John Michael Lewis and Jennifer Mary Hall.

SMYTH—HARKER. The engagement is announced between Neil Wolsely Smyth and Jill Patricia Harker.

BIRTHS

BEASLEY.—On December 30th, to Valerie and Dr. Reginald Beasley, a son (Patrick Henry) brother for Penelope, Jane and Clare.

DUNKLEY.—On December 19th, to Susan and Dr. Alan Dunkley, a daughter (Sally Ann), a sister for Janet.

KIELTY.—On December 28th, to Patricia and Dr. Michael Kielty, a son (Stephen Peter), brother to Michael John.

MALTBY.—On October 31st, to Margaret, wife of Dr. John W. Maltby, a son (James), brother to Richard.

DEATHS

BRIGSTOCKE.—On December 24th, Dr. Percy Ward Brigstocke, O.B.E., aged 89. Qualified 1896.

GREY.—On December 12th, Sir H. Martin Grey, aged 77. Qualified 1908.

HARRISON-CRIPPS.—On December 13th, William Lawrence Harrison-Cripps, F.R.C.S., aged 82. Qualified 1903.

HOSKYN.—On December 17th, Dr. Charles Henry Hoskyn, O.B.E., aged 48. Qualified 1938.

PRIDHAM.—On December 23rd, Dr. H. Llewellyn Pridham, aged 67. Qualified 1918.

STRAUSS.—On January 11, Dr. Eric Benjamin Strauss, aged 66.

HOUSE APPOINTMENTS
1st January to 30th June, 1961

DR. E. R. CULLINAN
Dr. K. O. Black
Miss D. I. Vollum
B. R. Middleton

DR. A. W. SPENCE
Dr. N. C. Oswald
J. H. Pennington
T. W. Meade

DR. R. BODLEY SCOTT
Dr. W. E. Gibb
J. J. R. Almeyda
A. V. Watkins

DR. G. W. HAYWARD
Dr. H. W. Balme
J. H. Holland
B. N. Ballantine

DR. E. F. SCOWEN
Dr. A. G. Spencer
G. J. Halls
G. M. Besser

MR. C. NAUNTON MORGAN
Mr. D. F. Ellison Nash
J. R. Garnham
P. M. Ashby

MR. A. H. HUNT
Mr. J. O. Robinson
P. G. Cassell
D. Booth

MR. A. W. BADENOCH
Mr. Ian P. Todd
D. J. Peebles
J. Chapman

MR. E. G. TUCKWELL
Mr. M. A. Birnstingl
M. J. K. Hudson
J. E. Cawdery

PROF. G. W. TAYLOR

J. D. Scobie
P. C. Weaver

CASUALTY H.P.
J. H. J. Durston

CASUALTY H.S.
C. P. Juniper

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Dr. A. W. Franklin
D. J. Tooby
J. Millward

E.N.T. DEPARTMENT
MR. CAPPS
Mr. Jory
Mr. Hogg
Mr. Cope
J. K. Bamford
D. F. Gibson

EYE DEPARTMENT
MR. H. B. STALLARD
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Dr. J. Howkins
K. R. Bowles } Interns
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Mr. Cambrook
Mr. Cowan
Mr. Schofield
Miss B. Levison

ORTHOPAEDIC DEPARTMENT
(Fractures)
MR. H. JACKSON BURROWS
Mr. W. D. Coltart
Mr. J. N. Aston
P. Smith

HILL END HOSPITAL
E.N.T. DEPARTMENT
MR. CAPPS
Mr. Jory
Mr. Hogg
Mr. Cope
J. K. Bamford
D. F. Gibson

ORTHOPAEDIC DEPARTMENT
MR. H. JACKSON BURROWS
Mr. W. D. Coltart
Mr. J. N. Aston
J. C. D. Plant
J. R. Robson

THORACIC SURGERY

MR. O. S. TUBBS
Mr. I. M. Hill
J. M. H. Buckler
K. A. Walker

DEPARTMENT OF NEUROLOGICAL SURGERY

MR. J. E. A. O'CONNELL
Mr. R. Campbell Connolly
Miss M. C. Goodchild
Mr. K. R. Durrant

University of London
Final M.B., B.S., Examination
October, 1960

Honours

Besser, G. M. (Distinguished in Medicine and Surgery.)

Pass

Andan, A.
Ballantine, B. N.
Booth, D.
Craggs, J. C.
Eddy, J. D.
Garrod, J. A.
Gould, W. A.
Hatch, J. D.
Horder, P. T.
Kingsley, D. P. E.
Martinez, G. S.
Morrison, J. D.
Parker, J. B. R.
Robson, J. R.
Stewart, A. F. S.
Tomkins, I.
Ashby, P. M.
Berry, W. H. C.
Chapman, J.
Davies, G.
England, R. W.
Geach, A. R.
Harrison, R. I.
Holloway, A. M.
Kilroy, A. W.
Makin, E. J. B.
Milburn, F. A.
Noble, M. I. M.
Priscott, R. B.
Smith, P.
Thomson, R. G. N.
Watkins, A. V.

Supplementary Pass List

Part I

Alder, D. E.
Anthony, P. P.
Bishop, M. B. J.
Bratton, L. W.
Darmady, J. M.
Davies, R. P.
Evison, P. R. H.
Gandy, R. H.
Hall, J. M.
Janosi, M.
King, D. E. L.
Lines, A. J.
Millington, M.
Shaw, A. B.
Telfer, A. C.
Therkildsen, L. K. H.
Thomson, W. H. F.
Weeks, S. K.
Al-Khedheri, S.
Bartlett, J. J. D.
Bonn, A. J.
Childe, M. W.
Davies, J. D.
Edmondson, R. S.
France, R.
Gill, B. V.
Herbert, D. C.
Kajtar, T.
Knight, C. R.
Macdonald, A., M.E.
Padfield, A.
Shaw, B. N.
Theobald, G. M.
Thomas, L. R.
Visick, J. H.

Part II

Darmady, J. M.
Evison, P. R. H.
King, D. E. L.
Thomas, L. R.
Davies, R. P.
Gillespie, H. M.
Thomas, B. O.

Part III

Bartlett, J. J. D.
Brown, M. D.
Davies, R. P.
Khurshid, M. N.
Theobald, G. M.
Thomas, L. R.
Beardwell, C. G.
Chawner, J. M.
Gillespie, H. M.
Smith, C. R.
Thomas, B. O.

Part IV

Beardwell, C. G.
Chawner, J. M.
Davies, R. R.
Gillespie, H. M.
Smith, C. R.
Brown, M. D.
Darmady, J. M.
Evison, P. R. H.
King, D. E. L.

M.D. Examination
November 1960

Hibbard, B. M.

M.D. Examination
December 1960

Moffat, D. B.

M.S. Examination
December 1960

Rothnie, N. G.

University of Oxford
Final B.M. Examination
Michaelmas, 1960

Pass

Busfield, H. M. B.
Meade, T. W.
Waring, A. M.
Cawdery, J. E.
Millward, J.

Supplementary Pass List

Medicine

—

Surgery

—

Midwifery

Stephan, J. C.

Conjoint Board
Final Examination
October, 1960

Pathology

Harrison, R. I.
Davies, R. P.
Janosi, M.
Macdonald, A., M.E.
Bonn, J. A.
Chawner, J. M.
Thomas, B. O.
Knight, C. R.
Anthony, P. P.
Davies, J. D.

Medicine

Robson, J. R.
Durston, J. H. J.
Lines, A. J.
Hare, B. W. E.
Harrison, R. I.

Surgery

Robson, J. R.
Harrison, R. I.
Andan, A.
Milburn, F. A.
Evison, P. R. H.

Midwifery

Durston, J. H. J.
Evison, P. R. H.
Harrison, R. I.
Mackenzie Ross, R. K.

SOME OPHTHALMIC EMERGENCIES IN A RURAL AREA

By A. Ross Wear—Consultant Ophthalmic Surgeon, Cumberland Imfirmary, Carlisle.

A MIDDLE-AGED LADY was sitting in the stern of a small rowing boat while her husband fished for trout from the boat. During one of his casts, the fly became hooked in her right cornea half lifting her from the thwart and causing both her and the fisherman considerable distress. The cornea was not perforated, but the barb of the hook had emerged again after going through the cornea so the local doctor was unable to remove it and neither was the Casualty Officer at Dumfries Infirmary thirty miles away. Five hours after the accident the Greenwell's Glory was removed at Carlisle by cutting the shaft with pliers; the cornea healed rapidly and her sight returned to normal.

A not unusual corneal foreign body during harvesting times is half a husk of corn held in place by the vacuum between its concave surface and the corneal epithelium. The slightly yellow colour of the husk gives it the appearance of a corneal ulcer, so that it is usually treated with a variety of antibiotic drops and ointments for a week or two before arriving at the Out-patient Department. A spud inserted under the edge of the husk to break the vacuum makes removal easy.

Motor cycling on a summer evening without goggles may lead to a similar accident when a winged insect strikes the cornea. Part or the whole of a wing may stick to the cornea by suction, and, being transparent, is difficult to see and often remains there for some weeks.

Perforating corneal injuries from hawthorn bushes during hedging operations are fairly common in an agricultural area and there is a strong case for the use of protective goggles when hedging; four such cases have been treated at the Cumberland Infirmary during the past twelve months and there must be many corneal abrasions which are not seen at the hospital.

The horns of a cow are about on a level with the average man's orbit and injuries produced by them are usually severe and many lead to loss of the eye; the tip of the horn seems to slide along the face and then catch in the orbit crushing the eyeball against the bone. I consider the cow to be a most dangerous animal as when alarmed it jerks its head about suddenly and violently.

I shall never chop sticks for firewood as I have seen dozens of eyes lost, or severely damaged, from this cause.

The most dangerous child's toy is undoubtedly the bow and arrow.

A man came to see me the other day with a perforating injury of the sclera and told me that he had been hit by a pig weighing machine, possibly in revenge for all the pigs he had weighed on it!

I hope that this short account of some of the hazards of country life may be of interest to those of you who practice medicine in the Cities.

HISTORICAL DIAGNOSIS

By A. M. Ward

ON JULY 8TH, 1497, Vasca da Gama left the Tagus on the first voyage by Europeans to India. He returned in August, 1498 with, only 55 survivors out of his original complement of 160 soldiers and sailors. The majority of those that failed to return succumbed to the disease that de Camoens described in the fifth canto of "The Lusiad".

" A dread disease its rankling horrors spread,
And death's dire ravage through mine army spread.
Never mine eyes such dreary sight beheld,
Ghastly the mouth and gums enormous swell'd,
And instant, putrid like a dead man's wound,
Poisoned with fetid stream the air around.
No sage physician's ever watchful zeal,
No skilful surgeon's gentle hand to heal
Were found: each dreary mournful hour we gave
Some brave companion to a foreign grave."

THE DEAN REPORTS AGAIN

A YEAR HAS elapsed and many hours of committee work have gone into the planning of the College's future programme. The University Grants' Committee, represented by its Medical Sub-Committee, inspected the College and Hospital in April. The report of that Committee is confidential, but when at the end of a somewhat strenuous day the Chairman, Sir Keith Murray, summed up the visitors' conclusions to a delegation from the College Council, it seemed clear that even that august body whose duty it is to inspect, criticise and make suggestions had found quite a number of things taking place in the College which showed that at least the flag was still flying. The College's Annual Report is published here again, but this can give little idea of the progress that has been made.

The whole of the pre-clinical entry of the Royal Dental Hospital is now at Bart's, and all is well. There are many regrets that it has not been possible to incorporate all these students in the full athletic activities of the College, but it is understandable that the R.D.H. should wish to maintain their own teams as they have an athletic ground at Colindale. In October next, first year students from the London Hospital Medical College who hitherto have attended at Queen Mary College will also be joining Bart's pre-medical departments. Incidentally in his farewell address, delivered to the new student entry on September 30th, Sir James Paterson Ross claimed that historically "Bart's" meant the College, and the term should not be used to describe the Hospital. He deeply deplored the corrupt abbreviation "St. Bart's"!

By the time this report is printed, work may have started on the new library block at Charterhouse Square. This will provide also for the new Department of Medical Radiobiology under the direction of a professor, yet to be appointed, and one floor will be occupied by the Medical Research Council's Air Hygiene Unit, under Dr. Lawther. It is good that a permanent home is being provided for this unit which has developed at Bart's.

In October 1960, 2nd M.B. entry will not be taking pharmacology at the end of their five terms, but will embark on the new curriculum. This will include an intermediate appointment covering pharmacology and pathology and the present content of the Introductory Course. Other interesting alterations in the clinical curriculum are under discussion and already it is possible for students who elect to do so to spend an additional fortnight in a Regional Hospital during the revision period, at Harold Wood, Whipps Cross or the North Middlesex.

The more exciting project is the construction of a further block of buildings on the Clerkenwell Road frontage to include a Psychiatric Day Hospital with an academic Department of Psychiatry forming part of a comprehensive centre for the study of community care. It has in the past always been assumed that the student's undergraduate education could be completed within an adequate teaching hospital. The College Committee never felt convinced that the attachment of students to General Practitioners for two weeks was really justified or contributed very much to their education. Nevertheless, with the greater emphasis now falling on community care both in the field of therapy and preventive medicine, it is essential that there shall be provision both for teaching and research in these subjects. Preliminary discussions have taken place with the Board of Governors of the Hospital, the medical department of the London County Council, the North East Metropolitan Regional Hospital Board and the City and Port of London Health Committee. All reactions have been favourable, and it is my great hope that this pioneer experiment will in fact materialise. Only by having direct access to the medical facilities of the community outside the Hospital Service can the College devise a practical and comprehensive programme of instruction in environmental medicine.

Some may wonder how time can be found for this additional subject, but with the return of the special departments from Hill End (long overdue, frequently delayed and still in gestation) special department teaching will be combined with the present clerkships and dresserships. An attempt is also being made to re-arrange these appointments so that students can work both in the

Outpatient Department and in the wards during the same appointment. Before the introduction of the N.H.S. almost all teaching rounds took place in the afternoons. All dressers and clerks were therefore free to attend outpatient clinics in the mornings. However, with the increased commitments of hospital consultant staff whose appointments elsewhere have to be fitted in with their colleagues' clinics in the smaller hospitals, things have changed insidiously so that many teaching rounds now take place in the mornings. Even a medical student cannot be in two places at once (though from time immemorial, records have shown that this has in fact been achieved!). We must never lose sight of the fact that the curriculum is only a preparation for a lifelong process of continuous education. The examination of patients is taught with observation training in view: general principles can be learnt just as well from the rare as from the commonplace illness and for those outside to criticise the teaching hospitals for their "exotic" collection of clinical material is as unfair and stupid as it would be for us to prepare our students solely for dealing with the obvious and commonplace.

To encourage "lodging-out students" to remain in the College after normal (*sic*) working hours, and to provide the opportunity for increased corporate life in the College, the hospital library is now open in the evenings and the refectory is producing cut price suppers. There is of course a good deal of clinical activity in the evenings and it may prove possible to open the museum also. (Perhaps we should adopt the Public School technique of recreation every afternoon and work after supper.)

On June 10th and 11th extensive displays of student work and research were organised in the departments at Charterhouse Square. On the Friday afternoon, the College was at home to the parents of pre-clinical students, but less than 50 students desired their parents to be invited. (The aetiology of this filial reticence has not been worked out.) An all day Saturday meeting for old Bart's men was arranged with clinical demonstrations and ward rounds in the afternoon. Over 70 attended and many people afterwards asked why they had not been invited. The announcement was made in the Bart's Journal and invitation forms with programmes were circulated *with the Journal*. It appears, however, that very few Bart's men take the Journal and many of those don't read it! This all goes to show that if you are about to qualify you would do well to place an order *now* because you are sure to forget when you leave. The secretaries of decennial clubs tell me they have terrible difficulty in extracting replies from their members. It was, however, a great delight to see these Bart's men (many of whom had been absent for up to 20 years) viewing with amazement the preclinical departments and once again the rich tradition of the Hospital. We hope shortly to organise regular programmes of postgraduate training for our old students, if only they will keep in touch with us so that we have their names and addresses.

We are no further towards the construction of the new block for student amenities at Charterhouse Square and in common with the Ministry of Transport we face a major difficulty of car parking. However, plans are completed for an addition to College Hall to house another 60 students. Lacking the resources of a big business combine the College has to wait its turn in the queue of the many who depend on the totally inadequate finances of the University Grants' Committee.

Britain has a Health Service of which she can be rightly proud. Bart's is but one of the many Medical Schools who have sought to produce doctors willing and able to maintain the high traditions of British medicine, but the Willink Committee misjudged the requirements, and the output of the Medical Schools is now inadequate. Though our pre-clinical school could be expanded still further the clinical entry cannot be increased without additions to the hospital facilities. There is therefore no room for passengers and the capacity of our graduates must be very high in intellect and industry! Sometimes we are told that we are living in the past; we are proud of the past and we will be even more proud of the future, but the present is nothing to be ashamed of. Bart's men are still in demand. We have more enquiries for prospective partners and assistants in practice than we have graduates seeking an opening. Conscription has ended and continuity in postgraduate training may help to keep the Mother Hospital in touch with her brood.

AMERICAN VISIT

By Donald Crowther

I HAVE RECENTLY returned from Houston, Texas, where I spent a year in research on virology. A number of research fellowships are offered by many American universities each year to foreign students and scholarships may be obtained from various organisations such as the Fulbright Foundation. We found that so many of our expectations about America were not realised, and living there for a while proved to be a fascinating experience. I would like to describe some of the differences of living in America, with which I came in contact, and which I found most alien to the English way of life. One example of these differences is the medical training as I found it at Baylor University in Houston.

A pre-medical training at a university is required before an American student can enter a medical school. This training is divided into three parts; namely, chemistry, biology and literature courses. The chemistry course involves a year of elementary chemistry, one year of quantitative analysis and a third year of organic chemistry. Biology is a two year course involving general biology and comparative anatomy. Most students take a Bachelor's degree in a subject of their choice such as English, History or Chemistry. The standard of these courses appears to be approximately that of a good A or AS level G.C.E.

The medical school curriculum consists of four years study at Baylor. This study is usually begun at the age of 21 or 22 upon completion of the pre-medical training. In the first year the main courses are Anatomy, Biochemistry and Physiology; Neuroanatomy, Histology and some Psychiatry are included. The Anatomy consists of two periods of four hours each week for eight months, the Biochemistry, of three lectures per week and two three-hour laboratory periods, and Physiology of about 10 hours per week for eight months. Pathology, Microbiology and Pharmacology are the three main subjects studied in the second year, and in addition to these, substantial lecture time and a considerable amount of laboratory time is spent in the study of physical diagnosis, introductory medicine and laboratory diagnostic methods. During the year I was in Texas, the Virology department was concerned with the organisation of a course in virology for the students. About a dozen or so lectures were given on topics ranging from the epidemiology of diseases such as poliomyelitis, acute respiratory diseases of viral aetiology and arthropod-borne virus disease, to the elementary biophysical properties of the viruses concerned and laboratory diagnostic procedures. The year before I arrived, students were given virulent polio virus with which to do their antibody neutralisation tests; however, it was noticed that one or two students received a mouthful of the fluid when pipetting the virus, so last year they were given attenuated polio viruses. I started my research work in the laboratory with no little trepidation when I heard that some of the viruses with which we were dealing had caused epidemics amongst four-times Salk vaccinated children. However, there have been very few accidental laboratory infections with polio virus. This is in contrast to certain other viruses, as many research workers using Arbor viruses have found to their cost.

In addition, during the first two years of the medical course, students are required to do some sort of research project. Two afternoons a week for most of each year are set aside for such a project. A bright student with a productive research programme may be allowed to publish a paper at the end of this period and such a project can be of great value to a medical student.

The last two years are very similar to our own and mostly spent in the clinics with an average of one hour's lecture per day. Some courses have almost no lectures during the last year.

It is clear from these remarks about the medical training that there must be many differences between the American and English educational systems. While in England we distinguish between different levels of intelligence from one school to another and within schools, there is no selection of this kind in America. We start specialising in a narrow range of subjects when comparatively young; in America the university student is still tackling at least twice as many subjects. These differences, together with the fact that there are few entrance requirements at most colleges and universities, means that there is in America a much greater range of standards amongst university students than there is in England. Although the purpose of this system seems to be to provide a university level education for everyone, there is, as yet, no system of providing financial support to the student, and university fees are quite considerable.

Houston is reputed to be the most rapidly expanding large town in the world. There is a large port and a great deal of money to be made in natural gas and oil. Consequently, there are many very rich people in Houston. One a Mr. Cullen stood up at a University of Houston banquet and announced that he was giving the University $80,000,000 worth of property and money. He gave Baylor Medical school at least a million dollars towards the cost of its present building and continued to support the medical school strongly until his death. He was a very spontaneous philanthropist; for example he became so excited when the University of Houston beat Baylor University once, in a football game, that he gave the winners $175,000 and the losers $125,000.

My research projects in Houston did not involve any clinical work; however, I did spend one or two evenings in the casualty department of a big charity hospital—Jefferson Davis Hospital. In 1960 there were about 14,000 in-patient admissions, 5,000 patients were seen each month in the Emergency Room, 500 babies are delivered each month and in all about 80,000 clinic patients were seen over the past 12 months. Considering the above and the fact that Houston has been among the top three candidates for the title of murder capital of the States for several years now, one can well imagine the end of week rush for treatment. Houston is sufficiently far south to have numerous patients suffering from the various parasitic infestations endemic in the area and I need only say that any student looking for experience need look no further.

Medical students in Houston are wealthy compared with students in England. Many are married with a pleasant modern house and one or two cars. Their income is usually derived from a working wife or parents. Some work for money, although this is usually a last resort. A friend of mine, a medical student in his last year at Baylor, is spending Christmas partly in Miami, Florida, and partly in Los Angeles, California. He is hoping to do his internship in either Miami or Los Angeles and will no doubt visit the hospitals of his choice during the vacation. It is possible for British medical students to do a rotating internship in a hospital in the States. This involves a series of specialties lasting three months each, such as medicine, surgery, paediatrics and obstetrics. It is equivalent to a house post in England.

Some hospitals in Houston have extremely modern buildings and one, Texas Children's Hospital, built in 1954 was awarded a prize for the pleasing nature of its architectural design.

In this hospital, the mother may live in with the child. Many of the rooms contain only one child, some two, and a few four children. The rooms are spacious and have large windows and the atmosphere of a luxury flat rather than a hospital word. One floor of the hospital is reserved for patients requiring isolation and "barrier nursing" and each patient has a separate room on this floor. It is so expensive to stay at Texas Children's Hospital that most parents pay only a part of the fees, the rest being provided by charity. There is a large volunteer nursing and catering staff, as well as the State Registered Nurses. In Houston, doctors' fees are exorbitant, a doctor with a reasonable practice can earn over $50,000 per annum. Insurance policies never cover the complete cost of treatment and the middle class is most affected, particularly the elderly, when a prolonged ailment with numerous visits to the doctor may spell financial ruin. It is, perhaps, not surprising that many of the doctors' bills remain unpaid. Since patients pay so much directly for their treatment, they are more ready to sue than they are in England if a mistake is made. Ambulance cars are privately owned and most drivers make it a rule not to give any treatment to a patient for fear that they may be sued successfully for causing grievous bodily harm. This dreadful state of affairs has reached such a pitch in Houston that many a would-be Samaritan has thought twice about tying a ligature round a profusely bleeding leg. It must not be thought, however, that the people in Houston lack medical knowledge. Advertisements such as "Buy your insulin here—Special" keep the layman primed with the problems of our time. There are many appeals for comparatively uncommon diseases such as "Give for Muscular Dystrophy". One frequently meets people who,

although having had no formal medical training, know something more about muscular dystrophy than the name. In America as in this country, all too frequently funds are raised for a lost cause or a cause which has too much money already, and the money is tied up and cannot be used for a more needy cause: I would not like to suggest, however, that a system similar to our own National Health Service should be introduced into America because the problems in many instances are very different. A scheme such as ours would be disastrous for the doctors' $50,000 per annum income. It is not surprising that a spokesman for the American Medical Association has said that should Mr. Kennedy attempt to bring such a system into force, the A.M.A. would raise its mighty strength to crush the proposal.

For the last five months of our stay my wife worked as the secretary to a clinical psychologist. The fact that there seems to be no equivalent over here to the American psychological clinic may sound like a good thing, so I shall explain briefly how a clinical psychologist practices. Usually he works with a psychiatrist and handles the testing of new patients, while the psychiatrist is responsible for the treatment. However, the doctor for whom my wife worked (he was a Ph.D. not an M.D.) was responsible for the testing, diagnosis and treatment of the majority of the patients. There were about 20 to 30 patients and many of these were children or adolescents whose problems were connected with school work. There was at the clinic a full-time tutor for general subjects and a number of part-time specialist tutors, including a dance therapist. The work was thus divided between two psychologists, three or four tutors and the secretary (the latter handling much of the testing). Frequently a patient was referred to a medical doctor and to a neurologist for physical examinations, sometimes drugs were prescribed by either of these or by a psychiatrist, and occasionally a patient was referred to the psychiatrist for treatment. There was a very sociable relationship among the psychologists, tutors and patients and I felt that only a part of the treatment was undertaken in the consulting rooms. Although I had felt somewhat sceptical about such a clinic doing any positive good, after becoming more familiar with this particular one I felt it was definitely of some benefit to the patients.

In July, a month before our date of sailing for home, we left Houston in our car (bought for £90) to see more of the States, particularly the West. From Houston, on the Gulf Coast, we went as far west as San Francisco, as far north as the Canadian border and east to Boston. We travelled about 9,000 miles through 20 states before reaching New York. A day or two was spent in most of the well-known National Parks such as the Grand Canyon, Yellowstone and Yosemite, and in many less famous ones—Bryce Canyon in Utah and Grand Teton in Wyoming, to mention two that particularly impressed us. We camped in about 12 parks in all, and have a very high opinion of the National Park Service. Owing to the vast size of the Parks—Yellowstone covers approximately 3,000 square miles!—one's visit is not spoilt by there being so many other visitors. There seems to be every type of scenery one can imagine in America, but the distances are so vast that one has to limit one's travelling.

To the visitor from Britain, I feel sure that the South-western states—Utah, Arizona, New Mexico, Nevada—are the most interesting and exciting, the endless deserts and canyons and fantastic rock formations being so totally different from anything in Europe. We were able to save sufficient money to spend about five weeks on the journey and this made a fascinating end to a visit which had proved so interesting and informative.

MEDICAL SUMMER SCHOOL IN SCANDINAVIA

By P. J. Watkins

THE MEDICAL SUMMER SCHOOL IN Scandinavia has been a remarkable experience. Arranged by Scandinavian Medical students for thirty of their foreign colleagues (of twelve nationalities) it took place at Aarhus, Oslo, Gothenburg and finally at Copenhagen, at which orthopaedics, cardiology, traumatic medicine and social medicine were studied respectively. This very varied and interesting course took the form of lectures and lecture-demonstrations, as well as ward rounds and many visits to places of

medical interest ranging from the remains of a 13th century monastic hospital to the World Health Organisation in Copenhagen, and of course the Carlsberg brewery.

The orthopaedic lecture-demonstrations of Professor Thomasen in Aarhus were a masterly exposition of instruction by combining the lecture with clinical demonstrations and the projection of slides and films, i.e. the use of all the so-called "audio-visual aids". At Gothenburg, we had the privilege of studying in the new and magnificent Sahlgrenska Hospital (for over 2,000 patients, completed in 1958) which demonstrated a myriad of new ideas in hospital design and apparatus, from the very simplest dispensers of elastoplast and paper mugs, to the complexity of electrically operated doors and a fully intercommunicating pneumatic tube system for messages and specimens, and a radiological department whose automatisation is beyond belief. In this exciting atmosphere, Professor Moberg (whose chair is of "Extremity Surgery" and really a joint one of orthopaedics and plastic surgery) showed us some of his fascinating work on the restoration of function after injury, particularly of the hands.

At least as valuable as the directly medical aspects of the trip were the numerous, indeed continuous opportunities to meet students and doctors of different nations. At the many receptions we had these opportunities—at dinner and dances, over cray-fish in Gothenburg, and at the homes of General Practitioners in Aarhus—a multitude of opportunities to enquire about the practice of medicine and the systems of medical education. Above all, one was impressed by the freedom of the Scandinavian students to study different subjects in different Universities, and to take locums and clerkships at times and in places which they feel will be most valuable to them. Another feature of great interest was the way in which administration of the Swedish courses is by student committees which are also in a position to discuss and suggest improvements for their courses with a committee consisting of the Dean and other teachers—a co-ordination between students and teachers here, which is sadly deficient at home.

The farewell celebration was aboard ship, the *Oresund*; and now three weeks in Scandinavia have become a memory of the past—of the fairy-tale islands of the Gothenburg archipelago, of the vast whaling factories of Sandefjord, of the magnificence of thousand-year-old Viking ships of the Oslo Fjord. Our great regret is that we cannot return such hospitality even by offering these students clerkships in our teaching hospitals (as they do to our students)—an opportunity they eagerly await. Surely it would be no great hardship for each such hospital to offer one student a place for one month each year. Such a move would inevitably foster friendships with our colleagues in other countries in the study of medicine, which knows no boundaries.

AN HISTORICAL NOTE ON THE ABERNETHIAN SOCIETY

By J. C. Crawhall

THE ABERNETHIAN SOCIETY will be presenting, in the coming two terms, a series of talks by eminent speakers from outside the Hospital in the manner which has been customary for the last few years. This pattern of meetings is not invariable and the function of the Society has changed considerably since its foundation as the Medical and Philosophical Society. The original laws of the Society and the minutes of its meetings are no longer available, and the second minute book which can be seen in the hospital library commences on the 30th April, 1799. John Abernethy who had founded the society four years previously was one of the six presidents. Meetings were held every Tuesday from 8 to 10 o'clock, excluding vacation periods, and papers were presented by the elected members of the society based mainly on cases seen at the Hospital and one of these of particular interest is reported in detail elsewhere in this journal. The Society only admitted a limited number of members who had to be proposed and seconded by members of the society and could then be elected. They were then entitled to attend the meetings, vote in elections and use the library which was at

that time being founded by John Abernethy. The administration of the library seems to have caused the committee considerable difficulty. On December 9th, 1800, Mr. Brickwell rose to complain of the conduct of the librarian, an honorary post, held by a member of the committee, at that time Mr. Haslam. He said that instead of the Society's books being in the library, they were on the shelves of individual members and that he had enquired for the ninth volume of —— (an abbreviated title) during the precedding week and he discovered that the whole of that work would be found on the shelves of the Librarian at his own house.

On April 20th, 1801, Mr. William Lawrence was appointed Secretary, and on February 18th, 1802, the library rules were altered so that "a member shall be entitled to have in his possession one set of books at a time and he shall at the time of receiving them deposit in the hand of the librarian their full value. If the books are of octavo size or under, he shall return them within ten days and if they are above that size, in twenty days. On failure, he shall forfeit sixpence for every day he keeps them beyond the time allowed in case any other member has applied for them." The accounts of the Society were audited and presented at that meeting.

	£	s.	d.
Balance remaining from last audit	12	4	10
Received since last audit	16	18	6
Total	29	3	4
Expenses for books, candles, etc.	26	3	4
Balance in Treasurer's hands	3	0	0

On January 8th, 1805, control of the library was handed over to trustees consisting of Physicians and Surgeons of the Hospital in return for an annual grant of 15 guineas.

A complete copy of the revised rules of the Society in 1819 is available in the library. At this time: "Each ordinary member shall on admission pay one guinea and sign the Laws, a copy of which shall be presented to him with a catalogue of the books of the library on further payment of three shillings. An ordinary member being absent at roll call shall be fined one shilling. Each ordinary member to pay sixpence a week during the session of the Society towards defraying the expenses attendant on its meetings. Ordinary members shall in order of their election, after the first year of admission, deliver to the Secretary a dissertation on some medical or philosophical subject under the Penalty of 10s. 6d." John Abernethy died in 1831 and on November 23rd, 1832, it was decided that "A society of the medical pupils of this Hospital be founded to be called the Abernethian Society and that the gentlemen present be enrolled as founders of the same". James Paget first attended the Society as a visitor on February 8th, 1935, and whilst still a student made his historical communication on the existence of trichinella spiralis which he had seen in a patient of Dr. Roupells who had died of phthisis. He was elected a member on February 27th, 1835. On October 30th, 1845, he gave an address to the Society to celebrate its fiftieth anniversary and was also able to attend the centenary anniversary on May 1st, 1895.

During this period from 1835 to 1895, the Society was attended mainly by students, but addressed by the staff of the Hospital. In his introductory address on October 12th, 1876, Dr. Gee said, "A medical society may be of two kinds. First there may be societies of men who are no longer students in the common sense of the word . . . and there may be societies of men who are still students, commonly so called, men whose business is not so much to discover new truth as to make themselves masters of the old. The Abernethian Society, whatever it may formerly have been, is now of the second kind rather than the first."

There is a report in the library of the Amalgamated Clubs of St. Bartholomew's Hospital for 1893–4. It states that the Society is composed of teachers and students of the Hospital, which meets in the Abernethian Room every Thursday evening at eight o'clock for the reading and discussion of papers on subjects of medical science or practice and for the exhibition of clinical cases and pathological specimens. The subscription was one guinea. Twenty-seven newspapers and periodicals which are listed were taken in the Abernethian Room. No smoking, refreshments, card playing or gambling was permitted. There was, in addition, a smoking room in which another nineteen newspapers and periodicals were available. Twenty-one medical papers were read to the Society that year, all by leading men in the Hospital including Sir Dyce Duckworth (Clinical aptitude), H. A. Bowlby (Mid-sessional address), A. E. Garrod (Cau-

sation of Rickets) and W. P. Herringham (Emphysema).

The practice at the moment is for guest speakers from outside the hospital to be invited to address the Society so that the type of speaker has changed since 1895. The transition seems to have been gradual, but an eminent non-Bart's man who addressed the Society on June 8th, 1922, was George Bernard Shaw on "The Advantages of being unregistered". Three-hundred members and 150 nurses were present. Mr. A. C. Visick was President and Mr. J. P. Hosford was Secretary. There were three sessional addresses, two debates, five clinical evenings, three discussions and six addresses held in that year so that the programme was of a varied type. Although it might be desirable to have a more varied programme at the moment these are two factors which will help to maintain the popularity of external speakers at the meetings of the Society. The first is the increase in the number of compulsory lectures in the course, so that for relaxation the student will want to hear people and topics differing from those heard in his day to day teaching, and secondly there is an increasing interest in the advances in medicine taking place outside the hospital and particularly in those allied subjects which are contributing so much to medical knowledge, but which do not form part of the student teaching programme.

LETTERS TO THE EDITOR

Dear Sir,

The September issue of the Journal published a statistical analysis of student opinion on general practice which, although a little confusing, did seem to bring out the fact that about 50 per cent. of medical students a little less at Bart's, became general practitioners. It might be inferred also that eventually a large proportion of the remainder have their patients referred to them by General Practitioners with whom they need to co-operate. Therefore, it certainly is a sobering fact to realise that in 1958 none, not even those going into general practice, had spent a day observing or assisting a general practitioner. Fortunately since then a small proportion have done so and more seem to do so each year. There is no difficulty now in arranging for a student to be attached to a general practitioner in any kind of practice from one day up to three weeks if he so desires.

Interested students should apply to the sub-dean's office.

Yours truly,
T. O. McKane,
Adviser in General Practice.

Dear Sir,

The Women's Guild has recently opened a flower shop, generously provided by the Governor's of the Hospital, at the entrance to the Colonnade.

Fresh flowers bought daily at Covent Garden will be on sale at prices competitive with the lowest quoted in the trade. In addition to the services of a trained florist, a rota of voluntary helpers is being organised which, when completed, will make it possible to keep the shop open continuously from 10 a.m. to 7 p.m. on week days, and from 2 p.m. to 4 p.m. on Sundays.

Flowers will be delivered anywhere in the hospital on the day on which an order is received. Wedding bouquets, corsages, buttonholes, etc., will be made to order.

The Guild sincerely hopes that the readers of the Journal will give this new project their full support.

Betty Tubbs,
Chairman of the Executive Committee.

BOOK REVIEWS

A STUDENT'S GUIDE TO OBSTETRICS AND GYNAECOLOGY by Christopher Dewhurst. **Published by Cassell.** Price 16s. 225 pp.

This small book does not pretend to be a comprehensive textbook, but rather tries to present the basic facts in a simple and uncontroversial manner. In many ways the marked austerity of the contained matter mars the impression which should be left with the reader, since some small detail and discussion of the more uncertain points make the text more interesting and the subject matter less circumscribed.

Two-thirds of the book is devoted to Obstetrics and the remainder to Gynaecology. The first part is well considered and deals with the major issues of obstetrics fairly adequately. The brief space accorded to gynaecology gives hardly any opportunity to present sufficient for more than a brief outline of the more common disorders.

This book is well prepared of its kind, but cannot be recommended as more than an introduction to the subjects and to adopt it as a main text for the qualifying examinations would be courting disaster.

M.L.P.

THE SEARCHING MIND IN MEDICINE by William A. R. Thompson, M.D. 187 pp. Illus. 25 × 13. **Published by Museum Press Ltd.** 21s.

Dr. Thompson, who is well known as the editor of *The Practitioner*, has based this book on a series of expert talks given in the External Services of the B.B.C. The problems considered range from "Radiation and Man" to "Blood Groups and Anthropology", from "The Whys and Wherefores of Antibiotics" to "Hypnotism", and in preparing this volume Dr. Thompson has completely revised each section to include the most recent work.

The publisher's blurb says that the book is "Intended primarily for the general reader . . . is written in non-technical language . . ." and to a certain extent this is true, but even that elusive figure "the Intelligent Layman" would probably have to possess a copy of Dr. Thompson's other famous publication—Black's Medical Dictionary—if he was to get the most from this very interesting volume.

To those whose work lies in the field of medicine this book has much to offer. To the student it provides a fascinating glimpse of how new knowledge and techniques are being applied to some of the problems facing medical research at the moment. For the specialist it provides an excellent account of the latest work in fields other than his own.

Rapid progress in medicine, as in any other science, depends upon good communications, and good communications imply a knowledge not only of a specialist study, but also of the genreal pattern of research. As a step in this direction alone this book by Dr. Thompson can be warmly recommended.

A.J.B.M.

THE EYE IN GENERAL PRACTICE by C. R. S. Jackson. **Published by Livingstone at** 21s.

This book is excellent value, and ideal for students: the subject matter is clear and concise, and covers a wide range of subjects, without delving into obscure matters. The illustrations are good; a few more would be welcome, though one can scarcely expect this in such a low priced book.

The short section on the welfare of the blind and the role of the National Health Ophthalmic Service should prove useful to those going into general practice. The chapters on "the eye in diseases of other parts" gives excellent and useful descriptions of important eye changes in common diseases—conditions which are but sketchily described in the shorter medical textbooks.

The only real criticism is that the author gives very little account of the aetiology of the various diseases; hence the reasons for the recommended treatments is far from obvious in many cases.

The book is beautifully produced and well printed (though, alas, on shiny paper). Altogether, it may be wholeheartedly recommended. S.M.W.

AIDS TO HISTOLOGY by Geoffrey Bourne. 168 pp. 7th Edition. **Bailliere, Tindall & Cox.** 10s. 6d.

In his preface the author suggests that this book can be of value to beginners who feel the need of a simple introduction to the subject, and also to students revising for an examination. The latter claim can (with some reservations) be upheld. It would, however, be little short of disastrous if a newcomer to the subject got hold of the book before he had received a grounding in the subject. The illustrations are in most cases so crude as to give a completely false idea of the real nature of microscopic structure, and might well prevent the average student from ever satisfying his teachers with his laboratory drawings in Histology; it is rare for examiners to be satisfied if teachers are not.

On the other hand the borderline candidate may find that use of the book helpful for the final cramming prior to the examination, but in this direction, to paraphrase the late T. E. Lawrence, the book might be helpful to those who know enough histology not to need helping.

ANATOMY AND PHYSIOLOGY FOR RADIOGRAPHERS by C. K. Warrick. **Edward Arnold** 30s. 265 pp.

The ideal textbook should be a pleasure to read, comprehensive, to cover the whole subject adequately, and concise, avoiding unnecessary detail or wordiness.

This book is the nearest to the ideal textbook for student radiographers that I have yet seen. Its clear printing on good paper and excellent diagrams conveniently placed throughout the text make it easy to read. The text is lucid and is specially to be commended for avoiding technical terms and facts beyond the scope of a book for radiographers. The whole of the syllabus for the anatomy and physiology for the revised (1960) regulations for the M.S.R. examination appears to be covered in an encouragingly small space.

Without any hesitation this book can be bought and should be treasured. Its price is very reasonable. It is likely to become the "standard" textbook in its field, and the author and publishers are to be congratulated for its production. D.H.T.

AN INTRODUCTION TO FUNCTIONAL HISTOLOGY by Geoffrey Bourne. 263 pp. **J. & A. Churchill.** 32s.

This is a first rate book. It deals with the cell as a functional unit in considerable detail. There is an excellent correlation between the results achieved by biochemical methods and the fine structure revealed by the electron microscopists. This is followed by a consideration of tissues, and finally the principle organ systems. In all these sections the stress is on the functional aspect.

In a book of this small size one does not expect the weight of structural details to be found in the larger works, but it seems a pity to devote less than four pages to a description of the ear, and yet to devote 32 pages to various technical methods, all of which can be found in several good "cookery books". The illustrations are of very varying quality. Many are excellent and some have not been surpassed in any text. On the other hand, some are of very poor quality, even in specimens where no technical difficulty can be pleaded in mitigation. It is also a pity that the fundamental error in the path of rays through the electron microscope should be repeated in Fig. 13 (the same Fig. appears in Ham's Textbook).

However, these are all rather minor points of criticism; this book should certainly be read by students reading for a degree in physiology or biochemistry. All second M.B. students who feel a special interest in the subject should certainly read it; and it ought to be familiar to recently qualified men who are embarking on a career in pathology.

SYNOPSIS OF PATHOLOGY by W. A. D. Anderson. **Published by Henry Kimpton.** pp. 876 with index. 70s.

The new edition of 'Synopsis of Pathology' need offer no apology for coming out only three years after the fourth and for being of a similar general pattern. The changes in content are unobtrusive, largely because of the basic soundness of the original plan. The new edition has grafted recent developments on to the body of previous knowledge with enviable clarity and discernment.

A small and concise book often suffers from the stigma of being suitable for cramming, rather than intelligent study.

Though this book cannot be bettered for final revision—when it can be read in two days—one may also use it as a standard textbook during a pathology course. What this book loses through brevity it gains in many other ways. It is not cluttered up with footnotes ,' small type ' and an excess of cross-references. And the index has not a single one of those infuriating entries, so common in some books, which refer to other items rather than give page numbers. The typography, format and illustrations are excellent. Only a purist (such as I) would wish for magnifications of microphotographs to be stated; and for something better than occasional scales in other photographs which cryptically state 'metric'.

There are many books which can be published only through simultaneous distribution both sides of the Atlantic and one is suitably tolerant of the idiosyncracies of the other party. So the fact that the bibliography of this book is related entirely to the American literature is understandable and is a small price to pay for such an admirable import. But the next edition would be even more valuable if it were to include some references for those who have access only to the popular British journals. I wonder how many medical students read original papers anyway.

Be that as it may, they will find no better *vademecum* for pathology and morbid histology than the new edition of 'Synopsis of Pathology'.

C.W.

AIDS TO PSYCHIATRY (8th Edition) by E. W. Anderson, M.D., M.Sc., F.R.C.P. (cond), D.P.M., W. S. Dawson, M.A., D.M., F.R.C.P. (cond), F.R.A.C.P., D.P.M. **Published by Bailliere, Tindall & Cox.**

In the preface to this extremely revised new edition, the author apologises for the dogmatic presentation which he says the character of the book demands.

Unfortunately, psychiatry lends itself less readily than other branches of medicine to being condensed into a short factual precis.

Newcomers to the subject will be submerged in a mass of undeveloped ideas and innumerable definitions too confusing to be assimilated.

Those already acquainted with the subject may find this volume to be a useful catalogue of conditions met in psychiatry, and a mine of psychologico-psychiatric terms, carefully defined (in psychologico-psychiatric terms!). H.W.

HEALTH AND HORMONES

This is a competent and entertaining do-it-yourself sex and gland book. Although it can be recommended for the intelligent and educated adult lay-public, no dormitory should be without it. I say chaps, have you counted your chromosomes lately! A. G. S.

CLINICAL ANATOMY

The student of to-day has a great deal more to learn than ever before: the vast subject of anatomy has to be crammed into a short period of learning, so that it is difficult, if not impossible for the facts which will be all important during the clinical training to be appreciated and grasped. Ellis has produced a book which stresses clinical application in anatomy. This must be of value during the preclinical period as a guide to those points which they must retain. During the clinical years anatomy is too easily forgotten. The large books are too large for quick reference, the smaller books are too topographical with little, if any, clinical application, so that the whole important subject is side-tracked by the student. This book fills a real need in the students' preclinical and particularly clinical years of study: in the post-graduate days it would serve as an easy and practical reference book. Such books are difficult to write for the errors of omission surmount those of commission: it is easy to pick out part or parts which are inadequately covered, but there are few such parts in this book, which is practical, well balanced and, above all, easily read.

J. O. R.

SPORTS NEWS

Viewpoint

The Students' Union has recently undergone a period of re-organisation, which it is hoped will render it better suited to its member's needs and easier to run. One of the more important functions of the Union is the allocation of funds to the various sporting clubs, and it is here proposed to deal with a few problems which arise from the differing attitudes of the members as to how this should be done.

In the past, every time that grants have been allocated, there have been complaints, firstly of not enough money all round; secondly by rival clubs of unfairness; and thirdly by the non-sporting section of the community. The second of these should be obviated by the new system, based chiefly on the numbers in the club, but there is no obvious answer to the first and third problems.

Those who think that their sport should be heavily subsidised must realise that it is an extra-curricular activity, and those who enjoy it must expect to bear the cost. The Union helps as best it can and excellent facilities are provided for everyone to use, but costs are heavy and funds are not inexhaustible. In spite of this, the Union is extremely generous and substantial allowances are made to teams going on tour, taking the view that in this way the good name of the Hospital is spread abroad.

Apart from welcome donations and dances (which have recently been restricted to one a month), there are few ways in which a club can augment its income. Whist drives are "out", but what about a series of draws and raffles, things that can be easily organised? And let us not forget the possibility of installing a "one armed bandit" down at Foxbury.

Finally, it is wrong to expect those who do not play games to subsidise the activities of those who do, and it would be a happier proposition all round if the non-sportsman was allowed a rebate, as he will certainly be indulging in one or more of the non-sporting extra curricular activities which are also run by the Students' Union and which also incur a certain expenditure.

In so little space as this, it is difficult to put forward arguments without exaggeration, and many of the issues raised here are not so clear cut as they would, seem, at first. The sentiments, however, are there and in so rigidly controlled and highly competitive a community as Bart's, there is indeed room for tolerance.

Rugby Club

Sat., Dec. 17th

1st XV v. K.C.S.O.B. Lost 0–11.

K.S.C.O.B. beat Bart's by a goal, a try and a dropped goal to nil. The Hospital lost right wing C. J. Richards after ten minutes, but the seven forwards managed to hold their own in the tight. Poor covering let in two K.C.S. scores both of which followed good handling movements between forwards and backs. One of the tries was converted. After the oranges a dropped goal from the opposing stand-off completed the scoring. For Bart's, G. J. Halls and R. V. Jeffreys came close to scoring and A. T. Letchworth produced some characteristic serpentine runs but the Old Boys' defence remained unruffled.

Team. Ross, C. J. Richards, Letchworth, Niven, Jeffreys, Bamford, Peek, Hamilton, Gurry, Knox, Doran, Orr, R. P. Davies, Jennings, Halls.

Sat., Jan. 14th

1st XV v. Taunton. Lost 0–11.

Taunton beat Bart's by a goal, a try and a penalty goal to nil, all points being scored in the opening twenty minutes. Close interpassing at speed between the opposition forwards and backs exposed gross inadequacies in the Hospital defence and was responsible for both Taunton tries. However, after half-time, Bart's came into their own and several promising moves were marred only by poor finishing, over-eagerness close to the line seemingly the main fault. R. P. Davies was always prominent in the loose, whilst outside the neat hands of R. R. Davies and the bullock-like charges of J. E. Stevens brought appreciative comment.

Team. Ross, Stevens, Britz, Niven, Jeffreys, R. R. Davies, Chesney, Hamilton, Gurry, Knox, Orr, Smart, R. P. Davies, Jennings, Goodall.

Sat., Jan. 21st

1st XV v. Cheltenham. Lost 0–13.

In contrast to the previous week, when all the scoring came at the beginning, Cheltenham crossed the Hospital line three times in the last quarter of an hour—two tries being converted. The powerful Smart was absent from the Bart's pack, but his substitute B. R. H. Doran had a fine game. Cheltenham had the better of the first half when the Bart's defence, with A. P. Ross outstanding, was at full stretch. After the interval, M. C. Jennings and R. P. Davies led many dangerous forward rushes, but Cheltenham opened the scoring when an opposing centre dashed through to touch down under the posts. Shortly afterwards, a wing-forward dribbled over and just on no-side a quick heel resulted in the right-wing scoring.

Team. Ross, Stevens, Britz, Niven, Jeffreys, R. R. Davies, Peek, Hamilton, Gurry, Knox, Orr, Doran, R. P. Davies, Jennings, Goodall.

Sat., Jan. 7th

1st XV v. Notts. Lost 3–6.

Notts won this morning game by a dropped goal and a try to a try. In the early stages, the Hospital with a liberal supply of the ball did much of the attacking, but gradually Notts came into their own and their outsides looked dangerous on several occasions. Their stand-off eventually gave them the lead with a neat drop-goal close to half-time. After the interval, Bart's hit back and P. A. R. Niven crossed near the posts after R. V. Jeffreys had come into the line and thus contrived a gap. To complete the scoring an elusive Notts centre gathered a grub-kick at speed and touched down by the posts. Barts fought to make up the deficit, but the Notts defence held strong.

Team. Ross, Stevens, Britz, Niven, Jeffreys, R. R. Davies, Peek, Hamilton, Jennings, Knox, Orr, Smart, R. P. Davies, Cripps, Goodall.

Sat., Dec. 31st

1st XV. v. Old Rutlishians. Lost 3–12.

The excesses of Christmas barely over and the fruits of Hogmanay as then unskinned, Bart's went down by two tries and two penalty goals to a try against the Old Rutlishians.

In the early phases, exchanges were even, although J. K. Bamford caused the opposing back row much consternation. However, the Old Boys took the lead with a penalty goal and a try before the interval. After this, Bart's besieged the Rutlishians' line for over twenty minutes, but only one try resulted, scored in the corner by R. V. Jeffreys, although Bamford and M. Britz went close. The opposition defence proved all too competent and in the last ten minutes the siege was raised when the Old Boys kicked a second penalty goal and then one of their fast wings raced seventy yards past deficient covering to complete the scoring.

Team. Ross, Burbridge, Britz, Niven, Jeffreys, Bamford, Peek, Hamilton, Jennings, Knox, Orr, Smart, R. P. Davies, Cripps, G. J. Halls.

Soccer Club

Sat., Jan. 13th at Chislehurst.

Bart's 0 Old Chigwellians 1.

This game was as even as the score suggests. The one goal that eventually decided the game was scored in the last ten minutes, and was the direct result of a defensive error on our part. P. Savage, D. Prosser and M. Hudson defended resolutely throughout, and at forward E. Manson made some good openings. However, the forwards were their usual "goal-shy" selves, and in order to win in the future, this fault must be corrected.

Team. J. Sawer (Capt.), P. Stanley, D. Prosser, H. Beecham, P. Savage, M. Hudson, E. Manson, M. Williams, H. Phillips, R. Choonoo, N. Davies.

Sat., Jan. 7th at Chislehurst.

Bart's 3 City of London College 4.

Once again we had a very enjoyable game against this team, and once again they proved to be just a little too good for us, despite their age. The Hospital were somewhat handicapped by having only eight men from the Bart's. The remaining three players were donated by the opposition. Indeed, a sorry state of affairs! The scorers for the Hospital were Prosser 2 and Phillips 1.

Team. N. Jones, H. Beecham, Andan, D. Delaney, P. Savage, M. Hudson, D. Prosser, H. Phillips.

Wed., Jan. 18th

Bart's 1 Chartered Accountants Society 8.

This really was defeat! The opposition fielded a team that had no weak links whatsoever. The football they played was far superior to that shown by the Hospital.

Bart's were 4–1 down at half time. However, for two-thirds of the second half the Chartered Accountants were fended off. Unfortunately, in the last quarter of an hour they put four more goals past J. Jailler, who had no chance of saving any of them.

Within two or three minutes of time, D. Prosser scored a consolation goal for Bart's.

Team. J. Jailler, T. Herbert, A. Howes, M. Hudson, P. Savage, D. Delaney, E. Manson, H. Phillips, D. Prosser, M. Waterworth, N. Davies.

Wed., Jan. 25th at Chislehurst.

Bart's 2 Royal Vet. College 1.

The Hospital achieved a long-awaited victory in this game. For the first time since October, the forward line played together as a unit and made many scoring opportunities. The opposition scored first, but Bart's replied within minutes through D. Prosser. The same player scored the winning goal just before half-time. The team managed to hold this advantage to the end. Manson increased the score, but the referee, standing on the half-way line, adjudged that the ball had not in fact gone over the goal line.

Team. J. Spivey, T. Herbert, A. Howes, P. Savage, B. Hore, M. Hudson, E. Manson, H. Phillips, D. Prosser, M. Waterworth, N. Davies.

Wed., Jan. 1st

Bart's 1 v. Royal Naval College, Greenwich 4.

Bart's had lost narrowly to a strong Naval College side earlier in the season. This time our defence played well but our weakness lay in the poor finishing. Orr distinguished himself in goal and Savage and Delaney were prominent with their able covering and sure tackling. Waterworth worked hard at inside forward and was rewarded with a fine goal to even the scores before half-time. However, a fifteen minute lapse late in the game proved irretrievable.

Team. Orr, Howes, Herbert, Beecham, Savage, Delaney, Chant, Waterworth, Jailler, Prosser, Davies.

Ladies' Hockey Club

Sat., Jan. 14th at Chislehurst.

Match v. Atalanta 2B XI.

Lost 5–7.

This was our first match for seven weeks and therefore the team was not as fit as it might have been! Bart's had difficulty raising a team, owing to the absence and loss of some defence, but the opposition goalkeeper did not arrive and the result was a most enjoyable and well-balanced game. Bart's forwards played well, and in the first half we led 2–0. In the second half Atalanta quickly made up the deficit and went into the lead, after which it was a continued battle, each side scoring alternately. Fitness told in the end, and Atalanta were the deserving victors.

Goals: R. Hall (2), S. Minns (2), R. Walters (1).

Team. C. Lloyd, J. Thoroughgood, C. Foot, M. Childe, J. Evans, A. Coates, A. Callaghan, R. Hall, R. Walters, S. Minns, P. Kumar.

Sports Calendar

March 2nd — A.F.C. v Balliol College, Oxford (A)
3rd — A.F.C. v St. Peter's Hall (A)
4th — R.U.F.C. v Streatham (H)
Hockey v Middlesex Hospital (H)
Ladies Hockey v University College
5th Hockey v Bandits
8th — Ladies Hockey v Royal Free Hosp. (A)
Lacrosse v Goldsmiths
11th — R.U.F.C. v Aldershot Services (A)
March 11th A.F.C. v R.A.F. Technical College (H)
Hockey v Oxted (H)
Lacrosse; London University Tournament
15th A.F.C. v Charing Cross Hospital (A)
18th — R.U.F.C. v Stroud (A)
A.F.C. v Accidentals (H)
Hockey v Kings College Hosp. (A)
Ladies Hockey v Lensbury (A)
25th — R.U.F.C. v Treorchy (A)
A.F.C. v Swiss Merchantile College (H)
27th — R.U.F.C. v Glynneath (A)

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

RENAL TRANSPLANTATION

(With apologies to Sir Philip Sidney—
He wrote of the heart; but why not the kidney?)

My true twin hath my reins, and I have his,
By just exchange, the one to the other given—
He hath my reins: his own he cannot miss—
There never was a better bargain driven.

He from my loins his failing strength renews,
I to his progress gladly give free rein:
His life is saved, and mine I cannot lose—
Twin souls, and both of a like kidney, we remain.

His reins renounced in spirit I retain,
Mine he hath stol'n by neat chirurgic craft:
I grant consent to that which he hath ta'en—
There never was a less dishonest piece of graft.

My true twin hath my reins, and I have his.

R. B. P.

ST. BARTHOLOMEW'S HOSPITAL JOURNAL

Vol. LXV, No. 3 MARCH, 1961

Editorial

A BRIEF GLIMPSE around the Hospital will reveal that few, if any of us are destitute; and yet, the matter of income continues to be a source of considerable discontent in the student body. Some complain that their income is insufficient to satisfy their essential needs and in a few cases this contention is probably justified; others say that although their income covers essentials, their life is dull because of the few luxuries they can afford. Whatever the case, all compare their income with that of their fellow, and this comparison contributes more to the discontent than any other single factor.

It is not in the nature of human beings to be satisfied with their own means, however adequate they may be, when their companions have better. Students are no exception and their attitude to money may not unfairly be likened to that of the Trades Unions.

With regard to subsidy, it is not reasonable to expect the authorities to contribute more than is necessary for the cost of education together with a basic living allowance, which does, in fact, take into account the occasional luxury. The way in which this allowance is distributed, notably by the means test, may not give satisfaction to all and has recently been under review; but viewed in perspective, the principle of the means test seems to be the fairest way in which money can be allocated.

One great difference between the student and the worker lies in the fact that although the latter derive their income from one employer, be he private or municiple; the large body of students gain their money from two sources, namely the education authorities and the parents. Now parents are a pretty mixed bunch, and their assessment of what a reasonable income should be varies within wide limits. Those whose parents tend to keep a tight grip on their finances in many cases paradoxically blame the education authorities for their lack. On the other hand, those whose parents are extremely generous, sometimes to the point of indulgence, often become self satisfied and spendthrift. Working in the same community, the former will sometime or other compare himself with the latter, only to increase his discontent with his own circumstances, and it is unfortunate the blame will be layed at the feet of the education authorities.

We do hope that our income will adjust itself to the changing cost of living, but it is morally unjustifiable to expect the authorities to subsidies our visits to the theatre and public houses: this should be afforded through our parents or our own private means.

Fifty years ago

THE MID-SESSIONAL ADDRESS before the Abernethian Society in the Winter term of 1911 was delivered by Mr. Henry Butlin who took as his subject "Public Speaking, particularly in relation to Medicine." The text of this address is reproduced in full in the April edition of the Journal for 1911, and makes entertaining and most instructive reading. In his Editorial the Editor at that time writes:

"We wish we could reproduce also the charm of delivery which characterises all Mr. Butlin's orations; but we feel confident that all those who have had the privilege of knowing Mr. Butlin as a teacher will easily recall with affection his intonation and mannerisms, and, when reading his lecture, they will feel, in a measure, that they were actually present to hear him speak. It is always a great pleasure to receive instruction from a master of his art, but to be able to learn from a speaker of Mr. Butlin's fame a few hints on public speaking appeals to us as indeed a privilege."

Space permits us only to reproduce the following short extract from Mr. Butlin's address:

"Of orator's I have only heard, so far as I can judge, two in my life—Mr. Gladstone and Mr. Gough (the 'Temperance Orator'); but I am not sure of Mr. Gough, for I heard him when I was quite a child, and had never heard any fine speaker in my life before. My experience of Mr. Gladstone is limited to a single speech. In the time of the 'Bulgarian atrocities' I happened to have some orders for the House, where I had never been. One afternoon, in the early summer, having nothing particular to do, I thought that I would go down and hear what took place. I had no difficulty in finding a seat, and the son of some nobleman was making his maiden speech. But before he had finished the benches became filled with members, and the Strangers' Gallery was soon filled to overflowing, and my next neighbour said to me: 'Something is going to happen; I should not wonder if Mr. Gladstone is coming down to speak.' And, presently, Mr. Gladstone entered and took his accustomed place. When the young man sat down Mr. Gladstone rose, and his first act was to compliment the previous speaker. It was delightfully done. If I had been provided with pen and paper and sat hours in a quiet room I could not have produced a more graceful or beautifully worded compliment. He then began to speak on the Eastern question. He described the cruelty of the Turkish soldiers and the sufferings of the Christians, and in such terms and with such power of language that we who listened could almost see the soldiers at their work, and hear the cries and groans of the wounded and dying. He summed up what the European countries had done for the Christians, what 'Holy Russia' had done. And when he stood silent for a moment, then asked in deep and tragic tones, 'And what has England done?' we lowered our heads, and were ashamed, and each one said to himself, 'What has England done?' I think, at that moment, we should have been ready to follow him even to Bulgaria; and, I am sure, if I had then been summoned to vote, I must have voted in whatever manner he had ordered me. For three hours and a quarter Mr. Gladstone spoke. Until then I had thought that I could never have listened to mortal man for more than an hour without fatigue and *ennui*. But, during all that time I had never wished that he should cease, and when he had finished I should have been content for him to have spoken longer. Few great orators are given to the world, and when there is one in this country by all means hear him if you can."

Calendar

MARCH

Sat. 25—On duty: Dr. G. W. Hayward
Mr. A. W. Badenoch
Mr. R. W. Ballantine

APRIL

Sat. 1—On duty: Dr. A. W. Spence
Mr. E. G. Tuckwell
Mr. C. Langton Hewer

Sat. 8—On duty: Medical and Surgical Units
Mr. George H. Ellis

Sat. 15—On duty: Dr. R. Bodley Scott
Mr. A. H. Hunt
Mr. F. T. Evans

Thurs. 20—Abernethian Society: Canon Charles E. Raven, D.D., (Chaplain to the Queen)—"Disease of the Body Politic".

Sat. 22—On duty: Dr. E. R. Cullinan
Mr. C. Naunton Morgan
Mr. R. A. Bowen

Abernethian Society

ON FEBRUARY 6TH, 1961, a Clinico-Pathological Conference was held, the first to take place at Bart's for three years, and certainly great interest was shown by the 160 people who came. Two cases were presented to Professor Scower and Dr. Stansfield by Miss Margaret Childe and Mr. David Gardner-Medwin, whose clinical diagnoses were widely discussed by members of the audience, and in part contradicted, but generally confirmed by Dr. Stansfeld's pathological evidence. Professor Scowen chaired the discussion and summed up the cases. The President, in closing the meeting, commented on the fact that it resembled the form of the earliest meetings of the Society which were always clinical evenings.

Surely clinical demonstrators, case presentations and clinico-pathological conferences are the very salt of a medical instruction, and could play a much more prominent part in the curriculum. Perhaps the interest shown in this venture of the Abernethian Society will be conducive to their inclusion as an integral part of the teaching.

ON MARCH 9TH, Dr. D. Stafford Clark, M.D., F.R.C.P., Consultant Psychiatrist at Guy's Hospital, addressed a large meeting of the Society on "Psychiatry and the Law".

Often in the law courts today "expert" medical evidence appears to be falling on stony ground. It seems to be at the mercy of the whims of cross examination. Yet, looking beneath the surface, the reason is at once apparent. The verdict in a law court is obtained in quite a different way to the diagnosis of a psychiatrist. Law is an entirely man-made innovation based on the concept of Justice. There is a rigid structure of rules and definitions enforced with great flexibility by lawyers—the only people who really know what it is all about. To obtain a verdict it is essential to have an opposition and a cross-examination; for this is the best way of arriving at the truth. Psychiatry, on the other hand, has no blue prints on which to rely; it depends much on hypothesis. Diagnosis is only reached, on the basis of probability, from a differential diagnosis, which may comprise any number of possibilities. The lawyer, subjecting this to his own method, may feel the doctor a poor witness in court. Indeed, during the trial of Haigh for the acid-bath murders the doctor's evidence for the defence, that Haigh was suffering from Paranoia, based on history, was dismissed as hear-say. In another case, the murderer of two children was undeniably mentally defective, but the court did not recognise mental deficiency as a disease of the mind and so he had to be "proved" insane. A judge once, in summing up a case, said of the accused: "He looks sane enough to me." Would he say of a newly built bridge, declared by an engineer to be unsafe, "It looks solid enough to me"?

"Expert" medical evidence would be much nearer the truth if obtained free of the methods of the law courts, by an independent tribunal; by a uniting of experience rather than a battle of experience.

Dr. Lindford-Rees proposed the vote of thanks.

Notes and News

WITH THE RAPID turnover of clinical students the Journal has a useful function to perform in publishing periodically notices of some of the services available to students and recently qualified men.

One such service, of which some may not be familiar, is Dr. McKane's "Employment Agency". Dr. McKane is the Adviser in General Practice to the hospital. He writes: "I am ready to help students in any of the problems related to General Practice, either in preparation for it or in settling into one when they have once become registered."

Dr. McKane gets many letters from doctors in practice, both in this country and abroad, asking for recently qualified men to fill vacancies as assistants with a view to partnership, assistants, trainee assistants and locum tenens. Many of these are excellent posts offering very good experience, but there is only any response from those applying for posts as "assistants with a view". This would seem a great pity and a great waste. The value to the potential hospital doctor of spending a period of time in general practice has been stressed time and again.

View Day 1961

View Day 1961 will be held on Wednesday, June 28th.

Engagements

HATCH–MOTTADELLI.—The engagement is announced between Dr. John Desmond Hatch and Signorina Antonietta Mottadelli Monticelli.

HURDING–HARDING.—The engagement is announced between Dr. Roger F. Hurding and Joy E. Harding.

LODGE–DURDEN SMITH.—The engagement is announced between Dr. Alan Blakey Lodge and Claire Durden Smith.

SUGDEN–PARK.—The engagement is announced between Dr. John Sugden and Dr. Pauline Park.

Births

HOVENDEN.—On February 1st, to Anne and Dr. Brian Hovenden, a son (Charles Brian).

MILLWARD.—On February 19th, to Wanda and Dr. John Millward, a daughter (Helen Madeleine).

PAGET.—On February 21st, to Joan, wife of Dr. Cecil Paget, a daughter (Sarah) a sister for Nicola, Wendy and Nigel.

PORTELLY.—On January 31st, to Wendy and Dr. John Portelly, a daughter.

WOOLRYCH.—On February 15th, to Ann and Dr. Michael Woolrych, a son (Thomas Geoffrey).

Deaths

ACTON–DAVIS.—On February 10th, Kenneth Acton-Davis, M.Ch., F.R.C.S., aged 78. Qualified 1911.

ARMITAGE.—On February 17th, Dr. Charles Ernest Augustus Armitage, aged 83. Qualified 1905.

BURKITT.—On February 1st, Dr. Frederick Thomas Burkitt, aged 69. Qualified 1918.

CUNNINGTON.—On January 21st, Dr. Cecil Willett Cunnington. Qualified 1905.

INGLEBY–MACKENZIE.—On January 17th, Surg. Vice Admiral Sir Kenneth Alexander Ingleby-Mackenzie, aged 68. Qualified 1916.

NICHOLSON.—On February 22nd, Dr. Cuthbert John Nicholson, aged 76. Qualified 1912.

SQUIRE.—On February 5th, Dr. Henry Fremlin Squire. Qualified 1918.

WOODFORDE.—On January 25th, Dr. Alfred William George Woodforde, aged 80. Qualified 1906.

Appointments etc.

Dr. E. F. Scowen has been appointed to the London University Chair of Medicine at St. Bart's Hospital Medical College.

The title of Sir William Collins Professor of Pathology in the University of London has been conferred on Dr. G. J. Cunningham in respect of his post at the Institute of Basic Medical Sciences.

The following have been elected Fellows of the Royal College of Surgeons:
Arthur Bates, Henry Poirier, Walter Graham Harris, Christopher Neville Hudson, Richard Loxton Rothwell-Jackson, Arthur Powell Wyatt.

Examination Results

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

Harrison, R. I.
Andan, A.
Evison, P. R. H.
Mackenzie Ross, R. K.

Students' Union

The results of recent elections for officers and representatives of the Students' Union Council for 1960/61 are as follows:

1. Executive

President:	Mr. E. G. Tuckwell.
Treasurers:	Professor G. W. Taylor (in place of Mr. E. G. Tuckwell).
	Dr. D. A. McDonald.
	Dr. A. G. Spencer.
Chairman:	A. C. Howes.
Vice Presidents:	(a) B.M.S.A. Representative: N. Whyatt.
	(b) Lady Vice President: Miss E. Knight.
	(c) Athletics Committee Chairman: P. A. R. Niven.
	(d) General Committee Chairman: M. J. G. Thomas.
Honorary Secretary:	J. A. H. Bootes.
Financial Secretary:	G. T. Sharp.
Publicity Officer:	J. Ind.

2. Student Representatives

Finalists:	M. Bishop.
"Midder & Gynae":	D. Metten.
"Kids & Specials":	D. B. M. Howells.
M.O.P.'s & S.O.P.'s	P. Ross.
First Time Clerks & Dressers:	J. Rushton.
Introductory Course:	A. Frank.
Clinical Ladies Representative:	Miss S. Cotton.
Third Year (& B.Sc.):	M. Casewell.
	B. Kasteliz.
Second Year:	T. P. Dutt.
	Miss W. Saunders.
First Year:	A. Bailey.
Preclinical Ladies Representative:	Miss M. Brown.
Dentals:	A. Basharatulla.
Athletic Committee	
Chairman:	P. A. R. Niven.
Secretary:	Miss S. Cotton.
General Committee	
Chairman:	M. J. G. Thomas.
Secretary:	Miss S. Williams.

Change of Address

Theresa M. Vearacombe,
c/o Major C. A. Vearacombe,
H.Q., B.F.A.P.,
B.F.P.O. 69

DR. J. R. HAMERTON—After June 24th, 1 Winterstone Way, Ramsgate, Kent.
Until that date, mail will be forwarded from Watchfield, Dodds Lane, Chalfont St. Giles, Bucks.

DR. T. M. G. SHARE, 2 Curzon Court, Postarlington Road, Bournemouth.

DRAMATIC SOCIETY — BUSMAN'S HONEYMOON

by Dorothy L. Sayers & M. St. Clare Byrne

PUBLICITY IS NOT usually the concern of dramatic criticism but, if underserved disaster is to be avoided in successive years, I must deplore the lack of publicity which preceeded this performance. Over the two nights less than half of the seats were filled. There are some six hundred students in the college and the hospital, staff and nurses probably double this figure, families and friends would double it again. All too often organisers wring their hands over widespread student apathy, when apathy is the favourite victim of clever publicity which is not aimed at discerning minorities.

The audience enjoyed this play and its performance and that, as Noel Coward wrote recently, is the most important factor in considering any production. Although Dorothy Sayers might have been somewhat perturbed because her script was cut about, which was probably an improvement, some of the actors failed to portray her characters as she depicted them. John Jailler as Wimsey's manservant came nearest as Bunter. Nick Loughnan as Lord Peter Wimsey himself, although smooth and amusing, was often too arrogant and too talkative, lacking the practised reticence and the unruffled pose of Sayers' aristocrat. Susan Williams, playing Harriett Vane, Wimsey's wife, could not convey the sophisticated blue stocking intelligence which should dovetail with Peter Wimsey's mind.

The first act was inclined to drag and the actors galloped through their lines in an effort to shorten it with the exception of Patrick Kingsley who got away with a somewhat over-stated performance of the kindly country vicar. In the second act, we saw a great deal of smart ad-libbing which got the investigation of the murder away to a good start. The actors must be given credit for keeping up with themselves and Peter Wimsey at this stage. This brutal procedure which probably had nothing to do with the producer lent colour to the play which stayed with it until the end. The last act was the best because we were forced to appreciate fully the evening's best performances, those of Mike Stewardson and Anita Roche as Frank Crutchley, the murderer, and Miss Twitterton, his elderly girl friend. His desperation was chillingly convincing and her spinster dreams and real frustrations professionally put across.

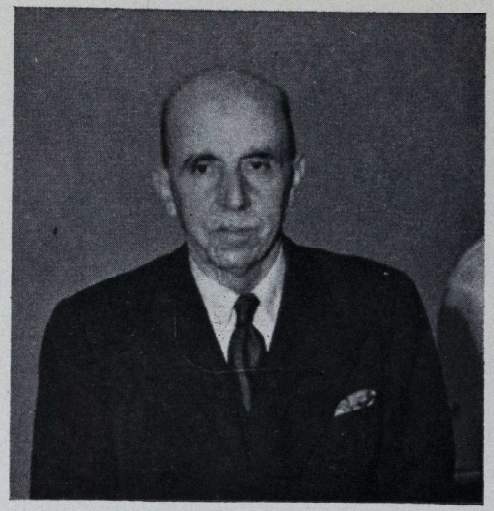
It is not an over-simplication to say that the play was not well produced, or rather, it was under-produced, but the performances of the supporting roles held the play together, made it lively and worth watching. John Graham Poke, the local builder, had an accent which was a joy; Diana Clark's charlady and Ben Bennett's debt collector were colourful and delightfully vulgar, the law, slow and solid was faithfully played by Simon Phillips and Bob Shearer.

S. C-S.

I have heard that the African pygmy,
And should I be wrong you will wig me,
To achieve social status
Will eructate flatus
In time to his gut's borborygmi!

OBITUARY

Sir Harold Gillies



SIR HAROLD GILLIES will always be remembered as the father of modern plastic surgery and when he died on September 10th, 1960, at the age of 78, all those engaged in this branch of surgery in the British Isles, and many in countries overseas, felt a deep sense of personal loss in having been first or second generation pupils of the great master.

The speciality has grown so fast in the last twenty years that it is difficult to realise that Gillies was a real pioneer and that for many years he fought a hard and sometimes frustrating battle to establish plastic surgery as a major speciality equally necessary in peace and war. The status which plastic surgeons now enjoy in the United Kingdom and in most Commonwealth countries is, in full measure due, to his untiring efforts.

In 1915, when thousands of patients with gross facial wounds started to pour into British Hospitals from the battlefields of Western Europe there was no one available to treat this type of problem and Gillies, who until then had been engaged in ear, nose and throat work, accepted the challenge and created the first plastic unit at Sidcup in 1917. He gathered round him a devoted team of surgeons, dentists and anaesthetists, and the outstanding work which was done at Sidcup soon received world-wide recognition. Gillies was appointed O.B.E. in 1919 for his wartime services, this was followed later by a C.B.E. and finally a knighthood in 1930.

After the First World War, Gillies experienced considerable difficulty in convincing his surgical colleagues of the necessity for a new specialty and it was only after much delay and disappointment that he was finally elected to the full consultant staff of St. Bartholomew's Hospital in 1932. Nevertheless, it was a source of satisfaction to him that Barts was the first London teaching hospital to appoint a plastic surgeon to its staff and, although few beds were available, the new department soon attracted patients from all over the country.

Gillies was an unorthodox, but talented teacher, who did not suffer fools gladly, but he was always prepared to spend endless time imparting knowledge to those who showed determination to learn no matter how junior or inexperienced they might be. He took little part in student teaching but his operative and out-patient sessions were heavily attended by surgeons from overseas, many of whom are now the leaders in plastic surgery in their own countries. Those old Barts men who had the privilege of being his house surgeon and are now engaged in other branches of surgery will remember with gratitude how much they learned about fundamental surgical technique from their old chief.

His writings were numerous and covered a wide variety of subjects including burns, congenital deformities, facial fractures, irradiation injuries and the design of skin flaps. The book published in 1920 on *Plastic Surgery of the Face* recorded his unique wartime experience at Sidcup, and in 1957 at the age of 75 he produced with Ralph Millard another outstanding book *The Principles and Art of Plastic Surgery*. In these two major works we are fortunate in having a record of some of the massive achievements of this great surgeon presented in a style which is completely unorthodox and individualistic and typical of the man himself.

Gillies had an amazingly inventive and ingenious mind and these qualities combined with the fact that he was a superb craftsman made him great. He was at his best when faced with a problem which to everyone else seemed insoluble and he would delight in putting forward not only a solution but perhaps two or three alternative plans some of which would probably seem more than a little fanciful to any other surgeon.

As an operator he displayed great gentleness, patience and meticulous attention to detail, but a complete disregard for time which was often exasperating for those working with him.

Between the Wars in addition to a very large private practice, Gillies held active appointments at many hospitals in and around London and served as Consultant to the three Services and to the Ministries of Health and Pensions.

Gillies was responsible for planning the units which received the Service and civilian casualties requiring plastic surgery in the Second World War, and the efficient organisation which he built up formed the basis for the plastic surgery services in the National Health Service when it was inaugurated in 1948.

In addition to bearing heavy responsibility in an advisory capacity Gillies was actively engaged in treating casualties at one of the major units at Basingstoke throughout the War years and during this period he trained many surgeons who were later appointed as plastic specialists in the new Health Service.

Although he had so many interests outside plastic surgery, Gillies' enthusiasm for his work never flagged and he was still operating and grappling with some of the problems which had previously eluded him to within a week or two of his death.

Over a period of nearly half a century, Gillies occupied a unique position in international surgery and although he is no longer with us, his name will endure as a great master surgeon and the founder of plastic surgery as we know it today. P. H. J.

I FIRST MET Harold Gillies when the Medical Art Society was first formed thirty years ago. He undertook this fresh activity with the zest so typical of him in everything he began. I well remember the original meeting when he was our host at the Garrick Club. The Senior Member of our committee was the late Sir Leonard Hill, the physiologist, who I remember in those days had the initiative to organise a private view of his work in Japan, with the proceeds of which he bought a car. Gillies was less successful financially with his painting, but it was a hobby which gave him constant and increasing pleasure. As an artist, he was always original and he had a real feeling for colour, light and composition.

My other contact with him was as a fisherman. He belonged to the famous Houghton Club on the Test at Stockbridge. His love of this sport rivalled his affection for painting, and he was as much an artist in casting a fly to a difficult fish as he was with brush and colour.

He was a Rowing Blue and a golfer of international status, in which latter sport one of his innovations was to drive his ball from a tee of unusual height. This on some occasions was actually a bottle.

He was a man who would never grow old. Arteriosclerosis made several attempts to diminish his persistent youthfulness but its attacks never succeeded. He was a *bon viveur*, and indeed there were few aspects of life in which he did not find perennial enjoyment.

Those who knew him—and they were many—will miss his vivacious and enthusiastic personality. G. L. B.

James Seymour

James Seymour died on November 27th 1960, as a result of injuries received in a road accident three days before. The death, in such circumstances, of a young man of rapidly maturing promise will have been regretted by all who were aware of it; to his friends it has brought a poignant sorrow and it is difficult for them to realise that his strong, lithe figure, quiet voice, shy smile and charming personality have passed from this world.

He was one of twins born in 1921 in India, where his father was stationed in connection with an engineering project. Much of his childhood was passed in Kenya and Natal, where he was educated. Having early expressed the wish to become a doctor he came to England shortly before the War and entered the Medical College here. In 1945, he obtained the London M.B., B.S. degree and then held house appointments, first with Mr. Rupert Corbett and later to the Neurosurgical Unit at Hill End. After an appointment in the Blood Transfusion Service his lasting interest in otological problems was aroused when he acted as assistant to the late Mr. Garnet Passe. Returning to South Africa he obtained practical experience in surgery and came to England again in 1948 with the intention of obtaining a higher surgical qualification. However, instead he became Bernhard Baron research scholar at the Middlesex Hospital and commenced the series of investigations on the inner ear which were to occupy him in the Feren's Institute for the remainder of his life. Here he was provided with facilities which his own hospital still lacks—a well equipped research laboratory, expert technical assistance and an income sufficient to enable him to live in the very modest way which was all he asked. He thrived in this environment, his scientific curiosity revealing the problems and his intelligence and imagination the means by which they might be attacked; to these qualities were added the patience, determination, manual dexterity and single mindedness which enabled him to work unhurried towards their solution. His work on Méniere's Syndrome had gained him the Norman Gamble prize of the Royal Society of Medicine in 1955 and this year he was to have given an Aris and Gale lecture at the Royal College of Surgeons. Though he had published little, the fruits of his labour were ripe, and indeed, in process of being gathered when he died. He had achieved a wide reputation for his work on the blood supply of the inner ear and the influence of the sympathetic nervous system upon it. This fundamental research illuminated the problem of Méniere's Syndrome and would almost certainly have lead to an increased understanding of other problems in otology. He gave much thought also to the nervous control of intracranial vascular circulation, and had he lived it is probable that he would have made a real contribution in this as well as other fields.

He was deeply interested in neurology and neurological surgery, and had always expressed his intention of returning to this work at the conclusion of his research. Indeed, he regularly worked in the Neurosurgical Department of the hospital each year. His intelligence applied to clinical problems, and the attention and sympathy he gave to his patients were quite outstanding. He was, moreover, a careful surgeon as well as a most able and loyal assistant. Had he returned to clinical work he could undoubtedly have become an outstanding neurological surgeon.

Although he had not married and was a shy man, he was always interested in people and made many friends. He could enjoy a social gathering but was happier in the company of those whom he knew intimately. Of recent years he had passed much of his leisure in Cumberland, where his uncle is in general practice. He derived increasing satisfaction from these visits to the valley in which he now lies buried, becoming a keen and able fly fisherman—"a pupil in ten thousand" as his expert teacher in this field described him. More recently he added farming to his interests in the area and found pleasure and relaxation in helping develop the land of one of his closest friends. A strong swimmer, when in London he endeavoured to swim daily as a means of maintaining physical fitness. Strangely, for one of his strength and energy, he was a fastidious eater. A competent artist, he had from his undergraduate days made excellent drawings of operations and pathological specimens in the Neurosurgical Department, and indeed had assisted with the illustration of several papers from the department.

James Seymour's personality was quite uncommon. In him were combined the sensitive temperament of an artist and the intellectual curiosity of a scientist; an acute critical faculty with understanding of others' viewpoints; absolute integrity and quiet faith. The great promise which was being so modestly fulfilled cannot now be realised and his personal charm is but a memory. But those who mourn his death are thankful for his life.

J. E. A. O'C.

AN EPIDEMIC OF MEASLES

By Dr. L. S. Castleden

AFTER SEVERAL YEARS in the same locality the General Practitioner can see and anticipate the spread of infectious diseases in his area. In the case of Measles the progress of the infection can be particularly easily followed. Not only is the disease readily recognisable but it is also notifiable and sufficiently severe for the doctor to be consulted in most cases.

The degree of immunity conferred by previous attacks is absolute so that the susceptible population is usually confined to the younger children. In these days when even the poorest families are highly mobile, there is a tendency even in Rural areas for smaller epidemics every other year, rather than more sweeping epidemics every five years or so.

Our area consists of a central small town (pop. 4,000) which has a secondary modern school (11–17 years) and a primary school as well as a small private school. Surrounding the central township are six smaller villages within five miles with primary schools. Some 15 miles away are four larger towns, each with complete quota of primary, secondary, high and technical schools. Although we do not see cases from these areas, infections often smoulder in their larger communities.

On two occasions I have been lucky enough to observe epidemics developing from the primary cases and they will serve to illustrate the spread of the disease.

In August 1958, a small family of parents and three children living in the central township returned from a visit to grandparents in Scotland. The middle child age 12 years was observed to have a "cold" and red eyes and a loud cough, whilst in the train. The typical eruption appeared two days after their return. Meanwhile visits had been paid to neighbouring children with the result that the next batch of cases included not only the other children of the family, but also several living in the town. The third batch of cases was more numerous and included children attending both the primary and secondary schools. Thus in their case, the epidemic in the central town was explosive and at the end of a month 95 per cent of the non-immunes in the schools had been attacked. These resulted in secondary cases amongst their own families. Thence the infection spread to two of the peripheral primary schools in October and eventually the last cases were seen early in November, leaving several of the smaller village schools unaffected.

The second epidemic to be described occurred last year. Late in August, I was called to see a boy, aged 3, who has infantile eczema. He had developed a severe cold and cough accompanied by a flowering of his rash, after a visit to a seaside resort. The rash in the mouth and reddened eyes made it probable that this was a case of measles. There were three other boys in the family who developed the disease, one attending the secondary school in the central town, the others were at the village primary school.

The result was an explosive and complete epidemic in the local village primary school but only one case at the secondary modern school where immunity was high.

However, the disease spread to the larger towns to the North and West and there it stayed until Christmas parties mixed these

urban children with those attending the primary school at the village to the westward. As this school had not been affected in 1958 the attack rate was again high. Thence the infection was transferred to the primary school at the central town where only the younger, susceptible, children were attacked.

Another remarkable feature about measles is that the severity of the disease varies so much. In the first epidemic many cases were severe. Some children were desperately ill. One fatality occurred in spite of oral penicillin treatment. This was due to massive pneumonia and not to encephalitis. There were a number of cases with otitis media and broncho-pneumonia, who required antibiotics.

On the other hand the present epidemic is of a much milder disease. The rash is typical but there is less conjunctivitis and so far both pulmonary and middle ear complications have not been observed.

That a familiar lack of resistance may account for the severity of some cases is suggested by the fact that an uncle of the only fatal case also died of measles. This was some thirty years ago. It should be remembered that this was when antibiotics and sulphonamides were unknown and therefore complications were not easily treated.

This brings one to the vexed question of "umbrella" treatment with sulphonamides and penicillin derivatives. In some specific cases this may be desirable, but each case should be considered carefully. My own opinion is that in an epidemic of "average severity measles", only established complications should be treated.

HISTORICAL DIAGNOSIS

By J. C. Crawhall

Second Meeting of the Fifth Session (of the Medical and Philosophical Society of St. Bartholomew's Hospital, 1799)

Mr. Abernethy President

Mr. Macartney related the case of a gentleman who had sores on his penis which were considered venereal he himself did not however think them so. Mercury was persevered until the Gums were made exceedingly sore whilst taking mercury blotches broke out on various parts of his body He was directed to take the nitrous acid which seemed to produce no effect alone but the oxygenated miuriate of potash being conjoined with it a complete salivation was the consequence The liver seemed to be particularly affected by the Medicines as a complete stoppage to the secretion of bile took place pro tempore the stools were of a clay colour. In this case there seemed at this time to be no particular danger, he had a blister on his Breast but a fever supervening he became exceedingly emaciated and the efforts that were made to restore his strength by Bark etc. proved ineffectual as he died suddenly.

The acid which was administered for the eruption removed them pro tempore Mr. Macartney did not consider them as venereal they having made their appearance whilst the constitution was under the influence of mercury.—

Mr. Macartney considered the effect of the Medicines on the liver as curious as sometimes the Bile was secreted at other times it was not.

(*Authors' Note.—The punctuation is reproduced as written in the original minute*).

THE HISTORY OF THE OSLER CLUB OF LONDON

By Dr. A. White Franklin

Read to the Osler Club's Combined meeting with the Harveian Society November 16th 1960

OUR OSLER CLUB of London is but one of a galaxy of eponymic Clubs and Societies, as it is but one of many commemorative Osleriana. The Club was conceived at Saint Bartholomew's Hospital in 1927 and born in 1928. Neither parent, neither I nor Walter Reginald Bett, would claim sole credit for the idea of a student's club for the study of medical history: it must remain an example of synchronised double parthenogenesis. I have told elsewhere* how Bett, inspired by Harvey Cushing's Life of Osler, insisted that the Club be called The Osler Club, and how I was converted by a visit to Oxford where Bill Francis showed us the books in The Library at 13 Norham Gardens, where Lady Osler gave us a stately tea and where I bought my copy of *The Life*.

It was my great good fortune to own encouraging parents, who allowed their home, until it was burnt in 1935, to be the Club's headquarters and regular meeting place, and my greater good fortune to have four friends who allowed themselves to be drawn into the plan. We had all toured America in 1926 with the Cambridge University Medical Society. We had all, notably in Montreal, in Philadelphia and in Baltimore felt the potent magic of Oslerolatry. Indeed writing up the tour for the Landmark, I called Canada " the land that gave Osler to medicine ". Pickering in the Oslerian Oration for 1960 described preparatory meetings in the students' refectory at Saint Bartholomew's.

And then on Monday, April 30th, 1928, the first meeting of The Osler Club of London was held at 27 Wimpole Street.

> " G. W. Pickering read a paper on Louis Pasteur his life and his work. Dr. Singer showed some reproductions of Pasteur's youthful drawings, lent by the Royal Society of Medicine. An informal discussion followed, dealing chiefly with Pasteur's predecessors, Redi, Paracelsus and Leeuwenhoek. Pasteur's classical works were displayed, and an interesting collection of photographs relating to the Pasteur Institute and the ' Pastoriens '."

Pasteur was chosen because Osler thought that his life should be the inspiration of every medical student. He had written an introduction to a translation of the Valléry-Radot biography, a copy of which was sent in 1911 through the generosity of Henry Phipps to the Library of every Anglo-American medical school.

How happy that the first speaker, Pickering, the most brilliant medical student of his year at Cambridge, should now occupy Osler's own chair in Oxford.

The five other founder members attended. Bett and Franklin, T. F. McNair Scott, now research Professor of Paediatrics in Philadelphia; Hal Mansell and C. F. Watts—Hal volatile, brilliant, a pianist with a passion for Vesalius, whose career as cardiologist ended so prematurely in 1941; Cecil Watts drowned in 1930 in a yachting accident leaving Jackson Burrows, orthopaedic surgeon, as his legacy to the Club.

The second meeting of the Club (tonight's is the 183rd) remains in my memory as an example of the heights to which medico-historical meetings can rise. The tercentenary of Aselli's discovery of the lymphatics was celebrated in six papers—by Bett on Aselli himself, by Franklin on Joyliffe and Cruikshank, by McNair Scott on Bartholin, and on lymphadenoma by Watts. The subject was brought up to date by papers on modern aspects of lymphatic study from Wilfrid Le Gros Clark and Scott Williamson. Important books and pictures relating to the men and their work were displayed and handed round during the meeting. Much hard work had gone into its preparation.

The third meeting took us to Sir D'Arcy Power's library to " see, handle, and smell, but not to lick the books " the fourth to The Open Arms in Oxford to be regaled by Gibson with the letters Osler had written to him, by Bill Francis and R. H. Hill with a tour of the Library and to begin our long

* Med. Press (1949), 122

and close friendship with John Fulton, who became Treasurer in 1930.

And then on July 12th the first Oslerian Oration was given by Sir Wilmot Herringham.

So our method of work was revealed, our prime object to encourage among medical students the study of medical history. The man, the work, the book, these were to be seen first in the context of their own time. What had been their effect then, their impact? What had grown out of the work? Where does the subject stand today? The history of medicine belongs properly in the laboratory and in the ward, and plays a humanising part in educating doctors.

The second aim was to keep green the memory of William Osler. In those first years, no member of the Club had actually known Osler. We were to find his influence strong in those, and they were many, who called him friend. We could see the golden afterglow upon the mountain tops, and feel how warmly that sun had shone, in the kindliness and the help from which we benefitted because we were the Osler Club.

There were guests of honour at our meetings—Charles Singer and L. W. G. Malcolm of the Wellcome Historical Medical Museum at the first, Singer, Arturo Castiglione, Geoffrey Keynes at the second, and at the first Oration, J. D. Rolleston and his distinguished brother, Sir Humphry, Thomas Lewis, Walter Fletcher, Andrew Balfour, Squire Sprigge.

During the academic year September 1928, to July 1929, three special meetings took us to the Wellcome Historical Museum, to Geoffrey Keynes' Library and to hear Sir Archibald Garrod give the second Oration. At the eight other meetings, fifteen papers were read by members (Bett scoring six) and five by close associates. Fifty meetings were held in the first five years, a pace too hot to maintain. On our tenth birthday in 1938 there had been 71 meetings and there were 29 ordinary members, 12 Honorary members, older men and established historians, with seven Friends including Harvey Cushing, D'Arcy Power, W. W. Francis and Geoffrey Keynes. I remained Secretary and now Paterson Ross was Treasurer. Bett, as ever the inspiration of the Club, the chief deviser of its programmes and our contact with the Diplomatic Corps, was Foreign Secretary. His tasks were keeping touch with corresponding members, the medical historians of other lands, and reporting on international conferences.

In the world of the gathering storm, the Club sank into a slumber from which it was roused in 1947 with Dr. Carlyle Lyon as Prince Charming to our Sleeping Beauty. The history of the re-awakened Club must await another day, but I must mention the Club's part in providing a commemorative plaque to be placed by the University on Osler's old house in Oxford.

A word too must be said of our literary activities. Many papers read to the Club appeared ephemerally in Hospital Journals; one day the Archives of The Osler Club will, I know, begin to appear on your bookshelves. In 1930, Robb-Smith proposed that the Club edit a selection with a handlist of all the writings of Sir D'Arcy Power in honour of our Friend's 75th birthday and Lord Moynihan presented him with a specially printed and bound copy in January 1931. In 1949, the Selected Writings of Sir William Osler was edited. Both were published by the Oxford University Press. A third volume, a tribute to our faithful S. Damian, will shortly appear.

May I make a sad quotation from myself? "A few old faces and old voices remain to link the second foundation with the first, but those who were in at the beginning know that for them it cannot be the same. Their own youth, in which the Osler Club played its inspiring part, cannot return." I like to think that their part in the Club meant something to our older friends, D'Arcy Power, Bill Francis, A. P. Cawadias, J. D. Rolleston, Warren Dawson and Geoffrey Keynes and that it helped and inspired such loyal members as Wilfrid Le Gros Clark, James Paterson Ross, John Fulton, George Pickering, Clifford Wilson, John Hunt and Stephen, now Lord, Taylor of Harlow, acting Secretary 1934–5.

What of the new Osler Club and its future? The violent growth of the last few years to a membership of 240, the success of the programmes, the unexpected fact that we have survived the departure overseas of Walter Bett, show that The Osler Club is still full of life. With our Friend (in the technical Osler Club sense) Dr. Tom Cotton here, I must choose my words carefully. Through his posthumous munificence the Club will be attached to the Royal College of Physicians and so William Osler, our little lamp, will be linked to that great beacon light, that other William—Harvey.

THE ASSESSMENT OF FITNESS FOR OPERATION IN CARDIO-VASCULAR AND RESPIRATORY DISEASE

By Dr. N. Courtenay Evans

THERE IS LITTLE doubt that even in the apparently physically fit, major surgery may be complicated both at the time of the operation and in the post-operative period, by medical problems, mainly cardio-vascular or respiratory. These complications can sometimes be prevented and often forecast by careful general examination of the patient's history and of the patient. Reassurance as to the patient's ability to stand operation, helps to produce the right frame of mind and his confidence that all will be well.

In the impaired life, particularly in the elderly or aged, the type of operation has to be considered carefully by the physician. These fall into four groups which are as follows:

1. Trivial or minor operations from teeth extraction to haemorrhoidectomy.
2. Major but not essential operations as, for example, herniotomy and other repair procedures, and the possible developments from an operation being postponed, must be considered in the knowledge that an emergency operation may later become essential with greater operative risk.
3. Essential operations, but not those for carcinoma, as for example, perforated peptic ulceration.
4. The major group consists of those operations performed for malignant disease.

THE PATIENT

The patient may be young and fit and clinical examination is satisfactory. In all major surgery particularly for malignant disease, a chest X-ray is essential. It is a record of normality in any post-operative complications which may occur. Unexpected lung abnormalities, such as active tuberculosis, or metastatic deposits, may modify the operative procedure if known beforehand.

In the over-forties, a cardiogram is advisable, as latent or old degenerative disease of the heart, may be revealed. The surgeon is warned, and it may be wise to warn the relatives of an increased risk. The anaesthetist makes his plans with the special knowledge of cardiac abnormality, and avoids cardiac irritants and hypotensive drugs, and is more than careful to avoid even temporary hypoxia.

A blood count, blood urea estimation and a laboratory examination of a mid-stream specimen of urine should be routinely carried out before major surgery is attempted in all but urgent emergencies.

In the elderly, it is common to find cardiographic evidence of previously unrecognised and symptomless cardiac infarction. This is probably no contra-indication to surgery, but it is a valuable fact for the surgeon and anaesthetist to know.

It is, however, the patient with concomitant disease, who is the main problem. Cardio-vascular and cerebro-vascular disease, respiratory disease, diabetes mellitus, blood diseases, acholuric jaundice and haemolytic anaemia, haemophilia and thyrotoxicosis are some of the more common diseases found, which may complicate a straightforward surgical problem.

CARDIO-VASCULAR DISEASE

Hypertension is one of the commonest cardio-vascular abnormalities. If there are no symptoms and the urine, the cardiograph, the heart X-ray and the clinical examination of the heart reveal no abnormality, little variation in surgical methods need be made. Kidney function tests are automatically done before prostatectomy. Bleeding may be profuse and extra care should be taken to avoid it, as severe haemorrhage may precipitate arterial thrombosis in a coronary or cerebral vessel.

An illustration is given of a man suffering from carcinoma of the colon. He was anaemic, haemoglobin 52 per cent, his blood pressure was 190/90 and there was an apical systolic murmur which was probably due to the anaemia.

The E.C.G. showed slight depression of the ST waves in the chest leads, again probably due to the anaemia. The X-ray showed a little calcification in the aorta and a pushed-up normal sized heart.

The anaemia was corrected by blood transfusion. Resection of the sigmoid colon was then done a week after admission and no complications occurred from a cardiac point of view and the patient made a good recovery.

Cardiac infarction makes operation inadvisable until three months have elapsed and all signs of failure are absent. Even then, only very essential operations are advisable and their extent should be restricted. If the infarction is several years old and there is no gross cardiac enlargement or angina of effort, any operation can be contemplated with reasonable hope of no complications from the heart. Anaesthesia must be carefully planned to avoid any chance of hypoxia.

Illustrations of *two* cases, both with low cardiac reserve.

The first case is that of a man aged 75, who was admitted for operation for carcinoma of the bowel. He gave a past history of coronary thrombosis three years previously, and a right hemiplegia a year previously. Three days before admission to hospital, he had further pain in the chest.

Serial E.C.G. suggested, and eventually confirmed, that he had had a further posterior infarct, and operation was postponed for five weeks while treatment was given for the heart condition which was complicated by a respiratory infection. Five weeks after admission he was enormously improved, his blood pressure had risen to 170/110 and his chest was clear. Operation was carried out after six weeks pre-operative treatment and the patient made an uneventful recovery from this.

The second case is that of another patient who was admitted for a carcinoma operation who had had a coronary thrombosis a year before.

The heart was found to be enlarged and there were signs of congestive heart failure. The E.C.G. showed the scar of an anterior cardiac infarct.

Operation was postponed but not for a sufficient length of time.

He was treated with Digoxin and Mersalyl.

Operation was performed a fortnight after treatment had been started. Four days after the operation urinary output became poor, his temperature rose to 101°F and he quickly became cyanosed and breathless. Ileus occurred and he died on the twelfth day after operation.

The lesson to be learnt from these two cases, is that operation may have to be postponed for considerable time before it can be attempted with a reasonable hope of success.

When angina of effort and angina at rest are present, much stricter assessment is necessary. Life-saving surgery for carcinoma is reasonable, as is essential non-carcinoma surgery. Prostatic obstructions with severe kidney damage resulting, is a good reason for operation in this type of cardiac disease. Repair operations are as a rule inadvisable, but if life is being made a burden, operation can be attempted with a reasonable hope of no irremedial cardiac complications.

An illustration of angina with high blood pressure, is that of a woman aged 66, who had a serious carcinoma operation with no ill-effects.

The blood pressure was 230/130. E.C.G. showed ST changes in the chest leads of cardiac ischaemia. She was given Aminophylline by mouth before operation, but no other treatment.

It must be remembered that if the operation goes smoothly and no surgical complications occur, the heart will behave, but with ileus, post-operative haemorrhage or anastomotic troubles, cardiac complications supervene quickly, with the resulting lowering of the cardiac reserve and frequently with the death of the patient.

VALVULAR DISEASE OF THE HEART

To assess this type of heart abnormality, clinical, radiological and cardiographic investigations should be made. A history of congestive heart failure must not be lightly dismissed, even if no failure signs are present at the time, as a low cardiac reserve is probably present. With no enlargement or only moderate enlargement, and a regular rhythm combined with an aortic valvular incompetence, the patient is a reasonable risk for most operations.

With mitral stenosis, pre-operative Penicillin and Digoxin are probably advisable. Post-operative auricular fibrillation is a common occurrence in patients with mitral stenosis. The pre-operative digitalis will control the ventricular rate and in a few days the rhythm usually returns to normal.

When heart failure is present, with or without auricular fibrillation, treatment must be given for two or even three weeks before any essential operation. This is the type of case where carcinoma would be the only excuse for surgical interference. Considerably increased risk will be run and pre-operative Penicillin and other antibiotics post-operatively, should be given. Anaesthesia should be discussed with the anaesthetist.

Congenital heart disease is rarely a problem in carcinoma patients and decision can usually be made easily. The cyanotic group must be regarded with great caution and only life-saving operations advised.

Syphilitic heart disease has a bad prognosis and extensive surgery would not be indicated and palliative surgery advised.

An example of valvular disease of the heart is that of a man of 78, who had had sub-acute bacterial endocarditis affecting the mitral valve, four years previously and had been treated for a long period with Penicillin with excellent results.

He was found to have a carcinoma of the rectum and it was decided in spite of the heart condition, to operate.

The heart was moderately enlarged and there was an apical systolic murmur which was conducted outward. Blood pressure was 150/90 and pulse 76/min. and regular.

The E.C.G. showed some sagging of the ST complex in leads 1 and 2 and X-ray of the chest showed some moderate enlargement of the heart and some atherosclerosis of the aorta. The complete operation was carried out without complications. Penicillin was given for two days before the operation and continued for one week after operation.

ARRHYTHMIAS

Auricular fibrillation and auricular flutter can be reasonably controlled by digitalis. With reasonable cardiac reserve and little or no change in heart size, operation can be carried out for most conditions.

A man of 72 was admitted for an operation for carcinoma. On admission his blood pressure was 190/90, and X-ray showed a full sized heart. E.C.G. was not done before operation.

Two days after operation, he developed auricular fibrillation and was given Digoxin intravenously.

The auricular fibrillation continued for two days and then the rhythm became regular and no further arrhythmia occurred. Recovery was uneventful after this.

Not such a satisfactory result occurred with another man who was first seen in 1950 at the age of 49, when he was found to have auricular fibrillation which had probably been going on for nine years previously.

Heart X-ray was normal and the blood pressure was 150/100. There was no evidence of valvular disease of the heart and the E.C.G. showed only the auricular fibrillation. An operation for a low level fistula was successfully performed without complications.

Ten years later he returned to the hospital with symptoms in the bowel which was diagnosed as a polyp in the colon and malignancy was suspected. He also had some gall-stones. Blood pressure was 210/120, the heart was enlarged and auricular fibrillation was still present. E.C.G. confirmed the auricular fibrillation and now gave evidence of disease of the heart muscle.

This was a patient who now had chronic myocardial disease and was not a good operative risk.

Operation was performed and the polyp was removed and found not to be malignant. Gall-stones were also removed. There was some pyrexia after operation and on the fourth day he became hemiplegic and the hemiplegia has remained.

RESPIRATORY DISEASE

Very many patients have bronchitis and a week or ten days pre-operative treatment can enormously help the post-operative condition and prevent complications. All smoking should be stopped and physiotherapy started, in particular, percussion drainage and postural drainage. Breathing exercises are also given. The sputum should be examined in the laboratory and antibiotic sensitivity estimated.

Penicillin can be started and is usually effective if it has not been given before. It has the advantage of causing few complications. The patient must always be asked if he is sensitive to antibiotics. Broad spectra antibiotics can cause diarrhoea and should be kept for the post-operative period, as a general rule.

In the majority of instances, Syrupus Calcidrine (Abbott) and Sod. Chlor. mixtures in hot water, are useful, but the expectorant mixtures are of little value. Inhalations of Alevair, a detergent fluid for liquefying the sputum, are sometimes helpful as are also Neo-epinine sprays.

This is an example of prolonged pre-operative treatment with a patient with a long history of bronchitis, a suggestive history of emphysema, heart failure and a poor cardiac reserve.

This patient collapsed after an enema and the blood pressure which had been 120, remained at under a 100 systolic, for 24 hours.

The X-ray of his chest showed some calcium in the aorta, some pleural thickening at the left base and a normal sized heart. The E.C.G. showed sinus arrhythmia, right axis deviation and an abnormal T wave in AVF. Tachycardia was present between 90 and 120, for the whole pre-operative period.

He was treated with Penincillin by injection, percussion drainage and breathing exercises. A mixture of ephedrine and phenobarbitone (Syrupus Calcidrine) was given by mouth and he was encouraged to walk about his room and not remain in bed.

Operation was performed four weeks after admission without any ill-effects. A prostatectomy also had to be performed three weeks later, also without any ill-effects, and he left the hospital four months after admission in good health.

A man of 74 was admitted for operation for carcinoma. He gave a history of razor-grinding for 50 years. X-ray of his chest showed a full sized heart with calcified apical lesions. Sputum was negative for tubercle bacilli.

Clinical examination showed rales at both bases. Blood pressure was 148/80. The E.C.G. showed abnormal T waves in leads AVF and chest leads, V3, 4 and 5. This man had chronic lung disease, with bronchitis and inactive tuberculosis, and a considerable amount of generalised arteriosclerosis.

He had three days treatment with Penicillin, Physiotherapy and ephedrine and Aminophylline.

After operation, the blood urea started to rise and he died in uraemia on the tenth day after operation.

PULMONARY TUBERCULOSIS

Patients should be nursed in single rooms, unless in a sanatorium, and sputum tested to exclude open cases. Even with a pre-operative negative sputum, post-operative conditions may cause temporary live tubercle bacilli to appear. This fact must be remembered in the nursing of these patients.

If activity is present or even only suspected, a course of Streptomycin and P.A.S. and I.N.A.H. is given for three or four weeks before operation is performed. Sterilization by this means, allows most essential surgery to be attempted in due course.

SUMMARY

It is important where advanced pulmonary or cardio-vascular disease is present, that sufficient time should be allowed for pre-operative treatment. If the operation goes without technical difficulties and complications, it is reasonable to expect a patient with serious heart or lung disease to make a good recovery. Adequate pre-operative assessment, with laboratory, radiological and electrocardiographic examinations by an experienced physician, is always advisable before major surgery is performed.

THE QUESTIONNAIRE — *By J. Spivey*

THIS ARTICLE ON the social and economic aspects of student life at Bart's is based on the answers received to the Questionnaire from 343 students, 57 of whom are of the fairer sex.

All live in Great Britain and a preponderance have spent most of their lives in the South of England (177). Thirty four come from the Midlands, 32 from East Anglia, 31 from the North, 28 from Wales, 20 from the West country and a small minority (1) from Scotland.

Schooling

Twice as many people entering Barts went to Public Schools (206) as went to grammar schools (103). Five went to schools abroad and a further seven went to other schools.

The Public School intake appears to hold General Practice in high favour as a career of choice and some 35 per cent. intend to become general practitioners as compared with the grammar schools 22 per cent. Specialisation in Medicine is the most common ambition of the grammar school intake, but apart from this disparity, the two groups seem to have similar ambitions.

General Branch of Medicine	*G.P.*	*Med.*	*Surg.*	*Mid.*	*Others*
Grammar	22	38	23	11	9
Public	71	56	44	16	19
Abroad	0	0	4	0	1
Other	2	4	1	0	0

Of note also, though perhaps not indicative of a general trend, are the four students from abroad who, of a total entry of five, all wish to become surgeons.

Choice of Medicine as a Profession

The majority seem to have decided to take up medicine between the age of 14 and of leaving school. A small proportion (less than 10 per cent.) made the decision after leaving, and a further 20 per cent decided before the age of 14.

	U–14	*14–16*	*16–leave school*	*After school*
Decided on Medicine as a career	69	103	123	34

Of the factors influencing this decision, the most common ones in the 0–14 group were

(i) Upbringing in a Medical Household (24.6 per cent).

(ii) Humanitarian reasons (nearly 19 per cent).

In the 14–16 age group

(i) Humanitarian Reasons (18.5 per cent).

(ii) Good financial prospects (16.6 per cent).

but many were drawn by the prospect of meeting people from all walks of life, and others were influenced by their upbringing in a medical household.

16—leaving school:

Good financial prospects seem to have attracted the hard headed A level examinees (17.1 per cent), but humanitarian reasons and interest in science and national history each accounted for another 13.8 per cent.

After leaving school:

Eight of the late deciders did so for humanitarian reasons and seven for the promised good financial prospects. At the other end of the scale, only one was swayed by his upbringing in a medical household and one decided for religious reasons.

In general, then, humanitarian reasons are the most popular cause of this decision, though mention must be made of the individual who, seeing no suitable reason provided inserted 'power' in the blank space provided.

Choice of a Hospital

Having decided to take up medicine, a hospital had to be chosen.

The largest group (85) chose Barts for family reasons. Next came the 53 who were first accepted here and 52 who were most influenced by the professional reputation of the Hospital.

One person chose Barts as a result of his or her experiences as a patient here; one because he had strings to pull and one because it was the only hospital he knew of.

Had they not got into Barts, the majority would have gone to St. Thomas's (101) or Guy's (95). Of the newer hospitals, the Middlesex proves the most popular as a second choice (37) and Kings (4) and the Royal Free (three, including one man) are least popular of all.

Eighty eight had parents or close relatives at Barts as a doctor, and 27 as nurses; also the women students have a higher proportion of family association with the Hospital than the men.

A more detailed study of the family connections of the students with medicine in general, reveals that just under 50 per cent of the students' fathers are qualified practitioners and of these, a further 63 per cent have a parent or close relative who is, or at one time was on the staff of this Hospital either as a doctor or as a nurse.

The proportion of mothers qualified in medicine or nursing is rather lower (18.5 per cent), but in these families, there is still a high proportion (45 per cent) with a parent or close relative who is or was on the staff.

These figures do suggest that doctors are not discouraging their children from taking up medicine and certainly the incidence of family linkage with the Hospital is more than can be accounted for by mere coincidence.

Marriage

Marriage has always been a controversial issue amongst students and the indications for and against have long been argued round the coffee table. It is no surprise, therefore, to find that only 3.5 per cent (11) were able to say yes when asked "Are you married?" Of these, two students had families also. The number of engaged was 10.6 per cent (34) and the remainder were single for a variety of reasons.

Of the single group, 57 per cent (167) offered no excuse for not being married; but this group apart, no less than 20 per cent (59) were postponing marriage for reasons of financial strain. A further 13.3 per cent offered 'other' reasons and 8.5 per cent were dissuaded because marriage might interfere with their professional ambition. This left a final group of 1.2 per cent who represented the hardened batchelors and misogynists amongst us.

Accommodation

370 students answered the question: "Where do you live?"

	Single	*Engaged*	*Married*	*Married with Children*
Live with parents	103	6	1	—
College Hall	72	7	—	—
Alone	30	6	3	1
With others	109	19	10	3

Of the engaged students, 85 per cent live away from home, as compared with 67.5 per cent of the single students. Set against this, however, is the fact that the engaged students are probably more advanced in career and years, and although no figures are available, it is not inconceivable that a higher proportion of pre-clinical students live at home. However, despite this suggestion, those figures do pose the question "Are students living away from home more susceptible to predatory ladies than their fellows who live under parental influence and care?"

Perhaps of some surprise also is the number of married students who live with friends and parents and of a total of 18, only four appear to live with their wives alone.

Politics

The political views of those who answered the Questionnaire are tabled below correlated against their educational backgrounds.

	Cons	*Lab*	*Lib*	*Other*	*None*
Total	204	32	41	11	51
Grammar	51	17	17	3	22
Public	149	12	24	7	27
Abroad	—	—	—	1	22
Other	—	3	—	1	1

One can only speculate, of course, about the odd man out whose education and politics were both 'other', but there is a considerable preponderance of conservative students with the liberals slightly outnumbering the socialists.

As might be expected, the public school entry is considerably more solid conservative than that from Grammar Schools, in fact 53 per cent of the Labour supporters are from the latter schools.

A correlation of the political views of students with their pre-clinical background also gives us some revealing information.

	Cons	*Lab*	*Lib*	*Other*	*None*
U.L.	149	29	34	8	38
Oxford	15	1	—	1	3
Cambridge	41	2	5	3	10
Other	—	—	1	—	—

We see here that there is a larger proportion of labour supporters amongst those who did their pre-clinical training at Charterhouse, than amongst those from Oxford and Cambridge. There is also more support for the Liberal party amongst those from grammar schools and London University.

Income

Correlating age against annual income, it is found that the Barts Student tends to increase his annual income as he gets older.

In the 18 year age group, some 55 per cent of the students have an annual income of less than £300 p.a. In fact, of these, 80 per cent live on less than £250 p.a., but most of this low income group appear to live at home. (Table I).

There are two, however who live in College Hall and receive less than £250 p.a. It is indeed a long stretch of the imagination to see how this can be done. The annual rent at College Hall is £233 10s. which would leave £16 10s. out of £250 for such luxuries as lunch and drinks. Indeed unless these two are living on charity, one finds it difficult to believe that they can exist at all.

Marriage also seems to bear some relationships to income and the married students have a considerably higher annual income than the single. (Table II).

Grants appear to be awarded in a rather haphazard manner and sometimes bear no relation to the student's actual income. Some with very low incomes have no grant at all and others have a high grant, but a much higher income. Of the 326 answers received, 19 (about 6 per cent) have an annual income of less than £250 p.a. and no grant at all and 24 (7 per cent) have incomes which correspond to their grant. At the other end of the scale however, 49 (15 per cent) have an annual income £250–450 above their grants whilst the remainder do receive considerable subsidy from persons other than the Minister of Education.

Table I

	Under £250	£250–300	£300–400	£400–500	£500–600	*Over* £600
Parents	62	15	9	6	—	3
College Hall	2	5	31	29	10	3
Alone	—	4	11	6	4	2
With others	11	21	54	27	8	8

Table II

	Under £250	£250–300	£300–400	£400–500	£500–600	*Over* £600
Single	69	400	96	54	15	6
Engaged	5	5	13	9	4	—
Married					2	11

Summary

Apart from one or two extreme examples, it does appear that the Barts student leads a pretty normal life, and indeed, on looking around one must look far before seeing a companion in dire financial or other difficulties. To most, money is a worry, but no problem; politics stay well below the surface, marriage is considered as seriously as conditions will allow, but few take the plunge.

The revelations in this article may not be sensational, but they do serve to give an objective view of Barts students as they live and put them into perspective with their surroundings.

LETTERS TO THE EDITOR

DEAR SIR,—It should not have escaped your notice that during the last few years there has, among parties interested, been discussion on the decline of British Medicine in the Overseas Territories; the unwillingness of young British graduates now to consider service overseas as a career, either temporarily or permanently: the reasons for this: and how the situation may be remedied. These matters are dealt with at some length by Sir Douglas Robb and in the leading editorial in the current B.M.J. (February 11th) and in the leading editorial in the current *Lancet* (February 11th).

As some have remarked, among the deterrents is the attitude in the teaching hospitals, to which young graduates are naturally very sensitive. When I qualified at Barts over 36 years ago, there was no doubt about it. To deviate from the accepted grooves to consultant or academic rank on the one hand, or refined general practice on the other, and shoot off to such a service as the West African (as I did), was regarded as not only folly and a confession of failure, but a positive insult to Barts. From recent correspondence with the Dean of the Medical School, it is a fair deduction that it still is.

As one writer put it, since the war, British Medicine has appeared to be satisfied with staying indoors and contemplating it's navel. As another, more rudely, that Barts retained it's lead in the field of auto-omphaloscopy.

The Board of Governors, I suppose, may not be directly concerned with the Medical School, and may take the view that overseas

problems are no business of theirs'. They cannot, of course, dictate to Staff, what their attitudes should be. I can only suggest to you that, if I am correct, this attitude, in a matter of such major importance, is rather deplorable.

Admittedly my own bias is the other way. My career has been in no way distinguished, and there have been many periods when life and work were trying indeed. But for interest, usefulness, variety and amusement I may, without vanity, award it an alpha plus. I think with pity of poor fellows dragging out their lives among the dreary residents of Brighton and Bournemouth, or (Oh! Horror!) a New Town: and without envy of the professors and consultants. After it all I have slid safely into the sixties in good health and reasonably well off. I can only hope that there will be no more discouragement from within to your young men and women to go and do likewise.

I would also suggest that expressions of points of view concerning the Hospital and Medical School, from however lowly a source, should not be despised.

Yours faithfully,

George L. Alexander, M.B., B.Ch. (Camb.), D.T. M. & H.

West African Medical Staff 1927–48.
Battalion Medical Officer, Abyssinia, 1940–41.
Surgeon, P. & O. and Union-Castle Lines 1948–56.
Ghana and Malaya 1957–59.
The Chairman of the Board of Governors, St. Bartholomew's Hospital.

DEAR SIR,—The portion of Dr. Bamford's report that you published in the January number has impressed me a great deal, for in addition to its pleasant readability (O.E.D.) it contained some excellent ideas.

Under the near-palindromic (not O.E.D.) title of "P.G. study for G.P.'s" he implies that an intending consultant ought to do some work in general practice during his training. I am sure he is quite right in this, for the benefit to the consultant when fledged at last is prodigious; I speak with personal knowledge on this point, and feel that the degree B.G.P. (Been in General Practice) has merits that the more usual B.I.A. (Been To America) has not. The experience is in fact very easily acquired: the only objection against a Registrar doing regular evening surgeries for a general practitioner, and some week-ends too, is an administrative one and therefore surmountable. Morally there is no objection. Between registrar appointments he can fill in time, and earn money, by doing locums in practice, and this provides even more valuable experience; he can also do the odd fortnight during his six weeks of annual leave. The experience gained is of obvious value to an intending physician, but is probably really of even greater value to a man going in for surgery or any one of the specialties. By a similar paradox, it would benefit a man going in for whole-time academic medicine more than the future part-time man, who will see at least some aspects of general practice when he establishes a private consulting practice.

Dr. Bamford also suggests that general practitioners should come on ward-rounds and contribute to the student teaching. To arrange this is simplicity itself, provided they would do it free of charge. ("Miracles take a little longer.") A Bart's man becomes a perpetual student on qualification and is welcome to attend any of the normal teaching of the College. With very little notice one could select suitable cases for teaching, and quickly get up a lively discussion along the very lines he suggests. I think it would be great fun, and certainly most informative for all of us.

Dr. Bamford has excellent suggestions about general practitioners looking after geriatric beds. One knows that in some geriatric units consultant cover is quite inadequate, and that a more efficient service, such as his plan would lead to, would speed the patients' recovery and discharge. Presumably a consultant would still have to be administratively in charge, if only in order to exercise some central control over the allocation of such beds, pressure for which is enormous throughout the whole country; but I see no particular difficulty in this.

About Merit Awards I am not so sure. In hospitals it is in any case all too common for stupid and prolonged antagonisms to arise between members of the staff; the merit award system is probably the most potent catalyst of this process yet devised. I myself feel, with Mr. R. S. Murley, that "The true reward for distinction is distinction". (Pardon me, Reggie, if I have misquoted you.)

Yours faithfully,

(Dr.) H. Wykeham Balme

DEAR SIR,—The Rugger Club deservedly had a great deal of support, including that of your correspondent, for their Cup matches at Richmond this season. It is well known, however, that those students who stayed away, perhaps having other sporting interests, came in for some criticism for not supporting their hospital at the acknowledged premier sporting occasions of the season.

Those who were so ready and loud with their criticism missed a far better occasion for admonishing their colleagues by not themselves going to the final of the Ladies Hockey Competition. At this match, only five students and some members of the staff troubled themselves to go and support the Hospital team.

There seemed to be few reasons for staying away, the match was advertised both in College Hall and outside the Abernethian Room, a coach was laid on, it was a fine Wednesday afternoon and no examinations were in progress. Only the Boat Club were engaged in particularly important training.

No doubt our valiant supporters of other more popular, or perhaps more social, occasions had their reasons for staying away. would be most interested to read them in these columns, and so too would the Ladies Hockey Team who were visibly disappointed at the lack of support.

But I almost forgot—the Final of the Hospital Rugger Cup was played on the same afternoon, and some of our enthusiasts went down to Richmond instead to watch the teams of two other hospitals. I hardly need draw the conclusion for your readers that for these steadfast supporters of our own functions, the game is of more importance than the hospital.

Thus we can all understand the point of view of those who criticised their fellows for not going down to Richmond.

Yours faithfully,

William Jory.

DEAR SIR,—By the time this circulates, we will be faced with "un fait accompli". However, I feel it worthwhile in attempting a protest against the further municipalisation of the beautiful precincts of College Hall.

This subject has been well-worn in the past and it is recognised that building will soon cause a more major upheaval. But now, some painters have marked out, with dazzling white paint, car parking lots in almost every conceivable space. It is presumed these are to supplant the well-organised parking arena for the moment in use. I also note a couple of untidy floodlights that surely cannot be permanent. Are these to guide the weary worker around the hazardous bends?

However, the necessity for the lines is obscure; they certainly do not enhance the attractiveness of the Charterhouse, to either local or foreign eyes. I would hope that the privileged few, who contravene the Minister of Transport's plea to commute by train, are of sufficient intelligence to park their vehicles in a reasonable manner. One wonders whether all the constructed spaces will be occupied, or will Parkinson's Law apply here and more cars be admitted to fill the gaps.

With this grabbing of squatters' rights by the Parking Committee, it would be good to know that Residents of College Hall—unlike daily commuters—will be guaranteed their small parking zone until it be built upon: official recognition of this in these pages would be appreciated. I trust their resident status will not therefore be totally ignored when construction overtakes the main area; I forget whether anyone has intimated that parking facilities will be incorporated beneath any of the new buildings, a necessary step.

Would the leaders of the senio rcommuter-car-parkers show a lead by forgoing the pleasure of that agonising drive to and from work? They could then avail themselves of the excellent facilities and relatively cheap service to Aldersgate, a most convenient station. The need for this correspondence would not then arise.

A final thought—I am hard put to find the connection that The City Pram Co. has with the Medical College—a van seems to occupy a slot each day. Is there a crafty solution? I suppose that Elizabeth does create a certain demand!

I remain, yours faithfully,

Brian J. Stoodley.

BOOK REVIEWS

HALE-WHITE'S MATERIA MEDICA, PHARMACOLOGY AND THERAPEUTICS by A. H. Douthwaite, M.D., F.R.C.P. 31st edition. **J. & A. Churchill Ltd.** 25s.

A new edition of this deservedly popular book has appeared, on the average, every two years since it first appeared in 1892—a commendable record for any book.

This edition has been brought up to date, but, unfortunately, a number of obsolete drugs remain. Thus, for example, picrotoxin continues to be described as useful in cases of barbiturate and paraldehyde poisoning; numerous substances are still recommended as expectorants, whereas current opinion suggests that true expectorants are unknown; and alum, copper sulphate and zinc sulphate are recommended as "commonly used" emetics. It is a pity that these remain in this otherwise excellent book.

The systematic lay-out deserves special comment, and the judicious use of bold type emphasises the main actions and uses of the various drugs. This arrangement makes for very rapid reading, and while the book pre-supposes some knowledge of the subject if one is is to derive full benefit from it, it is a most suitable one for preparation for exams in therapeutics. P.J.W.

THE METABOLIC BASIS OF INHERITED DISEASE edited by J. B. Stanbury, J. B. Wyngaarden, D. S. Frederickson. **McGraw-Hill Publishing Co. Ltd.,** New York, Toronto, London. pp. 1,474. 1st Edition. 132s. 6d.

There have been a number of books on biochemical genetics, two notable ones were that by Shia (Inborn Errors of Metabolism, The Year Book Publishers Inc., Chicago, 1959) and by H. Harris (Human Biochemical Genetics, Cambridge University Press, 1959). These two were about 300 pages each, the first is in the nature of an expended catalogue of inborn errors in man, the second is a much more integrated account which also deals with fundamental problems such as the Watson-Crick hypothesis of desoxyribonucleic acid (DNA) structure. The present book is about five times as big as the other two and much more comprehensive. Its price alone will make it unlikely that students can buy it, but it does represent the first comprehensive and extensive textbook on the subject. There are a large number of authors, some forty-six in addition to the three editors, and as for each subject a specially interested expert has been chosen the standard is universally high. One would recommend particularly the introduction which deals with inherited variation in metabolic abnormality and is an extremely useful summary of the basic concepts of inborn errors of metabolism. There is also a well written account of the biochemical basis of human heredity. Special sections deal with disorders of carbohydrate, amino acid and fat metabolism, others with disturbances in the metabolism of the steroids, purines and pyrimidines, metals and prophyrins, the diseases affecting the formation of the red cells and clotting factors, and with renal tubular transport. The last chapter deals with disorders involving a deficiency of circulating enzymes or plasma proteins and it is here perhaps that most might be added in a future edition. The book is lavishly illustrated and each chapter is followed by an extensive list of references, sometimes hundreds of them. There could be no better way for a student to get some idea of the huge amount of important new information, which has come into medicine in the last ten years, based on the classical work done at this hospital at the turn of the century by the then Dr. Archibald Garrod. H.L.

OUTLINE OF ORTHOPAEDICS by John Crawford Adams. 3rd Edition. **Published by E. and S. Livingstone, Ltd.** 35s.

The fact that before the new regulations were introduced a copy of this work was a distinctly *rara avis* in the Library testifies to the esteem in which it is held by the student population! As a clear and lucid outline of orthopaedics rather than a *textbook* it appeals at once to the student who wishes merely to satisfy his examiners rather than treat the subject as a speciality.

In this new edition the chapter on clinical methods has been expanded and some new illustrations added throughout the text. The material is presented under useful headings which greatly aid revision and the somewhat cumbersome chapter on orthopaedic pathology (100 pp.) is very useful to anyone revising this subject. However, the constant references to this chapter from other parts of the text become irritating to anyone trying to read through the book.

Apart from this, criticisms are few in number and some can be excused in view of the authors declared policy of omitting rarities and operative details. To quote one such example, however, I cannot help feeling that in his treatment of "frozen shoulder" the author should have mentioned that many cardiologists, regarding this as one of the earliest symptoms of myocardial ischaemia in a proportion of cases, now recommend a routine e.c.g.

My attention has been called to the fact that for the sake of completeness, a brief note on the obstetric paralyses might with advantage be included. A.J.B.M.

A LABORATORY HANDBOOK OF BLOOD TRANSFUSION TECHNIQUES by A. Derek Far. pp. 135+xi. **Heinemann.** 17s. 6d.

This little book is intended to cover the general practice of blood transfusion, with particular reference to the examinations of the Institute of Medical Laboratory Technology. Although much of the subject matter is outside the scope of the medical student, the book should certainly find a place in most Pathology Departments, as it contains abundant material valuable both to technicians and to pathologists.

Information is clearly and concisely given, apart from a few minor grammatical errors. The photographs and diagrams are particularly good.

The preparation of pyrogen and bacterial free intravenous solutions is carefully described, with some useful notes on sterilisation technique.

Although blood grouping and cross-matching methods are necessarily reduced to a minimum in a book of this size, such methods have been carefully selected for reliability and safety.

Frequently one finds information that is never given in other, much larger, textbooks. For example, there are helpful passages dealing with the advantages and disadvantages of various blood products, and a table giving the relative costs and durabilities of the types of tubing used in transfusion.

Throughout the book, one is impressed by the author's insistence upon the avoidance of error, and the reduction of blood transfusion risks to a minimum. As he himself says— "the margin of error permissible in blood transfusion work is not wide—it is nil". A.J.S.

GOOD ENGLISH FOR MEDICAL WRITERS by Ffrangcon Roberts, M.A., M.D., F.F.R. **Published by William Heinemann Medical Books, Ltd.** pp. 173+x. 17s. 6d.

This book has been written with the laudable object of helping the would-be author of a medical paper to avoid the many pitfalls of grammar, style, and usage provided by the English language and thereby to make his article more readable and to enable him to convey his meaning more clearly and accurately to the reader. Unfortunately, Dr. Roberts has performed his task with such thoroughness (although there are one or two surprising omissions) and has peppered his pages with such a superabundance of examples of "bad English" quoted from the recent medical literature that the book itself is not very readable. Those who have the patience and endurance to read every one of its sixteen chapters will be rewarded with a great deal of sound and useful advice, but it is to be feared that many readers will be discouraged by the amount of space sometimes devoted to the labouring of relatively small points, while others will be put off by the author's occasional tendency to allow personal preference to outweigh the claims of usage, convenience, and common sense. Moreover, although adequately indexed, the book's style and arrangement do not make for easy and rapid reference.

With some judicious pruning—particularly of the quotations, which in many cases are clearly the results of simple carelessness rather than genuine examples of faulty grammar or construction—this could be a very useful book. But in its present form it hardly presents a serious challenge to the standard works of Fowler or Partridge as the medical author's guide to good English. D.I.C.

HEALTH AND HORMONES
by A. Stuart Mason, **Published by Pelican,** 4s.

This is a competent and entertaining do-it-yourself sex and gland book. Although it can be recommended for the intelligent and educated adult lay-public, no dormitory should be without it. I say chaps, have you counted your chromosomes lately! A. G. S.

CLINICAL ANATOMY
by Harold Ellis, **Published by Blackwell,** 37s. 6d.

The student of to-day has a great deal more to learn than ever before: the vast subject of anatomy has to be crammed into a short period of learning, so that it is difficult, if not impossible for the facts which will be all important during the clinical training to be appreciated and grasped. Ellis has produced a book which stresses clinical application in anatomy. This must be of value during the preclinical period as a guide to those points which they must retain. During the clinical years anatomy is too easily forgotten. The large books are too large for quick reference, the smaller books are too topographical with little, if any, clinical application, so that the whole important subject is side-tracked by the student. This book fills a real need in the students' preclinical and particularly clinical years of study: in the post-graduate days it would serve as an easy and practical reference book. Such books are difficult to write for the errors of omission surmount those of commission: it is easy to pick out part or parts which are inadequately covered, but there are few such parts in this book, which is practical, well balanced and, above all, easily read J. O. R.

LANGUAGE!

USE OF NUMBERED
PARKINGSITESIS
RESTRICTED TO WHOM
ALLOCATED —
STUDENTS ARE
INFORMED THAT
PARKING ALL NIGHT —
OTHER THANBY PERMIT
HOLDERS — RESIDENT
CAR PARK ONLY — IS
PROHIBITED
BY ORDER
EXEC-COMM.

One of the many notices erected outside College Hall by the car parking authorities.

SPORTS NEWS

Viewpoint

IT IS a moot point whether we play games purely to win, or purely for pleasure, and the truth lies, as in all things human, somewhere between, wrapped in the mysteries of British compromise. A game is no more than a contest between two teams, or two or more players, to find out the better contestant. Let us not forget this—recently there has been a great deal of controversy over the way Test Matches should be played; England play to win, so do Australia and the West Indies (take note Mr. Worrell)—the difference lies in the way each goes about it, and the teams adapt their play to achieve maximum success with the available players and types of wicket.

Few who play, however, will deny that they do enjoy the game, and the less competitive gathering afterwards; in fact, which of us would prefer to play a dull game and win, rather than to lose in a gallant struggle? The essence of the whole thing is that, in the second instance, we play primarily to win, and the harder we play, the more we enjoy it.

There has been a certain amount of criticism recently that the Hospital is not holding its own, and many, though not blaming the teams themselves, ascribe the trouble to our lack of top class players. This is as may be, but let us not forget successes of the cross country team, the ladies hockey team and the chess team. And really, no one can complain about the rugby club after their showing in the cup match.

The addition of two brilliant players each to the rugby, football, and hockey teams (one in the forwards and one in the backs) would doubtless pull them up, but the Hospital has not got them, for some reason they go elsewhere. There is, however, plenty of talent available for coaching. And if this is correctly used, brilliance being met with ability, and enthusiasm the teams will go further than they already have.

Rugby Club

Hospitals Cup Rugger Match

Draw 5–5

PLAYED ON THE firm Richmond ground, with a very strong wind blowing straight down the pitch, this didn't turn out to be the close-up fighting game so often seen in Cup rugger. It was a most exciting and entertaining game in which Bart's rose well above their current form and came close to winning.

The first half Bart's played with the wind behind them and made good use of it. The long kicks of R. R. Davies, who early on narrowly missed a drop-goal, repeatedly took the Hospital deep into Guys' half. The pack fought very well against far heavier opponents, holding them in the set scrums and getting a lot of the ball from the line-outs where Orr's jumping was prominent. Thus assured of a reasonable share of the ball the Bart's three-quarter line was the more dangerous and opportunist. They were rewarded when, from a Guys handling mistake in mid-field, Britz got his boot to the loose ball, followed up fast and scored. Stevens converted.

At the start of the second half it looked as though a five-point lead might not be sufficient now Bart's were playing against the wind. On the one occasion on which Jeffreys missed his powerful opposite winger it took three men to stop him. However, Halls effectively prevented the Guy's fly-half from setting his line moving while the latters kicking was poorly judged, either going right over the line or straight to Ross at full back. Guys appeared to be held, but from a fine three-quarter movement they scored a try which was also converted. Thus the game ended as a draw with Bart's perhaps slightly unlucky not to have won after their valiant efforts.

Replay Lost 0–8

The replay was held on a windless day with the hot sun drying the mud to dust. It was a fast exhausting game. To start with, Guys forward onslaughts were held back by long defensive kicks while Bart's backs again looked the more dangerous in attack and sound defence, as witnessed by several shattering tackles by Britz. Once Niven found himself with a large gap, but unluckily he slipped, and the first half ended with no score.

After half-time, the greatly superior weight of the opposing pack began to tell, while their backs found fresh confidence. Desperate covering by Bart's forwards kept repeated attacks in check but eventually a Guy's three-quarter movement brought a try which was converted. Soon after this, Britz had to leave the field with an injured knee and from then on, in spite of fierce running by Stevens, Bart's no longer looked like scoring. Still Guys had to fight very hard before they gained a second try close to time. The result was a fair reflection of the play for Guys had improved greatly on their previous performance. It was a pity Bart's had not quite succeeded in taking the chance offered by the first game.

Team. A. J. P. Ross, J. Stevens, M. Britz, P. A. R. Niven, R. V. Jeffreys, R. R. Davies, D. Cherney, A. Knox, B. Curry, J. Hamilton, M. M. Orr, B. Doran, R. P. Davies, M. D. Jennings, G. Halls.

Sat., Jan. 28th

1st XV v. Old Paulines. Lost 3–6.

Old Paulines beat Bart's by a try and a penalty goal to a penalty goal. In the first-half, with the wind and slope to their advantage the Paulines deservedly took the lead when centre Britnor cut through in the home '25' to score. After the oranges, although the Old Boys still retained a clear majority in the lines-out, Bart's pressed continuously but despite dangerous runs by S. G. Harris failed to cross the Paulines' line. Close to no-side Harris for Bart's and Wheeler for the Paulines swapped penalty goals from straight in front—the latter's coming in a rare second-half excursion into the Hospital '25' A. P. Ross played a sound game at full-back.

Team. Ross, Harris, Stevens, Niven, Jeffreys, Davies, Peek, Hamilton, Gurry, Knox, Orr, Thomas, Moynagh, Jennings, Goodall.

Sat., Feb. 4th

1st XV v. Old Merchant Taylors.

Drawn 8–8.

A draw with the accomplished Taylors' side was a most encouraging performance considering the first Cup match was but five days away. The large O.M.T. pack gave their fast three-quarter line much of the ball but a swirling wind made passing hazardous and the Hospital back-row were quick on the resultant mistakes. Bart's scored first when B. H. Gurry crashed over from a line-out but after the interval O.M.Ts equalised when D. G. S. Baker's perfectly placed punt landed in the left wing's arms. An opportunity try by M. C. Jennings who pounced on a dropped pass followed by a fine conversion by J. E. Stevens regained the lead for Bart's but the Old Boys levelled again with a goal following a blind side break by their scrum-half.

Team. Ross, Stevens, Britz, Niven, Jeffreys, Davies, Peek, Hamilton, Gurry, Knox, Orr, Thomas, Davies, Jennings, Halls.

Sat., Feb. 11th

1st XV v. Esher. Lost 0–29.

The proximity of the Cup matches and the pulled muscles of Halls and R. R. Davies acquired in the opening minutes, which resulted in the former going off and the latter limping through the game finally as a passenger on the wing, contributed to this, the heaviest defeat of the season. A handful of reserves and rank bad Hospital tackling further contributed, but all credit to Esher who slipped smoothly into top gear from the start and gave the spectators a fine exhibition of close inter-passing between forwards and backs interspersed with French-style back row play. A negligible supply of the ball limited the Bart's attacks and seven times the 1st XV stood behind the posts and watched the Esher goal-kicker attempt to convert. He succeeded on four occasions.

Team. E. D. Dorrell, Harris, Britz, Niven, Jeffreys, Davies, Chesney, Harvey, Gurry, Knox, Doran, Orr, Davies, Jennings, Halls.

Sat., Feb. 18th

1st XV v. Metropolitan Police. Lost 9–16

Bart's took on the successful Metropolitan Police side and lost by two penalty goals and a try to two penalty goals and two goals. It was a scrappy game in which two bad defensive lapses cost ten points and nullified the territorial advantage enjoyed in the second-half. An exchange of penalty goals gave the Police a half-time lead of 6–3 which they consolidated with a try under the posts following an interception. Prolonged Bart's pressure followed, but Harris's second penalty goal was the only score to show for this. Then Edwards, the dangerous Police stand-off engineered a scissors with his right wing who ran through the peacefully grazing Bart's forwards to score by the posts. Finally Smart completed a multiple handling movement.

Team. Ross, Harris, Letchworth, Niven, Jeffreys, Davies, Peek, Jennings, Gurry, Shearer, Doran, Orr, Davies, Smart, Halls.

Barts Cross Country Club

THE SEASON STARTED very successfully with an accident: four members of the club arrived at Hampstead to train and found five teams lined up for the start of a race; they joined in and won.

Barts	31 pts.
London Hospital	32 pts.
University College II	44 pts.
Westminster Hospital	68 pts.
Charing Cross Hospital	74 pts.
College of Estate Management ..	103 pts.

Individual placings: 1st Littlewood, 2nd Foxton, 9th Pott, 19th Hardy.

The first match in the University's 2nd Division League was held at Parliament Hill on November 2nd. Some misunderstanding made three members of the team late for the start—they were also late for the finish and Bart's were placed 2nd, 3rd, 62nd, 63rd and 64th. This result left us fifth out of ten teams in the league.

On November 23rd it was Bart's turn to entertain the other colleges at Chislehurst. The course is an old U.H. course with a steep half mile hill on road and three quarters of a mile of deep black sticky mud. The "University road-running enthusiasts" took the lead from the start where the going was easy, but on the hill and in the mud Bart's and Guy's made places by the dozen. Littlewood finished first and a minute later Pott appeared hot on the tail of Quintan from Goldsmiths. Foxton ran in fast in sixth position and Lewis finished 12th after a ding-dong battle with three Guys men. The other members of the team marked the course, but inspite of their efforts and 140 arrows cut by Bart's patients, an economist from L.S.E. went off course in the woods. At 5.30 after the police had been informed and the course searched, he arrived grinning from ear to ear and stated that he had got lost!

Imperial College were the hosts on January 25th at Petersham. After the last match Barts were tying second in the division. Over a fast flat course on Richmond Common, Littlewood, Foxton and Pott stayed with the leading bunch and finished 2nd, 3rd and 4th. Macdonald finished 12th, Lewis 13th, Hardy 44th and Phipps 48th. This result brought us into first position in the league.

Having won the Inter-hospitals Cup, we ran the last match at Mitcham—organised by Kings—full of confidence. Littlewood, Pott and Foxton led the whole way over a very muddy common and finished first equal. Lewis, injured, came 12th. Hardy on top form 22nd and Phipps, after a very good run, 26th.

This excellent result makes Bart's top of Division II and means we shall run in Division I next year.

Besides running for Bart's, Littlewood, Pott, Foxton and Lewis have represented U.H. in nearly every match this season, the latter three have been awarded their U.H. colours. Hardy, Phipps, Macdonald and Phillips have run in U.H. home matches and shown up well against the other hospitals.

The season has also been a great social success thanks particularly to Lewis, and our rivals at Guys.

HOSPITAL CROSS COUNTRY CUP

(New Holders: Bart's)

THE CROSS COUNTRY CLUB scored a well-earned success by winning the inter-hospitals race, run over five miles at Barnet on Saturday, February 4th. It was an afternoon of cold sunshine with grassland sodden and the paths through the woods a quagmire —inches deep in mud. It was just these conditions which we hoped would dull the speed of the race and show up the Bart's strength on heavy going.

At the start it was St. Thomas's and the London who came to the front, though by the end of the first short lap, Bart's were well placed with Pott and Littlewood five yards ahead of Sperryn (St. Mary's) and Brotherhood (St. Thomas's), with Foxton just behind. Sliding through the mud on the way to the railway bridge, Sperryn overtook Littlewood and soon after Brotherhood and Foxton dropped back. This remained the order to Cockfosters Hill where Sperryn lost contact and a win for Bart's seemed assured.

As the Mary's challenge receded, Pott and Littlewood accelerated down the hill to the watersplash and along the road for home. The gap widened through the gruelling morass on the final hill and they finished together almost half a minute ahead of Sperryn.

Foxton fought off a stitch in the middle of the race to finish a creditable 8th, while good packing lower down by the whole of the team increased the margin of the Bart's victory.

Table Tennis Club

Tues., Nov. 22nd (University League)

v. Q.E.C. I. Away. Won 8–2.

Bart's continued their winning run, easily defeating our opponents. A. Eddelsten and A. Miller played up to their usual high standard.

Team. A. Miller (capt.), A. Eddelsten, M. Sandhu.

Tues., Nov. 29th (University League)

v. Q.E.C. II. Home. Won 6–4.

A somewhat weakened Bart's team played very poorly against the reserve team of Q.E.C. and many points were lost by lack of concentration and carelessness.

Team. R. K. Davies, M. Sandhu, A. Miller (capt.).

Tues., Dec. 13th (University League)

v. Q.M.C. (V). Won 7–3.

We finished the term's fixtures with an easy win against Q.M.C. and maintained our unbeaten record. B. Hore did well in his first match this season to win all his three games.

Team. R. K. Davies, A. Miller (capt.), B. D. Hore.

Swimming Club

WITH THE CLOSE of the 1960–61 season approaching the club's achievements have been as follows:

Winner of the U.H. Knock-out Water Polo Competition—beat St. Mary's in the final.

Second in the U.H. Swimming Championships.

Third in both divisions U.H. Water Polo League.

Second in London University Swimming Championships—the winners of which were Northampton Engineering College. Results of this competition:

Diving—1st D. Shand.
2nd C. Ruoss.
Medley Relay Team—3rd.
Freestyle Relay Team—1st.

Colours have been awarded to Groves, Ruoss, Sharey and Shand.

THE WRITINGS OF SIR HAROLD DELF GILLIES

Compiled by John L. Thornton

1916–17

Some cases of facial deformity treated in the Department of Plastic Surgery at the Cambridge Hospital, Aldershot. *St. Bart's Hosp. J.*, **24**, 1916–17, pp. 79–83.

1917

Formation of the upper half of the bridge of the nose. *J. Laryng.*, **32**, 1917, pp. 274–283.

Two cases illustrating plastic and dental treatment. *Lancet*. 1917, I, pp. 850–852.

(With L. A. B. King) Mechanical supports in plastic surgery. *Lancet*, 1917, I, pp. 412–414.

1917–18

The problems of facial reconstruction. *Trans, med. Soc. Lond.*, **41**, 1917–18, pp. 165–170.

1918

Demonstration on rhinoplasty. *Proc. roy. Soc. Med.*, **11**, i-ii, 1918, *Sect. Laryng.*, pp. 87-90.

Discussion on plastic operations of the eyelids. *Trans. ophthal. Soc. U.K.*, **38**, 1918, pp. 70-99.

1919

Paraffin wax in facial surgery. (*Corres.*) *Lancet*, 1919, II, p. 174.

1920

Plastic surgery of facial burns. *Surg. Gynec. Obstet.*, **30**, 1920, pp. 121–134.

Plastic surgery of the face, based on selected cases of war injuries of the face, including burns. . . . With chapter on prosthetic problems of plastic surgery by W. Kelsey Fry, and remarks on anaesthesia by R. Wade. London, *O.U.P., Hodder & Stoughton*, 1920.

Present day plastic operations of the face. *J. nat. dent. Ass., Huntingdon, Ind.*, **7**, 1920, pp. 3–36.

The tubed pedicle in plastic surgery. *N.Y. med. J.*, **111**, 1920, pp. 1–4.

1921

(With W. Kelsey Fry). A new principle in the surgical treatment of "congenital cleft palate", and its mechanical counterpart. *Brit. med. J.*, 1921, I, pp. 335–338.

1922–23

Case of depressed bony ridge of nose. *Proc. roy. Soc. Med.*, **16**, i-ii, 1922-3, Sect. Laryng., pp. 4–5.

Case of depressed fracture of nasal arch. *Proc. roy. Soc. Med.*, **16**, i-ii, 1922–3, Sect. Laryng., pp. 6-7.

Depressed fracture of nasal and associated bones. *Proc. roy. Soc. Med.*, **16**, i-ii, 1922-3, Sect. Laryng., pp. 4–5.

1923

Deformities of the syphilitic nose. *Brit. med. J.*, 1923, II, pp. 977–979.

The "eternal (plastic) triangle". A simple cure. *Lancet*, 1923, II, pp. 930–931.

1924

Plastic surgery. *In*, Carson, H. W., *ed. Modern operative surgery*, Vol. 2, 1924, pp. 368–402; 2nd ed., edited by G. Grey Turner, Vol. 2, 1934, pp. 403–452; 3rd ed., edited by G. Grey Turner, Vol. 2, 1943, pp. 1631–1701; (With John Barron). 4th ed., edited by G. Grey Turner and Lambert Charles Rogers, Vol. 2, 1956, pp. 1945–2021.

1926–27

(With T. Pomfret Kilner and Dudley Stone). Fractures of the malar-zygomatic compound: with a description of a new X-ray position. *Brit. J. Surg.*, **14,** 1926–7, pp. 651–656.

1929

Cleft palate; Hare-lip. *In*, Garrod, Sir Archibald E., Batten, F. E., and Thursfield, H., *eds. Diseases of children*, 2nd ed., edited by H. Thursfield and D. Paterson. 1929, pp. 162–169; 3rd ed., 1934, pp. 194–199.

(With T. Pomfret Kilner). Symblepharon: its treatment by Thiersch and mucous membrane grafting. *Trans. ophthal. Soc. U.K.*, **49,** 1929, pp. 470–478.

(With T. Pomfret Kilner). The treatment of the broken nose. (Modern technique in treatment, CCLXXXVIII.) *Lancet*, 1929, I, pp. 147–149.

1932

The design of direct pedicle flaps. *Brit. med. J.*, 1932, II, p. 1008.

(With T. Pomfret Kilner). Hare-lip: operations for the correction of secondary deformities. *Lancet*, 1932, II, pp. 1369–1375.

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Fractures of the lower jaw. *Trans. med. Soc. Lond.*, **56,** 1933, pp. 30–36.

(With A. H. McIndoe). The late surgical complications of fracture of the mandible. *Brit. med. J.*, 1933, II, pp. 1060–1063.

(With A. H. McIndoe). Plastic surgery in chronic radiodermatitis and radionecrosis. *Brit. J. Radiol.*, **6,** 1933, pp. 132–147.

1933–34

Experiences with fascia lata grafts in the operative treatment of facial paralysis. *Proc. roy. Soc. Med.*, **27,** ii, 1933–4, pp. 1372–1378; also in *J. Laryng.*, **49,** 1934, pp. 743–756.

Hemiatrophy of the face (unilateral lipodystrophy). Condition improved by insertion of fat grafts. *Proc. roy. Soc. Med.*, **27,** i, 1933–4, pp. 642–643.

Three cases of facial paralysis treated by temporal muscle graft and fascia lata control. *Proc. roy. Soc. Med.*, **27,** ii, 1933–4, pp. 1382–1388.

1935

The development and scope of plastic surgery. (Charles H. Mayo Lecture). *Northwest, Univ. Bull. med. Sch.*, **35,** 1935, pp. 1–32.

Experiences with tubed pedicle flaps. *Surg. Gynec. Obstet.*, **60,** 1935, pp. 291–303.

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1936

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1937

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Treatment of facial paralysis. *Trans. med. Soc. Lond.*, **60,** 1937, pp. 170–171, 179.

1938

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The primary treatment of facial injuries. *Practitioner*, **140,** 1938, pp. 414–425.

1939

Practical uses of the tubed pedicle flap. *Amer. J. Surg.*, N.S.**43,** 1939, pp. 201–215.

(With Archibald H. McIndoe). The technique of mammaplasty in conditions of hypertrophy of the breast. *Surg. Gynec. Obstet.*, **68,** 1939, pp. 658–665.

1940

Autograft of amputated digit: a suggested operation. *Lancet*, 1940, I, pp. 1002–1003.

1942

Cirurgía plástica. *Rev. Assoc. med. argent.*, **56,** 1942, pp. 196–198.

Technic in construction of an auricle. *Trans. Amer. Acad. Ophthal.* (1941), **46,** 1942, pp. 119–121.

(With Walter M. Levitt). Radiotherapy in the prophylaxis and treatment of keloid. *Lancet*, 1942, I, pp. 440–442.

1942–43

A new free graft applied to the reconstruction of the nostril. *Brit. J. Surg.*, **30,** 1942–3, pp. 305–307.

1943

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1943–44

Technique of good suturing. *St. Bart's Hosp. J.*, **47,** 1943–4, pp. 170–173.

1944

Note on scalp closure. *Lancet*, 1944, II, pp. 310–311.

1944–45

Operative replacement of the mammary prominence. *Brit. J. Surg.*, **32,** 1944–5, pp. 477–479.

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Late end-results of war burns. *Trans. med. Soc. Lond.*, **63,** (1940–43), 1945, pp. 134–136.

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1950–51

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1951–52

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1954–55

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1955–56

(With D. A. C. Reid). Survival of finger nail following digital autograft. *Brit. J. plast. Surg.*, **8,** 1955–56, p. 174.

1956

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1957

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1958

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1959

Plastic surgery in naval cases. *J. roy. nav. med. Serv.*, **45,** 1959, pp. 7–46.

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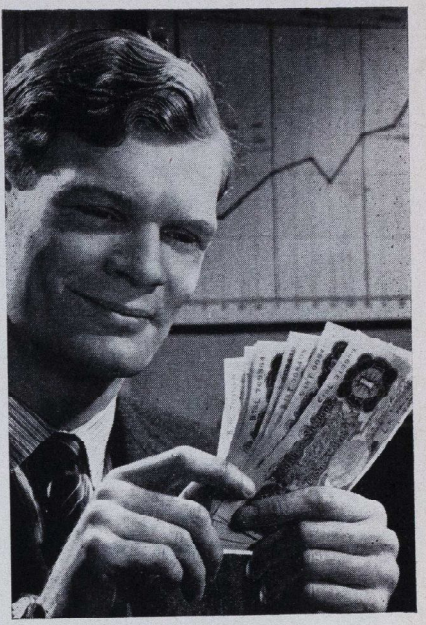


ST. BARTHOLOMEW'S HOSPITAL JOURNAL

Vol. LXV, No. 4 **APRIL, 1961**

Editorial

WE LIVE IN a world of crosses in boxes, and the cult of the questionnaire is now firmly established in this society of ours. At long last, after rather more than three years, the Journal has managed to slough off the last of a series of articles analysing the results of a student questionnaire compiled and hatched by a zealous former editor together with a team of industrious assistants. The value of such an undertaking is indubitable. Where else, for instance, could one glean such valuable and titillating pieces of information as (we quote): "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."

The last survey that the lucky, welfare-state-suckled medical student has been privileged to fill in was put out by the Association for the Study of Medical Education. This was a veritable behemoth amongst questionnaires. The editor sat for all of two hours chewing the end of his pencil and struggled with such thorny problems as whether he rated good appearance (or warmth, or curiosity, or persuasiveness) above businesslike attitude (or humility, or physical endurance, or shrewdness) as characteristics of a "good doctor". We await with eager anticipation the publication of the results and findings of the survey. We imagine something like this:

> "48 per cent placed General Practice as their first choice of career, whilst 53 per cent reacted unfavourably to the dirty and unkempt patient. 60 per cent showed no special reaction to the pregnant patient, whilst 32 per cent reacted favourably to both the self diagnosing patient, and the patient determined to recover.
>
> "The Association feels these figures to be of great significance for this means that 1.375 per cent of general practitioners in ten years time, when faced with a non-self diagnosing, dirty and unkempt, pregnant patient, who has no wish whatsoever to recover, are liable to throw up their hand in horror, dash from their consulting room in a state of hysterics and seek a job as a paediatrician (2nd choice, 12.8 per cent) in the Colonial Office (3rd choice, 22.4 per cent)."

The best questionnaire story we have heard recently was of the suave student who was approached by some earnest seeker after truth. He was asked what his annual income was, and what proportion of this figure was made up by his grant. His interrogator explained that this was part of a survey which was the beginning of an effort to improve the conditions of appalling poverty under which students were forced to exist. The student replied that he had never had a grant of any sort in his life, and although rather vague as to the actual figure of his income thought that it was somewhere round the £600 mark. His questioner looked thunderstruck, but recovering quickly he tore up the sheet of paper on which he had been writing busily, and curtly informed the student that he was in no way representative of his genus, and his replies were valueless. One is left wondering whether subjectivity or objectivity is the object of the exercise.

Engagements

BOWER–CLARK.—The engagement is announced between Dr. Hugh P. H. Bower and Sally Elizabeth Clark.

HOPPER–HENDERSON.—The engagement is announced between Dr. Peter Kennedy Hopper and Dr. Dinah Constance Milne Henderson.

RICHARDS–WHITE.—The engagement is announced between Dr. Hugh Morgan Richards and Christine Mary White.

SEATON–SHOOLMAN.—The engagement is announced between Dr. Anthony Trevor Seaton and Lucie Georgina Shoolman.

Marriages

DAWSON–MURRAY.—On April 4th, Dr. Alexander Michael Dawson to Henrietta Murray.

LANGHAM–EDWARDS.—On April 8th, at the Priory Church of St. Bartholomew-the-Great, Dr. David Langham to Ann Edwards.

STEPHENSON–GARNHAM.—On April 1st, Dr. Charles Graham Stephenson to Carolyn Ismea Garnham.

Births

FAIRLEY.—On April 1st, to Daphne, wife of Dr. Gordon Hamilton Fairley, a son (Geoffrey Neil).

GOODWIN.—On April 12th, at Vellore, South India, to Jean and Dr. Stewart Goodwin, a daughter (Caroline McLean) a sister for Ruth.

HEWER.—On April 19th, to Ann, wife of Richard Langton Hewer, a daughter.

MARSH.—On April 17th, to Peggy and Dr. Deryk Marsh, a daughter (Alyson Elizabeth).

THOMAS.—On April 4th, to Dorothy and Gareth Thomas, F.R.C.S.E., a son.

WOOSTER.—On April 26th, to Frances, wife of Dr. Gerald Wooster, a daughter.

Deaths

ENOCH.—On April 1st, Robert Henry Enoch, M.R.C.S., L.R.C.P., V.R.D., aged 64. Qualified 1923.

FLETCHER.—On April 16th, Ernest Tertius Decimus Fletcher, M.D., F.R.C.P., aged 69. Qualified 1918.

GRAY.—On April 22nd, Dr. John T. Gray. Qualified 1929.

HIGGINSON.—On April 1st, Dr. Henry C. H. Higginson. Qualified 1933.

SMITH.—On March 21st, Dr. Michael Carson Lyndon Smith, M.C., aged 53. Qualified 1934.

SYKES.—On March 31st, William Stanley Sykes, M.B.E., M.B., B.Chir., D.P.H., D.A., aged 66. Qualified 1919.

Appointments

Mr. B. N. Brooke has been awarded the Copeman medal for scientific research for 1960 by Corpus Christi College, Cambridge. He is to give the Sir John Marnoch lecture for 1961 at the University of Aberdeen.

Prince Bertil of Sweden has personally appointed Mr. C. Naunton Morgan as commander of the Order of the Pole Star.

Prof. Wormall has been re-appointed as a member of the Board of Governors of the Royal Hospital of St. Bartholomew by the Minister of Health for the period April 1st, 1961 to March 31st, 1964.

Prof. Wormall has been elected, in March 1961, a member of the New York Academy of Sciences.

University of Birmingham

The title of Emeritus Professor has been conferred on Henry Percy Gilding, Bowman Professor of Physiology in the University from 1933 to 1960.

University of Cambridge

Dr. D'A. Kok has been re-appointed a University Lecturer in the Department of Medicine with tenure from October 1st, 1961 to the retiring age.

University of London

Dr. Dennis Lacy, lecturer at St. Bartholomew's Hospital Medical College, has been appointed to the readership in Zoology and Comparative Anatomy at the College.

Fifty years ago

Case of Strangulated hernia at seventy-five. Operation under local anaesthetic. Recovery. By Sydney J. O. Dickins, M.D.(Brux.), M.R.C.S.(Eng.), L.R.C.P. (Lond.).

THE PATIENT, a feeble old man who had suffered from mitral disease for some years, was subject to right inguinal hernia, for which he was wearing a badly fitting truss.

Owing to a severe attack of bronchitis from which he was just recovering the rupture came down and he failed to get it back; vomiting commenced and as he was suffering considerable pain he sent for me in the night.

Upon arrival I found that he had a very tight strangulated hernia which could not be reduced, and was causing him great pain and frequent vomiting.

I decided to operate at once and single-handed, instead of sending for my partner, as it was six miles away from home and the night was terribly rough.

The operating theatre was not ideal! an old feather bed, and by no means cleanly surroundings or patient either.

I cleaned him up, shaved, and thoroughly swabbed all over the operating area with Tr. Iodi, and then prepared instruments and again swabbed with Tr. Iodi (which I find an adequate sterilising application which I have used for a long time with very excellent results). Owing to the patient's age and general condition cocaine was used as a local anaesthetic.

My light was provided by candles and motor acetylene headlight directed by my chauffeur, who promptly felt faint at the sight of a little blood.

I had, fortunately, foreseen this possibility, and an old woman came to the rescue until he was able to return to his post.

I found upon opening the sac a tight band at the neck which was nicked in several places and the gut returned, the sac was cut through and the ring closed with silk-worm gut sutures, the wound being stitched up with the same. The patient stood the operation very well considering his feeble state of health and hardly complained of feeling any pain.

I injected liq. strych. miij before and after the operation, and these were continued every six hours for a week.

A small pocket of pus formed under the skin, which was relieved by removing a suture and syringing with chinosol solution, after which healing was not long delayed.

The remaining stitches were removed on the eighth day, when the wound had quite healed. The patient, I am glad to say, made a very good recovery.

The great advantage of being able to operate early, and the use of local anaesthetic, especially in old and feeble subjects, are points one would like to emphasise.

A. E. Mattock

Obituary—*A. E. Mattock*

ON THE MORNING of February 15th, 1961, Albert Edward Mattock died in the hospital that he had faithfully served for nearly 40 years.

Born on January 31st, 1899, Mattock first came to Bart's as a general porter in the Autumn of 1921 after being demobilised from the British Army of Occupation in Germany. Shortly afterwards he became a Surgery Porter, and amongst other things an enthusiastic member of the Fire Fighting Team of that Department. Although during this time he was frequently required to assist in fracture work and plaster of Paris technique it was not until November 1934, that he was appointed full time plaster technician in the newly organized Fracture Clinic. It was then that the man and his craft became one.

Since that time countless numbers of casualty officers and housemen have become indebted to him for his diplomatic advice and help when they were faced with the task of using plaster for the first time alone. Always eager to be of help and never ruffled, his craftsmanship became a byeword in the hospital and many are the innovations and perfections of technique that he brought to fracture work.

His interest in hospital affairs was a very real one, and one of his prized possessions was the book in which he methodically entered the names and dates of all newly qualified men taking up their first house appointment. Going back almost 40 years his comments as he turned the pages were always amusing but equally penetrating and profound.

Perhaps he was at his very best with children with whom he had such a natural affinity. Without fuss and without fear he had the gift of coaxing small children to do exactly what he required of them, and they on their part would instinctively respond to the gentleness of the man.

Though gravely ill he continued to work until only a few weeks before he died and, so typical of him, would not take time off as in his own words, " that would be dodging the column ".

A man of compassion he was friend to all who knew him, and to his wife and son we offer our deepest sympathy and respect.

R.C.F.

Obituary—*T. J. O. Harcup*

ON FEBRUARY 26TH, Terry Harcup was drowned, when the canoe in which he and a colleague from the hospital were training for the Devizes to Westminster race capsized near Kingston Bridge. The tragedy was prolonged by a delay of over three weeks until his body was found.

By his death, the medical college has lost a well liked and valuable member, and the medical profession one who would have become a fine doctor.

He came to Barts in October 1957, and during his few years at the hospital made many close friends. To those who did not know him the news of his going is sad as any such occurrence must be; but it is for those who knew him well and worked with him to appreciate the kindness, sense of humour and other like qualities which gained him, popularity and deep affection. Even more would those patients, with whom he came into close contact during his 18 months of clinical work, feel the loss, for it is well known amongst his colleagues how they respected him and looked forward to seeing him in the wards: in particular the children in Lucas and Kenton where he was working just before his death.

Few of these can know that he is no longer here, and it is as well for he would be grieved to feel that anything concerned with him should hurt them.

Modesty was one of his strongest virtues—not many knew of his ability as a chess player or as a photographer for example: however, as with anything which he undertook, he would not be satisfied until he could do it well. But of all that contributed to the respect in which he was held, most important was his principle—if able to say nothing good of someone or something, say nothing at all. No more creditable thing can be said than that he succeeded in this.

Barts is the worse for having lost him, but the memory of him can do nothing but good.

P.N.R.

Gilbert & Sullivan Society

SINCE ALMOST EVERY member of the hospital with any musical pretensions (and a good few without) was involved to a greater or lesser extent in the Gilbert and Sullivan Society's Concert Performance of H.M.S. Pinafore on March 3rd, the Editor was hard put to find anyone to write a review, far less a criticism. This reporter, whilst not being totally tone deaf, is superbly unqualified to give a professional account of the performance.

Be that as it may, the evening was an enormous success. That it was probably enjoyed by those performing more than by the audience does not detract in any way from the entertainment provided. I was delighted to find that I could hear all the words of both the chorus and the soloist, who, incidentally, sang admirably in tune. The most competent orchestra at no time betrayed their short time in rehearsal.

Great credit must be given to Christopher Hood for his herculean effort of organisation, for the time he spent in rehearsing soloists, chorus, and orchestra, and for conducting with such aplomb. One only hopes that, on his eventual departure, someone else may emerge to make the Gilbert and Sullivan Society such a success.

The Students Union

by J. A. H. Bootes

ON NOVEMBER 1ST last year the new constitution of the Students' Union came into force quietly and unnoticed by the majority of its members.

Was a new constitution necessary?

By those students who were familiar with the workings of the Union Council it was recognised that the progress of business was slow, due to the many and varied topics of both general and specific interest that were discussed, decided and finally acted upon. However, the sedate and dignified progression of matters in Council rarely caused much comment, although the effectiveness of the Union had been criticised on a number of occasions. This painless advance would probably have continued had it not been for the most direct criticism thrown at a group of students by a member of the staff, who said that the Union Council was "an unwieldy and ineffective body". Prior to this, there had been some effort made to bring the constitution more in line with the position of the Union today, and this remark stimulated a more detailed investigation into the Union structure. Examination of the Union constitution revealed a dog-eared booklet between the leaves of which were packed many tattered, stencilled sheets of amendments. Several anomalies were soon brought to light and it was decided that a full investigation into the Union structure should be carried out.

At a glance the most noticeable feature of the new constitution is the reduction in the number of Council members from sixty-seven to twenty-four, and the absorption of the missing forty-three into the new Athletics and the General Committees. The Council now consists principally of the representatives of the years and the Chairmen of these two Committees, plus a Lady Vice-President and the Chairman of the British Medical Students' Association Subcommittee.

The Athletics Committee comprises the secretaries of all of the Athletic Clubs whose business is concerned with matters of both general and individual interest in sport. This committee aims at a closer liaison between the various athletic activities over the year and will be responsible for the organisation of Sports Day, the function in the Hospital's year that has not had the support it deserves in recent years.

The secretaries of all the non-athletic clubs and societies meet as the General Committee and discuss topics specifically related to their own interests aiming, as the Athletics Committee, at a more closely knit body, encouraging interest in all the activities represented there, so that the principal functions of the individual clubs do not coincide with one another and the support of all the group can be encouraged for any one event.

The B.M.S.A. subcommittee similarly concerns itself with matters appertaining to the national representative body.

At once it can be appreciated that two things have been achieved. The agenda for Council meetings has been reduced and directed to matters of general application, while an attempt is being made to establish a much closer relationship between the clubs and societies thereby encouraging the student body to support fully the outstanding events of each club calendar.

Ex-Council members will notice that there is a third advantage in a small Council, latecomers are no longer forced to perch on the drafty steps of the Small Abernethian Room in the Hospital!

By restricting the majority of the Council seats to year representatives it is hoped that this will lead to a greater sense of responsibility to the students represented. The preclinical students now find that they are not outnumbered as heavily by clinical students as when all the club secretaries were members of Council, and Charterhouse Square cannot be so readily dismissed when time is pressing for the meeting to be brought to a close. The five minutes walk between the Medical College and the Hospital effectively dissociates the two far too often and perhaps one might hope that a smaller Council will lend itself to a closer understanding of the differences between the two halves of the medical course.

The Council this year is concerning itself with one major issue—student amenities. In Charterhouse Square the position is not as acute as in the Hospital, although the rebuilding of the gym in the foreseeable future would be most welcome, and the restriction of the number of dances in College Hall has been viewed as a retrograde step by many students. In the hospital the student amenities for comfort have never exceeded the necessities, a room and something on which to sit. Recreational facilities boasted a fives court and a rifle range, once upon a time, not to mention the original "Vicarage Club". The fives courts are now given to oxygen cylinders while the fall of the rifle range to the frightening advance of the records has so far been postponed by the vialiant rearguard action of the rifle club. We know that in the rebuilding adequate provision is being made for students' comfort and possibly recreation, but money and priorities will delay the improved lot for the student by almost another ten years.

The Council's consideration of the problem is divided into an immediate improvement in the Hospital Abernethian Room and a long term approach to student amenities in both the Hospital and Charterhouse Square. In the latter the interest lies in the possibilities held in the extension planned for the hostel. If this will result in loss of the tennis courts then we should like to see alternative facilities provided in the new building. In addition too, one might think about a billiards room and a new situation for the rifle range.

With little prospect of having better student accommodation in the hospital for another seven or eight years, several plans have been considered for improving the Hospital A.R.

No definite plan has been agreed upon to-date, but suggestions have included rearrangement of the room, more small easy chairs and the possible introduction of a bar. It is hoped that a plan will be ready for presentation to the College Council before the half year is out. For the future, the clinical student representatives are considering what facilities they would welcome in new premises.

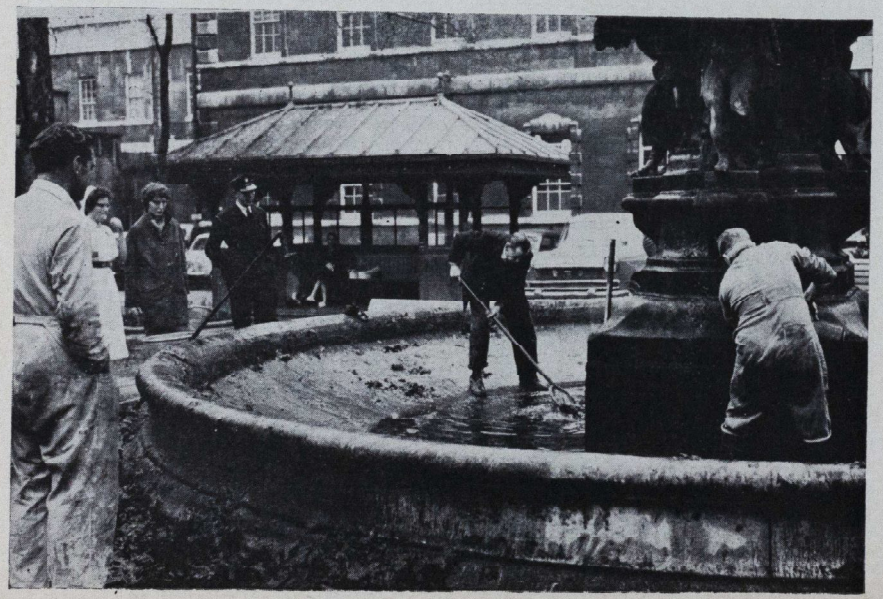
We can but hope that the proper authorities will consider the suggestions the Council makes with the same regard that the students who considered and agreed upon them took in coming to their decision.

The following Barts wares are now available from the student cloakrooms or from the Honorary Secretary, Students' Union.

Blazer badges	27s. 6d.
Woollen scarves	25s. 0d.
Silk Weft Striped tie	11s. 0d.
Pure Silk Striped tie	14s. 0d.
Silk Weft crested tie	16s. 6d.
Pure Silk crested tie	18s. 6d.

CLEANING THE FOUNTAIN

Part of the face-lift that the hospital has been acquiring in anticipation of H.M. The Queen's Visit on May 30th, an account of which will appear in a subsequent issue.



OPEN HEART SURGERY

By Bertrand Wells

DURING THE LAST ten years there have been very great advances in the surgery of heart disease. Operations on the open heart to repair congenital and acquired lesions are now comparatively safe. Nevertheless, there remain many operations which are better performed by closed methods. The closed methods apply to operations for persistent ductus arteriosus, coarctation of the aorta, constrictive pericarditis and mitral stenosis. Aortic stenosis at the extremes of age or when combined with mitral stenosis is better treated by closed valvotomy. A closed valvotomy is also better for pulmonary stenosis in infants or very young and severely ill children. It would be true to say that at the present time there are few centres where open heart surgery of any sort is readily undertaken under the age of four years.

Simple Hypothermia

Open heart surgery entails the arrest of the circulation so that the blood can be aspirated and the required surgery conducted under direct vision. Circulatory arrest for more than two and a half minutes at normal temperature usually causes permanent brain damage. By cooling the anaesthetised patient to 30 degrees centrigrade it has been shown that the circulation may safely be stopped for about nine minutes. Such cooling is achieved either by cooling the whole patient prior to surgery or by pumping the venous blood through a heat exchanger and back to the venous system. With either method it is dangerous to let the temperature fall below 30 degrees centrigrade because of the danger of ventricular fibrillation. If this should occur the circulation can only be maintained by cardiac massage which makes rewarming difficult and may damage the heart. The time limitation of simple hypothermia has more or less restricted its application to two conditions. Simple atrial septal defects may be sutured through an incision in the right atrial wall. This incision is first clamped while the circulation is restarted, and later sutured at leisure. Valvular pulmonary stenosis may be relieved under direct vision through the pulmonary artery which is likewise closed after the circulation is restarted. There is, however, no time to resect an infundibular stenosis and when this may be present the case is unsuitable for simple hypothermia. In fact the only reason for the continued use of this method is that the mortality in good hands is under one per cent.

Profound Hypothermia

The body temperature may safely be dropped to 15 degrees centigrade provided that the heart is not required to maintain the circulation. Mr. Charles Drew of the Westminster Hospital, has very successfully used a technique whereby the left atrial blood is pumped via a heat exchanger into the femoral artery and when the right heart fails the right atrial blood is pumped into the pulmonary artery. When the required degree of cooling is achieved the great vessels are clamped and the operation performed on a quiet dry heart. At 15 degrees centigrade the time available for surgery is about an hour. This represents a slight time limitation for difficult operations but allows any kind of intracardiac surgery to be performed.

The Pump Oxygenator

A more conventional and widely used method of circulatory arrest is the heart-lung by-pass. The method first used in humans only six years ago has been pioneered in this country by Dr. Denis Melrose of the Hammersmith Hospital. Venous blood from the superior and inferior venae cavae falls by gravity into an oxygenator. Here by one of numerous methods it is exposed to oxygen usually with 2½ to 5 per cent. carbon dioxide. The blood is then pumped through a heat exchanger and filter into the femoral artery. Thus the instrument by-passes both heart and lungs and may be run for two hours or more while any form of intracardiac surgery is performed. If the aorta has to be clamped because of aortic incompetence or the need to operate on the valve itself then the cessation of coronary flow causes anoxia of the myocardium. In such cases damage to the myocardium may be prevented by cooling the patient to 20 degrees centigrade or less before cross clamping, or by selective cooling of the heart alone.

The operations performed with cardiac by-pass or profound hypothermia will be increasing in number during the next few years. At present these methods are applied to atrial septal defects in which the defect goes right down to the mitral and tricuspid ring (ostium primum defect) or is continuous with a ventricular septal defect (persistent atrioventricular canal). Such a defect requires the use of a patch and perhaps the repair of a cleft mitral valve and is differentiated from the simpler atrial septal defect (ostium secundum) by the electrocardiogram. When the electrocardiogram is ambiguous the operation is better performed under by-pass. A secundum defect with right pulmonary veins entering the right atrium may also be better corrected with the greater time afforded by cardiac by-pass.

The repair of a ventricular septal defect always requires a by-pass or profound hypothermia. Many such defects require a patch which must be sutured with care because the conducting tissue usually lies in the margin of the defect and a badly placed suture will cause complete heart block. If complete heart block should occur, wires are sutured into the heart muscle and brought out through the skin so that the heart rate can be maintained by an external electrical pacemaker. When pulmonary stenosis exists in addition this must be relieved. Such a combination is usually considered as Fallot's Tetralogy when there has been cyanosis before operation. Although such patients may be subjected to a complete correction in one stage there is a rather high mortality amongst the more severely cyanosed ones and post-operative bleeding is troublesome in the older patients. Severe cases especially with a small pulmonary artery on angiocardiogram are therefore still treated by a palliative closed operation. This would be either a subclavio-pulmonary artery anastomosis (Blalock operation) or closed pulmonary valvotomy or infundibular resection (Brock operation).

Valvular pulmonary stenosis causing a very high right ventricular pressure and all cases of infundibular pulmonary stenosis require by-pass surgery. Aortic stenosis requiring surgery at other than the extremes of age should be relieved under direct vision with profound hypothermia, or by-pass and coronary perfusion. The repair of mitral incompetence by closed methods has been unsatisfactory and improvement can now sometimes be achieved by open heart surgery.

There are various conditions which have on occasion been corrected by open heart surgery. Aortic incompetence may be relieved by making the valve bicuspid by the excision of one cusp or sewing two cusps together. Complete transposition of the great vessels has been corrected by redirecting the venous return by flaps of atrial septum. Total anomalous venous drainage has also been successfully corrected. No doubt further developments will be made in the near future. So far the long term use of cardiac by-pass to nurse a patient through a major cardiac infarct has met with little success but further progress will no doubt be made in this direction.

This has been a general survey of open heart surgery. It might be ended on a more personal note by describing a case from amongst the fifty who have had open heart operations under heart lung by-pass in our Thoracic Unit.

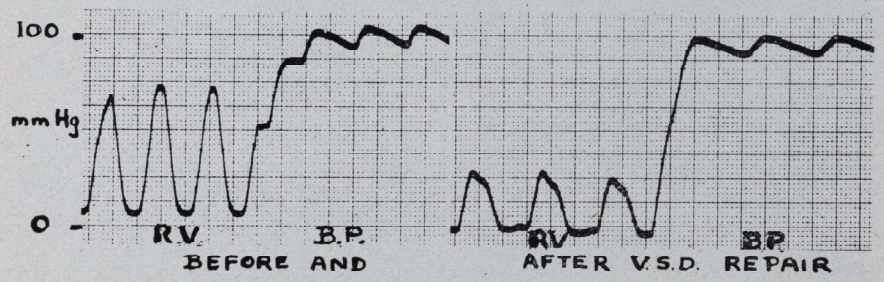


Fig. 1. *Pulmonary artery pressure at first operation showing minimal fall on trial occlusion of patent ductus arteriosus.*

R.C., aged ten, had an operation at the age of six years for a large persistent ductus arteriosus. A trial occlusion of the ductus at thoracotomy caused a minimal reduction of pulmonary artery pressure from 128/86 to 125/70 (Fig. 1). This indicated that there had been a predominent left to right shunt through the ductus. The ductus was divided by Mr. O. S. Tubbs and after operation the residual murmur of a ventricular septal defect was present. Four years later recatheterisation of the heart showed a considerable left to right shunt at ventricular level with moderately raised pulmonary artery pressure. It was decided that the defect should be closed and this was done by Mr. O. S. Tubbs with a heart lung by-pass of forty minutes. The repair of the defect caused the right ventricular pressure to fall from 60/5 mm. Hg. to 30/3 mm. Hg. with a rise of systemic arterial pressure from 100/85 mm. Hg. to 110/95 mm. Hg. (Fig. 2). The patient is now quite well a year and four months later, being completely cured of both lesions. The case is of interest because of the satisfactory outcome despite the minimal fall of pulmonary arterial pressure on trial occlusion of the ductus at the first operation, and because of his normal pulmonary vascular resistance four years later as indicated by his normal right ventricular pressure after the closure of the septal defect.

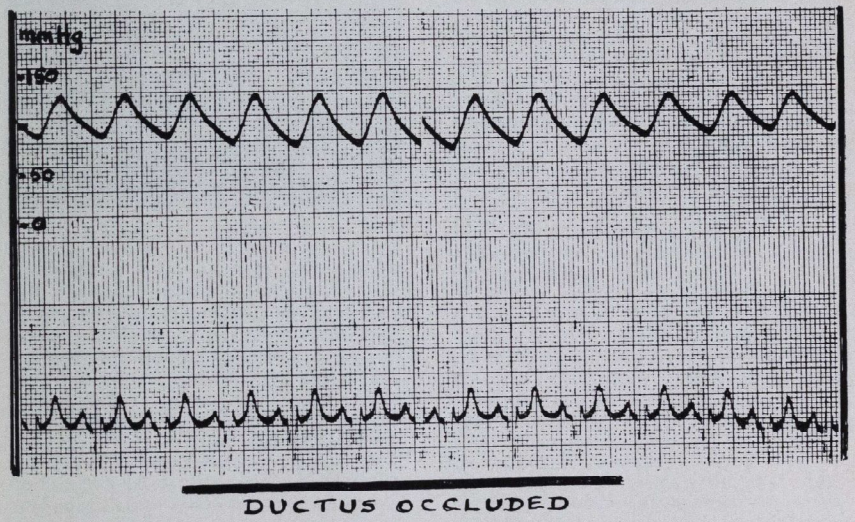


Fig. 2. *Right ventricular pressure (R.V.) and systemic arterial pressure (B.P.) before and after repair of ventricular septal defect.*

THE SCHWEITZER HOSPITAL

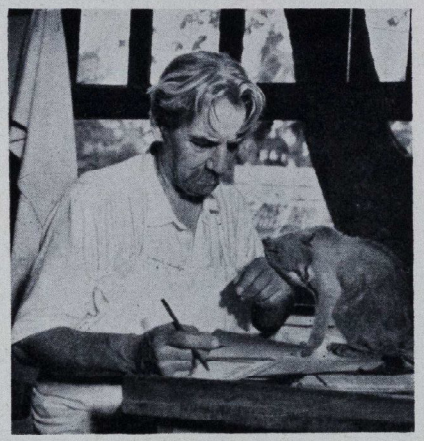
By Fergus Pope

THE REPUBLIC OF the Gabon straddles the equator on the West coast of Africa. The republic is larger than the United Kingdom, but contains fewer than half a million people. The Gabon was, until its independence in 1958 one of four administrative regions of French Equatorial Africa. Now the Gabon is a member of the French Community and is politically aligned slightly right of centre.

The Gabon has very little in common with Ghana and Nigeria. The main road through the country is unpaved and in places rocky and rutted for seasonal rains use the road as a river bed. Every 15 miles or so along the road there is a village of some fifty people. In between these large villages are smaller ones, with a few houses of thatch and bamboo. Occasionally nowadays one sees a wooden plank house set on a cement foundation, but these are rare outside the cities. At any village along the way where one stops one is welcomed and fed. At nightfall each village is open to travellers passing by on foot, bicycle, or truck. Doctor Schweitzer's village is also open to visitors, and these days there are many.

They usually come by airplane, city hopping as it were, across Africa. The air view of the Gabon is monotonous, the monotony of the green equatorial jungle broken only by the dotted rooftops of an occasional village. The Lambarene rooftops in contrast are tightly packed together and the tin roofs have been painted a barn red so as to preserve them. From the Airport the visitors are driven by an airlines Land Rover to the bank of the Ogowe River. Here they are met by a crew of six patients who will paddle them across the river to the Doctor's community. To call the community at Lambarene a hospital is slightly misleading, it is nearer the truth to regard the community as a nursing home with surgical facilities and three Doctors living in. But it is impossible to say where the nursing home ends and the community which supports it begins, for they are one. The goats at Lambarene seem no more out of place than the Doctors. People living in the town of Lambarene, which is across the river from the Doctor's community, need only cross the Ogowe river by pirogue and they are at the hospital. For those living farther away, the voyage may take up to a week.

The centre of the hospital is the pharmacy which the Doctor built in 1927. It is a strong building with mahogony beams and floor set upon cement pillars. The sides are screened to let light and breeze in, but to keep mosquitoes out.



Dr. Schweitzer with Cissi

Today the Gabonese have a choice of several hospitals to which they may go. The urban and city population usually attend the big hospital in the capital Libreville or one of the outlying regional government hospitals. The village people usually come to Lambarene. But many people, Gabonese and foreign, find conditions at Lambarene too primitive for their taste.

On arrival, non-emergency patients seek out a Doctor of their choice and wait in his queue during consulting hours, Mondays, Wednesdays and Fridays. If they come from far away they are admitted even for minor conditions unless they have relatives in a nearbye village with whom they would rather stay. Those patients admitted stay on until they can go home with no further treatment. Ambulatory in-patients come to the pharmacy whenever they need bandaging or medicine. Otherwise they are on their own.

Emergency cases requiring surgery are dealt with on arrival. Most of the emergency surgery is done for road or work accidents, strangulated herniae, or obstetrical catastrophes. Routine surgery is put on the waiting list for operation on Tuesdays, Thursdays or Saturdays. A year may go by without any major abdominal surgery. Most of the routine surgery is for herniae or gynaecological conditions. Some tumour removals are attempted and lately skin grafting for tropical ulcers and elephantiasis has become frequent. Though the wards are far from clean, post operative sepsis is not a major problem.

Each morning at 6.30 a small crew of regulars come up the hill to roll call on the veranda outside the Doctor's room and begin their morning chores. These men are ex-patients who have stayed on to help the Doctor. They are given lodging, food, and pocket money as are the nurses and Doctors. They work according to their ability at jobs which need to be done. The jobs are varied for Lambarene is nearly self-sufficient and an attempt is made to provide some 800 community members with the essentials of life. Tailoring, gardening, plumbing (crude), farm animal care, and general maintenance work are among the duties performed. While the day begins up the hill, the patients stir down below in the hospital and go out to the river and bathe. At 8.00, after breakfast, the crew of regulars is augmented by some twenty to fifty guardians. The guardians are men, women, and youths who have come with their families and while the sick are cared for, the able-bodied work for the community. The women do gardening or help with household chores and the men do general maintenance work or help in the plantation. And they have probably never worked so hard in their lives.

During the last twenty years the Doctor has practised very little medicine or surgery himself. He wants always to know about anything going on which is out of the ordinary but otherwise medical and surgical matters are left to the staff. His time has gone towards enlarging, improving and running the hospital community.

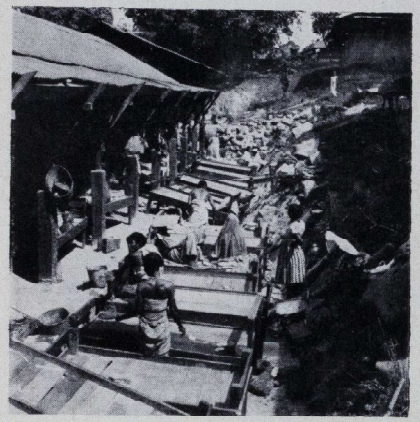
In the last five years the in-patient capacity has nearly doubled. There are five large wards with about twenty-five beds apiece and many smaller wards. When a new patient arrives he hangs a rectangular mosquito net over his bed and under this he and his family live in privacy. If his children are grown they sleep on the floor nearby. The daily ration consists of a large cup of rice or seven green plantain bananas. The patients supplement this with fish from the Ogowe and palm oil sauce pressed from palm nuts grown in the forest. Many villagers grow manioc tubers and bring them to the hospital to sell, but still there is a food shortage. Very few Gabonese eat sufficient protein and the country cannot yet grow enough food for its people. But what food there is for each family is cooked in an iron pot over an open fire protected from the seasonal rains by a wide over-hanging roof. The wards are full and there must be constant vigilance to keep them clean. The nurses do what they can, but there is much progress to be made.

In some of the smaller six bed wards, the Doctor built a second tier of bunks so that an extra six patients could be housed. This scheme worked well so many wards have been similarly modified. The second tier bunks are on the sides of the room and don't interfere with the light or ventilation. When all the beds are full the hospital limit of 400 patients is reached. In addition there is room for 200 patients and their families in the adjacent leper village. Here each family has one sleeping room and a kitchen in a separate building across an open alley-way. The great advantage of this system is that smoke from the cooking fires does not enter the sleeping room. The lepers usually stay at Lambarene for life and they form the nucleus of regular workers. Though they live apart, they work together with the other guardians. It would be medically correct to separate the uncontaminated children from leprous parents. In fact, the incidence of contagion is very low and the problems caused by breaking up families are considerable.

As the number of beds increases, so additional staff quarters are needed. Six new three-room bungalows for African staff and one new dormitory for visiting staff have since been built. The bungalows house African nurses who have been trained on the job. Most of them are ex-patients who have been helping at the hospital for many years. Constantly one is on the lookout for suitable patients who might be persuaded to stay on and help. There are never enough.

In 1959, a new pre-fabricated aluminium maternity ward was installed. This is now full to overflowing for there are about 200

babies a year being born at the hospital. It's too early to say if the new maternity ward will prove as sturdy as the older buildings, but it certainly does give us a bright modern look.



Saturday morning bed washday at Lambarene.

Between the big building projects there are smaller jobs which demand attention. The three hospital rowboats need frequent repair, for the Ogowe is a rocky river and dangerously shallow in the dry season. Last summer a new diesel water pump was installed which will pump water up to the vegetable garden. This garden supplies the staff with all its vegetables and owes its verdancy to the goats whose manure is collected each night and to the water which for thirty years has been carried from the river each day during the dry season.

When I left the Doctor last October, he was finishing the road on which he has been working for over a year. The government has now put a caterpillar at his disposal. Several miles have been finished and cobbled with stones in the hopes that the rains will not wash away the surface. The road is a lifeline today, for the hospital's big Mercedes truck each week scours the countryside for enough manioc and bananas with which to feed the hungry community. They have not enough food to feed themselves.

Nearly everyone with whom I have talked about Lambarene has sooner or later raised a query as to the future. The first question is usually " who will take over the hospital? " There is of course no reason why anybody need " take it over ". The question might better be asked will there ever be enough staff. Personally I believe there will be a shortage of trained people for a very long time to come. The second question usually raised is " will the hospital continue? " Yes, I think it will and that will be the test of how solid a foundation the Doctor has laid.

Missing Books

SEVERAL LIBRARIES WITHIN the Hospital and College have suffered from books being removed from the shelves without being signed for, and this is causing great inconvenience to other readers.

A notice is displayed in the Dunn Library requesting the return of missing volumes; a recent check of the Kanthack Library has revealed several bound periodicals to be lacking; and the Medical College Library has recently replaced by purchase a large number of textbooks that had been taken without signature. The money would have been spent to better advantage in buying new books and extra copies.

It is extremely difficult, and sometimes impossible, to replace volumes and parts of periodicals, and readers of this note are earnestly requested to return to the College Library all books that they might have in their possession, or might find in cupboards, drawers, lockers and rooms, and which obviously belong to one of the libraries in the Hospital or College. While in the libraries, the books are made available to a large number of readers; hidden away, they can only be a burden on the consciences of those responsible for their illegal removal.

A FURTHER EPIDEMIC

By L. S. Castleden

THE USUAL SEASON for gastro-enteritis is high summer, so that it was somewhat surprising when, towards the end of February, cases of diarrhoea and sickness appeared in the practice.

Generally these were mild with both vomiting and diarrhoea for twenty four hours followed by a looseness of the bowels for a few days.

However, several young children were quite ill, with high fever and headache. The stools in these cases were mucoid and with flecks of blood and pus. Vomiting and colic were tiresome.

From one of these cases a non-lactose fermenting organism was isolated which turned out to be *Shigella sonnei*. It was then noticed that the majority of the cases were children aged 5–10 years attending the largest local primary school, and we have now isolated the same organism from no less than 24 cases. The aid of the local Medical Officer of Health and his staff was sought and more cases came to light as contacts were checked. It now seems likely that the outbreak originated in the school, and the children then infected their brothers and sisters, or even parents, unless the hygiene was really good.

Two parents who were also infected are " food handlers " employed in shops, etc., and they have had to suffer economic loss by staying at home until their stools are free of *Shigella sonnei*.

The organism was carefully cultured and found to be resistant to sulphonamides, but sensitive to chloramphenicol and neomycin. Here the G.P. has a problem. Before the above result was known sulphaguanidine had proved to be clinically effective, although the organism did not disappear at once from the stools of all patients. In such a mild epidemic it does not seem justifiable to use expensive antibiotics—especially those which have been reported to produce occasional disastrous effects such as agranulocytosis. Nor has it been found that the persistent carrier is rendered normal by the most energetic treatment with these antibiotics. At the same time it must be realised that there are probably a lot of undiagnosed mild cases in the town also untreated.

Accordingly a campaign to improve prophylactic hygiene has been launched. The more severe cases are treated chemotherapeutically: the milder cases are given some such mixture as chalk and opium, and fluids only, for twenty-four hours, followed by a low residue, cold, diet.

Two cases which particularly interested me because I have been caught out by one like them before were as follows:

Case 1. A girl, aged 11, had had a " tummy upset " with vomiting and looseness of the bowels, commencing on the Saturday. She did not have much pain, nor did she seem to be ill. On Sunday she was a bit better, but on Sunday night she could not sleep, " because of pain in the stomach ". I was called on the Monday.

She was an intelligent little girl, and at once her story of a constant throbbing pain in the right lower abdomen, which was unlike the mild griping which had accompanied the " tummy upset ", suggested the diagnosis.

Examination showed well marked tenderness in the right iliac fossa, and some guarding. Temperature was slightly raised and tongue was slightly furred.

An acutely inflamed appendix was removed that day.

Case 2 was a little boy aged 6. His brother had had the dysentery four days before. The patient was up all the Sunday night with diarrhoea and vomiting. He was a little better on Monday when the vomiting began to abate.

Examination that day showed the temperature to be 99.6 F. Pulse rate was 90 per minute. His abdomen was soft and rather noisy bowel sounds were audible. What little pain he had originated in the right lower abdomen and rumbled up and across and down to the left abdomen culminating in a desire to defaecate. He had had bilateral congenital herniae cured, but the scars were sound and there were no signs of obstruction. He was given phalyl sulphathiazole 0.5G four hourly.

His mother telephoned on the Wednesday to say that he was worse. The pain was now constant and her description on the telephone was such that he was seen at once.

He looked more ill. Temperature was

100.6 F. Pulse rate was 120 per minute. He was "sore in the tummy" when he walked. The abdomen was now rather "stiff", with quite definite tenderness and guarding in the right iliac fossa. The appendix was so inflamed that it was unduly fragile at laparotomy although perforation had not actually occurred.

Is it that the gastro-enteritis, by the excessive activity of the intestine, causes mechanical stimulation of a previously infected appendix? Or, alternatively, does the lymphoid tissue of the appendix become directly involved by the dysentery organisms? Perhaps the pathologists and surgeons will give their opinions. All I know is that the "acute abdomen", which is at once the fear and the joy of the G.P., is much more common during these epidemics. It also prevents too complacent an attitude to "tummy upsets".

I HAVE BEEN asked as a Pathologist to comment on the questions proposed by the author of this paper.

With the exception of new-born infants, all healthy appendices contain potentially pathogenic organisms which are part of the normal flora of the intestinal tract.

It is now generally agreed that "obstruction" is the great causative agent in acute appendicitis and swelling of the lymphoid tissue and mucosa of the appendix, which may occur in inflammatory conditions of the intestine, is recognised as one cause of obstruction.

Obstruction allows secretions to accumulate, which raise the pressure in the lumen and this causes compression of capillaries and veins resulting in oedema of the wall of the appendix. This results in more fluid being poured into the lumen and finally the arterial supply is cut off. Meanwhile the organisms normally present in the appendix can readily invade the mucosa as the wall of the organ gradually becomes devitalised and loses the resistance to infection. A diffuse infection of the wall then occurs.

With this explanation in mind, the author is largely correct in both his suggestions, although from a pathologist's point of view there is nothing special in a "previously infected appendix" as we all have them, and the organisms of *Sonne* dysentery are probably only of importance in that they are responsible for the acute inflammation of the intestine and play no direct part in the causation of the acute appendicitis.

B.S.J.

LETTERS TO THE EDITOR

DEAR SIR,—Mr. Millington is perfectly correct in saying that it is possible for students to visit general practitioners, and I think it is a good idea that they should do so. Many will know of doctors already, whom they would like to visit; but if advice is wanted Dr. McKane, of this office, has a huge list of prospective hosts, and I and many other members of the staff would also be glad to come forward with suggestions.

Though it is not true that a majority of students finally settle in general practice—only about a third do so—it is, I agree, a good idea that students should learn something about it. But I do not think it should be made much of in the undergraduate curriculum. Prolonged visits are certainly not in the curriculum at the present time, and students can only undertake them therefore during their ordinary holidays. But they can easily, on their own initiative, arrange a number of day or half-day visits during their clinical course.

If they visit several different doctors they will notice how astonishingly great are the differences between them even though all are clearly good at their work; how misleading it might be if this College were officially to recognise a handful of "good G.P.'s" when all good ones are so grotesquely different from all other good ones; and how this very individual sort of medical practice, being a reflection of the practitioner's own personality, is not a suitable subject as a part of any academic curriculum. And I think they will agree that the doctor has to work so fast that only a post-graduate would have any hope of keeping up with him, or of learning at all critically what is really going on.

However, I should be delighted to give names and addresses of some doctors who, I know, would be of great interest to any student who cared to visit them.

Yours faithfully,
(Dr.) H. Wykeham Balme.

SPORTS NEWS

Viewpoint

WITH THE ADVENT of rockets came Societies who in all seriousness, mainly commercial, started to consider the exploitation of the moon. This seemed far-fetched, and yet today—with the return of the first man from space—is it beyond reality? This poses some interesting problems.

It is only recently that we have become obsessed with fact and figures and records (of all varieties). The ancient sportsmen was concerned with winning a given race or throwing more than his rival at the time. But the last fifty years have brought records into prominence—one of the reasons for super-dedication and professionalism.

What happens if man manages to establish himself on the moon? Each one of us must remember being told at school, by a harassed physics master trying to explain the principle of gravity to a lot of dunderheads, that man would be able to jump three or four times the world record (earthly)—its all a question of relative masses or so Newton would have us believe.

Think for instance of Hayward's record of 176 yards being surpassed by Sobers with 500 yards; or a long jump of 50 feet, or a discuss throw of 600 feet. For one thing all our arenas and stadiums would have to be vast otherwise a systematic annihilation of the spectators would result (or perhaps they could sit in iron-plated space suits). Then think of golf—one mile for one hole—would take ages and eliminate the over 40's (a good thing).

So all is well; perhaps it is better man restricts his sport to earth, and leaves the cosmos to rockets and unwanted Soviet generals.

Rugger

Sat., Feb. 25th

1st XV v. Oxford University Greyhounds. Drawn 8–8.

With slower backs and heavier forwards, the wet and slippery conditions were to Barts' advantage but this was offset by a first-half back injury to R. R. Davies which necessitated his leaving the field. R. V. Jeffreys took over from Davies and proved a more than useful substitute. Bart's took an early lead with S. G. Harris's penalty goal, but the Greyhounds, playing in assorted borrowed jerseys, scored a try and a goal from moves initiated by their stand-off. When Davies left Bart's played with much more fire and several foot rushes looked dangerous, but it was not until the final whistle was imminent that D. Goodall, who had played a fine game, picked up in the loose and dived over after a good run by Ross. Harris converted to put the scores equal.

Team. Ross, Harris, Stevens, Niven, Jeffreys, Davies, Chesney, Hamilton, Gurry, Jennings, Doran, Orr, Davies, Smart, Goodall.

Sat., March 4th

1st XV v. Streatham (Home). Lost 3–19.

In cricketing weather, Streatham ran up two goals, two tries and a penalty goal to one try in a fast game at Chislehurst. They were quickly on the attack and by half-time had acquired 16 points through strong running and passing in which their large Maori "No. 8" usually figured prominently and assisted by some half-hearted Bart's tackling. After the interval the Hospital came much more into the game and launched several attacks that were only scotched by bad finishing; eventually however, J. E. Stevens crashed over on the blind side. Streatham ill-tolerated this minor insult and responded with a pushover try, but at the end Bart's attacked vigorously and three times in the last five minutes the predatory covering of

the abiquitous Maori, apparently unsatisfied with his three tries, prevented a potential Hospital score.

Team. Ross, Stevens, Letchworth, Niven, Harris, Jeffreys, Chesney, Hamilton, Gurry, Jennings, Doran, Orr, Davies, Smart, Goodall.

Sat., March 11th

1st XV v. Aldershot Services (Away). Lost 6–12.

J. K. Bamford returned to stand-off for this match and his enthusiastic opportunism produced a disallowed try, several near misses and a neat dropped goal in the early stages. D. Goodall then crossed wide out following a well-judged kick ahead, in reply to the Services' penalty goal. So to the changeover with Bart's only 6–3 up, but well ahead "on points". However, in the second period the Services' pack bulldozed their way to supremacy and loose kicking and intrepid tackling let in two unconverted tries. Thereon the Bart's backs occasionally flickered promisingly but a late run to the corner by an opposing centre for an unconverted score finally extinguished the Hospital fire.

Team. Ross, Stevens, Letchworth, Niven, Jeffreys, Bamford, Chesney, Hamilton, Gurry, Jennings, Doran, Orr, Davies, Smart, Goodall.

Sat., March 18th

1st XV v. Stroud (Away). Won 5–3.

The 1st XV registered their first win since November when they beat Stroud by a goal to a try. Bart's dominated the loose play in the early stages and their try came when good backing up put A. J. S. Knox over after a run by R. V. Jeffreys, J. E. Stevens converting with a fine kick. Thereafter, J. K. Bamford hit the upright with a drop and H. G. Jones was almost over in the corner but gradually the home side improved and after the interval several individual efforts by their fly-half almost bore fruit. Eventually a clever change of direction by the latter resulted in former international wing C. G. Woodruff scoring. But for the most part the second period was conspicious only for some scrappy play and a hailstorm. E. D. Dorrell had a fine game at full-back.

Team. Dorrell, Stevens, Letchworth, Niven, Jeffreys, Bamford, Ross, Hamilton, Gurry, Knox, Doran, Orr, H. G. Jones, Smart ,Jennings.

Welsh Tour

1st XV v. Treorchy. Lost 0–16.

On the hard stud-pocked pitches of the valleys of the Dais, Ieuans and Iorries, Bart's intruded briefly into the province of Welsh Rugby. Firstly, to Treorchy where a rugged pack paved the way for an elusive and strong-running back division to carve holes in the Hospital defence, particularly in the centre. Treorchy crossed four times, converting twice to run out clear winners, but not before sustained pressure in the final minutes—when an attack of butterfingers seemingly affected Bart's—had all but produced a Hospital score.

Sat., March 25th **Mon., March 27th**

1st XV v. Glynneath. Lost 9–11.

Fortified by fantastic Rhondda hospitality the 1st XV crossed the mountain two days later to meet Glynneath, reputedly better than Treorchy and defeated only twice in 30 matches this season. Bart's, greatly improved on their previous showing and playing well together slowly gained supremacy and 9 3 up with five minutes left, seemed certain to win, but . . .

A kick ahead, an awkward bounce on the line and three Bart's defenders could only watch a Welshman crash at their feet—9-6. Then a scything 40-yard run to the line by the opposing stand-off, a scrum on the line, a quick heel and Glynneath's "No. 8" was diving through his scrum to put the scores level—the winning conversion from an easy position being mere formality. Thus Bart's succumbed by a goal, a try and a penalty goal to three tries, the Hospital scorers being H. G. Jones (2) and R. V. Jeffreys. The failure to consolidate advantageous situations, a feature prevalent throughout the season, had been finally if cruelly emphasised.

Soccer

Barts. 6 v. Charing Cross Hospital 2 (League Match).

A lovely afternoon at Cobham was further enhanced with a fine victory for Barts. On paper we weren't strong in the forward line and yet we scored six goals. Iregbulem was brilliant and scored a hat-trick of which two goals were superb chips from the edge of the penalty area. Marsh, Ross and Waterworth all deservedly got one each for they had moved fast and passed well.

The defence was unperturbed, although Orr was called upon to make one or two good saves. Delany played a very good attacking game and looked as though he enjoyed himself. The fact that our regular forwards rarely score six must not pass without comment. Although the opposition was weak, it was noticeable that our forwards were always in the penalty area anxious to score when we attacked and that they weren't out to demonstrate their individual skills.

Team. Orr, Jailler, Howes, Savage, Hare, Delany, Marsh, Ross, Iregbulem, Waterworth, Cripps.

THE SOCCER TOUR TO OXFORD

THE SUMMER SUNSHINE of March blazed down on the Bart's party as they set off to play Balliol College on Thursday, 2nd March. Delany, Howes and Om found a lift in Jailler's car a mixed blessing when one tyre was written off outside London Airport and the spare wheel replacement could not cope with the wait at Magdalen bridge traffic lights. However, the ground was reached on foot (with lunch having been abandoned) and battle commenced. Balliol proved a competent side with a fast forward line, but Savage was magnificent in a sound defence and a 2–0 loss was a fair result. Most of the team patronised the local hostelries in the evening in the traditional manner.

Next day we took on St. Peter's Hall; formidable opponents indeed. In perfect conditions on a lovely ground on the Southern By-pass, the Hall began with exhibition football but failed to score. Now Bart's rose to the occasion and no goals were scored before half-time. However, almost immediately after the resumption the Hall went ahead but were then penned back in their own half by our attacks down both wings. Finally, Delany found Stanley with a typical long clearance and Jailler was on hand to score a good equalizer. Play then moved to our half and just before time St. Peter's Hall scored the winning goal, but Bart's had done well. After excellent hospitality, a small number found themselves at a Hop at the Radcliffe. Howes proved a shrewd disinterested observer but with the discovery that no nurses were present attempts at fraternisation were abandoned.

Saturday morning entailed borrowing five players, to complete the side against Christ Church. The captain was further worried by trying to find out whether he had a partner for a theatre party in the evening. The latter proved the greater task! The game itself bore no relation to the other two matches and in a general kick and rush, Manson scored a excellent goal from the right wing and Phillips added another but these proved insufficient for the House scored three.

So the tour ended without a victory, but we had done well both at football and socially. At one time and another the following made an appearance: Om, Stanley, Howes, Delany, Hare, Savage, Hudson, Manson, Phillips, Jailler, Waterworth, Hubert, N. Davies and Choonoo. J.M.J.

Boat Club

BEDFORD HEAD OF THE OUSE RACE

ON SATURDAY, MARCH 11TH, the Hospital made a creditable debut at Bedford, entering two Eights. Following an early start, a morning outing gave the coxswains an opportunity to aquaint themselves with the one and three quarter mile course (including two weirs, two narrow bridges and numerous turns) and the oarsman a chance to adapt themselves to the feel of the water so different from that of the tideway. The first Eight were anxious to give Bennett some time to settle down, having come in as a substitute for Knight at 3, who developed Flu almost at the last minute.

The first Eight had a good row to the Town Bridge, and were well poised to overtake Bedford Town, which they did shortly afterwards. Just before the Take-in the bow four showed signs of strain, and began to hurry their slides, understandably perhaps, with a relatively unfit substitute. Possibly

this stole Dunn's thunder for the Take-in, certainly the rating did not come up naturally. The crew rallied however, and went away from St. Peter's Hall, Oxford and Downing College, Cambridge, who were both beaten by two seconds. Throughout the race Laughnan steered impeccably. The first eight were second in their division to Sidney Sussex College who rowed in a Shell. Out of the forty four crews who entered Bart's, finished 21st overall, being the sixth fastest Clinker Boat that entered.

The Second eight started last in their division and were denied the undoubted impetus of a chasing crew. In this their very first event, which had only one other novices entry, they showed encouraging form, and had a controlled row. In coming fortieth equal with the Bedford School Colts Eight, they can look forward to the Maiden Events of the Summer with confidence.

Of the value of going to this event, timed as it is two week's before the tideway Head there can be no doubt. To both crews it gave valuable experience, and to the first eight in particular it brought the focus of their ability into sharp reality . . . the potential was there.

1st VIII Bow, N. Whyatt; 2, H. Coleridge; 3, B. Bennett; 4, N. E. Dudley; 5, J. D'B. Bartlett; 6, I. Wilson; 7, D. E. King; Stroke, D. C. Dunn; Cox, N. Laughnan.

2nd VIII Bow, T. Hamer; 2, B. Lee; 3, D. Robins; 4, M. Aveline; 5, G. McElwain; 6, I. Basharatulla; 7, B. Garson, Stroke, R. Anderson, Cox, I. Cole.

Two coaches accompanied the crews P. Mansell and T. Hudson whose presence on the towpath was greatly appreciated.

THE TIDEWAY HEAD OF THE RIVER RACE

THREE HOSPITAL VIII'S took their positions on Saturday, March 25th for this year's race which boasted a record entry of 293 crews, from all over the country. Field Marshal Sir Francis Festing, G.C.B., K.B.E., D.S.O. started the race. The course as usual was from Mortlake to Putney (the Boat Race course in reverse) a distance of 4½ miles approximately.

The 1st VIII arrived at the start in a healthy state of tension and struck 10.20.38 in the first minute. The start was a good one and set the tone for the first part of the race. The "flying-start" introduced this year (already experienced at Bedford) made for closer racing and must have accounted for much of the over taking during the early stages. It was gratifying that the crew managed to settle down and maintain a steady 32, shooting Barnes Bridge at 34 and reaching Hammersmith in one of the fastest times recorded by the hospital. The crew then began to feel the strain of the heavy clinker boat and the rating dropped dangerously low —past the mile post it was recorded as 26. Meanwhile our chasing crew, Beaumont College, who had been a speck on the horizon started to come up and we answered none too soon. At Beverley Brook we started to "take her in" and once more the rating rose above 30. The hospital rapidly took a length off Beaumont and still racing well reached the finish utterly rowed out.

It must have been disheartening for the 2nd VIII to inherit such a high starting position from last years highly talented Gentlemen. It was inevitable that they would be overtaken by numerous crews. It was, however reported from Barnes that the crew was using the faster boats intelligently and that Anderson was controlling any tendency to rush.

The "Gentlemen" rowing as the Hospital 3rd VIII clearly enjoyed their exercise and, with shoulders well braced back and olfactory regions athwart the sky, overtook their London Hospital counter-parts in great style. The prospect of returning to Chiswick was obviously not to their liking for they promptly ran aground on the Fulham Flats and after wading ashore, retired to the bar at London Rowing Club and were seen no more.

At the time of going to press the official times and placings are not yet available. Unofficially the 1st VIII went up one place on last year to 3rd with King's College, London, in a time of 20.39 sec. It appears that Bart's may have been the first hospital crew home. The 2nd VIII in coming 252 beat the Westminster and London Hospital 2nd VIII's as did the "Gentlemen" who came 278.

1st VIII Bow, N. Whyatt; 2, H. Coleridge; 3, A. H. Knight; 4, D. C. Dunn; 5, J. J. D'B. Bartlett; 6, I. Wilson; 7, D. L. King; Stroke, N. E. Dudley; Cox, J. U. Watson.

2nd VIII Bow, T. Hamer; 2, B. Lee; 3, D. Robins; 4, M. Aveline; 5, G. Mc. Elwain; 6, I. Basharatulla; 7, B. Garson; Stroke, R. Anderson; Cox, I. Cole.

3rd VIII Bow, D. Hardy Esq.; 2, M. Thomas Esq.; 3, I. H. Wan Ping Esq.; 4, R. G. Wilson Esq.; 5, M. Stewartson Esq.; 6, P. Scriven Esq.; 7, Dr. C. Dale; Stroke, K. Stevens Esq.; Cox, T. Hudson Esq.

Ladies Hockey

Sat., Feb. 18th

Semi-Final U.H. Cup v. St. Thomas's Hospital at Chislehurst. Won 11–0.

This was a good match, if a little one-sided. Our defence was not really tried, but played well when St. Thomas's attacked, and soon gave our forwards the ball again. The half-backs deserve special mention for good play. Our forwards gave one of the best performances this season, and although to win the cup we shall have to improve, this was most promising. It is impossible to remember who scored goals, but they were well distributed throughout the forward line, a further indication of the improved combination by the forwards.

Team. C. Lloyd, J. Thoroughgood, G. Turner, M. Childe, E. Knight, A. Coates, A. Callaghan, R. Hall, R. Walters, S. Minns, S. Cotton.

Sat., Feb. 25th

U.L.W.H.C. Inter-Collegiate Woman's Hockey Tournament.

v. Goldsmith's. Lost 0 5.

v. R.F.H. and Q.M.C. Combined XI. Lost 0–3.

The tournament was played at Motspur Park in pouring rain. Bart's fielded only ten players, consequently could not hope for much success. Play was as good as the circumstances permitted, but neither game could really be described as enjoyable! We left the field wet, cold and coated with mud.

Team. C. Bostock, J. Thoroughgood, G. Turner, M. Childe, J. Evans, E. Knight, R. Hall, P. Jumar, S. Minns, S. Cotton. Umpire: S. Weekes.

Wed., March 8th at Royal Free Hospital ground.

Cup Final v. St. Mary's Hospital. Lost 7–4.

ALL GOOD THINGS come to an end sometime. Professor Wormall hoped to present the Shield to Bart's for the eighth successive year, but a very much stronger Mary's team took it instead.

The pitch was firm, but the insipid sun barely penetrated the haze; good conditions, excellent play, but only a small band of supporters to echo Dr. Lehmann's "please" for goals.

Mary's attacked continuously for the first quarter, only a desperate defence kept them at bay. Bart's suddenly turned on the pressure and their second attack enabled Minns to score. Two more well-constructed attacks within the next eight minutes brought two more goals through Hall. Then a couple of right wing raids reduced the arrears for Mary's, an unfortunate easing up on the part of Bart's. The half-time score was 3–2.

After the interval the side seemed to tire, the forwards struggling to break out from the close-marking defence, the defence having great difficulty in coping with the fast Mary's attack. This speed, aided by some poor clearances, enabled our opponents to hit four more in the next twenty minutes. The defence marking was ragged, few recovering to tackle-back once they were beaten; often there were five Mary's forwards with only a couple to mark them.

A last glimmer of hope came when Callaghan went through to score, following their sixth goal bully. Mary's added a seventh before the end.

The girls put up a good performance against a superior side: they might have done better had they had the attendance the Rugger XV expect for their matches. As it was their five vociferous student supporters were far outnumbered and rather hoarse by the close. B.J.S.

Team. C. Lloyd, J. Thoroughgood, A. Coates, M. Child, J. Evans, E. Knight, A. Callaghan, R. Hall, R. Walters, S. Minns (Capt.), S. Cotton.

Sailing Club

THIS YEAR, THE icicle seems to have melted before it had time to form, and it was on one of these halcyon days of warm spring sunshine and tantalising winds that three Bart's helmsmen, complete with crews assembled at the Welsh Harp to compete in the "Castaways Cup", a knock-out team racing competition between the London colleges.

The form of the previous summer was not maintained, and after winning two rounds, we were gently but firmly thrust ashore by Northampton College in the quarter-final.

Saturday morning saw us competing with Chelsea college who boasted a strong team. Fortunately, by accident or design, the winds seemed to favour us, and after winning the first race by the narrow margin of a first, a fourth and a fifth, we confirmed our superiority with a first, a third and a fifth, though considerable suspense was provided when our leading boat was becalmed two yards from the line and overtaken by the two boats behind.

In the afternoon, the winds strengthened, and we had two interesting races with Birkbeck College, both of which we won. The second, perhaps, deserves a mention as, although we came first, second and third, our opponents entered protests against Spivey for baulking and Mulvein protested one of their helmsmen for not taking avoiding action before a collision. Fortunately, our protest, being heard first, was upheld and our opponents withdrew theirs.

Sunday dawned much as Saturday, and there was no wind until 10.15 a.m. Our opponents, Northampton College put up a good team containing two University of London helmsmen and we expected a good race.

The first race was disappointing, as we were in a winning position with first, third and sixth until Fischer was "luffed" out about 50 yards from the finish. This left us dispirited and in the second race, Northampton College did nothing wrong to gain victory with first, second and fifth.

Individually, the Hospital helmsmen sailed well, friction (of all sorts) with other boats being kept to a minimum, but as a team, it was regrettable that we were either too far separated, or too closely bunched, and not able to contain or cover the "enemy" adequately.

Team. J. Spivey, R. M. Benison, W. G. Fischer, R. K. Davies, W. M. Jory, A. M. Pollock, J. T. Mulvein.

BOOK REVIEWS

THE CATARRHAL CHILD by John Fry, M.D., F.R.C.S. **Butterworths Publications.** 25s.

Dr. Fry is well known for his writing from general practice and his new book. *The Catarrhal Child* is an excellent documentation of 10 years experience as a family doctor in one of London's more salubrious suburbs.

The book gives a good account of the natural history of these only too common respiratory illnesses in children. Although it is a personal series, it is not greatly at variance with the other similar studies which have been undertaken. References in the text make this quite clear. These facts should be useful to those just going into general practice and not familiar with children and help them to see the child with recurrent coughs and colds in true perspective. The book will also help to remind those working in hospitals that they see a very selected group of these children and it leaves no doubt that, in some areas, the indications for tonsillectomy need reviewing.

The important point that Dr. Fry's tables and statistics show is that there is a peak incidence of all these respiratory infections. This occurs somewhere between the age of four and eight depending on the child's contact with other children and sources of infection, social conditions, and on his mother's ability to manage. After the age of eight there is a dramatic fall in the occurrence of all the catarrhal child's symptoms. It is on this background that the effects of any treatment should be measured. In discussing the management of these cases Dr. Fry pleads for a better understanding and liaison between doctor and family to prevent the mother losing confidence and becoming overanxious, rather than depending on a multitude of cough medicines, antibiotics and irrational removal of tonsils and adenoids. He proves with his figures the relative benignness and perhaps inevitability of the respiratory illnesses, and the success of his conservative methods of treatment.

K.H-J.

AIDS TO PHYSIOLOGY by E. T. Waters, D.Sc., Ph.D. 288 pp. 7th edition. **Bailliere, Tindall & Cox.** 10s. 6d.

In the preface the author hopes that his book will supplement the standard textbook. It does not. Whole chapters are wasted on the internal environment, metabolism and blood, subjects that are much better written about in many textbooks of biochemistry and histology. Instead of using space in a small book on related subjects, presumably to preserve the usual inter-subject liasions, the author would have done better to expand chapters of a strictly physiological nature, since it is these which suffer badly from over simplification.

Available textbooks would have to be thin indeed before this little book could supplement them. If the book lent itself to casual reading, I would recommend it only to the ablest student who feels bound to do some quick casual revision before his examinations.

S.C-S.

PHARMACOLOGY FOR NURSES by J. R. Trounce, M.D., M.R.C.P. **Churchill.** 16s.

Dr. Trounce has produced a compact and easy to use reference book for nurses.

It covers a much wider field than might be expected from the title Pharmacology. Medicine is included as in descriptions of paroxysmal tachycardia, atrial flutter and heart block in the chapter on cardiovascular drugs. Nursing appears in many aspects including ways of administering oxygen: Anatomy and Physiology in a chapter headed Autonomic Nervous System.

The text appears clear and concise and the exclusion of latin terminology welcome. However, one would like to see the Metric System taking predominance over the outdated Apothicaries measures. Also the inclusion of Schedule numbers with the text might be more helpful than a long list in the appendix.

Continued overleaf

The diagrams are clear and relevant, particularly the sites of action of hypotensive drugs, which simplifies this extremely well.

One wonders if antiseptics in such detail is still necessary: but otherwise the drugs included are very up-to-date.

The reference list of drugs giving Trade and Approved names is useful and the index comprehensive.

This book would be valuable to both student and trained nurse and is one that is convenient in both size and price.

R.E.B.

AIDS TO THEATRE TECHNIQUE by Marjorie Houghton, M.B.E., S.R.N., S.C.M., D.N. (Lond.) and Jean Hudd, S.R.N. 3rd edition. **Bailliere Tindall and Cox.** 8s. 6d.

In this third edition of their already popular textbook, Miss Houghton and Miss Hudd have revised and brought up to date all aspects of theatre technique necessary to provide a basis in the training of theatre nurses. The layout has been altered slightly to advantage and the book is easy and surprisingly interesting to read.

After covering the layout of a typical operating theatre, there follows an excellent chapter on sterilization which includes reasons and explanations of the methods given which is a great help to better understanding of the subject.

The Theatre nurses duties are clearly set out and these follow a comprehensive chapter on anaesthesia. A list of technical terms precede the lists covering all fields of operative surgery, and this second part of the book is exceptionally well illustrated with good enlargements where necessary. These lists also include relevant details as to procedure and suggested sutures. My criticism here is that the chapter on Eye Surgery is not better illustrated as these instruments are difficult to learn and are needed in emergency work. This also applies to the section on Vascular Surgery which only receives one page.

The book ends with chapters on Traumatic Surgery, plaster and radium work and this ends a book which I can thoroughly recommend to anyone interested in theatre work.

J.A.A.

ST. BARTHOLOMEW'S HOSPITAL JOURNAL

Vol. LXV, No. 5 MAY 1961

Editorial

Most people would agree that the public image of the doctor is not held in such high esteem as it was twenty, or even ten, years ago. This is no isolated case. Most of the humanitarian professions have suffered similarly, most notably the church, but also the law and teaching. There must be many reasons for this lack of faith. Perhaps it is the inevitable result of the great rise in the standards of education in the welfare state.

What status, then, should the doctor hold in the eyes of the public? It would be futile to suggest that he should be looked upon as an infallible, wise and dedicated being; but just that, in any society, by virtue of the job he is doing, the doctor must possess characteristics of integrity and responsibility towards the community which he serves. In order to equip himself for his job the medical student must acquire an awareness of problems outside those of his own immediate sphere.

There is a natural tendency for the student, having decided on medicine as his career, to see himself in the role of the traditional guide, counsellor and friend, and there is an end to it. Having taken the initial plunge he tends to feel that he has dedicated himself to society, and can afford to treat the rest of the world with a certain amount of arrogance and disdain. Within the hospital, through the various social and athletic clubs, his sphere of friends and acquaintances is very largely confined to the medical and nursing professions. The medical student and the debutante, although both would hate to admit it, have something in common in so far as both cultivate a studied indifference to everything outside their own small world.

It has been said that there is a lack of social life within this hospital. Surely any further increase in our communal activities would be burying our heads yet deeper in the sand. What is required of us is that we take the opportunity of being in London to meet people in all walks of life so that we may formulate our own opinions on matters which are important to the community. Our present indifference surely does not promote a better understanding of the patient, which is the one thing so many of us pride ourselves upon. We cannot hope to maintain much respect in this rapidly-moving world if we persist in isolating ourselves from it.