

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



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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.

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Marriage

COLLINGWOOD-HARVEY.—On May 13th, Rupert Collingwood to Carole Ann Harvey.

Births

ADAM.—On March 6th, to Valerie and Dr. Robert M. Adam, a second son (James Thomas).

HADFIELD.—On March 10th, to Beryl and John Hadfield, M.S., F.R.C.S., a daughter.

Deaths

EVANS.—On March 1st, Dr. David Gordon Evans. Qualified 1938.

FEARNEY.—On March 15th, Dr. Allan Baines Fearnley. Qualified 1907.

MARKHAM CARTER.—On March 13th, Robert Markham Carter, C.B., F.R.C.S., Lieut.-Col. I.M.S. (Retd.), aged 85. Qualified 1901.

Parking at Charterhouse

IN RECENT MONTHS there has been much criticism of the parking arrangements at Charterhouse Square, although most of this has been quite unjustified and stems from the sad, but obvious, fact that most of the critics have not taken the trouble to inform themselves correctly, if at all.

Since the beginning of this year when rebuilding at Charterhouse became imminent, Doctor Quilliam has had the most difficult job of re-organising the parking facilities, a task whose only reward, it appears, is abuse. One of his first moves was to contact the Students' Union and after discussing with them the parking requirements of the students, he generously set aside the car park next to the tennis courts for the use of College Hall residents.

Another concession made was the provision of two hour parking for visitors to Charterhouse, although rebuilding has now necessitated the withdrawal of this privilege.

In order that the maximum number of cars be accommodated, and still allow free passage for building contractors' vehicles, parking spaces have been marked out, and, to avoid damage to private cars during the dark winter evenings, lights have been erected to light the parked cars. However, these thoughtful provisions were lately described in the Journal as "Municipalisation". If we are to accept the building site at Charterhouse, which none will deny is necessary, surely we must also accept these temporary and minor scars in "the beautiful precincts of College Hall".

Students' Union.

Appointments

Dr. R. A. Shooter has been appointed to the Chair of Bacteriology at Bart's Hospital Medical College.

Dr. P. B. Kunkler has been appointed Medical Director of Radiotherapy at Charing Cross Hospital.

Professor H. P. Gilding has retired from the Bowman Chair of Physiology at Birmingham University.

UNIVERSITY OF CAMBRIDGE.
M. Chir.: R. V. FIDDIAN, L. R. H. GRACEY, W. M. KEYNES.

ROYAL COLLEGE OF SURGEONS OF ENGLAND.
F.F.A.R.C.S.: Patricia A. Edwards, M. E. B. Hayes, R. C. Nainby-Luxmore.

ROYAL SOCIETY.
Professor A. A. Miles has been elected a Fellow of the Royal Society.

The Major Accident Scheme

THE LEWISHAM TRAIN disaster in 1956 provoked an enquiry into what provision was made by hospitals, if any, for raising an emergency team at short notice. In the opinion of the Regional Board, it was the duty of each hospital in the Metropolitan area to draw up for itself a major accident plan. The instruction prepared by Barts in 1957 has been re-drafted this year.

In the event of a major accident occurring near Barts, the ambulance service may call on the Hospital to provide an emergency surgical team consisting of a surgeon (or chief assistant), anaesthetic registrar, 2 nurses and 6 male medical students to go out to the site of the accident. If another hospital becomes the designated one, Bart's may be one of a number of supporting hospitals to which overflow casualties are routed. The Board of Governors has accepted the advice of the medical council and agreed to take not more than:

25 casualties requiring life-saving surgery.

100 lightly-injured casualties.

The whole Barts operation is a simple practical plan designed to make a close knit unit of the police, the ambulance services and the hospital staff. The city police will establish wireless communication between the accident site and the hospital. Their other important function in the event of further hospitals being opened up, is to route the ambulances to avoid congestion, both of roads and hospitals, for, in an operation of this kind, the ambulances are an important feature. Mean-

while, at the hospital the exchange is responsible for alerting surgery at the major accident. The message at surgery is passed on to Sister Surgery, duty anaesthetist, duty theatre, house officers, and duty radiographer.

The duty surgeon decides which senior member of the firm is to be in charge, who picks his team and sees that a responsible member of the surgical staff remains in surgery to be in charge of subsequent casualty organisation.

The duty anaesthetist informs his chief of the emergency, and collects anaesthetic and blood boxes loaded with dextran and group O rhesus negative blood. Sister Surgery is responsible for seeing 2 nurses accompany the party to the site, and making added arrangements for receiving the casualties in surgery. The steward acts as liaison between the site and the duty surgeon. He must determine the exact site of the emergency, and the expected number of casualties; arrange for transport of the team to the site; arrange for surgery lifts to be manned by extra porters; arrange for reception of ambulances at Giltspur Gate; arrange for additional canteen requirements and clerical help; and prepare a press notice for Reuter.

The equipment is to be stored in a cupboard in Sister Surgery's office.

The only weak, but perhaps unimportant, link in this operation is the 6 male medical students. If the emergency occurs in the day, the nearest 6 available are to be used, but if between 6.00 p.m. and 9.00 a.m., College Hall is to be notified.

Viruses Maybe?

Culture is almost sterile.

—Path. report

Just Slip Your Things Off

"No lung lesion is seen, though it is probably worth repeating the film with both scapulae completely off."

X-ray Report.

Fifty years ago

EXTRACT FROM "THE CHRONICLES OF CHRISTOPHER", Part II, "I Dress for Mr. Cutler".

It was a full day in Augusta, and number one was occupied by a patient of mine, a sweet young lady, who had parted with her appendix, and who, to my inexperienced eyes, seemed amazingly fit.

"Who's her doctor? Let's see, you are? —Mr.? Chatterton? Chatterfield? Ah! Chesterfield—Well, Mr. Chesterfield, what's happened to this patient since her operation?"

"The patient seems to have stood the operation remarkably well," said I, sententiously.

The great man frowned; "I will not have slang in my wards; you may keep *that* for your Mayfair duchesses."

My heart warmed to him. At last! at last, I had met a man who would appreciate my epeolatry, and hastily I searched my mind for something appropriate, sadly realising that one's extempore utterances are ever so much better for a little preparation. Nevertheless, it was not long before I opened fire.

"As regards—" "Do speak up," he interrupted. "I'm getting old, and all animals when they get old get deaf; you fellows speak as if you were paid for the sound you make, and don't get a good price for it."

It is very exasperating to get well off the mark, and then be hauled back for a fresh start, and to be compelled to "speak up" discounts the effects of your carefully modulated accents. I scowled, and resumed *fortissimo*:

"As regards the *sequelae* of the operation, I am gratified to inform you that nothing undesirable appears to have supervened."

Mr. Cutler's face ran the gamut of all the emotions, and finally assumed the appearance of a composite photograph taken from persons in various stages of sorrow and scorn.

And then he gave tongue. . . .

ROYAL ST. BARTHOLOMEW—THE CITY'S HOSPITAL

by *W. R. McGrath, F.R.S.H., F.S.I.A., Senior Public Health Inspector of the City of London, and J. Greenwood Wilson, M.D., F.R.C.P., Medical Officer of Health, Port and City of London*

THE STORY HAS been told many times by chroniclers and writers of the Heavenly vision of Rahere, the Augustinian Canon, of Bartholomew the Apostle of Jesus Christ, and of the command Rahere received eight and a half centuries ago which resulted in the founding of a church, a hospital and a priory. Not only was he so commanded but the site was also chosen for him. In the modernised version of the words of the original chronicler—"Know we truly by the Commandment of the High Trinity, and the common favour of the Celestial Court and Council to have chosen a place in the suburbs of London at Smooth Field (Smithfield)". The site for this early redevelopment was anything but a Heavenly one. It was described as "this place before the cleansing of it held forth no hope of goodness; right unclean it was and like as a marsh, dank and fenny with water everywhere abounding". However, it was near to the highest ground in the City, and, equally important, there was a deep layer of fine river gravel under the mud and filth. Upon this foundation Rahere built his hospital and priory, on ground known as "Noman's Land". The ground was valued at five shillings and was at that time outside the City wall.

So, many hundreds of years ago, began the association of St. Bartholomew's Hospital with the City of London.

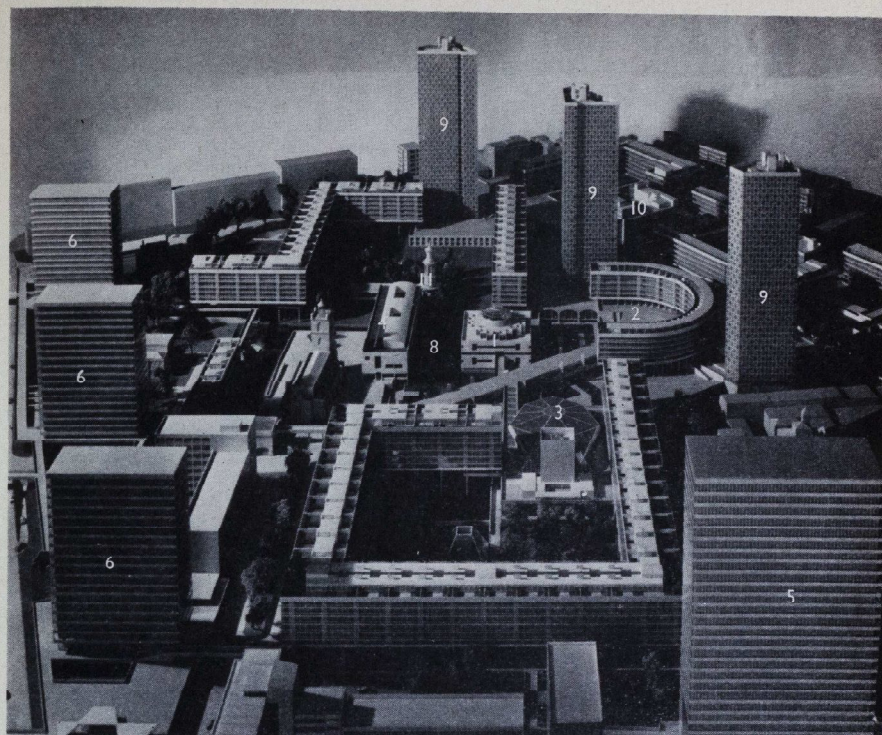
The Hospital was completely rebuilt in the 18th century, and although no trace remains of the original buildings, the site of the hospital is in the exact position in which it was placed by Rahere. It remained a religious foundation until 1544 when Henry VIII gave it a new constitution, which, however, proved so unsatisfactory in practice that in 1547 the City authorities took over in a determined effort to govern the hospital in a manner similar to that of the Livery Companies which had been so successful. A Court of Governors, presided over by the Lord Mayor, comprised Members of the Court of Aldermen, the Common Council, and other co-opted Members drawn from those who had contributed to the upkeep of the Charity. Effect to this was given by the Deed of Covenant

of 1546 upon which the present constitution of the Hospital is founded. It was governed as a separate institution for about 10 years when it was associated with the rest of the Royal Hospitals—Christ's, Bridewell and St. Thomas's. Owing to disagreements an Act of Parliament of 1782 separated St. Bartholomew's from the other hospitals. The final separation of the Hospital from what may be termed the patronage of the Corporation of the City of London occurred in 1866 when a lawsuit determined that the Governors had the power of electing whom they might choose as President. Of interest also is a City of London Act of 1851 which provided that the Royal Hospitals of St. Bartholomew and Christ should not be assessed for rating. Subsequent rating reforms altered this and now only a moiety of the rate on the Medical College is excused on the ground that it is a charitable organisation. So after four hundred years as an ecclesiastical institution and four hundred years as a Royal Hospital administered by its own Board of Governors, St. Bartholomew's Hospital became part of the National Hospital Organisation set up by the National Health Service Act of July, 1946.

Concurrently with plans for the growth and expansion of the Hospital the City Corporation, mainly as a result of the devastation of the last War, has also been faced with problems of reconstruction and redevelopment. In all the various plans and proposals associated with these problems it has been manifest that the City of London has prized the function and value of the Hospital and anticipated its improved and greater facilities. How, then, does Bart's fit into the overall plan?

Unlike many local hospitals the "catchment area" for patients of St. Bartholomew's extends far beyond the boundaries of the cause the number of City residents is so few (5,000) — although the hospital does, of course, cater nobly for emergency treatment of the City's half million day workers.

For many years the Corporation, as the local authority for the City of London, was responsible for the administration of such services as Maternity and Child Welfare, the



Model of the Barbican Redevelopment

View from the West showing, at the left, the new Route 11, with a key to a few of the more conspicuous landmarks.

KEY

1. Guildhall School of Music and Drama—Music School.
2. Amphitheatre.
3. Concert Hall, Theatre and Guildhall School of Music and Drama—Drama School.
4. City of London School for Girls.

5. 27-storey office block.
6. 18-storey office blocks.
7. St. Giles' Church.
8. Lake.
9. 37-storey tower block of flats.
10. Hotel.
11. Tower—(Coal Exchange).

Tuberculosis Dispensary Service and the Special Treatment Centre for Venereal Diseases, all of which were, by agreements City and Metropolitan areas, particularly financial and administrative, undertaken by St. Bartholomew's Hospital. Reluctantly, the Corporation's active interest in these services came to an end when their control was transferred to the County Council and the Regional Hospital Board by the provisions of the National Health Service Act of 1946. As

a consequence, apart from the inclusion on the Board of Governors of the Hospital of prominent City personages, and the value to the Corporation of the facilities provided by the Department of Pathology for the examination of samples of food, water, etc., in connection with the statutory duties of the Corporation, any claim at the present time that St. Bartholomew's is the City's Hospital, from a realistic viewpoint, would be somewhat tenuous. However, it may well be that

the more local form of administration recommended by the Royal Commission on London Government for the Personal Health, Welfare, Children's Service, and the care of aged persons, will not only restore the close co-operation which previously existed between the Hospital and the Corporation in these matters, but will be extended to the creation and maintenance of a domiciliary team which will include all those in the various branches of the personal health and welfare services working in close co-operation with general medical practitioners. Consideration will need to be given to the intimate connection between these services and the environmental health service and their integration.

Active preliminary steps have already been taken by the Corporation to set up an Occupational Health Service for some of the ever-increasing number of City workers. When this service comes into being there would seem to be an obvious opportunity for co-operation with the authorities of the Bart's Hospital Medical College in the use of the Industrial Health Centre which, it is understood, they propose to provide shortly in Charterhouse Square as part of a Community Health Centre.

Another non-statutory venture initiated by the Corporation in association with the Hospital is the City of London Cancer Diagnostic Clinic for the benefit of women who live or work in the City. Its aim is the application of a simple and well-tried test to advise on the absence of any cancer peculiar to women.

The Corporation is developing the 35-acre Barbican area to the east of the Hospital. St. Giles' church, recently restored after Hitler's bombing, is to be the centre of the Barbican Scheme. In his book, "Cripplegate Ward",

United Easter Service

ON TUESDAY, 28th March, at 1 p.m., a special Easter Service was held in St. Bartholomew's the Less. This was arranged so that Christians amongst both staff and students might have an opportunity for united witness within the hospital, and was led by the Vicar, the Rev. H. Norton. The Rev. Dick Rees, the well-known Church of England evangelist, was the visiting preacher.

In his sermon Mr. Rees spoke of the wonder of the Easter message and showed its relevance to man's everyday life. Using, as

Sir John Baddeley wrote: "Eight centuries have passed since Rahere, the Monk, founded the Hospital of St. Bartholomew on the confines of the Ward, at the same time giving material assistance to Alfune in building the fine church of St. Giles." The Barbican Estate will provide housing for some six thousand people in the middle and higher income groups employed in the City. The scheme also includes an hotel, hostel, fire station, the City of London School for Girls, the Guildhall School of Music and Drama, a theatre and concert hall, a recreation centre and a secretarial college. The whole scheme will fulfil the intention of the Corporation which is not merely to bring about the construction of a number of buildings serving several functions but, beyond this, to bring back Londoners to the City so that they may again make their homes near to where they work—as they have done for centuries.

Clearly in all this redevelopment and planning the Hospital, in association with the Corporation, will have a large part to play in the well-being of this considerable addition to the existing day and night populations of the City, and the Hospital will become, perhaps more than ever before, the City's Hospital.

The opening of the New Special Department Ward Block and Nurses' Home by Her Majesty the Queen on Tuesday, 30th May, will no doubt recall the comment in a short history of the Hospital written many years ago:—

"St. Bartholomew's Hospital, though growing for centuries, is indeed growing still. Long may it grow. For when it has ceased to grow it may indeed have come to the perfection of maturity; but such perfection will be the signal for decay."

one of his illustrations, the picture of a ladder up to heaven, he reminded us of the true way to a personal and vital experience of God in one's life. This, he said, was not something to be arrived at as a result of our own efforts at striving to climb up to God; rather the staggering fact was that God in the person of Jesus Christ had Himself come down to our level and as a consequence of His death and resurrection now offered new life to those who came in simple faith to Him.

The service was very well attended, the church being filled almost to capacity with people drawn from all walks of hospital life.

THE THORACIC DEPARTMENT AT HILL END

by Mr. I. M. Hill

THE THORACIC DEPARTMENT is the youngest of the Hospital's special departments; it is a post war birth and surely no precocious child has ever developed more rapidly. Admittedly its conception was pre-war, but no special branch of surgery has ever progressed in such a meteoric way and it has been a tremendous thrill to watch and take part in its development over a space of almost twenty years.

In 1939, such thoracic surgery as there was—largely that of chronic sepsis—was carried out by Mr. J. E. H. Roberts, surgeon to the Green Firm, and his Chief Assistant, Mr. O. S. Tubbs, newly returned from America. This was the time when dissection operations for lung resection were being introduced to supplant the old techniques of mass ligation with the tourniquet. Sulphonamides were new; there were no antibiotics.

When September, 1939, came upon us after a year of uncertainty it was clear that routine surgery in the centre of London might prove impossible and under the Emergency Medical Service (E.M.S.) the Green Firm broke up, Mr. Rupert Corbett going to Friern Hospital in the presumed safe suburbs and Mr. Roberts and Mr. Tubbs to the wilds of Hill End. Here, though it remained a general surgical firm, an E.M.S. Chest Unit was formed specifically to deal with thoracic casualties, both military and civilian. It was not, of course, until Dunkirk and the London Blitz of the next winter that traumatic work started in earnest. Hill End was far from the only commitment of the two chest surgeons to the unit, for service overseas had denuded many sanatoria of their surgical specialists and those compelled to remain in this country found themselves endeavouring to cope with the surgery of pulmonary tuberculosis in fleeting visits over vast areas in the South of England. Only at a few sanatoria were the facilities adequate for safe major surgery and therefore the transfer of patients to such major units as Hill End was essential, when the

casualty pressure on beds allowed routine civilian surgery.

The contrast between the surgery of this time and that seen in Vicary Ward of the Queen Elizabeth II Block is difficult to appreciate by those whose clinical experience is limited to the antibiotic era. In 1942, the second house surgeon to the Thoracic Unit at Hill End had the care of some 20 beds of general surgery (mainly inguinal and scrotal) and about 40 beds of thoracic surgery. In these were a few cases of thoracoplasty for tubercle; but most were empyema, lung abscess and suppurative pneumonitis. Though he drained several empyemata in his six months' appointment, he saw only one resection of lung, and this was for lung abscess which had been treated for a year with sulphonamides before the considerable (and fatal) risk of surgery was taken. All resections of lung undertaken for septic conditions were accompanied by rib resection drainage for the almost inevitable empyema that followed. Carcinoma of the bronchus was scarcely a surgical proposition and surgery of the heart itself was unknown. Lung abscess was usually treated by drainage and chronic suppurative pneumonitis by diathermy morcellation. Secondary haemorrhage was common and all patients with packs in their lungs had, by the bedside, a pair of long forceps and a roll of packing gauze for this emergency. Perhaps this welter of chronic infection was more concentrated at Hill End for Roberts had devised an operation for the closure of chronic empyema avoiding the massive tissue loss of the Schede type thoracoplasty. Certainly there were many patients who would cheerfully have accepted any operation to rid themselves of a tube constantly draining pus, and they owed a great debt to the sisters, Miss Lightfoot and Miss Piper, who cared for them and kept their morale high over the long and often painful stay in hospital. Pulmonary tubercle was treated surgically only by phrenic interruption, pneumothorax and thoracoplasty: a spread of tuberculosis in

the lung at operation was not uncommon and spent months of delay and an infection of the subscapular space was a disaster which, even if not fatal, ended in permanent tube drainage. In retrospect it seems remarkable that this speciality could attract those active surgeons who have made it their life's work: yet there was a glimmer of light, for Tubbs had already shown that subacute bacterial endarteritis could be cured by ligation of a persistent ductus arteriosus, before the advent of penicillin.

The introduction of antibiotics altered the situation beyond recognition and by the end of the war pulmonary surgery was safer and more meticulous. As thoracic surgery extended its scope it became clear that it demanded all of a surgeon's energies, leaving him little time or opportunity to practise general surgery, and St. Bartholomew's was the first teaching hospital to recognise this by forming a Department of Thoracic Surgery, appointing Mr. Tubbs to the honorary staff as its first surgeon. With the coming of streptomycin the onslaught on pulmonary tubercle was supplemented by resection of the disease, and the Regional Hospital Boards formed under the new National Health Service found it necessary to make additional appointments of consultants to shorten the waiting lists for surgery, which were often two years long. There followed a period of rapid expansion of the thoracic surgical services in the country. Barts undertook to continue in the country. Barts undertook to tubercle for the North-East Metropolitan Region, who had no special surgical unit of their own, but it also served the North-West and with the appointment of Hill as assistant thoracic surgeon, spread its net further in the South-East as well.

By 1950 the anastomotic operations for congenital heart disease were consuming our time and energy, and a year later direct heart operations for both congenital and acquired heart disease were started. No account of the Thoracic Department at this time is complete without reference to Miss Biggs, first sister of the men's ward MA1 and then of the whole unit when it moved into its more compact quarters in the enlarged FA1. Her utter devotion to the patients set us all a standard of service which would be hard to excell. Her prescribing may have been unorthodox; but her sympathy, firmness and self sacrifice inspired a loyalty in her colleagues and a sense of gratitude in her

patients that enabled her to build the most extensive private follow up system in Barts. As the surgery of the tubercle waned, that of carcinoma of the bronchus loomed larger and now with the bronchial carcinoma deaths at over 20,000 per annum, already greater than that of pulmonary tubercle, the pattern of pulmonary surgery has changed and we must look forward to the day when satisfactory chemotherapy for this dread disease will enable us to make surgery for it as satisfactory as it has become for tubercle.

But it is in the cardiac field that the most spectacular changes have occurred. Though direct closed heart surgery continued from 1951, this was clearly only a temporary phase. In 1957 we started using hypothermia as a means of limited open heart surgery and this method will probably remain in use for some years as it has proved most satisfactory for the closure of secundum atrial septal defects under direct vision. The limit of ten minutes circulatory arrest imposed by this method is unacceptable for more complicated operations and Mr. Tubbs persuaded the Governors that St. Bartholomew's should play a part in the furthering of open heart surgery with extracorporeal circulation. This work has been carried out with very generous help from the endowment fund of the hospital. Believing that such a project needed animal experimental work to place it on a safe basis for human use, we started in 1957 with an American Mark version of the Gaertner-Kay pump oxygenator in the laboratories of the Medical College in Charterhouse Square, using from the beginning the same team concerned with its clinical application: surgeons, registrars, housemen, physiologists, anaesthetists, biometrist, theatre sister, nurses and technicians. After more than a year's work and a change to the British made and designed Melrose-N.E.P. machine, the first human perfusion at Hill End was successfully carried out in October, 1959. Now that this method is established clinically, the laboratory is turning to deep hypothermia and we have hopes that 1961 will see this method in use in the operating theatre in the Queen Elizabeth block. Surgery of this complexity has brought its problems to both medical and nursing staff. Demands on the surgeon's and theatre sister's stamina increase. Geographical divorcement at Hill End from the cardiac department threw a load of biometry on the surgical unit and the mass of complex

electronic equipment almost filled even the large converted hairdressing saloon which served us so airily as a theatre for more than twenty years. True, as the doors swung, dust was sucked from between the ceiling boards, and in a north wind the fan shutters clattered alarmingly; but there was still standing room for the team of 18 involved in a perfusion operation and we could even welcome visitors.

Now the days of the drive to the country, of ward rounds in the garden, of tea in the

shade of Chloe's memorial after summer operating lists, are over. There is much of Hill End and its cameraderie we shall miss. Forgotten are the ice and fog that could separate us from our patients and our colleagues. We are now back to the stimulating contacts of the metropolis to work in a long awaited new block. This should surely conserve our energies for the daily crawl through London traffic, and give us even greater opportunity to keep Barts in the forefront of the field of Thoracic Surgery.

CANOEING—DEVIZES TO WESTMINSTER, 1961

THIS YEAR THE Hospital had one of the largest civilian entries in the race, with five crews in canoes of assorted sizes and quality. The two veteran crews of last year's race had both built their own boats. Watkins and Caile, with little thought for their own comfort, had ambitiously assembled a sleek 22 ft. fibreglass racing canoe, comparable with the best craft in the race. Ward and Courtenay Evans with more consideration for the anticipated many hours on the water had built their boat to stouter specifications out of struts and canvas.

The three new crews to the 125 mile race across the South of England were Bacon and Spivey in a stubby little lightweight canoe of seemingly nerve-racking fragility, which they had found decaying in some Thames-side boat-house; Lewis and his partner from Guys in a sturdy versatile canvas boat, and S. Phillips and M. Freeth from Charterhouse in a heavy folding Tyne, ideal for a comfortable weekend's camping, but needing considerable determination to cart it round the seventy-odd locks on the course.

Our five crews were started at Devizes at varying times on Good Friday, each apprehensively anticipating the trials and excitements of the next few days, of which exhaustion proved to be the greatest. In spite of a fairly steady drizzle most of the way, with the occasional torrential down-pour, the weather was good, especially encouraging was the following breeze we had

all the way, and we were spared the devastating cold experienced during the nights last year.

In view of these conditions the race itself was comparatively uneventful. Several of the crews had considerable rudder trouble, and it was this troublesome accessory that finally forced Spivey and Bacon to retire at Maidenhead.

The remaining crews all reached County Hall, Watkins and Caile, after some trouble with the tides and the river police were the first Barts crew in, followed soon after by Courtenay Evans and Ward, coming respectively 2nd and 3rd in the civilian class, but competing with the Marines, S.A.S. and Parachute Regiment we had less favourable positions. The other two crews made more of a weekend of it, spending at least one night under canvas, their ambition being to finish the race at all costs, an ambition well fulfilled, and with the exception of the Royal Marines and the 1st Battalion of the Parachute Regiment, Barts had the highest number of finishers in the race.

RESULT

117 Crews entered, 65 finished.
Winners: Royal Marines in 20 hrs. 59½ mins.
Bart's Crew placings:—B. Watkins & R. Caile, 23rd, 31 hrs. 20 mins.; H. Ward & R. Courtenay Evans, 25th, 32 hrs. 16½ mins.; A. Lewis & Phipps (Guys H.), 60th, 56 hrs. 38 mins.; S. Phillips & M. Freeth, 61st, 58 hrs. 7 mins.

SOME DISEASES AND THE NEGRO

by Lawry Iregbulem

THE WORD "NEGRO" usually designates members of the African race and their descendants in America and the West Indies. The race is typified by brown or black skins, woolly hair, semi-flat noses and everted lips. No doubt, one can write a catalogue of diseases which occur with remarkable frequency in the negro and thereafter elaborate on this rather special feature. In this article, however, it is not intended to cover such a scope.

Until the advent of vaccination a few years ago, methods of combating poliomyelitis in Europe and America consisted primarily of strict adherence to the basic laws of sanitation and exhortation by modern propaganda methods during epidemics. This drive is not so intense in West Africa for instance, where the people are "blessed" with a measurable degree of natural immunity due to what is usually referred to as "the primitive sanitary and overcrowded living conditions". On account of this, poliomyelitis is comparatively rare in the African negro. Being conversant with the doctors' incessant effort to eradicate insanitary environment, one automatically recognizes this situation as a great paradox. The doctor's efforts are still desirable and indeed, imperative. But there can be little consolation in the thought that, by those efforts, he is increasing the risk of poliomyelitis in children and adults.

However, poliomyelitis of the non-paralytic form is not uncommon in the African

negro. What is rare is the bulbar type which is very frequently encountered in the European. Furthermore, there seems to be a difference in the age group incidence. In the European, poliomyelitis, though common in the child, is also frequently seen in the adult, in the adult African it is decidedly rare.

The systemic blood pressure in the negro presents a fairly different picture. In the following paragraphs, attempts will be made to summarise the great diversity of views on the subject.

Starting with the West African negro, one finds that there is a deplorable paucity of literature on the subject. A resumé of two papers procured at the University College, Ibadan, Nigeria, is as follows:—Hypertension with primary glaucoma was common in the Gold Coast (now Ghana) African; Hypertension was present in elderly mental defectives in Western Nigeria (Lambo 1958).

A recent survey of the systemic blood pressure in a rural West African community by Abrahams, Alele, and Barnard, all of the University College, Ibadan, showed that the average systemic blood pressure did not differ significantly from that in any comparable European community. Taking a systolic blood pressure of 150 mm Hg and diastolic B.P. of 95 mm Hg as arbitrarily raised, they examined 641 individuals and obtained the following results on which their conclusion was based:

DECADE	MALES			FEMALES		
	No.	Average Systolic B.P.	Average Diastolic B.P.	No.	Average Systolic B.P.	Average Diastolic B.P.
20-29	67	122.6	75.7	135	112.2	70.2
30-39	75	123.4	76.0	96	116.0	73.4
40-49	57	122.4	76.1	56	129.4	78.8
50-59	51	128.8	77.7	50	148.4	85.4
Over 60	31	136.9	78.2	23	144.1	82.6
	281			360		

Literature on other parts of Africa on the subject invariably contains conflicting reports. Workers in East Africa, notably, Jex-Blake (1933), thought that hypertension was rare in the African negro. Donnison (1929), however, concluded that up to the age of 40, the blood pressures of the two races were similar but, whereas those of the negro fell in subsequent years, those of the European rose.

These discrepancies with the findings in the West African negro are quite inexplicable. Besides, the facts are too complex and one is therefore hesitant over even drawing the most tentative conclusions. With regard to the European and the African negro it has been suggested by some authorities that any attempts to compare the two races in this respect would ever yield fallacious results since the average expectation of life of the European was higher!

The American negro belongs to a class by himself. Apart from being mainly of African descent, he also forms part of a contemporary western civilization in North America. It is generally agreed that the incidence of essential hypertension in the American negro is more than double that in the White American. For years this has puzzled many workers. Schulze and Schwab (1936), reviewed personal correspondence from doctors working in Zululand, Ghana, and the Rhodesias to the effect that essential hypertension was virtually unknown among the negroes of these parts and they wondered why it should be so common among their descendants after 200 years residence in America. Now, however, most American authorities agree that essential hypertension in the American negro is largely due to psychodynamic factors.

Coronary disease (viz. Coronary thrombosis and Angina pectoris), however, is generally accepted as being infrequent in the African negro. Most studies on this have been done on the Bantu alone and one must quote these generalisations with extreme caution. Two theories have been postulated to explain this finding in the Bantu:

1. The left coronary artery has an extra branch (third primary division) (Brink, 1937) which arises close to its origin and might serve to maintain an adequate blood supply to the heart in the event of narrowing or occlusion of the main branches.

2. The Bantu may have a higher threshold of pain than the European and con-

sequently suffers from painless coronary ischaemia. Indeed autopsy reports on elderly Africans who died from congestive cardiac failure showed marked atheromatous lesions of the coronaries. During life these patients never complained of Angina pectoris!

Becker may have been struck by all this when in 1946 he wrote as follows: "One of the most significant features of the state of the heart in hypertensive arteriosclerosis in Bantu and coloured subjects is the relatively low incidence of coronary occlusion and coronary thrombosis." Could it be, then, that essential hypertension and coronary disease are not so related as hitherto thought?

Now to yaws (Framboesia Tropica). This is a non-venereal disease endemic in hot climates. The causative organism is the spirochaete, *Treponema pertenue*.

The exact relationship between yaws and syphilis is still a matter of great controversy. Lately, however, the general opinion is in favour of both maladies being distinct entities. The following distinctions between the two make this view the more easily acceptable:—

1. *T. pallidum* is panblastotropic (but especially mesoblastic) i.e. tendency to produce lesions in all tissues; *T. pertenue* is epiblastotropic—producing lesions in skin and bones.

2. 99 per cent of framboesian lesions are extragenital.

3. Yaws is not hereditary, i.e. unlike syphilis, it does not produce congenital stigmata like Hutchinson's teeth, iritis, etc.

Nevertheless, that the two diseases are closely related is beyond doubt. The organisms are identical morphologically, share common serological relationships and respond to the same therapeutic measures. Indeed some authorities still eloquently equate syphilis to yaws. C. S. Butler in his numerous articles and monograph (1936) takes the view that yaws is syphilis modified by climatic factors, immunity, extragenital infection in childhood and absence of specific treatment. As if to compromise with the opposite school of thought, Butler and Peterson suggested the term *treponematosi* to include yaws and syphilis—a term which can be most aptly applied in tertiary syphilis and yaws when, in the absence of a good history, lesions produced by both are almost indistinguishable.

The incubation period averages 3 or 4 weeks, being accompanied by malaise, slight

fever, headache and gastric disturbance. The primary lesion, which is a painless papule and may be multiple, appears at the site of inoculation and soon enlarges to the size of a pea with serous exudation and scab formation. Mild constitutional upsets 6-12 weeks after appearance of the primary lesion herald the beginning of the secondary stage of the disease. The eruptions are now multiple, itchy and frequently coalesce to form large excrescences. The usual sites are the face, limbs, neck, axillary regions and perineum.

Yaws tubercles developing in the palms of the hands or soles of the feet may be very painful and incapacitating. The epidermis splits from underlying pressure and the ulcers have a worm-eaten appearance. Those on the feet are referred to as "crab yaws"—a term likening the disability produced to crab locomotion. Non-destructive bone lesions are

present at this stage and the Wasserman reaction is positive.

The secondary stage lasts up to 2 or 3 years after which tertiary manifestations of the disease occur. Characteristically these are gummatous nodules in the subcutaneous tissues which break down to form chronic ulcers causing contractures and deformities of the extremities. Gangosa (rhinopharyngitis mutilans), goundou and juxta-articular nodes, until recently regarded as separate diseases, are now recognised as tertiary manifestations of yaws.

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INTER HOSPITALS LONDON TO BRIGHTON WALK, 1961

GENERAL SITWELL FIRED the starting gun and thirteen hundred students representing every London teaching hospital swarmed across the Royal Fusiliers' barrack square at the Tower of London to the skirl of pipes played by three Pipe-Majors who led the throng. Ten hours and twenty-five minutes later Nick Pott of Bart's strode across the finishing line at Brighton, the first man home.

This year each hospital had set up one depot and these were at five mile intervals along the route. Competitors were therefore able to receive foot treatment and food all the way to Brighton. Barts depot was at Handcross, south of Crawley, and here we had erected two tents, one fitted with calor gas cooking equipment and the other to accommodate our "pedoclinic". To mention any one name in connection with this depot would be unfair to the several students, nurses and staff who spent the whole of Friday night and most of Saturday untiringly tending to the needs of competitors. Some ten gallons of hot soup and four hundred hot sausages besides large quantities of

orange juice, apples and rolls were served by the food depot, and the "pedoclinic" gave over three hundred and fifty treatments. The Barts depot was acknowledged by all to be one of the best on the route and without this help, many who completed the course would certainly have been obliged to retire.

Of the 120 Barts starters 83 arrived at Brighton; quite a remarkable achievement as this number represents about fifteen per cent of our total student population. The first lady to arrive at Brighton was Christine Carr, a Barts nurse who had entered unofficially in response to a wager. Miss Carr was among the several competitors who were greeted by the Mayor of Brighton at the finishing line.

On reaching Brighton every competitor was able to take a free bath after which A. Wander, Ltd. (Ovaltine) served a magnificent breakfast, and there was free Guinness all day.

With such keenness as shown this year one cannot but have high hopes that in future years Barts may well win the "Strolling Toucan" trophy. J.I.

SPORTS NEWS

Viewpoint

It takes many kinds of people to make a community—all have their good points and all have their bad; it's just that the majority have more bad than good, and a few have more good than bad. It is the latter who work the harder for the community, usually behind the scenes, content not to push themselves forward, but happy that their efforts bring pleasure to others. Such a person is Mr. White—Laurie to the many hundreds who have used, or are using, Foxbury.

By the end of this month he will have been with Barts' for 25 years. During this time he has provided magnificent playing facilities for the Hospital; to the extent that Barts has one of the finest grounds in London—visitors are endlessly commenting on this fact.

It is, perhaps, the cricketers who owe him the biggest debt, throughout the summer they see him every week-end, often for two whole days. They have him to thank, both for providing the best wicket on which they play, in or out of London (even if the bowlers' union occasionally feels like going on strike!) and for looking after them so well off the field. He is always ready to go out of his way to help anyone—but to continue would only cloy. And he is the last person, writing about whom, one would want to do this.

So we will end simply by thanking both him and Mrs. White for everything; and hope they will accept as a token of this the gift the Students' Union has made to them.

Cricket

1st XI v. U.C.H., 29th April, 1961—Drawn.

Put in to bat, Bart's scored quickly mainly due to the efforts of Warr and Davies, both of whom drove and pulled powerfully in mid-season fashion. Useful supporting innings came from Merry and Harvey and Bart's declared in a strong position. Harrison struck early at the better U.C.H. batting with three quick wickets, but the other bowlers were unable to complete the collapse and our opponents finally held out with 8 wickets down. Scores: Bart's 178—4 dec. (Warr 53, Merry 42 not out, Davies 38).

U.C.H. 90—8 (Harrison 4—4).

1st XI v. London House, 30th April, 1961—

Won by 3 wkts.

Lusty hitting brought quick runs to the London House scorecard but with the Barts outfielders holding their catches their score was only 155 when the last batsman lofted a drive into the sure hands of Warr. Another sweetly-timed 50 from Warr and Barts were well set for victory but it took the studied hitting of Harvey, backed up briefly by Phillips to ensure the 3 wickets' success. Scores: London House 155 (Niven 4—51).

Barts 156—7 (Warr 60, Harvey 57 not out).

1st XI v. The Crickets, 6th May, 1961—

On a two-sweater day threatened always by rain, The Crickets batted first. However, the attraction of the Cup Final broadcast proved too much for them and one by one they retired to listen assisted by some hostile fast-medium bowling from Richards. The opposition out for 99, a Bart's victory seemed as inevitable as Tottenham's, and indeed with the broadcast over Merry and Jeffreys lost little time in accumulating the necessary runs, but not before Pagan and Warr had succumbed.

Scores: The Crickets 99 (Richards 3—16).

Bart's 103—2 (Merry 50 not out, Jeffreys 33 not out).

1st XI v. Putney Eccentrics, 7th May, 1961—

Drawn.

A quick break-through by Harrison augured well for Bart's but a solid third wicket stand scotched any hopes of collapse. Big hitting by the middle order batting consolidated on this such that when the declaration came Bart's were required to score rapidly. Warr smote encouragingly but his dismissal heralded further losses and with the score at 59—5 things looked black. However, Jeffreys, Delany and a stoppage for rain restored stability to the innings and a draw was assured.

Scores: Putney Eccentrics 201—7 dec. (Harrison 4—51).

Bart's 110—7 (Jeffreys 29 not out, Warr 27).

1st XI v. Wimbledon, 13th May, 1961—

Drawn.

There was much speculation in the pavilion as to the aetiology of Jeffreys' pulled muscle but despite his consequent restricted driving his 80 runs provided the backbone of the

Bart's score. Wimbledon started stodgily and even when encouraged to go for the runs by moderate bowling and a defensive field they seemed unable to extricate themselves from their rut until the last 10 minutes, by which time they had slipped irretrievably behind the clock.

Scores: Bart's 176—8 dec. (Jeffreys 80, Pagan 29).

Wimbledon 155—6 (Niven 4—46).

1st XI v. Hampstead, 14th May, 1961—Drawn.

The morning's play at Hampstead produced a 150 opening stand and an unprecedented nadir in Bart's outcricket. Just before lunch Stoodley contrived a breach and an immediate improvement resulted. Stoodley bowled intelligently and wickets fell steadily until the declaration when Bart's were left to score 275 in 150 minutes on a fast, true wicket. Warr and Jeffreys—both in peak form—drove, glanced and pulled skilfully, and runs came fast in the early stages. However, with their dismissal wickets tumbled and it was left finally to Harrison, batting for only the second time in two seasons, and Jailler to play out the last 20 minutes.

Scores: Hampstead 274—9 dec. (Stoodley 5—95, Niven 3—101).

Bart's 192—9 (Jeffreys 57, Warr 50, Delaney 24).

Rowing

UNITED HOSPITALS BUMPING RACES

(Held May 10th, 11th and 12th)

THE SEVENTH ANNUAL Bumping Races will surely be recorded as an outstanding year, not least for Barts whose entry of 6 crews has never been equalled or surpassed by this or any other hospital. Gratifyingly, by the last night it had been confirmed that it indicated the healthy state of the club, for as a result of the racing the 6 crews had collectively recorded 6 bumps and rowed-over on 8 occasions.

As in previous years the crews were staked out on the ebb-tide along Isleworth Ait and given a length of clear water and approximately 7 minutes' rowing to catch the crew ahead before reaching Kew Road Bridge. The highlights of the 3 nights, which were crowned with magnificent weather and ideal racing conditions, were as follows—

1st Night: The 4th VIII chalked-up the first

bump for the hospital catching the Westminster 2nd VIII in $\frac{1}{2}$ -minute—a very creditable effort. The 1st VIII, rowing below par, failed to catch Guy's, who made a bump in the first minute, and proceeded to row over ahead, Thomas's having caught Mary's. The 6th VIII had difficulty in getting on their stake and were technically bumped.

2nd Night: In bumping Westminster, the 1st VIII recorded the first bump ever to be made by a first boat from the hospital. We hasten to add that the hospital rowed with St. Thomas's at the head of the river for many years untouched by any other hospital, until an unfortunate affair 2 years ago over women coxes (who fortunately no longer appear) which necessitated the withdrawal of all the Bart's VIIIs.

The 2nd VIII suffered their only Bump, on this evening, at the hands of a fast crew from Queen Mary College (an invitation entry) who had a spectacular rise to fame.

3rd Night: Altogether a night of sweet success—mainly at Guy's expense. For the first time the 1st VIII showed their paces and in bumping Guy's, who were on the verge of bumping Mary's, proved to many that Bart's were probably the fastest boat on the river, for Mary's nearly bumped Thomas's back on the 2nd night. It was a great pity that the 1st VIII failed to get their 3 bumps and win their oars—they deserved them this year. The 3rd VIII, who remained uncaught, rounded off their 3 days' racing in fighting trim and bumped Guy's II. The Rigger Boat, rowing as Barts V, put up a consistently stout effort (it was good to have 8 members of the 1st XV with us) and urged on by distinctly non-rowing (nor rigger for that matter) exhortations from their cox made 2 technical bumps on the last night.

A synopsis of the racing is provided in the table below.

The Committee would like to take this opportunity to thank the many people, too numerous to mention, whose assistance was invaluable in marshalling, pushing-out and counting-down crews. In addition it was heartening to have such good support on the tow-path, particularly on the last night, despite the counter-attraction of the Brighton Stroll. In conclusion, Ian Wilson, this year's Secretary of the United Hospitals' Boat Club, is to be congratulated on the running of the bumps, which brought for the first time sound organisation into an event which has in the past been notoriously ill-managed.

A Synopsis of the Bumps—

Initial Position	Boat	First Night	Second Night	Third Night	Final Position
5th	1st Boat	Row over	Bumped Westminster I	Bumped Guys I	3rd
9th	2nd Boat	Row over	Bumped by Q.M.C.	Row over	10th
13th	3rd Boat	Row over	Row over	Bumped Guys II	12th
15th	4th Boat	Bumped Westminster II	Bumped by Westminster II	Row over	15th
17th	5th Boat	Row over	Bumped by Guys II	Bumped Westminster III	17th
18th	6th Boat	Bumped by Guys III	Bumped by Mary's III	Row over	20th

CREWS:—

1st VIII—Bow, Dr. D. L. King; 2, A. I. Wilson; 3, A. H. Knight; 4, M. E. Dudley; 5, Dr. J. J. D'B. Bartlett; 6, D. C. Dunn; 7, H. Ward; Stroke, H. Coleridge; Cox, I. Cole.

2nd VIII—Bow, I. Wam Ping; 2, T. Hudson; 3, D. Hunter; 4, J. Ransom; 5, B. Bennett; 6, E. More; 7, N. Whyatt; Stroke, K. Stevens; Cox, R. Gleadle.

3rd VIII—Bow, E. Havier; 2, B. Lee; 3, D. Robins; 4, M. Aveline; 5, G. McFlwaine; 6, A. Basharatulla; 7, W. Garson; Stroke, R. Anderson; Cox, I. Gibbs.

4th VIII—Bow, T. Dutt; 2, P. Scriven; 3, D. Hardy; 4, D. Sutton; 5, J. Jilkes; 6, T. Beedham; 7, J. H. Pusey; Stroke, M. Stewardson; Cox, R. Wilson.

5th VIII—(Rigger Boat)—Bow, M. Britz; 2, P. Ross; 3, S. Harris; 4, B. Gurry; 5, A. Knox; 6, P. Niven; 7, M. C. Jennings; Stroke, M. Britz; Cox, G. Renn.

6th VIII—(Gentlemen's Boat)—Bow, D. Glover, Esq.; 2, M. Rolfe, Esq.; 3, Dr. T. Ellison; 4, P. Caine, Esq.; 5, R. Courtney-Evans, Esq.; 6, J. Challis, Esq.; 7, K. Anderson, Esq.; Stroke, J. Merrill, Esq.; Cox, T. J. Powles, Esq.

Tennis

THIS YEAR THE Club has a large number of playing members, most of whom are probably more of 2nd VI standard rather than 1st, but P. Mitchener and A. Edelston, both newcomers to Charterhouse, should help to raise the standard of the first six, they with Jennings, the captain, Kohli and Poore could form the nucleus of a very competent side. D. Delaney, a cricketer from Cambridge, is a great asset on Wednesdays. He plays with a steadiness unrivalled in the club, and at the net his height and eye render him a formidable proposition.

As usual we started badly, against Clare at Cambridge, with a crushing defeat 9-0, only Kingsley and Kohli putting up any show at all. We are always unfortunate in this fixture, it being our first, while the undergraduates have been playing almost daily for several weeks, but nevertheless, there was little doubt as to the abler side in the match. Inevitably the pangs of defeat were rapidly lost at The Ditton Plough, while Kingsley availed himself of the Addenbrookes Casualty Dept.

Team: Kingsley, Kohli, Jennings, Courtenay Evans, Poore, Davies.

The match against West Heath at Hampstead was, as usual, brought to a premature finish by the failing light, but the decision just went against us 4-5.

Team: Jennings, Mitchener, Kingsley, Kohli, Poore, Davics.

The following Saturday the 13th May, we had a scorching hot afternoon's tennis against the Old Wellingtonians. The match was drawn 3-3, our opponents only being able to produce two pairs, and an attempt to give them a pair was thwarted by the Guinness Brighton Stroll. All our pairs easily defeated their weak second pair, but all unfortunately succumbed in three sets to their 1st pair, a useful combination of infuriating but nevertheless accurate lobs from "the Colonel" and some good hard volleying and serving by his younger partner.

Team: Jennings, Kohli, Cooke, Butler, Poore, Robertson.

The following day, we had an unsatisfactory match against the Stonyhurst Wanderers, they again only appeared with two pairs, and this time we had no warning.

All our pairs had no difficulty in beating both their pairs to win 6-0. A Frank showed he had a powerful forehand shot and first service, but he must learn to control the former for it to become really effective. Prosser, in his first game of the season, must have found this game ideal to get his eye in.

Team: Jennings, Kohli, Courtenay Evans, Frank, Prosser, Robertson.

The Physiology of Love

I'm quite appalled when love is called
'A beautiful emotion';
And, sad to tell, I must dispel
This well-established notion.

The tender glow that lovers know
Defies interpretation;
But who would pause to learn the cause
Is vasodilatation?

And textbooks claim the human frame
Is more than two-thirds water;
A damping thought, which ought to thwart
Romance in any quarter!

Each kiss you steal, the thrills you feel,
Are only smallish fractions
Of quite extensive, comprehensive
Chemical reactions.

For learned minds have found all kinds
Of inter-acting factors;
Which operate to stimulate
Our cerebral reactors.

So all in all, if you should call
Your sweetheart terms like "darling",
Do not forget the massive debt
We owe to men like Starling!

R.M.W.P.

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(continued on page 113)

BOOK REVIEWS

The Complete Cookery Book for Diabetics by Iris Holland Rogers. Published by H. K. Lewis and Co., Ltd. 6s.

A survey of diabetic out-patients, which was carried out at Leeds, revealed that in only one sixth of the patients could the accuracy of the dietary treatment at home be regarded as satisfactory. One reason why patients fail to keep to their diet is lack of variety. This difficulty of monotony has been overcome in masterly fashion by Miss Rogers who in the second edition of her Cookery Book for Diabetics has given us a wide range of recipes suitable for inclusion in the diabetic diet. At the head of each recipe is clearly stated how much carbohydrate, protein, fat and total calories it contains. There are dishes with as little as five grams of carbohydrate suitable for low calorie diets and others with twenty grams or more allowing the introduction of such unlikely items as cream of potato soup, steak pie, risotto and golden pudding.

Apart from the cookery section, there is much useful information on food values, on bottling and preserving fruits and on the preparation of meals suitable for invalids. This is an invaluable book which should be in the possession of every diabetic.

K.O.B.

The Newly Born Infant by Andrew Bogdan. Tutorial System Publications. pp. 38. 3s.

At first sight (and even subsequently) it is very easy to criticise this little pamphlet. The preface is anxious to point out that the book is "planned to assist the student to acquire a minimal background". This is probably achieved but the blank pages (for personal notes) might well be potentially more important than the text, as the author

STOP PRESS

Rowing Club

On June 24th the hospital 1st VIII will compete in the Thames Cup event at Marlow Regatta. In the following fortnight they will be living at "The Greyhound Inn", Wargrave, in training for the Ladies' Plate at Henley Royal Regatta (July 5th-8th). The Club would be happy to see past and present Barts' men at the Regatta.

suggests! In effect the pamphlet is a set of ready-made notes and most students would be suspicious of using them to programme an exam-machine.

H.W.

The Clinical Apprentice by John M. Naish and John Apley. Second edition. Published by John Wright and Sons, Ltd., Bristol. pp. 199. 12s. 6d.

This is the second edition of a pocket book which is intended to help students when they, as the authors state, "cross the no-man's-land into the strange, empirical atmosphere of the wards". The aim of the book seems to be to guide students through the steps of a clinical examination and show how the physical signs lead to a diagnosis being made. The book is divided into two sections. The first half is entitled "Examination at leisure" and the second "Examination of Acute Cases". It is arguable whether this is a particularly helpful division in such a manual. Although the book is commendably small the text is not brief enough in many places.

"when you have examined the pulse (and what has taken a considerable time to read about will take up only a little time in actual practice) you must not pass on. . . ."

seems to show that the authors have anticipated a possible criticism! It would have been helpful to have more tabulated information and a greater variety of type to help swift reference to the main points of importance. The diagrams of the chest depicting expansile lung, compressed lung, patent bronchus, collapsed bronchi, vesicular murmur, bronchial murmur and absent murmur all on one glorious silhouette could with advantage be lost before the next edition appears!

H.W.

To the Editor of the Journal:

Must you go all pink and glossy?

Wasn't Rahere quite enough?

I liked it with the paper dull,

And the colour buff.

Even Punch has had to do it.

And more copies may have sold,

But, surely, you could just be Bart's,

Eight hundred years old.

—from an 82-year-old subscriber.

(continued from page 111)

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ST. BARTHOLOMEW'S HOSPITAL JOURNAL



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JUNE 1961

Editorial

THE LONG-AWAITED building has at last begun at Charterhouse. The residents are daily woken at 7.45 by the insistent noise of pneumatic drills and other paraphernalia associated with the building trade.

Many will have noticed the passage of the remnants of the old physiology block, but few will regret their removal; those dungeons of darkness, luring the unwary student from his rightful place in the library to gaze yet again at the dank bricks, the broken bottles and the vast pile of rubbish, which, festering behind the decayed rubble, lay witness to the ravages of Hitler's bombs. More attention, at the time, was focussed on the car park. Indignant students thronged the bar at College Hall denouncing the efforts of the car parking authorities to make them dispose of a proportion of their fleet of old corks.

In vain did they fight. At the end of

November, 1960, the old car park lay empty and desolate, awaiting the arrival of the bulldozers, the dumpy levels, the drills, air compressors, pile drivers, picks, shovels and even jib cranes.

These necessities have now arrived, and we look forward to seeing the completed buildings. We hope that these buildings will equal in design and convenience the new buildings recently opened by Her Majesty the Queen, though it may not be found necessary to have a large extraction fan blowing hot air on all passers by, as does occur in Little Britain.

The Journal welcomes this new development, without which the Hospital would find it difficult to maintain its position of high respect in medicine. If noise is an index of the progress, these new buildings will rise rapidly from the grave of the old physiology block. We herald their arrival.

THE VISIT OF HER MAJESTY THE QUEEN

ON TUESDAY, 30th May, Her Majesty the Queen visited the Hospital to open the Queen Elizabeth II Wing of Special Department Wards, Gloucester House, the new expansion of the Nurse's Home, and the new Radiotherapy Department.

The Queen Elizabeth II building accommodates the Ear, Nose and Throat, the Ophthalmic, the Neurosurgical and the Thoracic Departments. The basement houses the Cardiologist Department, and on the ground floor there is the Diagnostic X-ray and Isotope Departments. Gloucester House is a 12-storey building providing accommodation for 130 nurses, together with a complete Nurse's Training Unit, a Swimming Pool and a large Recreation Hall. The Radiotherapy Unit houses a 15-million volt linear Accelerator, together with a Cobalt Unit.

It was a warm and sunny afternoon, and when Her Majesty arrived she was received by the Lord Mayor of London, Sir Bernard Waley-Cohen, the President of the Hospital, H.R.H. the Duke of Gloucester, and the Minister of Health, the Right Honourable John Enoch-Powell. At the doorway of the Great Hall the Treasurer of the Hospital, Mr. Michael Perrin, and the past Treasurer, Sir George Aylwen, were presented to Her Majesty, after which Nurse Susan Wallace, the last gold medal winner, presented a bouquet.

HER MAJESTY'S VISIT TO THE TEACHING DEPARTMENT

WE HAD BEEN looking forward to Her Majesty's visit for some months with the keenest pleasure. Fifty second-year nurses were having their main medical, surgical and paediatric course at the time, and they worked very hard to prepare for the Queen some demonstrations of the work they were doing in theory and practice, and they were more than repaid by the interest Her Majesty was kind enough to show.

Her Majesty came up to the 11th Floor in the lift, accompanied by H.R.H. the Duke of Gloucester, Lady Margaret Hay, the Rt.

Within the Great Hall were a large number of the Governors of the Hospital and senior members of the Medical and Nursing Staff. H.R.H. the Duke of Gloucester invited Her Majesty to declare the new building open. The text of Her Majesty's speech and also of Sir George Aylwen's reply are reproduced elsewhere in this journal. Mr. Perrin then presented Her Majesty with a copy of a new history of the Hospital written by Mrs. G. Whitteridge and Miss V. Stokes, the Hospital Archivist.

On leaving the Great Hall Her Majesty and the Duke of Gloucester drove around the Square, in which there was a large and enthusiastic crowd of patients, nurses and students. The Royal party then drove to the Queen Elizabeth II block, where Her Majesty unveiled a plaque in the foyer. Accompanied by Mr. Capps and Miss Kendall, the ward sister, she then inspected the Ear, Nose and Throat Unit, where she talked individually to all the patients.

After leaving the Queen Elizabeth II block, Her Majesty walked across Bartholomew Close to visit Gloucester House. There she inspected a nurse's bedroom and sitting room and the Nurse's Training School. An account of her visit to the teaching department is published separately in this issue. Later Her Majesty was entertained to tea in the Sun Lounge on the top floor of Gloucester House by the Governors of the Hospital and their wives.

Hon. Sir Michael Adeane, Matron and the Treasurer. On the landing Mr. Perrin asked leave to present Miss Hector, the Principal Tutor, and the tour of the floor began.

The Queen asked if we liked our new premises, and on being told that we were the highest school in London, remarked that it was a very nice thing to be able to say. She was, as always, a delightful guest, displaying interest in everything, and she graciously spoke to the sisters and many of the nurses whom she met.

She walked around the main lecture room

where a class was in progress, and looked at the illustrative material that the nurses had prepared. In the corridor we had, in a projector, a colour transparency of a snow gum planted by the Queen on her last visit to Canberra. This has grown into a most beautiful tree, and was photographed by the Principal Tutor when she was in Australia this year for the Congress of the International Council of Nurses. Since Her Majesty had stated a week earlier that she was not noted for green fingers, it was pleasant to be able to show her this evidence to the contrary.

The demonstration room was a scene of great activity, and the Queen remarked to the tutor in charge that practical teaching was of the utmost importance. To the student who was bathing the plastic baby, she commented on the slipperiness of model babies, but added that they were not nearly

as slippery as real ones.

In the small classroom was a display about the history of nursing, which made Her Majesty feel that illness in the 18th century must have been most uncomfortable. She then went down the corridor, with its wonderful view to the west over London, commenting on some of its outstanding features: admired the little coffee bar; and said goodbye before going up to the roof for tea.

Though Her Majesty was behind schedule when she arrived and still more so when she left, she was unhurried and relaxed, she gave the impression not of merely performing a duty punctiliously, but of taking a warm interest in our new premises and our work. It would be pleasant if we could tell Her Majesty how beautiful we thought she was in her sunshine-yellow and how often since her visit we have recalled her charm and graciousness.

Fifty years ago

"IF THE PEN be mightier than the sword, then, *a fortiori*, must the pen be mightier than the lancet: and it is with legitimate self-complacency that we seat ourselves in the editorial chair, and take up the editorial pen still warm from the fingers of its recent possessor. We would fain indulge in a Gilbertian autobiographical lyric expressive of our appreciation of the honour which has been granted us, but the difficulty of rhyming in the plural has proved insuperable.

"We have a threefold duty to perform . . . etc. . ."

Thus, every six months, with almost un-failing regularity, each new editor starts his term of office with a pious editorial setting out what, under his leadership, the editorial policy will be. And yet, in spite of a hundred different editors in the last fifty years, the Journal has changed remarkably little. Even the editor's domestic problems never seem to change. . . .

"Our first duty, as always, is to our readers. . . . If there is one feature in which, more than any other, we aspire to emulate our immediate predecessor it is in the commendable regularity with which, under his leadership, the Journal has appeared at the beginning of every month."

Perhaps a few editorial promises are not such a bad thing after all.

Calendar

JULY

Sat.	1—On duty:	Dr. E. R. Cullinan Mr. C. Naunton Morgan Mr. R. A. Bowen
Sat.	8—On Duty:	Dr. G. W. Hayward Mr. A. W. Badenoch Mr. R. W. Ballantine
Sat.	15—On Duty:	Dr. A. W. Spence Mr. F. G. Tuckwell Mr. C. Langton Hewer
Sat.	22—On Duty:	Medical and Surgical Units Mr. George Ellis
Sat.	29 On Duty:	Dr. R. Bodley Scott Mr. A. H. Hunt Mr. F. T. Evans

Readers who enjoyed Fergus Pope's article about Lambarene in the April Journal may be interested to know that an article about surgery at the Albert Schweitzer Hospital has appeared in the 18th May, 1961, issue of the *New England Journal of Medicine*.

THE QUEEN'S ADDRESS AT ST. BARTHOLOMEW'S HOSPITAL.
30th May, 1961

The connection between the Royal Hospital of Saint Bartholomew and our Family is a long one and is happily exemplified today by the presence of Your Royal Highness in the office of President.

I am glad to be able to maintain this connection by coming here to share with you an occasion which is of great significance in the history of your ancient institution.

It marks the formal opening of three new buildings. The Queen Elizabeth II Wing of Special Department Wards, the new Radiotherapy Department, and Gloucester House, the extension to the Nurses' Home. I look forward to seeing the new Wing and Gloucester House during the course of the afternoon.

It would be hard to exaggerate the importance of these three additions to Bart's, each in its different way, and they do great credit to the hospital and to those responsible for planning its development. As a result, all the hospital's activities, which had become dispersed, have now been brought back to one site where they are provided with the most up to date facilities.

However familiar you may be with the achievements of Sir George Aylwen, your past Treasurer, I know that you will agree with me that his services during twenty-three years of office were vital to these developments, and we are pleased to see him here today. He has done much for the hospital and in what he did he had the able help of someone whose name will be remembered with gratitude by all who have the welfare of Saint Bartholomew's at heart—the late Lord Hardinge of Penshurst.

Today we are accustomed to rapid progress in all branches of science, and not least in the practice of surgery and medicine. But this progress brings with it the constant need to develop any great Hospital.

I know that you are still planning for such expansion and I am confident that whatever success the future may bring, the traditions of Saint Bartholomew's, which reach back to the year 1123, will be carried on, as they are today, in the interests of your patients, in the teaching of your students, and in the continuation of research.

I now have great pleasure in declaring open your three new buildings.

SPEECH OF SIR GEORGE AYLWEN IN REPLY TO
HIER MAJESTY'S ADDRESS

ON BEHALF OF all those who serve Bart's and the guests here present, I humbly thank your Majesty for Your gracious presence here today to open additions to our beloved Hospital.

Bart's stands magnificent not only in its antiquity, but in its service to mankind. That Your Majesty has found time to be with us on this great occasion gives enormous pleasure and encouragement to those who give of their best in serving a foundation so famous and so beneficial to all who seek its service—indeed, encouragement to all who work in the ever-expanding field of healing.

It is fitting that I should pay tribute to the many who have devoted time, energy and intelligence over a long period, to the planning and building of our additions. It has not been an easy task and we were very fortunate to have had as chairman of our Planning Committee, during a difficult period, the late Lord Hardinge of Penshurst. Bart's became a major interest in his life and he gave unsparingly his time and energy to the task he had undertaken. His death, a year ago, was a grievous loss and we mourned the passing of a true friend, a man of outstanding integrity, a man whose courage we admired. His work for Bart's will long be remembered.

On the administrative side, I thank Mr. Carus Wilson for his invaluable assistance at all times over many years, the additional burdens placed on his shoulders by our building operations have been nobly borne.

The help and advice received from Mr. Gibbins, our Surveyor, have been of inestimable value, and the Hospital owes much to his foresight and powers of negotiation.

It was Francis Bacon who said "*It is a miserable state of mind to have few things to desire and many things to fear*". Such is not our state of mind at Bart's. There are many things we desire and if there are many things to fear, we shall do our best to dissipate those fears by striving to satisfy our desire for still more buildings in which research work can be expanded with beds for continuous following-up of experiments and sufficient housing and amenities for all our nurses and necessary staff.

The problems of The National Health Service are devastating in their immensity; Mental Health and the Cry of the Chronic Sick call for more attention. Longevity is ever on the increase and this is having a marked effect on all matters affecting health. Much has been done in all these fields, helped very substantially by King Edward's Hospital Fund for London to whom we should be grateful, but the canvas on which the health picture is to be painted is still pretty bare. The grim spectre of Finance overshadows all our vision. Vast sums are spent on unproductive Arms and Defence throughout the world and the attempts to conquer Space would seem to be at the cost of neglecting the *Planet* on which we all exist and makes us rather seek to cure those ills we have than *rocket* "to others that we know not of".

One wonders what value can be put on human life when the Peoples of the world seem bent on producing the means for destroying life at tremendous cost; what a wonderful thing it would be if money and talents so spent were available for betterment and not destruction. To-day we live in a disrupted and ever-erupting world, a world in which the mind is all awry in its efforts to visualise a future, or even to understand the present. Let us hope that sanity will eventually return to a crazy world; in that hope Hospitals will, I am sure, continue to play their part in increasing the value of human life, by helping to prolong it in happy and healthy conditions.

Your Majesty, you have been graciously pleased to receive a bouquet, I will presume to offer you a simple Nosegay, a *mythical* nosegay, made up of those flowers which bloom so abundantly in the wards and operating theatres, indeed, in all parts of this great and ancient Hospital, where Nurses, Surgeons and Physicians do forgather—the flowers of *Self-Sacrifice, Patience, Tolerance, Courage, Kindness and Understanding*. The flowers are bound together with that never-failing perennial—Service.

I would humbly ask Your Majesty to accept this offering with the deep respect, the great esteem and the unfeeling affection of your most loyal servants.

Engagements

- BEKINN—PEAT.**—The engagement is announced between Dr. Peter John Bekinn and Judy-Gay Peat.
- DAVIS—ADDISON.**—The engagement is announced between Dr. John Douglas Davis and Patricia Maureen Addison.
- HARRIS—FARREN.**—The engagement is announced between Dr. David S. Harris and Dr. Patricia Farren.
- HOWELLS—MOORE.**—The engagement is announced between David B. M. Howells and Pauline F. Moore.
- LEHMANN—WILLIAMS.**—The engagement is announced between Dr. Nigel John Paul Lehmann and Julia Jane Williams.
- MAJOR—DAVIS.**—The engagement is announced between Dr. Victor T. D. H. Major and Priscilla A. T. Davis.

Marriages

- FOX—BRANSON.**—On May 12th, Dr. George Noel Fox to Mrs. Marion Branson (Tuppy).

Births

- BEST.**—On May 27th, to Audrey, wife of Dr. Robin Best, a sister (Mary Nora Kathleen) for the boys.
- DUFFY.**—On May 12th, to Juliet and Dr. Thomas Duffy, twin daughters.
- EVANS.**—On April 27th, to Margaret and Dr. Clive Evans, a brother for Gillian and Jane.
- GRAHAM.**—On May 14th, to Christine and Dr. Malcolm Graham, a daughter (Louise), a sister for Jennie and Wendy.
- HAVARD.**—On April 29th, to Mhairi and Dr. Cyril William Holmes Havard, a daughter (Mary Louise), a sister for Mark, John and Susan.
- KNIGHT.**—On January 11th, at Morwell, Victoria, Australia, to Gillian, wife of Dr. John Knight, a son (James Robert).
- LEWIN SMITH.**—On May 22nd, to Rosemary and Dr. Richard Lewin Smith, a son (Guy).
- MCKINNA.**—On May 18th, to Marilyn (née Pearce) and Dr. Alan McKinna, a sister for Andrew (Fiona Elisabeth).
- PEARSONS.**—On April 29th, to Mary (née Jarvis) wife of Dr. David Pearsons, a daughter (Sarah).
- ROBINSON.**—On May 6th, to Barbara and Dr. Keith W. Robinson, a son (Guy), brother for Claire.
- ROCHE.**—On May 21st, to Brenda and Dr. David Roche, a daughter (Pamela Helen).
- TOOBY.**—On May 18th, to Winifred and David Tooby, a son (Hugh Alaric).

Deaths

- CHESTER—WILLIAMS.**—On May 12th, Dr. Frank Edward Chester-Williams, aged 60. Qualified 1924.
- GRIFFITHS.**—On May 16th, Sir Hugh Ernest Griffiths, C.B.E., M.S., F.R.C.S., aged 70. Qualified 1916.
- PINKER.**—On June 1st, Henry George Pinker, F.R.C.S. Qualified 1900.
- SHARPLES.**—On April 22nd, in Georgetown, British Guiana, Dr. E. M. Sharples. Qualified 1924.

Change of Address

- DR. R. JOHN KNIGHT,** lately of Appletree Cottage, Staplecross, Robertsbridge, Sussex, from Millicent, South Australia, to P.O. Box 97, Morwell, Victoria, Australia.

Appointments

- University of London*
M.D. P. A. T. Wood.
Dr. O. J. Lewis, senior lecturer at St. Bartholomew's Hospital Medical College, has been appointed to the readership in anatomy at the college.
- University of Bristol*
On May 6th, the honorary degree of M.D. was conferred on Professor L. J. Witts, Nuffield professor of clinical medicine in the University of Oxford.
- University of Cambridge*
On April 29th the following degree was conferred:
M.D. R. M. Buckle
- University of Melbourne*
Dr. E. B. Verney, F.R.S., Shield professor of pharmacology in the University of Cambridge, has accepted a personal chair in the department of physiology at Melbourne, Australia.
- College of Physicians of London*
M.R.C.P. R. A. Shooter, M.D. Cantab.
- Board of Governors*
Dr. Frank Gray and Mr. C. Naunton Morgan have been appointed to the Board of Governors of St. Bartholomew's Hospital. They will hold office till March 31st, 1964. Mr. F. C. W. Capps was re-appointed.
- Society of Apothecaries*
Sir Geoffrey Keynes gave the Gideon Delaune Lecture at the Faculty of the History of Medicine and Pharmacy, on April 28th 1961. The lecture was entitled "Timothy Bright".
Mr. C. Wendell Smith, lecturer in anatomy, Guy's Hospital Medical School, has been appointed associate professor of anatomy at the University of New South Wales.
Dr. M. W. Partington has been appointed by the Canadian Fund to aid in Research on the Diseases of Children as the first Queen Elizabeth II Scientist.

JAMES MACARTNEY (1770-1843)

by J. L. Thornton

IT HAS USUALLY been assumed that Sir Richard Owen (1804-1892) was the first Lecturer on Comparative Anatomy at St. Bartholomew's Hospital Medical College, following the statement by Sir Norman Moore in his *History* (Vol. 2, 1918, p. 809): "Mr. Owen, who had been a pupil of Abernethy in 1825, was the first lecturer on Comparative Anatomy. . . . He held the office . . . from 1829 to June 6, 1835." In fact, Owen was only officially Lecturer for the last year of that period, although he had been asked to deliver the lectures in 1828. In tracing advertisements of early lectures at the School we encountered James Macartney lecturing on comparative anatomy from 1800 to 1811. On consulting the *Dictionary of National Biography* we found that Sir D'Arcy Power, writing on Macartney, was fully aware of these circumstances, and it is strange that Norman Moore had not read this article. The latter (*Ibid.*, Vol. 2, p. 827) wrote: "James Macartney was Abernethy's demonstrator of anatomy in 1798, and gave lectures in the school between 1800 and 1811." Moore must have been unaware of the subject taught by Macartney, or he would not have given priority to Richard Owen.

Since James Macartney has been forgotten in recent times, and his contributions to comparative anatomy have been overlooked, a brief survey of his life, and an appreciation of his character is herewith presented. His biographer, Alexander Macalister (1900), described Macartney as, "the first man in Britain who taught systematic comparative anatomy to medical students and gave us the first English textbook on the subject; he was the first systematic lecturer on pathology, the first teacher of physiological psychology, and one of the foremost reformers in practical surgery." How came such a genius to be almost forgotten?

James Macartney was born on March 8, 1770 in Ballyrea, Co. Armagh, the son of Andrew Macartney, a gentleman farmer, and his wife, Mary. In early life James suffered from bad eyesight, and did not learn to read until his ninth year. As early as 1780 he was enrolled into a body of Irish volunteers, and was mainly educated at a private school. His school career terminated in his fifteenth year,

and in 1788 his mother died. The following year James left home and entered the office of his cousins who were linen merchants at Newry. However, his father died in 1790, and the three surviving sons returned home, sharing the property, and James was engaged in farming for two years. He joined the United Irishmen, and for a time was keenly interested in politics, but finally decided to study medicine.



Dept. of Medical Photography

JAMES MACARTNEY

Macartney was bound apprentice to William Hartigan (1756?—1812) by articles dated February 10, 1793, but actually signed in March, 1794. He studied anatomy at the College of Surgeons, and chemistry at the University of Dublin, but after his marriage to a Miss Ekenhead on August 10, 1795, he decided to concentrate more heavily on his career, and early in 1796 he left Dublin for Bristol, and travelled up to London. Macartney studied at the Great Windmill Street School, Guy's, St. Thomas's and Bart's, deriving benefit from eminent teachers such as Cruikshank, Baillie, Cline, Astley Cooper and Abernethy. Appreciative of the many gaps in his early education, Macartney now

proceeded to fill them, and kept numerous notebooks containing extensive abstracts of lectures. In 1798 John Abernethy appointed Macartney Demonstrator of Anatomy at £50 per annum, which post he held until 1800, when he qualified as a Member of the College of Surgeons on February 6. During the next month he was appointed Lecturer on Comparative Anatomy at St. Bartholomew's Hospital, and his lectures have been described as the first systematic and comprehensive course on comparative anatomy in Britain. A large number of students attended and the lectures were sometimes advertised as being devoted to "comparative anatomy and physiology". In 1805 the *Medical and Physical Journal* carried a general advertisement for the lectures at the School, as usual, but Macartney was credited with lectures "on Comparative Anatomy and the Laws of Organic Existence". This title varied in subsequent advertisements, but it was this that was one of the main causes for Macartney leaving Bart's. In 1810 he wanted to change the title of his lectures to "Lectures on the forms and laws of life", to which the Medical Officers objected. At the end of the spring term in 1811, Macartney severed his connections with Bart's. He had already had a disagreement regarding the ownership of specimens placed in the Museum, and his relations with Abernethy and other members of the staff were occasionally strained. Macartney was an Irishman, and although John Abernethy was born in London of Scottish ancestry, both his father and grandfather had been born in Ireland. John Abernethy could be very stubborn, and James Macartney had a similar characteristic, as subsequent events proved. In his biography of John Abernethy, Macilwain (1856) quotes two passages attributed to Abernethy, explaining why Macartney left Bart's:

"He saw, from time to time, many men, of whose capacities we know he had the highest opinion, shut out from the hospital by the mere circumstance of their not having been apprentices; and two of these were the late Professor Macartney, of Dublin, and the present distinguished Professor of Comparative Anatomy, Professor Owen."

"He said 'You know the Hospital will not have any but apprentices. Macartney left on that account'."

Soon after beginning to lecture at Bart's, Macartney had taken a cottage at Shanklin, Isle of Wight, coming to London every spring

to deliver his course of lectures. In 1803 he had accepted the appointment of surgeon to the Royal Radnor Militia, but continued to obtain leave each year in order to deliver his lectures. He went to Ireland with the Militia, but ended his military service in 1812, and remained in Ireland. In June, 1813, he was appointed Professor of Anatomy and Surgery at Trinity College, Dublin, and Physician to Sir Patrick Dun's Hospital.

Without doubt James Macartney raised the standard of medical education in Dublin, and his lectures attracted so many students that he had to lecture twice daily. The teaching accommodation was extremely bad, and eventually a new building was erected, but it was badly sited, and not planned as Macartney desired. In fact, when the building was almost completed Macartney met the architect and expressed views that led to his umbrella being broken over the architect's head! Unfortunately, Macartney did not mix well with his colleagues, and his reforms were not appreciated by the other teachers. He met with petty persecution from certain members of the College Board, and the Royal College of Surgeons refused to admit him as a Fellow, although he was elected an Honorary Fellow of the Royal College of Physicians in Ireland in 1818. He had been elected a Fellow of the Royal Society on February 21, 1811, was admitted M.D. at St. Andrew's University in May, 1813, and received an honorary M.D. from Cambridge on August 31, 1833.

Macartney travelled widely during vacations, visiting other schools of anatomy, keeping up-to-date with modern research, and conferring with the eminent teachers of the period. He assisted Warburton in providing evidence which led to the passing of the Anatomy Act in 1832, and had much practical experience of difficulties regarding vivisection, the supply of bodies, and relations with resurrectionists. He was one of the promoters responsible for the formation of the Pathological Society of Dublin, with the object of promoting and diffusing the knowledge of pathological anatomy (*Lancet*, 1838-9, 1, p. 568), and also initiated a process of embalming, and injecting bodies for dissection (*Lancet*, 1838-9, 1, p. 626).

The final dispute leading to James Macartney's resignation on July 11, 1837, was his refusal to alter the times of his lectures, as ordered by the Board. The University of Dublin refused to purchase his museum of

2,007 specimens, which Macartney promptly sold to Cambridge University for an annuity of £100 for ten years. He did not live to the end of that term of years.

On Monday morning, March 9, 1843, he was completing a discourse on "The history of the development of faculties in the animal", to be read before the College of Physicians. He completed the paper with the words:

"The last great event is the extinction of the systematic functions which is commonly called death. As soon as the vitality of the tissue is lost, the body becomes subject to the laws of inorganic matter. The greater part of it is exhaled and is carried by the winds and clouds to distant regions, and finally they descend with rains to fertilise the earth. We thus repay our great debt to nature, and return the elements of our bodies to the common storehouse. Thus ends this strange, eventful history.

"All forms that perish, other forms supply:
(By turns we catch the vital breath and die),

Like bubbles on the sea of matter borne,
They rise, they break, and to that sea return."

The pen dropped from James Macartney's hand at this point, and he was found dead some time later.

Reference :

MACALISTER, ALEXANDER. *James Macartney . . . : a memoir*, London, 1900.

(The preface to this mentions the use of various diaries, letters and notes, which I attempted to trace in the various medical libraries in Great Britain, but without success. After this preliminary communication had been completed, a chance remark to Mr. A. L. Moreton, F.R.C.S., prompted him to volunteer the information that his late wife had been a descendant of James Macartney, and that her brother probably still had a diary belonging to his ancestor. This proved to be the case, and Professor C. Aylmer Macartney of All Souls College, Oxford, kindly lent me the manuscript, which has been photocopied and transcribed. He also put me in touch with Dr. W. F. M. Fulton of Glasgow to whom he had presented one of James Macartney's notebooks. Dr. Fulton kindly lent me this, and I am indebted to all these gentlemen for their interest and co-operation. A later paper will be devoted to the fascinating contents of the diary and notebook, and will also provide details of his publications.)

THE ANDERSONVILLE TRIAL—MERMAID THEATRE

The aftermath of war brings to the victors that for which they have fought: to the vanquished, defeat and the humiliation of answering to crimes and atrocities committed during the preceding strife. Many come to mind, amongst them in recent times the horror of Auschwitz, Belsen and during the American Civil War, Andersonville.

In Andersonville, fifteen thousand Unionist soldiers died. The man held responsible was Captain Henry Wirz. He was tried in Washington in 1865 on the charge that he had carried out a high command policy of deliberate extermination of Union prisoners-of-war in his charge. This trial, the first ever recorded for War Crimes, is the subject of the latest production at the Mermaid Theatre.

The play depicts a conflict between the defence, claiming that Wirz was only obeying his military superiors, and merely carrying out orders as everyone does: for each of us is subject to powers and authorities directing us, but at the same time providing security

and in doing so making us surrender our individual capacity to decide for ourselves. While for the victorious Unionists, the Judge Advocate maintained that the moral right of the individual should influence their action. Right is right and wrong is wrong in the conscience of man.

Right from the start the play holds the attention. The verbal battle on moral issues between Defence and Prosecution make good listening and make up a thought-provoking evening. For at last the Mermaid has obtained the services of actors who know their job, may we hope that this heralds a change of policy the theatre badly needs.

Wirz's fate is in no doubt from the beginning, he is convicted, but should he have been?

Was he right to obey his orders to the letter or should he, in the circumstances, have been ruled by his own personal feelings? It's for you to decide!

J.W.

WANDERINGS THROUGH MEDIEVAL LONDON

By John Newton

LONDON WOULD NOT be London without the River Thames; but what has become of the many tributaries that once flowed into this great river, and what part did they play in the history of our city? Today the only visible signs of these streams are a dip in Oxford Street, near Bond Street tube station, and a twelve-foot opening in the embankment under Blackfriars Bridge—the modern mouth of the River Fleet.

To trace the course of these streams we must first look at the geography of the area. The early settlement of London stood on its twin hills on the northern bank of the Thames, where the river turns through a right-angle and flows southwards again. To the south of London spreads the low-lying ground of what is now Borough, Bermondsey and Southwark; to the east, London looks towards the sea; to the north a ridge of hills rises from the plain, and on these hills the villages of Hampstead and Highgate were to be built. From the numerous ponds and springs which are still to be found in these hills there rose three streams which ran southwards to the River Thames. The most easterly, the River Fleet, rises from two small rivulets which join near Camden Town Station then run on past King's Cross and down Farringdon Road, under Mount Pleasant Post Office, where its waterlogged silt caused a lot of trouble when the new building was erected. The stream then flows under the present Ludgate Circus and New Bridge Street to enter the River Thames under Blackfriars Bridge.

The next stream, the middle of the three, rises at Shepherds Well on the southern part of Hampstead Heath; the name given to this stream is the Tyburn. It flows down to the western part of Regents Park under Marylebone Lane. The name Marylebone is taken from a Church which was built by the side of the Tyburn, called Mary by the Burn, corrupted today to Marylebone. From here the stream flows across Oxford Street near Bond Street tube station, on through Green Park and Buckingham Palace; then it divides, one stream running south to enter the Thames near Vauxhall Bridge, the other

runs eastwards to end in the Thames near Westminster Bridge, thus surrounding the gravel island of Thorney, upon which the city of Westminster has been built.

The third stream—The Westbourne (or Bayswater) rises on Cannon Hill in West Hampstead and flows past the site of Kilburn Abbey, hence its upper reaches were also known as the Kilburn. Thence it runs through Hyde Park, where in 1730 by order of Queen Caroline part of it was dammed to form the Serpentine. It then flows on under Knights Bridge and reaches the Thames at Victoria Pier.

The ground on the north bank of the River Thames consists of the River Gravels which rise in a series of terraces to approximately 100 ft. above sea level, and spread northwards to about King's Cross and Paddington. These are water-bearing gravels and explain the numerous wells which are to be found along the line of the River Fleet.

Now to the River Fleet, or Floet, which is an Anglo-Saxon word meaning creek or inlet. It has had throughout History several names—River of Wells, Holeborne, Turmill Brook and The New Canal to mention just a few. It started off as a defensive moat, then a busy port and finally a nuisance and an obstruction, a source of much annoyance to the inhabitants of the city and to the travellers, as it caused a large dip in the Western Highway leading to the City.

From its source on Highgate Heath down to Kentish Town it ran through farms and fields, which provided a lot of the fresh vegetables for the city. Kentish Town got its name from the River Fleet, as this part of the River was known as The Kent Ditch. The town which grew up around it was therefore known as Kent Ditch Town, corrupted to Kentish Town. At this point it was a stream some three feet across winding between high banks, often overgrown with brambles, it flowed south past St. Pancras and Battle Bridge, running between steep gravel banks to Holborn Bridge. The water from the many wells in Clerkenwell and Islington flowed into this part of the river, which was known as the River of Wells or the Holbourne—the

stream in the hole. From Holborn Bridge to the Thames the Fleet was tidal, widening considerably at its mouth to some six hundred feet. This lower stretch was navigable for quite large vessels and was used by barges and fishing boats until the 14th century.

The wells which were found near the Fleet assumed some importance during the 17th century as many of them were found to be medicinal. Their wares were widely advertised and soon they grew into small Spas with drinking houses, gardens and resting places. Many a young couple were to be seen walking through the fields on a fine afternoon to quaff a pint of the waters and listen to the music provided by the owners, or perhaps to dance a little. At Hampstead Wells in 1688 the waters were threepence a flask, with a concert every Monday at ten o'clock, admission one shilling, and dancing in the afternoon price sixpence. At Islington Wells, often called New Tunbridge Wells, the poor could obtain the waters gratis, provided they produced a certificate under the hand of a known Physician or Apothecary. Another well called Sadlers Well is known to have been in use before the Reformation. The priests of the priory of St. John in Clerkenwell used to dispense the waters to divers ill persons, saying that it worked miracles, but at the time of the Reformation it was stopped up. Then in 1683 two workmen were digging in the garden of a certain Mr. Sadler, who owned one of the new Music Halls, when they found a stone slab some six feet below ground level. On moving this stone they discovered a well lined with stone and richly carved. After making their discovery known to Mr. Sadler, restoration work was carried out and the following advertisement appeared in the *Flying Post*, June, 1697: "Sadlers excellent steel waters at Islington having been obstructed for some years past, are now opened and current again and the waters are found to be in their full vigour, strength and virtue, as ever they were, as is attested and assured by the Physicians who have since fully tried them. They have been for several years known and experimented to be very effectual for the cure of all hectic and hypochondriacal heat, for beginning consumptions, for melancholy distempers, the scurvy, diabetes, for bringing away gravel, stones in the kidneys and bladder and several other diseases. The well will be opened on Monday next, the 21st inst."

Another of the wells in this district went by the name of Royal Bagmidge Wells—nobody quite knows why it is called Royal but there is a delightful story which appears to explain it. In about 1760 two mineral springs were found in the garden of a country house called Bagmidge House, and this house was supposed to be the country residence of Nell Gwynn, favourite of King Charles II. In this house was an effigy of that lady in carved work with fruits of all sorts about her, gilt and in good condition. It was a chimney piece and was supposed to allude to her practice of selling fruit at the playhouses. From this tenant of Bagmidge house the Wells are said to have acquired their Royal title. In December, 1813, the house and contents were sold by auction, as the tenant had gone bankrupt, and among the items in the catalogue is to be found the following entry: 400 doz. bottles of ale, but no mention of the price is made. Near this house was to be found a tumble-down shack called Black Mary's Hole. It got this rather dubious title from the original inhabitant, who kept a black cow. She also had near this shack a conduit through which flowed the spill water from Bagmidge Wells, and the gentlemen in those days were wont to go and drink the milk from the cow and the waters from the conduit.

Having traced the course of the Fleet in its upper reaches this leaves us with its lower or tidal part. Standing on Holborn Viaduct today it is not easy to picture the valley of the Fleet, but the best guide to the contours of the valley are the churches, as these have remained undisturbed while the roads have changed their position. Looking north the valley widens out and on the east is the remains of the burnt-out market hall. On this site in the middle ages was a large pool called Horsepool. Stowe had this to say about it—"Horsepool in Westsmithfield, was sometime a great water, and because the inhabitants, in that part of the city, did there water their horses, the same was called horsepool. It is now much decayed, the springs being stopped up; and the land water falling into this small bottom, lined with brick, is but foul and is called Smithfield pond. This since the fire of London is filled up."

Now to the south of the viaduct and on the Western bank, there is still to be seen today a small lane called Shoe Lane, which links Holborn with the Strand. This was the

main highway in Roman times, when Holborn Bridge was the lowest bridge across the Fleet, and it linked Newgate with Fleet Street.

Facing Shoe Lane across the Fleet was the Fleet Prison, first mentioned in 1170. It was the King's Prison and was used more as a place of detention than punishment. It was first an island site, being surrounded by a ditch, but by 1356 this ditch had become so stagnant and contaminated that the mortality of the prisoners was rising alarmingly. So a commission was asked to report and they found that originally the ditch had been 10 feet wide and of sufficient depth to float a vessel carrying a tun of wine. But by now, 1357, it was completely blocked up with rubbish so the ditch was filled in with rubble. The warden of the prison had other duties. He was keeper of the King's Palace at Westminster, controller of customs on the Fleet, and was responsible for the arches of the Fleet Bridge but not the roadway. His annual remuneration was seven pounds twelve shillings and one penny, but it does not seem to have been enough, for the wardens accepted bribes from the prisoners, and in 1294 Matthew del Eschequer, a prisoner, was allowed out to dine with friends at Christmas, but for this the warden lost his post. The amenities of this prison would have caused the present prison reform committee to die of shock. If you had money everything was all right as it was possible to buy everything from the gaoler. A bed cost a penny a night or a simple couch a penny a week. Charcoal for a fire could be bought for twopence a bushel—giving the gaoler a profit of one half-penny a bushel. Water was brought in buckets, though Newgate and Ludgate prisons in 1436 obtained the overflow from the conduit to the Priory of St. Bartholomew, granted by the monks out of charity. Beer was the universal drink and could be got out of the prison tap at twopence a gallon; it cost the gaoler three-halfpence. The prisoner could also pay to prevent himself being placed in irons, but he had to promise to behave himself. The prison was finally demolished in 1842, and the land was sold to the London, Chatham and Dover railway. Its site is now marked by the Memorial Hall and the railway lines behind it.

St. Bartholomew's Hospital owned two properties in the area east of the Fleet Prison, they also had the use of the Hospitallers' wharf, near the open end of Seacoal Lane,

opposite the North gate of the Fleet Prison. This wharf was owned by the priors of the Hospital of St. John in Clerkenwell. Along with this wharf our Hospital was granted free use of the River Fleet. This wharf was used by Brother Stephen, the hospital procurator, for a grant of certain lands at Rainham in Essex, the rent for this land being brought by boat and delivered at this quay: 28 quarters of corn, 4 cartloads of hay, to be delivered annually two times in the year. The 28 quarters of corn were to be made up of 5 quarters each of wheat, rye, barley and beans and 8 of oats.

There were several industries near the Fleet. In 1343 the mayor allowed the butchers of shambles in Newgate Street to clean the entrails of slaughtered beasts in the Fleet. The butchers had always been a nuisance to the city because of their slaughtering, and it was hoped that they would be less trouble if they used the Fleet. For the privilege of using the Fleet they had to provide the mayor with a boar's head each Christmas. But very soon complaints were voiced that the butchers were causing trouble again; because of the smell it was impossible to live in the area, so the problem was never solved.

The tanning industry was also present, as they found it profitable to be near the butchers for this was where they got their raw materials. But they also hastened the decline of the Fleet by building weirs and by tying hides to stakes in the river in order to clean them. The tanners were also present in the 13th century on the west bank, and the cutlers, in the 14th and 15th centuries in and near Fleet Street. Seacoal Lane as its name implies was near the wharf where the coal brought by sea was landed. It was called seacoal to distinguish it from charcoal, which was used for heating houses, seacoal being used mainly in industry. There is also a reference to a capper, whose presence is accounted for by the facility for scouring his hures in water. Hures were shaggy caps made of sheep's wool and dyed with various bright colours, of which scarlet was one. In the course of manufacture they had to be fulled like cloth, a process performed by hand with earth and water. Fulling by the feet produced inferior work, and the hurers were not allowed to make use of the mills belonging to the fullers of cloth, because the caps being mixed with cloth would crush and

(continued on page 131)



By courtesy of the Evening Standard

Her Majesty receiving a bouquet from Nurse Susan Wallace, the last gold medal winner



By courtesy of the Dept. Medical Photography



By courtesy of the Evening Standard

THE VISIT OF HER MAJESTY THE QUEEN

Tuesday, 3rd May, 1961

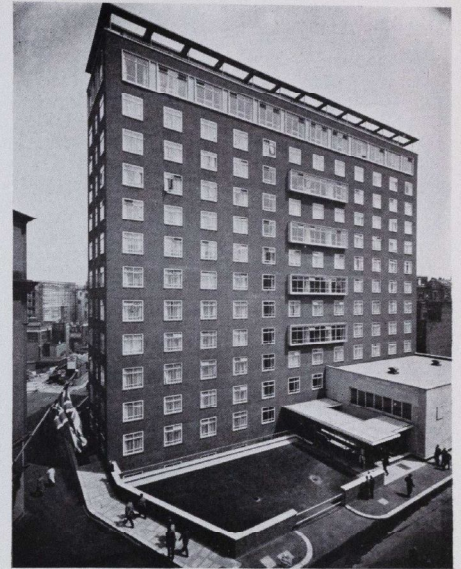


By courtesy of the Evening Standard

Above : The Royal Party crossing Bartholomew Close



By courtesy of the Evening Standard



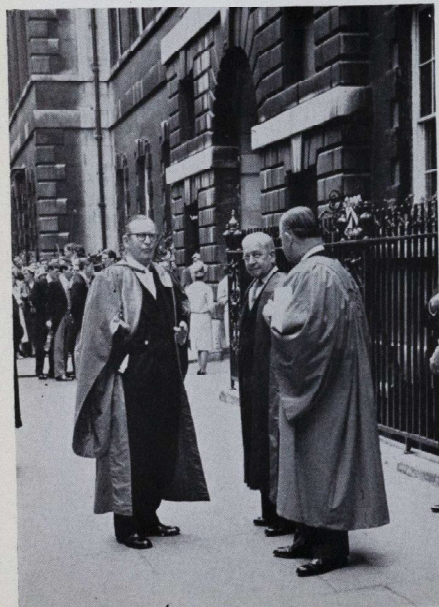
By courtesy of the Barratt's Photo Press, Ltd.

Above : A view of Gloucester House, the new nurses' home

Gloucester House: The Coffee bar
on the 11th floor



By courtesy of Barratt's Photo Press, Ltd.



Dr. Cullinan, Mr. Naunton Morgan and Dr. Bodley
Scott awaiting the arrival of the Queen

tear it. The overseers often prosecuted those who produced inferior work, and in such a case in 1391 the caps were found to have been oiled with grease which, becoming putrid, had caused them to stink when offered for sale. In the middle ages any such goods confiscated on the grounds of being unfit for sale were burnt in the public streets, adding one more to the amenities of London in that time. At various times we find that, besides caps treated in this way, gloves, nets, baskets, blankets, and fish; but perhaps the worst example from the point of view of the inhabitants must have been that recorded in 1471, when a shipload of treacle, after being condemned by a number of Physicians and Apothecaries, was divided into three and burnt at the cross roads by Leadenhall, Cheapside and Tower Street.

Trade on the Fleet was never as busy as in the other London ports, such as Queenhithe and Wallbrook, but there are records of it being used by fishing vessels—oysters and herrings being sold on the quayside, grain for our Hospital, stone for the rebuilding of St. Paul's in Henry I's time, stones for paving Holborn in 1418, and wine for the Fleet Prison. There is also mentioned several blackmarket loads of Welsh cheeses being sold off the boats to avoid the landing charges at other berths. Most of the wharves were private and were used by the owners of the great Inns when they crossed the Thames by boat to avoid the crush on London Bridge.

That the Fleet had a tidal entrance is vividly described in the following story: The year was 1348. Two Florentine merchants, having been robbed by five highwaymen between Romford and Brentwood, followed them to London, and started the next morning to search the city for them. The robbers having separated on reaching London, the merchants came up with one of them named John the Brewer near Paul's wharf, who, to make his escape, plunged into the river which was at low tide, with the object of walking along the foreshore of the Thames and the Fleet as far as the Fleet Bridge, from where he could make his escape out of London. The robber, however, was caught by the rising tide and drowned, and his body, being

washed into the entrance of the Fleet, was left high and dry on its western bank two days later. On his body were found coins and a seal belonging to the merchants.

In 1236 the mayor and aldermen of the city decided to buy fresh water from Tyburn springs, and to pipe it to the city to ease the water supply. The conduit went from Tyburn Valley via Charing Cross and Fleet Street over Fleet Bridge and up Ludgate Hill to Cheapside. But due to the low level of the Fleet and to the pressure required to carry the water up the hill, there were frequent bursts at its lowest point and many houses near the Fleet were flooded on several occasions.

After the fire in 1666 the inhabitants of London were all for cleaning up their city, and a great effort was made to carry this out, the wharves on the Fleet were rebuilt in stone and all the rubbish was cleared out. The lower reach of the Fleet below Holborn Bridge, after this transformation, was renamed the New Canal. Then in 1737 efforts to keep the Fleet clean had again failed and the city council ordered it to be covered over to rid the city of all the trouble it was causing them. The covered area was known as the Fleet Market and it absorbed the old Stocks Market which, with the building of the new Mansion House had to be moved. But the Fleet has not altogether departed from us, as it still wends its muddy and slughish course under Farringdon Street in a 12-foot channel entering the Thames through a culvert 12 foot by 18 foot beneath Blackfriars Bridge and at low tide the flood gates covering the entrance can still be seen from the south bank of the river.

But what is to happen to the River Thames in the future? Is it to go the same way as the Fleet and the other tributaries—with the new "heliports" to be built along its banks and the riverside highway it looks as though in time it might disappear. But whatever happens the magic that is London will always remain within its gates, requiring only a little effort to turn the key—and in the words of Dr. Johnson: "No, Sir, when a man is tired of London he is tired of life; for there is in London all that life can afford."

HOSPITALS AS SEEN BY A G.P.

By J. B. Bamford

I HAVE HAD nothing but help, understanding and guidance from Consultants in hospitals during my 26 years in General Practice, but I do feel that there are many improvements which could help the harmony of the medical profession and the work of the General Practitioner.

This is an attempt to stimulate thought and to encourage Consultants to insist that the lay administrators of our hospitals are made more efficient.

A General Practitioner, when referring a patient to hospital, requires assistance to help his patient to recover from disease, either real or imaginary.

The majority of one's patients, especially in rural districts, have a fear of going to hospital either as an O.P. or an in-patient.

The G.P. hopes, and I feel, should expect, that his patient should be received with courtesy and kindness. Most Consultants, thanks to appointment systems, do not keep their patients waiting long before seeing them, but how many Consultants realize how long their patients may have to wait for the investigations which they have ordered: X-ray, blood test, E.C.G., etc.? The wait for these investigations may be hours, days or weeks. Would any Consultant be prepared to wait even a week for the result of a chest X-ray of his wife?

I make no apologies for quoting in full a letter written to "The Times" this September:

Sir,—If we are to enjoy the benefits of that early diagnosis which is held to be desirable, it is important that a kinder welcome should await the patient than is to be found in many surgeries.

If he is to come before his condition is so bad as to be "interesting", he needs to be made to feel that he has done well to come and not, as so often happens, that his visit is an unwarranted encroachment on the time of a busy man, and that his illness is not serious enough to justify this. Unless he can be made to feel that, he will keep away."

I feel that this is so true equally to G.Ps. (including myself) and to hospital staff that it shows that we members of a great profession must improve our "bedside manners"

which I think have deteriorated a little since 1948.

Firstly, a G.P. likes to be able to refer his patients direct to the X-ray Department and to have a full laboratory service at his disposal. Most of us have these privileges.

Now the biggest annoyances and frustrations to G.Ps. are nearly all administrative, and these are:

1. Delay in receiving reports.
2. The patient returning home without a letter.
3. The patient returning loaded with pills and tablets with no means of identification.
4. Inefficient hospital telephone exchange.
5. Ill patients being sent home from hospital in small crowded uncomfortable cars or by Public Transport to save a few pounds for the Ambulance Service at the patient's expense.

From a medical point of view:

1. The infuriating condescension with which an H.S. or H.P. or even registrar so often treats the G.P. I feel that this can only be cured by students and Hospital M.Os. getting to know more G.Ps. I suggest that all Teaching Hospitals should appoint one G.P. to each Medical and Surgical Firm. That this G.P. should give up one half-day a month and, after a ward round, talk to the students and answer questions, in other words, be the link between G.P. and hospital.
2. The apparent callousness of many casualty departments, i.e. too long a wait before patient being admitted.
3. The long wait for an appointment to see a Consultant.

G.Ps. choose the consultant they think best for that particular patient and often have to "build up" the consultant. In good general practice it should never be a matter of referring a patient to a hospital but to a particular Dr. X or Mr. A. Choosing the consultant for a particular patient is sometimes difficult. A Consultant may find that he only gets one type of case from one Doctor. This is because in a small town the surgeon has become known as a super specialist in this particular disease in this particular town!

Most G.Ps. except those in very remote areas usually have one or more hospitals to choose from — the local hospital, the general hospital in the nearest large town or maybe farther afield to a teaching hospital in London, Edinburgh, Manchester, etc., or a specialist hospital. The choice of hospital is decided by the G.P. and is often no easy task. The patient, the disease, the patient's relatives, the consultant and the nursing staff have all to be considered. I feel that liaison between G.Ps. and Consultants needs to be further improved. The majority of patients trust their G.Ps. whom they know rather than anyone in hospital, consultant or registrar. There is no doubt that consultation between consultant and G.P. is an ideal as so much more can be discussed than written. I personally feel that even a consultation by telephone is not used nearly enough, especially in the difficult case. Nothing is nicer for the G.P. than when a consultant phones him to say that he saw Mrs. X in O.Ps. and thought that she was a case of ——— or says he could find nothing wrong—or that he has operated on Mrs. Z. In other words carrying out the common practice done for one's private patients as for one's hospital patients. Of course, many cases require no special consultation; the hernia and other such straightforward cases.

I feel very strongly that all hospital medical officers are horrified (quite rightly) if a patient comes to them without a letter from their G.P. *But* I do feel then that hospital medical officers must reciprocate and send a

letter back with the patient to their G.P. Surely he is just as entitled to hear from the hospital at once, not days or weeks later. The use of proformas is greatly appreciated such as in Fig. 1, when a patient is discharged, inserted into envelopes printed as in Fig. 2 and given to the patient. In O.Ps. a proforma

Please see that this is given to your doctor at his next convenient surgery

Fig. 2

such as Fig. 3 is probably all that is required for a large number of cases. Carbon copies can be kept if these are made up in booklet form. The proforma in Fig. 4 is most valuable if filled up during a tea break in the operating theatre. It enables the G.P. to phone or call and see the patient's relatives the next day, which inspires confidence all round. One's patients and their relatives then all feel that a real team is at work on their behalf. I wish all hospitals and all consultants would use these forms.

It is always a difficult decision for a consultant to make; deciding what to tell patients and their relatives. For an example, a young

NAME OF HOSPITAL

Date.....

Hospital Reg. No..... Name

Address

This patient was discharged on..... The following diagnosis was

made

and the following treatment is recommended:—

A fuller report will follow.

Signed

Fig. 1

wife, sixteen miles from home, to be told by an H.S. outside a hospital ward that her husband, aged thirty-two, has an inoperable carcinoma of the rectum is absolutely wrong. In this particular case her husband lived three and a half years and she, poor girl, had three and a half years of hell watching him die. If it had been left to the G.P., when he came out of hospital this could have been broken to her gradually as the end drew near.

Another point is that a G.P. likes to know *who* has operated on his patients. He knows perfectly well that H.Ss. and registrars have to operate on his patients. I feel that I like to know who has done it. The credit (or discredit) should go to the person involved.

Chance remarks by sisters, nurses, and even housemen, sometimes have terrible effects. It is so easy for a sister or H.S. to say to a relative after an exploratory laparotomy, where an inoperable carcinoma was found, "If only he had come to us sooner, we might have been able to help him but it

NAME OF HOSPITAL	
.....19.....	
Dear Dr.	Owing to shortage of Staff Secretaries I hope you will accept this brief summary of your patient
.....	
whom I saw this morning.	
Provisional Diagnosis:	
Investigations advised:	
Suggested treatment:	
Yours sincerely,	
A further more complete letter will be sent in due course. (Cross out if not applicable).	

Fig. 3

had gone too far". This was said to the wife of a patient of mine. She was so knocked out by this remark and had no reply as her husband had been attending the hospital O.Ps. for the same complaint for over two years!! It is not always the G.P. who "sits on" the wrong case.

NAME OF HOSPITAL	
Tel. No.	
Hos. Reg. No.:	
.....	
Dear	Your Patient
was operated on to-day.	
A summary of our findings and operation notes is as follows:	
.....	
A further note will be sent to you on the patient's discharge.	
Yours sincerely,	

Fig. 4

I know the difficulties of the hospitals, lack of building, lack of staff, etc., but feel that the time has now come to insist on many improvements. "The friends" of many local hospitals have provided many luxuries for the patients. The time has come for some of these funds to be used to improve consulting and examination rooms, where a consultant can see the patient in privacy and comfort both for the patient and the Doctor. No executive in any big business would see a client in the room provided by many hospital authorities.

I think that G.Ps. may tend to persuade patients to attend hospital too frequently and are not prepared to carry the responsibility of backing their own diagnosis and treatment. I also feel very strongly that patients are often asked to return to hospital too frequently and it should be unnecessary for the patients to return to hospital to get the result

of an X-ray. Surely this could be sent to the Doctor to deal with according to the report.

Nothing is more frustrating than finding that an appointment is for four to eight weeks ahead, except possibly having to wait more than a few days for a report from hospital! Seeing the patient daily and saying "no news yet" does not inspire confidence and is really gross inefficiency. Surely the immediate modern photography of notes could be used extensively and incidentally would encourage better note-writing!

If so many old patients were not asked to return to hospital perhaps the medical staff would have more time for seeing new patients sooner. The time lag is longer now than it was twenty-five years ago, although the medical standard and length of the report are much better. Often, too, a patient with nervous dyspepsia merely requires re-assurance, i.e. a second opinion, not always a full X-ray and blood investigation, especially when serious cases have to wait.

To summarize, I expect my patients to be received at hospital:

1. With courtesy and politeness, remembering that both educated and uneducated patients are terrified of hospitals, sisters, nurses and doctors.

2. With promptitude. It is a crime to keep anyone waiting if it can be avoided. The patient's time may be much more valuable to the community than the Doctor's. Apologies for delay are always appreciated and cost nothing!

I HAVE READ the article "Hospitals as seen by a G.P." and am in full agreement with the spirit in which it is written namely, the desire to improve the service to the patient. There are times when all members of our profession—usually by omission but sometimes by commission, are guilty of some of the faults mentioned in the article, but steps have been taken at our Hospital to overcome many of the difficulties.

I agree that delay in sending reports about patients should be reduced to a minimum. It is not often that the result of an out-patient's consultation requires to be given by

3. Diagnosis and treatment of the patient as well as the disease.

4. Prompt report to the G.P. of diagnosis, treatment and disposal.

I have always enjoyed full and excellent X-ray and laboratory services without which General Practice would not be so enjoyable. To be able to refer a limited number of cases to a physiotherapist would help to make my life as a G.P. more complete.

I also humbly suggest that every Medical and Surgical Consultant should have a private secretary (paid partially by himself and partially by the hospital) to help him to organize the numerous minor and personal details which are so important not only to the consultant but also to the patient and by no means least to the G.P. It is a joy for a G.P. to speak on the telephone to an efficient, reliable and cheerful secretary, rather than having to bother a busy consultant on some trivial point which may be most important to a patient.

As a final suggestion, I should like to see the consultant's domiciliary consultation fee doubled for any visit more than five miles from his residence. To ask a busy consultant to come fifteen miles for £4 4s. is asking him to do a favour. It is a great credit to my local consultants, who have never once hesitated about coming at my request. The value of the domiciliary visit is most important to medicine as a whole. Consultant meets G.P. Consultant sees patient's environment, etc. It affords an occasion for the G.P. to keep up to date by picking the Consultant's brains.

return but should this be necessary, a report is written by hand and given to the patient, or some responsible member of the firm contacts the patient's Doctor by telephone. The usual practice is for all opinions to be dictated, at the end of the consulting session and a letter typed, signed and despatched within the next 48 hours. I may say that this also occurs in my private practice.

In the case of in-patients, the despatch of some information is much more urgent. The houseman fills in a brief summary of the diagnosis, treatment in hospital and suggested follow-up treatment on a form and this is

given to the patient on discharge, so that the attending practitioner may be kept in the picture. It may, however, be a week or so before a full typewritten summary, which will include the results of investigations, is prepared and sent out.

I agree entirely that all pills and medicines should be dispensed with information on the label, sufficient for any doctor to be able to identify them. The number of unidentified pills—expensive and probably useful—which must clutter up drawers and cupboards in most households, is frustrating, wasteful and adds appreciably to the cost of the Health Service.

Telephone communication in most hospitals is notoriously bad. Considerable improvement has resulted at Barts, with the introduction of the House Officer and "Electrical Call System".

G.P. relationship throughout the country has traditionally been a little tricky. Every doctor knows that he was most confident and full of knowledge on completion of his house jobs. The facilities of Hospital allow for more accurate diagnosis and treatment and the arrogance of youth may at times seek to denigrate the overworked general practitioner. For some years there has been a liaison practitioner at Barts, and all students are encouraged to spend some time—admittedly short—working in general practice before qualifying. We hope this may not

only add to the student's knowledge of practice, but may militate against false superiority.

I agree entirely about indiscriminate remarks and innuendos in regard to delay in treatment by any member of the staff. The passing on of adequate information to patients and relatives is an important duty and the extent of this information will vary from case to case. A physically ill patient is often not quite mentally stable and it is important to remember that patients and relatives usually listen avidly to all that is said, and often attribute much more to a chance remark or even to an inflection in the voice than is intended.

We must always remember that the doctor is in a most powerful relationship to his patient. Not only has he, occasionally, the power of life and death, but he has always the power of re-assurance and of consolation.

The appropriate psychological approach to each individual comes with experience and we are consciously and unconsciously trying to cultivate and instil in our juniors the best approach. This must always be kindly and tolerant. Fortunately, most members of the profession look on medicine as a vocation as well as a scientifically interesting and not unrewarding way of earning a living. As long as this continues, so, too, will the doctor-patient relationship remain reasonable.

A.W.B.

Epitaph for a Perennial Student

He stood outside the Pearly Gates,
His head was bent and low,
And wearily he asked the Clerk
Which way he ought to go.

"What have you done," the Clerk inquired,
"To be directed here?"
"I've failed my Finals, sir," he said,
"In the fourth successive year!"

"Good gracious me!" St. Peter cried,
"Another ne'er do well!
But, come inside and choose your harp,
You've had your share of hell!"

R.M.W.P.

THE PEDAL GLANDS OF OWEN

By Professor A. J. E. Cave

SIR RICHARD OWEN (1804-1892), the most distinguished of the scientific sons of Barts, was a student under John Abernethy (1764-1831), whose greatest claim to the gratitude of later generations lay perhaps in his recognition of Owen's extraordinary talents as a morphologist and his singular fitness to be the custodian of John Hunter's unique Museum. Largely through Abernethy's influence, Owen abandoned clinical work to become Assistant Conservator (1827), under William Clift, and later Conservator (1852) of the Hunterian Museum at the Royal College of Surgeons of England. The routine checking, re-examination, cataloguing and augmentation of the extensive comparative series in that Museum, conducted for the most part under considerable difficulties, compelled Owen to undertake an increasingly wide and detailed exploration of the comparative morphological field, both vertebrate and invertebrate, work resulting in a phenomenal output of memoirs, catalogues and papers which were to remain classics of their kind.

As an anatomist Owen displayed an acute observational faculty and a promptitude of attention to detail. Since his avowed and constant practice was "to describe with accuracy and to delineate with fidelity", it is small wonder that his copious and varied monographs were exemplars of their kind, that numerous discoveries in palaeontology and morphology stand to his name, and that his findings were, and are still, accepted almost unreservedly.

To some of these findings attention has been previously drawn (Cave^{1, 2}) in these columns, as much for their moral as their scientific value, since the observant eye and the accurate pen are not devoid of exhortatory influence in any department of medical or biological science. In similar fashion, and in a spirit of filial piety, attention is hereby drawn to another of Owen's minor, but not insignificant, discoveries—that of the pedal glands of the Great Indian Rhinoceros (*Rhinoceros unicornis* Linn.), and corroborative evidence is given (seemingly for the first time) of the accuracy of Owen's original observations.

In 1834 Owen had persuaded the Council

of the Zoological Society of London to purchase for £1,000 a male Indian rhinoceros, the first of its kind to be acquired by the Society. This animal died in 1849 and was immediately anatomised by Owen³, whose subsequent monograph (1862), with its 14 lithographic plates, remains the classic account of the anatomy of this species and by chance the first such to be published. (By chance, because another male animal of this species had lived in the Royal Menagerie at Versailles from 1772 to 1793. At death it was dissected by Vicq D'Azyr and Meritud and its skeleton is still preserved (No. A7974) in the Musée d'Anatomie Comparée in Paris. Vicq D'Azyr also wrote an account of its anatomy, illustrated by some 31 plates prepared by Marechal and by P. J. Redouté père et fils, but this account and the accompanying plates have remained unpublished in the Archives of the Muséum National d'Histoire Naturelle.) It may be argued that the establishment of the descriptive anatomy of any large mammal requires no particular acumen or knowledge but merely industry, prosecutorial assistance and a sufficiency of time. This contention is but partially true, for the known gross anatomy of man is necessarily based upon a vast number of meticulous dissections, and, where the dissection of large mammals is concerned, certain adverse factors inevitably complicate procedure. The material under examination is both bulky and unwieldy: its injection or embalment is usually impracticable: the physical labour of manipulation is considerable, and investigation tends quickly to become a race against advancing putrefaction. Not surprisingly, therefore, an accurate and complete picture of the morphology of any very large animal is unlikely to be obtained from the examination of a single carcass, while the necessary specimens themselves become available but sporadically. Consequently, knowledge remains wanting of the gross structure of a wide variety of undomesticated mammals. Though much is known, much more requires elucidation.

It is ever a tribute to the original recorder of morphological data that subsequent investigation should but confirm the accuracy of his findings. And in this present matter

of the pedal glands it is a tribute to Owen that his original description requires merely the slightest emendation.

Examining the external characters of his rhinoceros specimen in 1849, Owen³ noted a feature missed by Daubenton, F. Cuvier and other earlier and excellent observers, namely the presence of an "orifice behind each carpus and tarsus, which forms the termination of the duct of a pretty large subdermal glandular pouch". In the thick and tuberculated skin of this species this orifice is easily enough overlooked, particularly since all four orifices "are concealed from cursory observation in the middle of the transverse fold that runs parallel to the interspace between the carpus and metacarpus, and between the tarsus and metatarsus"³. Even when their existence is known beforehand, these gland orifices are by no means obtrusive, so that their original discovery reflects great credit upon their finder's observational acuity. The authors of subsequent zoological treatises have been content to accept the existence of these pedal glands solely on Owen's great authority, without, apparently, any re-investigation of their presence and nature, but taking due notice of these structures in connexion with the niceties of rhinoceros taxonomy.

The present writer has, however, confirmed the presence of these pedal glands in three specimens of the Great Indian Rhinoceros from the menagerie of the Zoological Society of London, viz. in a male ("Felix") of 20 years in 1941; in a younger male ("Hush") of some 15 years in 1945, and in an adult male ("Mohan") aged 18 years at least, in 1961. From the last of these specimens the glands were dissected and are illustrated in the accompanying figure.

Owen³ described the pedal glands, which he duly figured, as "of a compressed ovate figure, measuring one and a half inches in length and one inch in breadth" with parietes "two to three lines" thick (i.e. about one quarter inch), and consisting of "a compact congeries of follicles, surrounded externally by a muscular and tendinous coat". The duct orifice could stretch to some three quarters of an inch. Personal observations are largely confirmative of this original description. The formalin-preserved forefoot gland of specimen "Mohan" (Fig. 1, A) measures 44 mm. long by 29 mm. wide; the similarly preserved hindfoot gland (Fig. 1, B) measures 48 mm. long by 22 mm. wide. The transversely

elliptical neck of each gland when fresh was readily distensible up to 20 mm.: The gland wall is some 8 mm. in thickness; the undisturbed ostium is a round orifice, some 3 mm. across. The shape of either gland is apparent in the accompanying illustration, which shows also the substantial fundal vasculature, the anchoring "ligaments", and the short neck of the sac: in the fresh state, compression of the gland causes the exudation of a thick grumous secretion.

The pedal gland in *Rhinoceros unicornis* is essentially a local invagination of the entire skin supported by a circumscribing condensation of the dense collagen tissue of the subcutaneous fascia: this dermal invagination is associated with a localised augmentation of modified sebaceous glands which are strikingly absent from other areas of the skin of the foot. Histologically the wall of the invagination shows successive dermal, capsular and fascial layers. The epidermis lining the sac is a thick, excessively cornified, stratified squamous epithelium. In its stratum corneum "ghost" cells are discernible and one particularly obvious layer of such cells represents a stratum lucidum. The stratum granulosum, which in places is 8 cells thick, shows basophilic granules of varying size, some of the granules being relatively large. In the cells of the basal layer of the stratum Malpighii (i.e., next to the basement membrane) considerable patches of melanin are present. The dermal papillae are long, narrow and close-set, and penetrate so far into the epidermis as to reach the stratum granulosum: dermis and epidermis are thus very tightly keyed together. Outside the dermal layer lies the capsular component of the sac wall, a thick, dense, felting of collagen fibres liberally supplied with blood vessels, some of which possess extremely muscular walls. This tough, thick, collagen layer is a condensation of the local subcutaneous fascia from which it is easily separable and by local "ligamentous" thickenings of which the whole sac is anchored in position.

Deep in the dermal layer of the sac wall lie numerous, large, apocrine glands, the acini of which manifest recognisable myoepithelial cells. The mouths of these specialised mucous glands open at intervals through the epidermal lining of the sac to discharge their thick secretion into its lumen. The abundance of these apocrine glands, in conjunction with the extreme vascularity of the sac wall, sug-

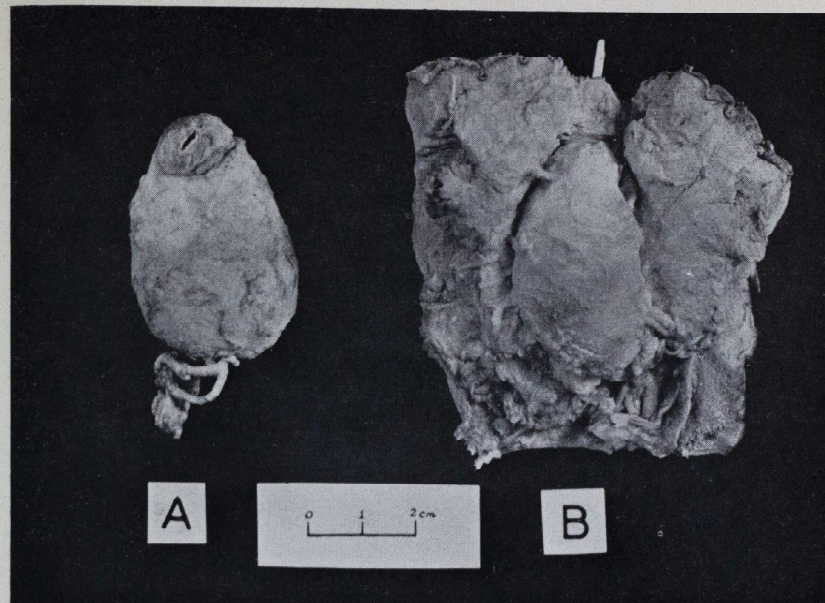


Fig. 1 Pedal scent gland of Great Indian Rhinoceros (*R. unicornis* L.). Adult male animal. (a) Isolated gland of left manus, showing ostium and fundal vasculature. (b) Gland of left pes, dissected *in situ*, showing vasculature, retention "ligaments", and introduced rod. Cm. scale

gests that secretion is a fairly continuous process, and that the lumen of the sac is never wholly devoid of content. Apart from the smooth muscle in the walls of the local blood vessels, no muscle tissue whatsoever is present in the sac wall, contrary to Owen's original statement. This discrepancy of description doubtless arises from Owen's omission to make a microscopical preparation of the wall of his pedal gland and hence to realise that the pinkish colour of the sac parietes is due, not to the presence of muscle, but to an extremely elaborate vasculature.

The presence or absence of the pedal gland is helpful in connexion with the taxonomy of the extant Rhinocerotidae. This family comprises two Asian genera (*Rhinoceros*, *Didemnoceros*) and two African genera

(*Diceros*, *Ceratotherium*). The genus *Rhinoceros* has two species, viz. *R. unicornis* (Great Indian Rhinoceros) and *R. sondaicus* (Javan Rhinoceros). The exact relationships of *Diceros* (Black African Rhinoceros) and *Ceratotherium* (White Rhinoceros) remain unsettled, largely for want of sufficient morphological knowledge concerning these two forms. Certain it is, however, that the living rhinoceroses represent the products of three distinct phylogenetic lines, one leading to the Great Indian and Javan species, a second to the two African species and a third to the Sumatran species.

In certain of its anatomical characters this last form (*Didemnoceros sumatrensis*) agrees with its Asian congeners, but in other characters it agrees with the African forms. In a

particular character (e.g. the separation or confluence of the foramina lacerum et ovale) different specimens may show variant affinities.

The pedal gland is confined to the genus *Rhinoceros*. Noted first by Owen³ for *R. unicornis*, it was later observed by Beddard and Treves⁴ in *R. sondaicus*. According to Garrod⁵ it is absent in *Didermoceros*, which herein would seem to agree with the African rhinoceroses. The gland was also wanting in three specimens (a 2-year-old female, a 1-year-old male and a late foetal female) of *Diceros* examined by the writer and, so far as observation is possible of captive animals, it is wanting also in *Ceratotherium*.

In the remaining Perissodactyla the gland is unknown in the Equidae and appears to be equally wanting in the Tapiridae, for it is not recorded for the Malayan Tapir by Murie⁶ or Beddard⁷, nor for the American Tapir by Beddard⁸ or Bressou⁹. The writer found no trace of any pedal gland in a very young specimen of the American species. So far, therefore, as present knowledge goes, specialised pedal glands among the Perissodactyla are confined to the genus *Rhinoceros*, whilst among the many families of the Artiodactyla such organs are widely distributed (Pocock¹⁰).

Since the pedal glands are undoubtedly scent glands, expressing their secretion pretty continuously during the animal's peregrinations and so blazing an olfactory trail for the benefit of its male, young or fellows, their restriction to a single genus among extant rhinoceroses is puzzling. An olfactory trail

is obviously most successfully laid in a firm, dry terrain (e.g. grassland, low bush, savannah) and can scarcely prove successful in a marshy or swampy habitat. Thus, a priori, well-developed pedal scent glands might be expected to occur in *Diceros* and *Ceratotherium*, which frequent the dry African bush, and their absence in *Rhinoceros* and *Didermoceros*, inhabiting swampy jungle, would not be surprising. As indicated, however, the facts are obstinately otherwise and the answer to this apparently anomalous distribution has yet to be sought.

It may be added that problems of function and distribution are not confined to the pedal glands, which are but one among the many forms of specialised cutaneous appendage which the multi-potential mammalian skin is capable of producing. Other intriguing cutaneous glands include those of the face (Wart Hog), the preorbital region (Cervidae), the temporal region (Elephant), the occipital region (Camels), post-cornual region (Chamois), dorsal mid-lumbar region (Pecary, Tree-Hyrax), the tail (Goats), the perianal region (many Carnivores and Rodents), the prepuce (Aard-Vark, Pig, Musk Deer, Grybok), the inguinal region (many Ungulates), the metatarsus (Llamas, Deer), the digits (Pig), the nails (Four-horned Antelope), the sternum (most Marsupials, Gibbon, Spider Monkey), the gular region (Saki Monkey) and the epigastriumi (Tarsier).

The function of some of these glands is extremely obscure, so that a wide and rewarding field of exploration still awaits the attention of both the histologist and the animal ecologist.

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UNIVERSITY OF LONDON

Final M.B., B.S., Examination April 1961

Honours

Bonn, J. A. (Distinguished in Obstetrics and Gynaecology)
MacDonald, A.-M. E. (Distinguished in Surgery)

Pass

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Bartlett, J. J. D.	Herbert, D. C.
Beardwell, C. G.	Janosi, M.
Bishop, M. B. J.	Kajtar, T.
Bratton, L. W.	King, D. E. L.
Childe, M. W.	Knight, C. R.
Darmady, J. M.	Lines, A. J.
Davies, J. D.	Millington, M.
Davies, R. P.	Padfield, A.
Drake, R. M.	Shaw, A. B.
Edmondson, R. S.	Shaw, B. N.
Evison, P. R. H.	Telfer, A. C.
Fell, R. H.	Theobald, G. M.
France, R.	Therkildsen, L. K. H.
Gandy, R. H.	Thomson, W. H. F.
Gill, B. V.	Weeks, S. K.

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Jones, J. R. L.	Watson, J. U.
Jones, N. O.	Welch, D. M.

Part II

Banky, P. I.	Collingwood, R.
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Part III

Barton, M. T.	Davies, R. R.
Christian, P. B.	Pagan, W. H.

Part IV

Amponsah, F. I.	Collingwood, R.
Banky, P. I.	Pagan, W. H.
Barton, M. T.	Visick, J. H.
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McNeill, C. A.	

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Shaw, A. B.	MacDonald, A.-M. E.
Kajtar, T.	Bonn, J. A.

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

Thomas, B. O.	Theobald, G. M.
Knight, C. R.	Darmady, J. M.
Davies, J. D.	Kajtar, T.
Lines, A. J.	Herbert, D. C.
Telfer, A. C.	MacDonald, A.-M. E.
Shaw, A. B.	Bonn, J. A.
Anthony, P. P.	Childe, M. W.
Davies, R. P.	

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SPORTS NEWS

Sailing Club Regatta May 10th - 12th 1961

The Sailing Club was blessed this year with three days of perfect weather for its Annual Regatta.

The United Hospitals' Sharpies were in full use, and other boats used were the Enterprise, a Firefly and a Royal Burnham One Design.

The first day of the Regatta was spent in acclimatising members to the vagaries of the Sharpie, and a most enjoyable practice race was held in the afternoon.

The morning race on May 11th was for The Commodore's Trophy.

The wind was light with a fair tide for the first part of the race, and reaching with the tide, the majority of helmsmen overstood the second mark.

In the confusion at this mark, there was a collision between two boats, one of which then drifted onto the mark, and several near misses. David Dorrell did not make the mistake of overshooting the mark and drew clear away to win the trophy by one minute from A. M. Pollock.

The 1960 Cup was awarded this year to the winner of The Ladies' Race.

The two Flag Officers present each took part as pace-makers. The Commodore proved to be such a good pace-maker that he won the race by almost half-a-mile! However, the first lady home was Rosemary Benison, with Ann Brodribb second.

The choice of "The Ship" for the Annual Dinner that evening was no reflection on the culinary accomplishments of the resident cooks, Margaret Wood and Jill Snow, who provided most appetizing meals during the regatta.

The Dinner proved to be a great success and a most enjoyable evening was spent during which the cups and prizes were presented.

The last day of the Regatta was devoted to a cruise to Fambridge, but the wind proved too light and the tide too strong and not one boat reached the destination in time for lunch!

However, everyone spent a most enjoyable day combining a gentle sail with opportunities for sunbathing, thus bringing to an end a memorable regatta.

D.B.M.H.

RESULTS

Practice Race

1. Miss R. S. Benison
2. D. B. M. Howells
3. D. Colin-Jones

Commodore's Trophy

- | | | | |
|-------------------|-----------------------|-----------------|--|
| | | <i>1960 Cup</i> | |
| 1. D. Dorrell | 1. Miss R. S. Benison | | |
| 2. A. M. Pollock | 2. Miss A. Brodribb | | |
| 3. J. C. Crawhall | 3. Miss E. M. Wood | | |

Rifle Club—Small Bore Report

The 1960-61 season has seen generally mixed fortunes. Only one league team, the "C", has been successful, but all the other teams have been well placed. There have been a number of individual successes in the United Hospitals and University of London competitions.

In all, 80 matches have been shot, 51 won and 29 lost.

United Hospitals Winter League

Division 1

Two poor shoots by the "A" team meant that the best they could achieve was a third place behind the Westminster and Guy's.

"A"	Shot 9	Won 7	Lost 2
	Pts. 14	Score 4331	3rd
"B"	Shot 9	Won 5	Lost 4
	Pts. 10	Score 4172	5th

In the Individual averages, A. M. Ward was second with 98.4, P. N. Riddle tenth with 97.1, and A. J. B. Missen fifteenth with 96.3.

Division 2

This division proved a close fight between the "C" team and Westminster "C", with the "D" not very far behind.

"C"	Shot 7	Won 6	Lost 1
	Pts. 12	Score 3265	1st
"D"	Shot 7	Won 4	Lost 3
	Pts. 8	Score 3135	3rd

A. J. Austin was first in the Individual averages with 93.86, K. E. Gray was fifth with 93.6, and M. Smith-Walker sixth with 93.4.

National Short-Range League

Division 33

The entry of a team in this league was a new

venture, and the standard of the competition was unknown. We were placed in Division 33, a little above half-way, there being 78 divisions each of 11 teams. The final position was sixth.

Shot 10	Won 5	Lost 5
Pts. 10	Score 4764	6th

The League medal for the highest average in the team was awarded to A. M. Ward, 97.80, A. J. B. Missen was second with 96.00.

University of London Pistol League

Division 2

Having been left with only three of our pistol shots from last season, the team did very well to finish second to a strong Queen Mary College team, at whose hands they received their only defeats.

Shot 10	Won 8	Lost 2
Pts. 16	Score 4170	2nd

The highest individual average was returned by F. J. R. Hardy, 151.1.

United Hospitals Knock-Out Competition

Of the five teams entered, three shot in the last eight, and two reached the last four, but this proved to be the end of their run, both the "A" and "B" losing in the semi-finals.

University of London Knock-Out Competition

The field here was divided into three divisions, the "A" being drawn in Division 1, the "B" and "C" in Division 2, and "D" in Division 3. Of these only the "D" survived the first round, and they went on to win their division, albeit with an ever decreasing score.

United Hospitals Individual Competition

This year the competition was run in two stages, the top six in each class shooting in the second stage. A. M. Ward was fifth in Class A; F. J. R. Hardy was first and M. T. Barton second in Class B; and J. D. Edwards second in Class C. Miss J. C. Stephan was second in the Ladies' Competition.

University of London Individual Competition
F. J. R. Hardy won Class C, and J. D. E. Edwards won Class D.

University of London Small-Bore Meeting at Twickenham

Six members were among the entry of 72 at this meeting, and it is the first time that a team from this Club has been entered. For many of the members it was a completely new form of small-bore shooting, it being the first time they had shot at ranges greater than 25 yards. The changes in conditions

with increased range, variations in light, and the effects of wind produced problems that could only be ironed out with practice. Even those conversant with the effects of wind on the service rifle bullet seemed at a loss when it came to allowing for the effects of a gentle fishtailer on the light small-bore bullet at 100 yards. The team was second in the Hospitals event, but unplaced in the Handicap event. Individual successes were limited, J. D. E. Edwards was second in the Class C Unlimited, and F. J. R. Hardy first in the Pistol Unlimited.

Shoulder-to-Shoulder Matches

One pistol and ten rifle matches were fired under these conditions during the season, and no fewer than twenty members of the club took part. On an aggregate of three matches, the club beat the G.P.O. by two matches to one, the aggregate scores being 3356-3296. In a pistol match against the same club, the result was another win, this time by the small margin of five points.

v. St. Mary's Hospital (Away)	Won 754—723
v. London Hospital (Home)	Won 762—699
v. Westminster Hospital (Home)	Lost 1519—1547
v. City Police (Home)	Lost 1148—1162
v. St. Thomas' Hospital (Away)	Won 752—743
v. St. Thomas' Hospital (Home)	Won 754—750
v. City Police (Away)	Won 1156—1155

Browne-Martin Competition

As in this competition last year, the team was knocked out in the first round, but this time by the losing finalists, Twickenham, by the fairly large margin of 753—787.

Inter-Year Match

This was won by the First Clinical Year with a score of 377.

Lady Ludlow Challenge Cup

Winner: A. M. Ward.
Runner-up: A. J. B. Missen.
Mrs. H. J. Waring Challenge Cup
Winner: J. D. E. Edwards.
Runner-up: S. J. Sinclair.

During the past season the following have shot for the United Hospitals.

1st VIII and Pistol V:

A. M. Ward and F. J. R. Hardy.

2nd VIII:

A. J. B. Missen; P. N. Riddle; A. M. Pollock; and J. A. Pearson.

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To be continued in the July issue

BOOK REVIEWS

Midwifery, Ten Teachers. Tenth Edition.

Published by Edward Arnold, Ltd. pp. 739. 45s. Edited by Frederick W. Roques, John Beattie, Joseph Wrigley.

This is the tenth edition of a deservedly popular textbook. The only change in the distinguished list of contributors is that Mr. Douglas MacLeod has retired and he has been replaced by Mr. Robert Percival. When a book of this sort has been used so extensively by students since the first edition in 1917 it is only possible to make minor criticisms and suggestions. Sometimes it seems to be assumed that a student has, or will have, read the companion volume 'Diseases of Women'. In some ways this is justifiable but occasionally it would be an advantage to have the same ground covered in each book to save cross reference. The new chapters on Blood Transfusion in obstetrics and Vital Stastics are very welcome. Since the last edition the chapters on Abnormal Presentations, Diseases Associated with Pregnancy, Obstetric Operations and Caesarian Section have been largely re-written.

H.W.

Great Biologists by Harley Williams.

Published by G. Bell. 159 pp. 13s. 6d. The popular biographies by Dr. Harley Williams have been greatly appreciated by the general public, and by all interested in portrait sketches rather than in serious, documented, biographical studies. This volume contains pen portraits of eight biologists: Aristotle, the father of biology, and the first scientific naturalist; Linnaeus, whose classification of plants greatly influenced the development of botanical science; Antony van Leeuwenhoek, pioneer microscopist; Erasmus Darwin, grandfather of the immortal Charles (who is also represented), and Lamarck, a far greater scientist than is generally appreciated; Alfred Russel Wallace, whose name should be closely connected with that of Charles Darwin when natural selection is under discussion; and Thomas Hunt Morgan, who greatly advanced the science of genetics through his studies of *Drosophila*.

The illustrations add to the value of the essays in this moderately priced book, which can usefully be read as an introduction to the more lengthy biographies listed as references. J.L.T.

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The authors have called acute abdominal pain and vomiting, which have no diagnostic label, intra-abdominal crises. First they analyse the problem of the abdominal emergency, indicate the lines of early management, and stress the importance of diagnostic exclusion. The main theme of the book, however, is the increasing role played by the techniques of radiology and biochemistry under conditions of crises. The significance of the results obtained involves wide possibilities of anatomical and pathological interpretation, with a broadening of the problems of differential diagnosis.

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in ENDOCRINOLOGY**

Editor: H. Gardiner-Hill
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CHILD**

John Fry
136 pages price 25s.

This book is based on the observations, records, and clinical conclusions of one family doctor, into the causes, the natural history, and the many and various problems of the condition. It is the outcome of a 10-year study and follow up of 750 children, reporting unique source material for all medical men and women investigating common respiratory illnesses among children.

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**ST. BARTHOLOMEW'S
HOSPITAL JOURNAL**



Vol. LXV, No. 7

JULY 1961

Editorial

ALL THE EMPLOYEES down to, and including, the level of secretary in a very large business organisation in London are insured against N.H.S. hospitalisation under the British United Provident Association. By far the greater proportion of the insurance premium is paid for by the firm. The reason for this is that during the course of the last sixteen years, since the beginning of the Health Service, their employers have found that it is more economical to pay, albeit indirectly, for the employees to receive private treatment when they are ill than come under the Health Service. This is due to the hours wasted in hospital out-patient departments, and the weeks or months spent on waiting lists for admission to hospital with conditions which, whilst not emergencies, are nevertheless incapacitating.

That more and more companies are joining B.U.P.A. under the group scheme con-

stitutes a severe indictment on the efficiency of the hospital services. Were this trend to continue, as more and more employers come to realise the economics of the position, socialised medicine in this country would be heading towards redundancy. Where a state of very nearly full employment exists we cannot afford the millions of man-hours that are wasted each year.

There has been a lot of literature written on the subject of Out-Patient Waiting Time, including a useful pamphlet put out by the Ministry of Health in 1958, but these deal largely with the day to day administrative problems, and granted they are many. But until there is some drastic reappraisal of the present system, wherein a man whose time is valuable cannot afford to be treated under the National Health, then socialised medicine is making a mockery of itself.

Engagements

BEKENN—PEAT.—The engagement is announced between Dr. Peter John Bekenn and Judy Gay Peat.

DUMUGHN—ROBERTSON.—The engagement is announced between Derek Barry Dumughn and Margaret Elspeth Robertson.

EDDY—GAUNT.—The engagement is announced between Dr. John David Eddy and Mary Priscilla Gaunt.

HAMMOND—CONEY.—The engagement is announced between Francis Keith Hammond and Lilian Janet Frances Coney.

Marriages

CHURCH BEE.—On June 3rd, Dr. Robin Birdwood Church to Joan Mary Bee.

JUNIPER—BLAIR GRIFFITHS.—On June 17th, Colin Pudan Juniper to Jane Margaret Blair Griffiths.

MYERS—CLIFFORD.—On May 6th, David Michael Myers to Anne Clifford.

Fifty years ago

“DEMOCRACY, REPRESENTED by the State, insists that there be no privileged class, that every person has a right to decent education, housing, and food, and that the net for preferment, promotion and office, should be cast widely; but there are drawbacks to this Utopian scheme. We are not all constituted alike and to avoid waste of energy on the part of the State to bring about equality, as well as on the part of the individual to be equalised, it is well we should know the ‘square pegs’, ‘misfits’, and even ‘impossible’. We know people as tall or short, fair or dark, square or slim, and we know by experience that ‘one man’s meat is another’s poison’, and if we can discover by some special means of observation the distribution of endowment, the capacity for education, the fitness for after life, the disposition or tendency to act, or even the susceptibility to disease; in other words if we can ascertain the ‘temperament’ of the individual, we and he, or she, may be saved much disappointment and sorrow, possibly also misery and shame.”—*Robert Jones, Mid Sessional Address to the Abernethian Society.*

Births

CHAMBERLAIN.—On April 25th, to Jennifer (née Ellison) and Dr. Douglas Chamberlain, a daughter, sister for Mary.

GALBRAITH.—On June 3rd, to Gillian and Dr. Alan Galbraith, a son.

HEWER.—On April 19th, to Ann (née Wotherpoon) and Dr. Richard Langton Hewer, a daughter (Marian Jane).

OWEN.—On June 26th, to Susan (née Cullinan) and John Owen, a daughter (Joanna), a sister for Clare.

Deaths

DAVENPORT.—On June 17th, Robert Cecil Davenport, M.B., F.R.C.S., aged 67. Qualified 1916.

HAMAND.—On June 25th, Dr. Charles Robert Hamand, M.A. (Cantab.), L.R.C.P.S. (Edin.), aged 53. Qualified 1936.

RICHARDSON.—On June 29th, Geoffrey Bower Richardson, F.R.C.S. Qualified 1914.

Appointment

University of Oxford
The degree of D.M. has been conferred on G. Hamilton Fairley.

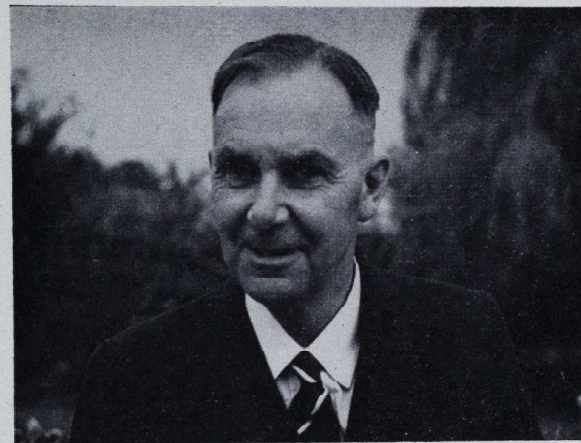
Sir James Paterson Ross

ON FRIDAY, JUNE 2ND, a presentation to mark his retirement was made to Sir James Paterson Ross, by the Clinical Students of the Hospital. The gift of a William IV silver sugar bowl was purchased with money collected in the Clinical Medical School towards the end of last year. Some delay in arranging a suitable time and place for the presentation occurred, for Sir James is a very busy man, even in retirement. However, no better venue could have been found than the comfortable home of Sir James and Lady Ross, and at their kind invitation a group of eighteen students made their way in a fleet of cars to North London, where they were most lavishly entertained with a superb supper and charming hospitality, which all who attended will remember for a long time.

An article by Arthur Oswald about the Great Hall, together with a number of photographs, appeared in the May 25th edition of *Country Life*.

CHRISTOPHER LANGTON HEWER

An appreciation



TO WRITE AN appreciation of an old friend should be a joyous occasion, yet when it is with reference to his retirement it is, for the writer, tinged with a certain sadness. “Gloomy” (to use his ill-deserved nickname) really has an extremely well-developed sense of humour, and many a chuckle have we had together over the vagaries and eccentricities of past members of the Staff.

Christopher Langton Hewer entered Bart’s as his father, grandfather and great-uncle did before him. The latter, John Langton, although surgeon to the hospital, held the post of “Administrator of Chloroform” from 1865 to 1868. Hewer early showed promise for he obtained the junior scholarship in anatomy and physiology and was awarded a distinction in physiology in the 2nd M.B. (Lond.) examination.

After qualification he became House Surgeon to Mr. W. McAdam Eccles and during this time he contracted diphtheria after performing an emergency tracheostomy. Having happily recovered from this he was gazetted

into the R.A.M.C. and became Regimental M.O. to the 1st Reserve South African Infantry. In 1918 he was transferred to a military hospital where he gave anaesthetics under that great gentleman Torrance Thompson of Edinburgh. This well-known anaesthetist had brought with him his own Gwathmey gas-oxygen apparatus which Hewer was able to use and with which he was much impressed. After demobilisation he returned to Bart’s as Resident Anaesthetist and six months later at the end of 1919 was elected to the consultant staff at the age of 24.

Dr. Mackenzie Wallis, who was chemical pathologist to the hospital, did much work on the purification and preservation of ether from decomposition. Hewer and he reported on the use of copper in avoiding oxidation of ether and observed that ethylene dissolved in pure ether increased its anaesthetic properties. This led to the investigation of ethylene by American workers who found that it was itself an anaesthetic agent.

At about this time long upper abdominal operations such as partial gastrectomy were becoming common and the need for quiet respiration with full relaxation was paramount. Hewer thought that endotracheal anaesthesia by the insufflation method would decrease the alveolar carbon dioxide and provide very shallow respiration with adequate oxygenation. The method also had the added advantage of preventing laryngeal spasm and proved a most successful method.

In 1921 T. P. Dunhill was appointed Assistant Director of the Surgical Unit and Hewer gave most of the anaesthetics for the patients with severe thyrotoxicosis, and it may safely be said that Hewer has had more experience in anaesthesia for thyroid surgery than almost any other anaesthetist, for until Dunhill's advent to this country, operation for severe toxic goitre was comparatively rare.

In 1939 the joint anaesthetics committee of the Medical Research Council and Royal Society of Medicine was engaged in trying to find a safe and practicable non-inflammable anaesthetic suitable for air raid and battle casualties. As a member of this committee Hewer was asked to investigate trichloroethylene. He was at first sceptical of this drug, but his experimental work carried out at Hill End Hospital gave us a most useful analgesic and anaesthetic drug.

After the war the new gynaecological theatre was opened and, with the collaboration of Mr. John Beattie, Hewer was instrumental in having a mural painting in the anaesthetic room and a curtain which could be drawn so that a patient entering saw nothing of a disturbing nature. Dr. Hewer also designed the ribbed rubber mattress which has eliminated the need for shoulder pieces in the Trendelenburg position.

Dr. Hewer, together with Sir Ivan Magill and the writer, gave anaesthetics at the Brompton Hospital when thoracic surgery was almost in its infancy. He was also for many years consultant anaesthetist at Luton and Dunstable and Harpenden Hospitals. He is consulting anaesthetist to the Hospital for Tropical Diseases and senior consulting anaesthetist to St. Andrews, Dollis Hill. He is also anaesthetist to the Florence Nightingale Hospital.

Dr. Hewer was one of the original members of the Board of Faculty of Anaesthetists in the Royal College of Surgeons. He was an examiner for the Diploma in Anaesthetics and is an Examiner for the final F.F.A.R.C.S. Dr. Hewer was the Frederic Hewitt Lecturer in 1959 and has been President of the Anaesthetic Sections both of the Royal Society of Medicine and of the British Medical Association. He was a vice-president of the Association of Anaesthetists and is a member of the Council of that body and has been Editor of *Anaesthesia* since 1946, when it was but 40 pages long and sold only 800 copies. Now it has grown to 140 pages with a circulation of 3,500 copies.

Dr. Hewer is rightly famed for his "Recent Advances in Anaesthesia and Analgesia". The first edition was published in 1932 and the eighth edition, in collaboration with Dr. J. A. Lee, came out in 1957. He was co-author with H. E. G. Boyle of the third edition of "Practical Anaesthetics" (1923) and also wrote "Anaesthesia in Children" (H. K. Lewis, 1923).

During the course of a long and busy private practice Dr. Hewer has met many famous and interesting people. He has anaesthetised two members of the Royal Family, Sir Winston Churchill, Lord Dawson of Penn and George Bernard Shaw. Incidentally he once told the writer that he himself had had 29 general and local anaesthetics which included practically all known techniques and drugs except halothane and subarachnoid block. His main hobby is motoring and he always had specially hotbed-up cars, one of which the writer remembers had an air-cooled aero-engine. Although a fast driver he is a safe driver. He once gently pushed a traffic policeman in the back owing to a brake failure. Hewer's comment was one of masterly understatement: "He didn't seem to like it and got rather annoyed!"

Gloomy, you have served Bart's long and well for the last 33 years. You carried on the family tradition by sending your son Richard to Bart's, and you will be sadly missed by us all. We hope you will have many happy years to continue with private practice, and you will always have with you the affectionate good wishes of all your colleagues.

F.E.

A NEW ABERNETHIAN ROOM

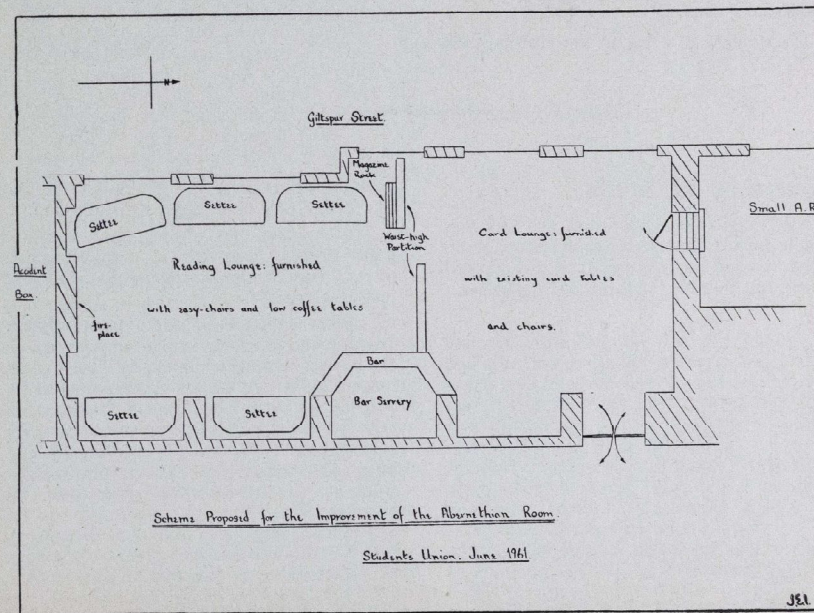
FEW WILL DENY that the Abernethian Room is wholly inadequate for the needs of the many clinical students who use it. However, one fully realises that it is beyond possibility for the Hospital Authorities to offer any additional accommodation to the students. Indeed, it is rumoured that the wards are soon to be closed in order to provide further storage space for the vast quantities of past notes, which daily multiply with terrifying rapidity.

To the early arrival at the Hospital, the A.R. presents a picture of tidy disrepair—by evening it is grossly untidy. The blame, however, must not be too readily heaped upon the students, for on closer examination it becomes apparent that there are few places other than the floor for newspapers and periodicals, and the card-player finds no ashtray to hand for his cigarette ends. In an attempt to solve this problem, the Students' Union appointed a committee to

review the existing facilities and draw up plans for their improvement.

One of the first points appreciated was the lack of seating accommodation. The theoretical seating capacity of the Abernethian Room is fifty-two, but as sleeping on the settees is a popular pastime and the recumbent figure fills the space normally sufficient for four seated individuals, the total accommodation in practice becomes twenty-five (about 6 per cent. of the total clinical student population). In view of this, it was thought best to remove half the settees and replace them with individual easy chairs and a sprinkling of low coffee tables.

Card playing being the second most popular pastime, the card tables were accepted as necessary, but, as at present they occupy more space than is essential, it was decided to banish them to the north end of the room, divide the room in half with a waist-high partition and thus create a separate reading



lounge at the fireplace end of the room, in which the remaining settees would be concentrated. To add to the general comfort of the reading lounge, a fitted carpet was thought desirable, and perhaps most important of all the provision of knee-high, counterbalanced ashtrays, in sufficient quantity, placed about the entire room.

It is probably true to say that a bar in the A.R. is an innovation which would be welcomed by most of the students (and, we hope, the staff) at the Hospital. A bar in the A.R., one feels, might have the atmosphere which is so lacking in the many public houses surrounding the Hospital, and it would certainly serve to entice a more social gathering within the Hospital after the lectures in the evening. A recent Editorial suggested that "any further increase in our communal activities would be burying our heads yet deeper in the sand". In fact, a tidy, comfortable A.R., with a bar, whilst engendering social life within the Hospital, would enable one to entertain one's non-medical friends within the Hospital and thus bring to Bart's that variety of conversation and personality which the Editor rightly contends is missing.

The thought of a bar in the Hospital will

Pharmacy at Bart's

IN THE LIGHT of a recent article in *The Times* which deplored the state of pharmacy in St. Thomas's and other hospitals, it was decided to enquire into the state of this department at Bart's.

An interview with Mr. Edwards, the chief pharmacist, revealed that at present, although Bart's possesses a sufficient number of qualified pharmacists, who have taken a three-year degree course or its equivalent, only three out of thirteen have had more than three years' practical experience. This appears to be the direct result of better prospects being obtainable in retail pharmacy, a fact which can be appreciated when it is realised that the basic starting salary of a hospital pharmacist is £690 per annum and increasing by £30-35 per annum to reach a maximum after seven years, whilst that of

no doubt be considered with horror by a few who have visions of inebriated students staggering into the wards and descending on the helpless patients. This could, of course, happen now, for one only has to walk a few paces from the Hospital to find a public house; but it does not happen, and will not, for the Medical Student, though often wild in his more leisure hours, still retains a very strong sense of responsibility and duty to the patients.

By the time this is published the decision of the College Council concerning these plans will be known. One thing, however, is fairly certain now, there will be several, who, on reading this article will throw up their hands in horror at the thought of anyone daring to alter the Abernethian Room; how often one hears the words, "I like a room to be lived in". They may rest assured that nothing will be done to alter the essential character of the Abernethian Room, but if by "lived in" they mean squalor then disappointment awaits them, for the principal objective of this scheme is tidy comfort in the A.R., and the success or failure of the plan rests ultimately with the students who use the Abernethian Room.

Students' Union.

a retail pharmacist is between £800 and £1,000 and may be doubled by promotion.

The repercussions of this state of affairs have already been felt in many hospitals though Bart's appears relatively unaffected just at present.

Lack of experienced staff, apart from decreasing the efficiency of an important service, wastes much money by forcing the hospital to buy its drugs. An example of the cost involved was obtained in 1956 when the bulk sterilising department was undergoing reconstruction. During this period, the hospital was forced to buy its intravenous solutions; dextrose saline alone cost the hospital £900, whereas its preparation in the pharmacy would have amounted to approximately £200 over the same period. Last year, manufacture in the hospital of a number of hydrocortisone preparations amounted to £770 9s. If bought as proprietary brands at

the special hospital rate, these would have cost £2,249 12s., representing a saving of £1,479 3s. Another 30 per cent. should be added to give an idea of the true retail cost.

Locums, at 18 guineas per week, provide an additional headache for anyone who is trying to obtain a permanent staff. Last summer, Bart's had approximately six such people, but at present all members of the staff are permanent though they are liable to continual change.

The answer appears to lie in the equalisation of the basic salaries in the different pharmaceutical fields. Until the Whitley Council achieves this it appears that much money and efficiency is being needlessly wasted.

R.S.B.

Clinical Conferences in the Orthopaedic Department

THE ERA of Hill End is rapidly becoming history and with the ending of this era there has come to the Orthopaedic department the privilege of "private quarters". These are to be found on the first floor of the west wing, overlooking the square. Here the Orthopaedic staff have the use of two rooms: a small room for secretaries, and a long pleasant room for the staff. This room is well equipped for several purposes. There is a screen, projector and a large filing cabinet of teaching slides. This collection of slides, both in colour and in black and white, is gradually being built up, and it is eventually hoped that most types of fracture and bone disorders in general will be demonstrated to the student by means of these slides. There will be a series of slides for each fracture showing the initial deformity, the reduction of the fracture, the plaster or other treatment, and the final result of complete healing. The room is therefore used for tutorials and although groups for teaching are usually small, the room could accommodate as many as 30 students if necessary.

Another feature is a small library containing current textbooks and journals and there are several tables in the room which enable the staff to study if they wish to. It is also possible to see patients in conjunction

with research work and there is a workshop bench outside in the passage for the use of the staff. As well as teaching, studying and doing research work here, it also serves as a common room.

However, the main outcome of having their own room has been that the Orthopaedic department has been able to begin a project of weekly conferences. These conferences are held on Tuesdays at 4 p.m. On the first Tuesday of the month one of the other departments in the hospital is invited to discuss a subject of mutual interest.

The topic each second Tuesday is Rheumatology and on the other two Tuesdays there are Clinical conferences, when patients are seen and discussed by the Orthopaedic staff, sisters, nurses, physiotherapists—in fact anyone who is in any way responsible for the welfare of the patients while they are in hospital. The conferences held so far have been very worthwhile, and it is hoped in the future to open these conferences to other members of the hospital who are interested and eventually to members of the profession outside the hospital.

P.S.L.

Last Month

ON JUNE 1ST, after six weeks advertising and many prestige-anxious women had extracted nearly £800 from the male population of Bart's, the Dorchester Hotel played host to the students of St. Bartholomew's Medical College and Hospital and their wives, sweethearts and last-minute pick-ups. It rained most of the day!

By 10 p.m. most had arrived; at 10.30 p.m. many were not amused to hear dinner announced, having already had a light supper anticipating a midnight meal—such was the organisation. With only three hours dancing time left, everyone was eager to get on the floor and the crush was inevitable, but complaints of the size of the floor were unjustified. Those who favour full-blown conventional dancing should visit Hammer-smith Palais; it is the size of a Rugby pitch and the inmates will spend considerably less than £3 10s. In the West-End postage-stamp dancing must be the rule; locked hips merely

sway to every other beat in the quicker rhythms. It is much more comfortable.

Paddy Roberts delayed the shuffle session further. I could quite happily have sat and listened to him for the rest of the evening; he was amusing and sang his better known songs in his usual bedtime-for-children-manner. The band was good, even after the cabaret, and those who wanted to avoid the phalanx of hipwiggles on the floor were able to dance between the tables. The evening was pleasant with the exception of the establishment. Never again the Dorchester; the service was slapdash and mannerless and its operators clumsy and quite without a vestige of charm. Most of them would have passed unnoticed on a greyhound-track. "Hurry-up there and get eating, because I am behind." This was perhaps a gem, but not out of character. I do think we should leave the Dorchester for the Americans.

On the following Saturday, a sunny day, some fifty students and their escorts travelled to Chislehurst to continue the social life by taking part or interest in Sports Day and the subsequent hearty dance.

It was the preclinicals' day, and in a close contest their second year prevailed over the clinicals who had tried to beat down opposition by sheer weight of numbers. Malcolm Freeth, in his first year at Charterhouse, led the preclinical prowess with some fine track achievements. Someone who runs a record-equaling hundred yards and has time to look round for opposition has nerve as well as potential. The children's races and the "Housemen's" hundred yards provided the best entertainment for the non-sporting spectators. An ambitious punter was lucky to get odds of £2 to £5 against Dr. McDonald being last irrespective of handicap!

There were not a lot of people at Chislehurst, but those who were there enjoyed themselves. I mention this because year after year organisers bemoan the poor attendance, possessing, as they do, a strange doctrine which decrees that social events are a flop unless patronised and praised by a milling mob. In the early evening after the presentation of cup, beer tickets and dinky toys, coach loads of freshly washed and un-uniformed nurses over-swelled the female element.

S.C.S.

View Day Ball

An account of the View Day Ball by a seasoned *habitué* of London night life appears in the LAST MONTH column of this issue. However, it should be put on record that over £70 was given to hospital charities from the takings on the Tombola. An enormous amount of hard work by officers of the Students' Union made this innovation a resounding success. A long list of prizes included a Remington typewriter, a Parker-Knole chair and a magnificent cake given by the Catering Superintendent of the hospital. Our grateful thanks are due to all the donors for their generosity.

View Day Photographic Exhibition

Four of the winning photographs in the exhibition are reproduced on the centre pages of this issue. There were more than forty entries in the competition, the standard of which was particularly high this year.

The Journal Publication Date

We feel that some apology is owed to our faithful and long-suffering subscribers for the irregularity in the appearances of the *Journal* in recent months. However, in a frenzied burst of activity after many barren weeks, we suddenly disgorged three issues within the space of three weeks. At least the *Journal* is now published within the current month, and we will endeavour to bring the publication date nearer the beginning of the month.

Questionnaire Supplement

A notice appeared in a recent *Journal* stating that all the articles relating to the Student Questionnaire would be published as a separate pamphlet. The editor has received one or two letters from readers who are interested, but it appears very unlikely that there would be anything like sufficient demand for this pamphlet to meet the printing costs.

It is proposed, therefore, unless this office is suddenly flooded with angry letters from readers demanding their rights, that those who have already written asking for this pamphlet should be sent all the back-numbers of the *Journal* containing the articles concerned.

Editor.

LETTERS TO THE EDITOR

"EYE OR OPHTHALMIC"

Dear Sir,

Whilst the English language owes much of its richness to words which have Latin, French and, in a few cases, Greek origins there is strength and simplicity in the shorter Anglo-Saxon words, clear in their meaning to the common people. The literary beauty of the 17th Century version of the Bible and of Shakespeare's works lies in the use of short Anglo-Saxon words.

It is regrettable that officials and administrators seem to prefer long, woolly, often pseudo-Hellenized terms to the curt incisive Anglo-Saxon words. The wall tablet in the entrance of the Queen Elizabeth II Wing commits this fault and other inconsistencies.

Many of our patients are barely literate. To them an eye means an eye, and judging by their correspondence "ophthalmic" suggests to their confused minds something pertaining to the umbilicus and to intestinal parasites. Whilst it is true that we may have to search these lower anatomical realms to discover the cause of some eye infections patients are disillusioned in their misunderstanding of "ophthalmic"—which incidentally the administrators often spell without the second "h".

The continental countries leave no such doubts in their patients' troubled minds—augenkllinik—coartz—clinique pour les yeux, etc., so why not in England the Anglo-Saxon "eye".

To be consistent with "ophthalmic" our surgical neighbours, the ear, nose and throat department, should be labelled the Oto-rhinolaryngo-pharyngologic department. Indeed on the tablet in the entrance of the Queen Elizabeth II wing and beneath the long stretch of "ophthalmic" is the disagreeable abbreviation E.N.T., not quite so bad as O.K.! To a Suffolk rustic E.N.T. may suggest either some electronic explosive or a new de-lousing powder.

Our hope for correcting this tablet must now lie in the grateful benefaction of a monumental mason whose sight has been restored by eye surgery and whose life has been saved by an Ear, Nose and Throat surgeon.

Yours sincerely,

H. B. STALLARD.

Dear Sir,

In the February *Journal* the Dean writes: "... The library is now open in the evenings ... and it may prove possible to open the museum also." After a short trial of evening opening the museum is again closed at five p.m.

The reason given for the "early-closing" decision is that the evening attendances were poor, and it was not worth while keeping a supervisor on duty until nine o'clock. Two reasons can be given for this sparse attendance.

Firstly, the trial began during the senior bacteriology course; there were no demonstrations to draw the more senior students and those with bacteriological studies felt that their effort should be elsewhere than in the museum. I feel sure that, had the trial been held concurrently with the pathology course, the attendances would have been higher.

Secondly, those who did avail themselves of the opportunity to use the museum in the evening soon discovered that the lighting was so poor that it was extremely difficult to see the macroscopic specimens, either on the shelves or those on the demonstration benches. I understand that rewiring the museum was started some 7 or 8 years ago; could not this very necessary operation be completed?

Yours faithfully,

J. HARRINGTON PUSEY.

(Abernethian Room.)

MYOPE

Clerk—"Good Morning Mr. Smith. I see you have a new pair of glasses."

Patient—"Yes, Doctor. The pink one's for me teeth, an' the white one's me drinkin' water!"

BENIGN GANGRENE ?

"She had known rheumatic heart disease with mitral insufficiency and chronic mild decomposition."—*Amer. J. Cardiol.*, June, 1961, p. 794.

HOUSE APPOINTMENTS—1st JULY TO 31st DECEMBER, 1961

		<i>Male</i>		<i>Female</i>	
DR. E. R. CULLINAN	B. R. Middleton	Rahere	Colston		
Dr. K. O. Black	A. P. Joseph				
DR. A. W. SPENCE	T. W. Meade	Dalziel	Annie Zunz		
Dr. N. S. Oswald	Miss M. Janosi				
DR. R. BODLEY SCOTT	D. P. E. Kingsley	Harvey	Luke		
Dr. W. E. Gibb	J. A. Bonn				
DR. G. W. HAYWARD	B. N. Ballantine	Smithfield	Mary		
Dr. H. W. Balme	G. L. Scott				
PROFESSOR SCOWEN	G. M. Besser	Stanmore	Garrod		
Dr. A. G. Spencer	A. B. Shaw				
MR. C. NAUNTON MORGAN	P. M. Ashby	Waring	Abernethy		
Mr. D. F. Ellison Nash	R. H. Gandy				
MR. A. H. HUNT	D. Booth	Fleet Street	Harmsworth		
Mr. J. O. Robinson	D. W. Gau				
MR. A. W. BADENOCH	J. Chapman	Bowlby	Heath Harrison		
Mr. Ian P. Todd	A. N. Fawcett				
MR. E. G. TUCKWELL	J. E. Cawdery	Rees Mogg	Pagei		
Mr. M. A. Birnstingl	W. S. Shand				
PROFESSOR TAYLOR	P. C. Weaver	Percivall Pott	Lawrence		
	Miss M. W. Childe				
CASUALTY HOUSE PHYSICIAN	R. B. Priscoott				
CASUALTY HOUSE SURGEON	Miss S. K. Weeks				
	CHILDREN'S DEPARTMENT				
DR. C. F. HARRIS	G. J. Halls		Lucas		
Dr. A. W. Franklin	P. J. Watkins		Kenton		
	E.N.T. DEPARTMENT				
MR. CAPPS	Mr. Hogg		Henry Butlin		
Mr. Cope	Mr. McNab Jones				
	EYE DEPARTMENT				
MR. H. B. STALLARD	Mr. R. P. Bonner-		Radeliffe		
	Morgan				
	Gynaecology and Obstetrics Department				
MR. JOHN BEATTIE	P. G. Cassell	Interns	(O) Martha		
Mr. Donald Fraser	J. D. Scobie		(O) Elizabeth		
Mr. J. Howkins	Miss A. M. E. Macdonald		(G) Sandhurst		
	Junior H/S		(G) Piteairn		
			(G) Harley		
	DENTAL DEPARTMENT				
MR. HANKEY	Mr. Schofield	D. L. Simmonds	Fleet Street	Harmsworth	
Mr. Cambrook	Mr. Cowan				
	ORTHOPAEDIC DEPARTMENT				
MR. H. JACKSON BURROWS	A. Padfield	Hogarth		James Gibbs	
Mr. W. D. Coltart	J. E. L. Sales			Henry	
Mr. J. N. Aston	Miss C. R. Knight				
	(Fractures)				
	DEPARTMENT OF THORACIC SURGERY				
MR. O. S. TUBBS	J. R. Garnham			Vicary	
Mr. I. M. Hill	R. G. N. Thomson				
	DEPARTMENT OF NEUROLOGICAL SURGERY				
MR. J. E. A. O'CONNELL	R. M. Hadley			W. G. Grace	
Mr. R. Campbell Connolly	C. G. Beardwell				
	SKIN DEPARTMENT AND SPECIAL TREATMENT CENTRE				
DR. R. M. B. MacKENNA	J. F. Holland	Smithfield	Mary		
Dr. P. F. Borrie					
DR. C. S. NICOL		Rahere	Colston		
DEPARTMENTS OF NEUROLOGY AND PSYCHOLOGICAL MEDICINE		Stanmore	Garrod		
DR. J. W. ALDREN TURNER		Harvey	Luke		
			Radeliffe		
			Annie Zunz		
DR. W. L. LINFORD REES		Dalziel			
Dr. C. M. B. Pare					
	DEPARTMENT OF ANAESTHESIA				
MR. FRANKIS EVANS	T. A. R. Cox				
Dr. R. Bowen					
Dr. G. Ellis					
Dr. R. Ballantine					
Dr. T. Boulton					

RESEARCH AT BART'S

Department of Gynaecology

by Gordon Bourne

THE DEPARTMENT OF obstetrics and gynaecology at St. Bartholomew's Hospital is a clinical department under the direction of Mr. John Beattie in which the welfare of the patients and undergraduate teaching are the two main and outstanding considerations. It is toward the fulfilment of this dual purpose that most of the energies of the department are directed. The problems associated with an undergraduate teaching programme and the different methods of its presentation are continuously under discussion and, whilst the editor of this journal may not have originally intended that the lectures and grinds should find a place in this article, it is, nevertheless, a fact that provision for the needs of the undergraduates occupies quite a large percentage of departmental time. "Research in teaching" has perhaps not achieved in this country the popular status that it sometimes enjoys elsewhere, but even so a considerable effort is expended by the staff of the obstetric and gynaecological department in their continuous endeavour to provide better and more efficient methods to meet the ever-changing requirements of students. The importance attached to this aspect is perhaps best illustrated by the fact that the department contains the joint editor of "Midwifery, by Ten Teachers" and "Diseases of Women, by Ten Teachers", the joint author of "Textbook of Midwifery", the author of Shaw's "Textbook of Gynaecology" and Shaw's "Textbook of Operative Gynaecology".

The two main aspects of research, as they affect the clinician, are clinical research and fundamental or basic research. The material requirements for the former are usually not very exacting, whereas the modern investigation of the latter frequently demands an intimate knowledge of the use of instruments and techniques with which the practising clinician is not normally familiar. It is, therefore, in the field of clinical research that most of the efforts of the unit are concentrated.

The department is fortunate in having the Williamson Laboratory available for routine histology and for further and more extensive

study of pathological material, when desired. A comprehensive histological, as apart from macroscopic or pathological, museum is at present being assembled. It will eventually contain several hundred histological sections, each of which will be described in a catalogue and fully illustrated with photomicrographs, thus enabling both the tyro and the more advanced worker to obtain full value from the collection. This is a long and arduous project which will take several years to complete.

It is inevitable that some of the attention of the gynaecological surgeon should be focussed upon malignant disease of the female genital tract. Mr. John Howkins has now performed more than 70 operations of synchronous combined abdomino-pelvic hysterectomy for advanced carcinoma of the cervix. This operation, the result of much painstaking research, offers to those unfortunate patients with advanced cervical neoplasm a new surgical approach.

Endometrial carcinoma has never received the same publicity or attention as that accorded to cervical carcinoma, partly because it is less common and partly because of the ease with which it may be removed. The incidence at Bart's of these two cancers is now approximately equal, especially if consideration is given to the inevitable referral of advanced cervical neoplasm from peripheral hospitals. Mr. Donald Fraser has evolved a new and simple pathological classification for carcinoma of the endometrium.

- Stage 0. Growth removed entirely at curettage.
- Stage 1. Growth confined to the endometrium.
- Stage 2. Growth invading uterine muscle.
- Stage 3. Tumour spread to involve the peritoneum in the pelvis, pelvic nodes or particularly the ovaries.
- Stage 4. Direct involvement of the bladder or rectum, or metastases outside the pelvis.

As a result of this classification super-voltage irradiation is given to Stages 3 and 4 in the post-operative period, but only to

Stages 0, 1 and 2 should they develop metastases at a later date. The results of this therapeutic regime are most encouraging. A detailed report of the results of the treatment of 350 cases of malignant disease encountered in the department from 1948 to 1950 and treated in conjunction with the department of radiotherapy has been compiled and will shortly be published in the St. Bartholomew's Hospital Report.

The newer range of cytotoxic drugs, whilst representing a major advance, are still relatively crude and inadequately understood. One looks forward in eager anticipation to their inevitable evolution, which it is hoped will be accompanied by their greater specificity and increased efficiency. The gynaecological department, working in close co-operation with Mr. Whittle of the department of radiotherapy, has so far used these drugs only in those patients suffering from ovarian carcinoma. The initial response to treatment has invariably been most satisfactory and occasionally startling, but it is unfortunate and depressing that the majority of tumours seem to develop resistance to the drugs in six or twelve months, after which they do not again respond even to increase in dosage.

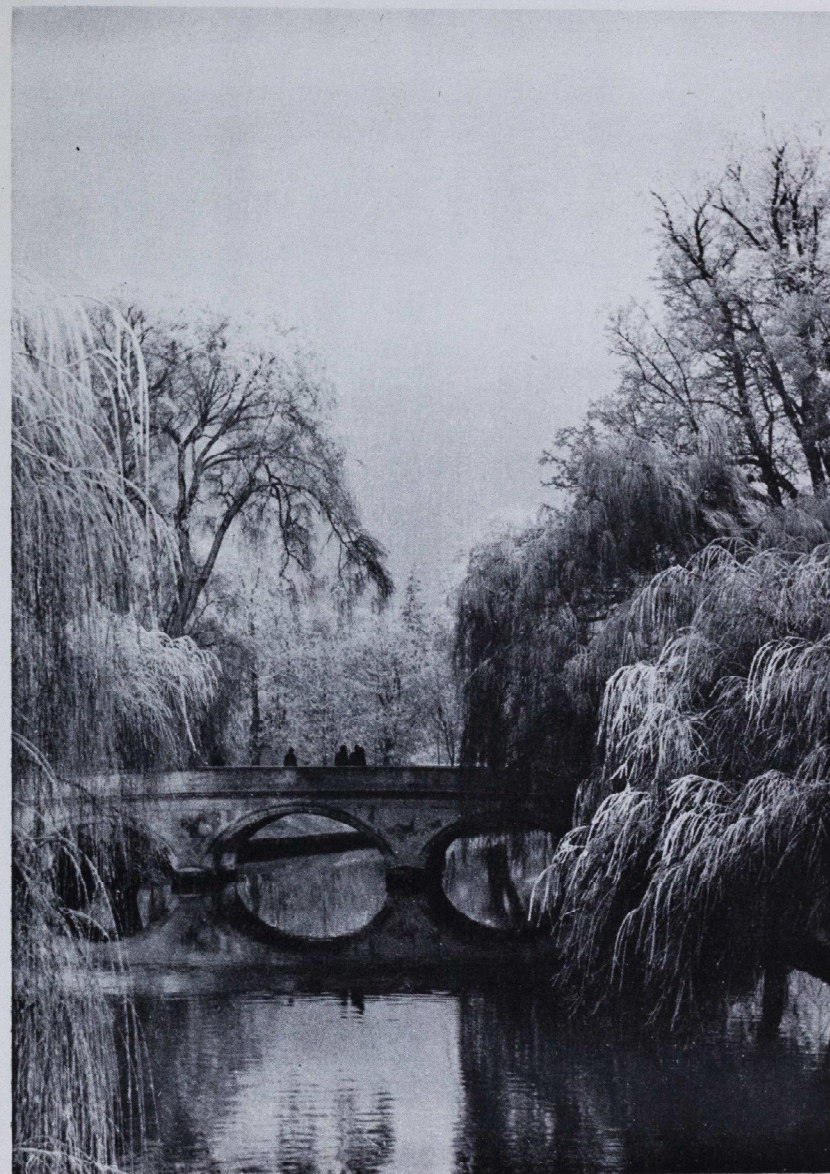
The corollary to the treatment of advanced malignant disease is the early detection of neoplastic change. Apart from the accepted clinical approach to early cervical cancer, which includes general and regional examination, exfoliative cytology, biopsy and curettage, etc., there are two interesting diagnostic projects at present in progress at Bart's. The first is the colposcopy clinic under the direction of Mr. James Andrew. The colposcope is a binocular instrument giving a magnification of ten to twenty times, which is primarily employed in the study of the *portio vaginalis* of the cervix, but which can equally well be used for the examination of the vulva and vagina. The use of the colposcope opens up a whole new range of normal and abnormal appearances in the cervix and its epithelium which are undetectable to the naked eye. With increasing experience it is possible to grade the findings with considerable accuracy into benign, malignant and atypical. The main changes are seen in the epithelium itself and in alterations from the normal arborescent branching appearance of the subepithelial capillary network. Accurate and selective biopsies can be taken from suspicious areas in order to confirm the diagnosis.

The second project is the routine examina-

tion of apparently healthy women to exclude cancer or other diseases of the genital tract. Exfoliative cytology is a procedure now accepted as reliably diagnostic in malignant disease of many organs and is especially applicable to carcinoma of the uterine cervix. The principle underlying this relatively simple test is that all surface cells of the genital tract possess the property of exfoliation and may be inspected in a smear of vaginal exudate or cervical mucus. Malignant cells are ten times less cohesive than normal cells so they are consequently shed more readily and in greater numbers, and when recognised in the smears they are diagnostic of a genital tract cancer but do not always indicate its exact site.

Financial assistance from the Corporation of the City of London has made it possible to start a cancer diagnosis or cytology clinic and to pay for the services of a trained cytologist. The main purpose of this clinic is the diagnosis of cancer of the *cervix uteri* in apparently healthy women. The value of the early diagnosis of cancer, often before it is invasive and therefore eminently curable, is already being realised. The Department of Gynaecology provides senior clinicians to interview the patients. This has resulted in the smooth running of a potentially delicate clinic. In addition to taking smears from the vagina and cervix, the breasts, abdomen and pelvis are examined. The patients attending this clinic do so voluntarily in response to a pamphlet suggesting that routine medical examination is a worthwhile procedure. Consequently two-thirds of these people are without any complaint whatever and they thus represent a unique group in which to assess the incidence of benign gynaecological pathology. The actual incidence of chronic cervical lesions and polypi, fibromyomata, ovarian tumours and vaginitis has been most interesting and instructive. As numbers and experience increase, these results will form the basis of a paper affirming the value of exfoliative cytology and emphasising for the first time the value of the trained gynaecologist in any future expansion of a cancer diagnosis service. This clinic already diagnoses and treats a quantity of minor benign gynaecology which is incidental to its main purpose. These conditions are thus treated before they reach a stage of producing morbidity—surely an ideal to be attained on a much larger scale in years to come.

(continued on page 161)



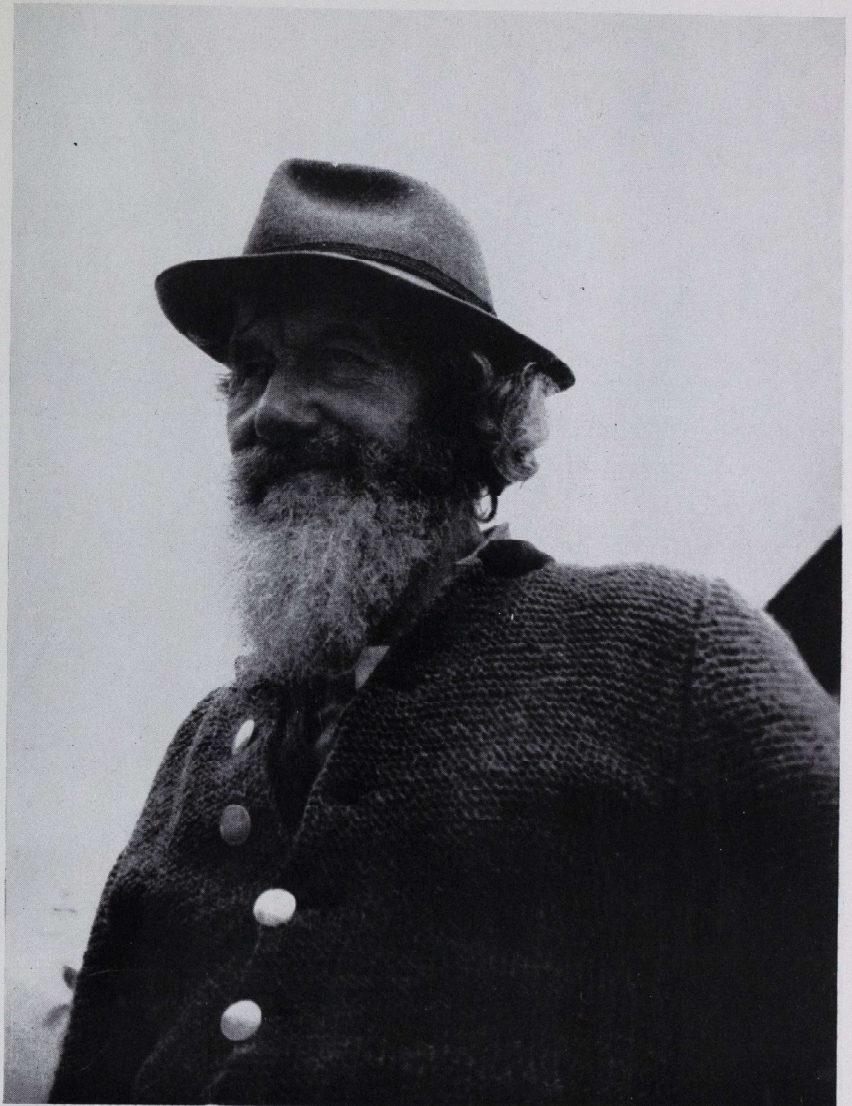
Trinity Bridge

John Catlin



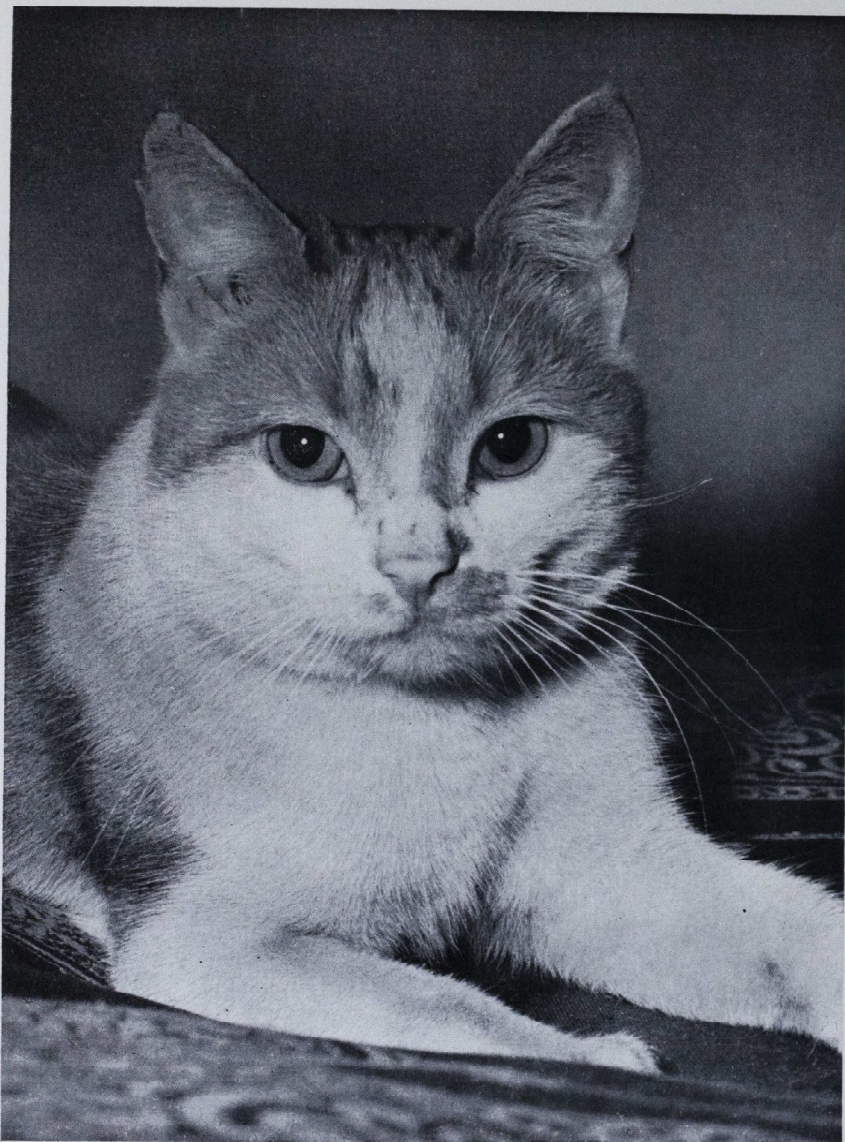
Eiluned

Adrian Stephens



Der Dorfbewohner

Guy Sharp



Tiberius

John Catlin

The opportunity presented of comparing and contrasting the use of hysterosalpingography at St. Bartholomew's Hospital with that at the London Hospital. Altogether the clinical notes concerning 723 X-ray examinations were studied and a published report concerned largely the incidence of inflammatory complications. A comparison of the actual techniques involved suggested that hysterosalpingography might be safer when carried out with a premedication but without full anaesthesia. It was noted that greater risks were involved when the investigation was undertaken in the presence of quiescent disease of either pyogenic or tuberculous origin. The only clinical evidence of such prior infection might be found in the history, or in the presence of tender, palpable adnexa. Morbidity in the presence of previous pyogenic inflammation was found to be more frequent but possibly less disastrous than in tuberculous infections. It was possible to emphasise from this analysis that an awareness of past infection was of vital importance to the safe application of hysterosalpingography and to other investigations into infertility.

A retrospective analysis of the morbidity and mortality occurring in 1,000 consecutive total hysterectomies performed by Mr. Howkins for benign gynaecological conditions is to be published shortly. This is not the correct place or time to anticipate the results of such a study, but a mortality rate of 2 per 1,000 is worthy of comment even in the most exclusive circles and one is left to harbour a perhaps ungenerous hope that the incidence of morbidity will be sufficiently high to merit analysis and prove instructive.

The department has always been interested in the problems associated with urinary tract infections in women who suffer from gynaecological complaints, especially stress incontinence. In co-operation with Professor Garrod, a study is now in progress which is designed to demonstrate the value of the prophylactic administration of Furadantin to women who undergo pelvic floor repair. Catheter specimens of urine are examined and cultured before operation, after operation and on the seventh post-operative day immediately prior to removal of the catheter. Alternate patients are given a predetermined course of Furadantin. This study has been in progress for four months and the results should prove most instructive. A

similar study was conducted using sulphonamides and it was the incidence of resistant organisms which has led to the present investigation using a less toxic drug of wider spectrum.

The new range of progesterone steroids will certainly deserve a place of honour in any gynaecological Valhalla if they live up to their early reputation and promise. These extremely potent progestogens, as they are now called, have two main and several secondary properties. They have a very powerful progesterone action and are thought to exert a highly specific action on the anterior pituitary by which they suppress the production of gonadotropin. Two of these drugs, namely Enavid and Primolut-N, have now been given to nearly 500 patients suffering from a wide range of gynaecological complaints. The results, now being analysed, of such an extensive clinical trial are awaited with interest, especially since a preliminary survey has indicated that these drugs will prove to be a major therapeutic advance notably in the treatment of dysfunctional uterine haemorrhage.

The so-called physiological anaemia of pregnancy has, in recent years, aroused considerable interest amongst both obstetricians and haematologists and there are even some who feel that anaemia should never be physiological, least of all in pregnancy. Macrocytic anaemia of pregnancy is virtually unknown if the haemoglobin level is in excess of 9.5 Grams per cent., but subnormal serum folic acid levels have been demonstrated in many patients whose haemoglobin levels are higher than 9.5 Grams per cent. The implication of these facts is that a relatively low serum folic acid level may predispose to an anaemia which only becomes megaloblastic as it increases in severity. It is possible that subclinical folic acid deficiency (and subclinical megaloblastic anaemia) may be a definite entity during pregnancy. The ante-natal clinics have, for the past two years, been bedevilled by a series of clinical trials, involving nearly 2,000 patients, designed to determine the value of folic acid during pregnancy. The department is grateful to Glaxo Laboratories for the special manufacture of 150,000 tablets for use in a double blind study of ferrous fumarate versus ferrous fumarate and folic acid. The early results indicate that a subclinical folic acid deficiency may be partially responsible for the

"physiological" anaemia of pregnancy but the final analysis, especially of the double-blind series, will not be ready till the end of the year.

Research of a basic nature has also been undertaken in the investigation of the human amnion, chorion and umbilical cord. The incidence of absence of one umbilical artery from the length of the umbilical cord has been investigated and assessed at 1 per cent. of all births of whom 58 per cent die or are stillborn. Only 35 per cent. of the infants so afflicted are developmentally normal, the remainder suffering from congenital abnormalities of varying severity. The anatomy, physiology, and pathology of the foetal membranes have been studied and the results are now in publication. This work includes a new description of the histological anatomy of the amnion and chorion and a detailed explanation of the possible causes of premature rupture of the foetal membranes, intrauterine inflammation and infection and intrauterine pneumonia.

The water of the amniotic fluid is exchanged once every three hours and the sodium and potassium content are completely replaced in less than 24 hours. Some of this exchange occurs across the foetal membranes directly from amniotic fluid to maternal circulation. It should be remembered that the

amniotic fluid is a foetal compartment, in so far as it is surrounded by foetal tissue, so that this rapid extraplacental exchange of material between mother and foetus stimulates interest in the control exercised by the foetus over its own environment. It almost certainly involves the immunological inter-relationships of the foetus and the maternal organism since some of the immunological mechanisms of the mother are temporarily in abeyance during pregnancy and the foetus *in utero* is immunologically inert. In association with the department of zoology, the amnion and chorion have been studied at high magnification by the electron microscope and the details of two possible routes of transfer of material from the amniotic cavity to the maternal circulation have been described. This work, which has been supported by a grant from the United States Government, is proceeding using colloidal gold as an experimental transfer material.

Several other clinical investigations are also in progress. They include a study of the possible prognostic value of blood urea levels in pregnancy; the cause of exacerbation of the symptoms of hiatus hernia in pregnancy; the use of halothane as an anaesthetic agent for external cephalic version and, in association with the department of pharmacology, the action of various drugs upon the contractility of uterine muscle.

NOTICE

MENTAL HEALTH RESEARCH FUND

The Mental Health Research Fund awards annually to **Medical Students and Doctors in their Pre-Registration Year three Monetary Prizes** and a **Travelling Fellowship** as the result of an essay competition on a subject relating to mental health, and a subsequent interview.

Applicants gaining the top three places in the essay competition will be given **prizes** of **£100, £50 and £25** respectively.

The **Travelling Fellowship**, tenable in a Psychiatric or other Department abroad for up to six months, will be awarded as the result of an interview combined with consideration of the candidate's undergraduate record. Persons interviewed will be chosen from the top ten in the essay competition. The travelling fellowship will normally be

taken up at the end of the pre-registration year or, in the event of it being awarded to a medical student, may be taken up after qualification.

The subject for the essay this year is "*Discuss the Role that Parental Attitudes Play in Shaping the Personality of the Child*".

The Panel of Examiners consists of two members of the Research Committee of the Mental Health Research Fund and one member of the Association of Teachers of Psychiatry in Undergraduate Medical Schools.

Essays should be sent, **before March 1st, 1962**, to the Secretary, Research Committee, Mental Health Research Fund, 39 Queen Anne Street, London, W.1 (Tel. WELbeck 1272), from whom further details may be obtained.

THE MOZELLE SASSOON ONE MILLION VOLT X-RAY THERAPY DEPARTMENT

by I. G. Williams

AFTER THE 1914-18 WAR the Government gave to the Medical Research Council a quantity of radium which had been in use during the war in gun sights and other instruments. This radium was loaned to hospitals for scientific and medical purposes, and at St. Bartholomew's Hospital the Hospital Governors entrusted the control of their allocation of this radium to a Radium Committee. In 1921 members of this Committee visited Erlangen to investigate Wintz claims of the value of deep X-rays in the treatment of cancer, and following this visit the Hospital decided to acquire apparatus for deep X-ray (200 Kv.) therapy. It was at this time that the new medical and surgical Ward Blocks were being erected, and money to purchase the apparatus (some £5,000) was not available. It took Dr. Malcolm Donaldson three years to collect the money privately, so that it was not until 1924 that the first apparatus was installed. The Radium Committee now embraced deep X-ray therapy and its name was changed to Radiotherapeutic Research Committee. Coincident with this there was a Lead Research Committee, which was investigating Blair Bell's work with lead in the treatment of cancer. In 1928 these two Committees were linked together into a Cancer Research Committee under the Chairmanship of Sir Thomas Horder (later Lord Horder). It became clear, however, that its scope included a cancer service as well as research, and in 1934 it became a Cancer Department Committee (Department: a separate division of a complex whole, esp. of activities or studies—O.U. Shorter Dictionary). In 1929 Dr. Finzi and Dr. Levitt, under the guidance of the Cancer Research Committee, presented a statistical assessment of the results of 200 Kv. therapy at the Hospital. These results were so superior to those of less powerful voltages that it seemed reasonable to investigate the still more powerful machines. Preliminary discussions on these lines took place in 1931. It was decided to explore the possibility of constructing a machine to operate at one million volts. The largest obstacle to this

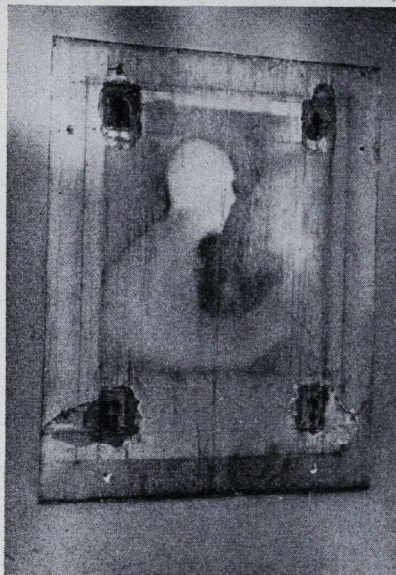
project was financial, but it was finally made possible through the generosity of Mrs. Meyer Sassoon, who financed the cost of the development of a machine and the building to house it; of the Sir Halley Stewart Trust, which granted a five-year fellowship to the Radiotherapist appointed to do the work; and the B.E.C.C., which gave annual grants towards its maintenance.

In 1932 the High Voltage and Vacuum sections of Metropolitan Vickers, under the direction of Mr. Allibone and Mr. Bancroft, had, in collaboration with Dr. Frank Ellis, Director of the Radiotherapy Dept. at Sheffield (and now of Oxford), and the assistance of Mr. George Innes, designed, built and installed two 200,000 volt continuously evacuated, demountable X-ray tubes at Sheffield Royal Infirmary. In 1934, the Cancer Committee, on behalf of the Governors, approached the Metropolitan Vickers Electrical Company for the supply and installation of a continuously evacuated X-ray tube together with the necessary D.C. generators to operate at a guaranteed voltage of 600,000 volts, with the proviso that an attempt would be made to operate continuously at one million volts. The apparatus finally developed was made possible by the co-operation of a voluntary hospital with the Research facilities of a large manufacturing business concern.

From 200 Kv. to 1,000 Kv. was a considerable step. Each theoretical calculation had to be investigated practically by experimentation before it could be put into practice, but by the end of 1936 these researches had shown the pattern and design of the equipment as we knew it. The 14 inch diameter steel tube spanned a treatment room and projected on one side into a 500 Kv. positive generator room, and on the other side a 500 Kv. negative generator room. The vacuum in the tube was maintained by two 250 litre per second pumping plants. The tube was surrounded and thus protected by eight tons of lead shot.

The plant was installed during 1936, and the Mozelle Sassoon Supervoltage X-ray

Therapy Department was formally opened by the donor, Mrs. Meyer Sassoon, on December 10th, 1936, in the presence of Lord Rutherford, Lord Stanmore, Lord Horder, Sir Bernard Halley Stewart, and a distinguished assembly. The first patient was treated on June 1st, 1936; since this date, except for September and October, 1939, when the equipment was temporarily and partially dismantled, it has been used continuously for the treatment of patients, and



Dept. of Medical Photography

Even after the demolition of the Sassoon Unit the ghost of Dr. Ronald Canti seems loath to desert the department in the planning of which he played so great a part.

for research work in physics, biochemistry and radiobiology. During the war it survived many near misses. One 750 lb. bomb fell 10 yds. away, but failed to explode. A large piece of the Smithfield roadway crashed on to the roof, and the end of a roof wire reinforcement punctured an oil-immersed condenser. On another occasion, concussion shifted the moving floor platform of the treatment room. "These minor effects of air raids never caused interruption in the treatment of patients" (Phillips).

The plant was the second 1 million volt plant to be put into clinical use in the world. The American unit which preceded it functioned for only two years; the Sassoon unit ran for 24 years. The reliability of the unit was due partly to its heavy engineering construction, and partly due to the ability then achieved of continuous evacuation of the thermionic vacuum systems. The main reason, however, was that in 1937 a complete set of spare parts was purchased and the maintenance of the machine was entrusted completely to Hospital staff. Mr. George Innes not only helped to develop and build the machine, but personally directed and supervised its complete maintenance. The longest mechanical failure was in 1959, after 22 years' running, and lasted for four days. This was due to a number of safety interlocks failing at the same time, and all due to the wear and tear of old age. Since 1937 the total summation of all such breakdowns amounts to about 30 days, less than 0.5 per cent. of the operating time. Half of the vacuum pumps operated non stop since 1937—approximately 198,000 hours, while the others operated with only one overhaul for the same time. To complete these few statistics, high voltage was applied to the tube at one million volts for about 55,000 hours at a cost of 2s. 6d. per hour.

In America, in the early days of high voltage therapy, unfortunate injuries occurred because the dosage distribution and other potentialities were not fully understood at that time. In recording the opening of the Department, the Year Book of Radiology for 1937 remarked: "Presumably the operators of the new plant will familiarize themselves with the not always happy effects of such high voltage radiation by conferring with their American colleagues before starting therapy on a large scale".

The holder of the Halley Stewart Fellowship was Mr. Ralph Phillips, F.R.C.S. In the planning of the installation he had the continuous assistance of the late Dr. Canti, the late Professor Hopwood, and also Dr. Finzi, Dr. Levitt, Mr. Donaldson and Dr. (now Professor) Scowen, and Mr. G. Innes. Phillips published a report in 1944 of the work done with the machine in the five year period 1937-1942. Statistics were available in the Hospital on the treatment of 1,081 cases of cancer treated by deep X-ray therapy in five selected groups: 1. Breast; 2. Cervix

uteri; 3. Upper air passages; 4. Rectum; 5. Oesophagus. (Levitt & Phillips, 1936.) Originally, it was decided to select cases in these five groups for one million volt therapy in order to compare the two voltage ranges. This was, however, handicapped by the war, and with the increase of knowledge in radiotherapy, it soon became obvious that 1 MeV. X-ray therapy was more efficient physically than deep X-ray therapy. Even palliative radiotherapy gave greater scope, so that the machine was used to capacity for routine radiotherapy. All treatments were planned with accurate isodoses. Each year between 125 and 160 new patients were treated, requiring about 3,000 individual applications and each treatment was supervised by a medical officer. On comparing with 250 Kv. therapy, differences in effects and results were found in many instances—e.g. advanced breast cancers, the upper air passages, the rectum and anal canal, the brain. Indeed, the higher dosage which became possible and the easier and more accurate application, together with increasing experience, led in later years to the treatment of as many patients as was possible, almost irrespective of site. 1 MeV. is a little too low to exploit fully the optimum physical conditions of megavoltage X-ray therapy. It is probable that this optimum voltage is of the order of

5 MeV. For this reason, and because of the wear and tear of long service, the Sassoon one million volt unit has been dismantled. The rubber installation of the wiring had degenerated into small beads, and replacement of the cables would have been costly and time consuming. Many of the pieces of equipment had survived three times their normal life and an increased rate of breakdown was possible. More efficient, more compact, and more powerful units are available and have been acquired by the Governors, for a hospital such as ours is never still, never at rest, but is continuously exploring and expanding in the interests of the treatment of patients, and of research. In these respects the Mozelle Sassoon 1 million volt X-ray therapy department made valuable contributions, in physics, in radiotherapeutics, in knowledge of neoplastic processes, and served as a pointer to further development and progress.

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 PHILLIPS, R., & LEVITT, W. M. (1936) *St. Bart's Hosp. Reports*, **69**, 337.
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THE CHURCH AND MEDICINE

ON MAY 23RD, the Rev. Michael Wilson, M.D., Chaplain to the Guild of Health, spoke to the Augustine Society on the subject of "The Church and Medicine". He drew a vivid picture of the Church as "a healing community" united by the Communion and acting by personal contact and by prayer. The healing power of the Church is, in addition, channelled through the priest and enables him to heal (in the widest sense) by giving Communion to the sick and anointing them as well as in its specific ways. Dr. Wilson explained that olive oil was originally used for anointing because, in its various uses—for heating, lighting, healing and for food—it drew together the different parts of the individual's life. He stressed the importance of the laying-on of hands but emphasised that this could be done in a quite informal way.

Dr. Wilson pleaded for more liaison between doctors and clergy, more understanding of the totality of the individual and a greater realisation of the essential unity of faith and work amongst Christian doctors and nurses.

The meeting ended with an interesting discussion concerning, among other subjects, the best attitude for the Christian to adopt in approaching the sick.

(The Augustine Society is a Church of England Society whose main meeting is at Holy Communion in St. Bartholomew the Less every Tuesday at 5.35 p.m. This service is, of course, open to all Anglicans, and the vicar hopes that many of the staff of the hospital, both medical and lay, will find it valuable to meet together for worship within the Hospital at this time.)

THE NORTH-WEST FRONTIER

by John Goldman

who, with three friends, drove to India in a Land Rover

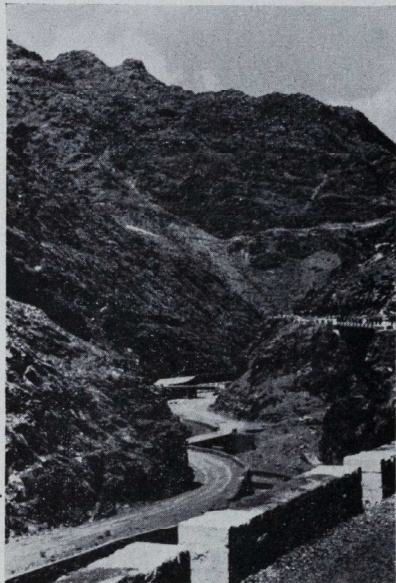
OUR FIRST HINT of what the North-West Frontier today involved was given to us by the Second Secretary of the British Embassy at Tehran: he had served in this area in the Indian Army and asked to be remembered to any official we might meet on our journey. He explained that whereas the East India Company and the succeeding British Government had been able to bring law and order to the greater part of the Indian sub-continent, neither party had effectively subjugated the local tribesmen living in the rugged and desolate country that adjoins the border of Afghanistan and what is now West Pakistan and stretches from Peshawar in the north to Quetta in the south.

The tribesmen are mainly descendants of the Afghans who so fiercely resisted British attempts during the 19th century to "keep open the route to India". The two Anglo-Afghan wars (1839 and 1878), claimed as victories by both participants, reflect at least the determination of the Afghan tribesmen to maintain their independence and serve only a native Emir. In this century the British Government has undertaken to guarantee the safety of the traveller in this area provided that he travels in the hours of daylight and does not depart from the main road; the Government of Pakistan has in effect taken over this responsibility in 1947.

We had difficulty in finding out exactly what risks were involved in travelling in the frontier area today; it appears that trouble may be expected not so much from the village tribesmen as from some vagabond or band of outlaws who, disowned by their tribe and deprived of their livelihood, may choose to indulge in highway robbery or murder. In addition, we were repeatedly warned that "tribesmen just enjoy taking potshots at strangers anyway".

We drove through tribal territory twice on our journey to India by Land Rover. From Kabul in Afghanistan we took the descending mountain road through the Khyber Pass to Peshawar. The road is in excellent condition and only the rugged terrain on either side gives some idea of the hardships that

faced the advancing British soldier of the last century. Many of the old fortifications sited at the top of every hill and pinnacle are still manned, not now so much against the British soldier or Afghan marauder but because relations between Afghanistan and Pakistan are not all that they might be. From Peshawar we drove to Lahore and crossed the frontier into India at Amritsar.



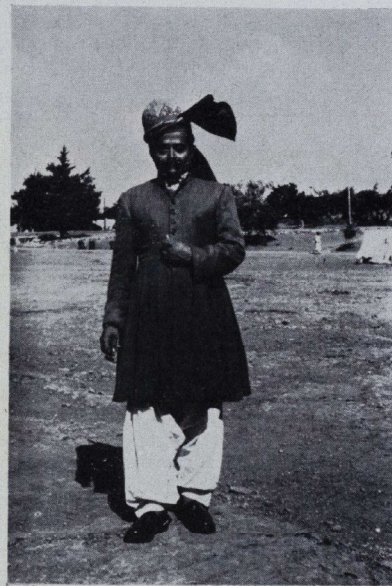
B. W. William-Powlett

The road through the Khyber Pass

Returning a few weeks later by the same frontier route, for it is the only land frontier between India and Pakistan open at the present time, we headed south-west for Multan and crossed the Indus at the new Taunsa Barrage. At Dera Ghazi Khan on the west bank of the river we took twenty

gallons of petrol, ample to take us the 250 miles to Quetta if we did not have to make excessive use of our four-wheel drive, and started out into tribal country in the early afternoon.

To ensure that travellers do not make use of the road after dark, a chain is stretched across the road at four o'clock in the afternoon at twenty to twenty-five mile intervals throughout the territory, and the traveller must stop and spend the night at the adjoining police post. We aimed to pass the last chain before Fort Monro before 4 p.m. and so reach Fort Monro (5,000 ft.) for the night. We did in fact get there at about 4.30 and were directed to the *dak bungalow*. The *dak bungalows* of British times, where a travel-



E. W. William-Powlett

Tribal Chieftain

ling government official could put up for the night and have his meals cooked for him, have been taken over by the Pakistan government and are now under the control of the Public Works Department, hence their name PWD Rest Houses. The one at Fort Monro looked immaculate, but before we called

there we decided to drive into the village square.

In the middle of the square was an enormous marquee flanked by a smaller one; as soon as we stopped the Land Rover we were surrounded by the usual crowd of observers who followed avidly our every movement. Fresh dates were on sale at the bazaar and we bought some. As we returned to the car a slight but neatly dressed man approached us in company of a taller and darker man; the former introduced himself as a tribal chieftain and invited us to join him at his house nearby, and we gratefully agreed.

Over a meal of soft-boiled eggs, biscuits and tea our host apologised for the state of his room and explained that he was chief of some 18,000 tribesmen living in an area near the Afghan border 100 miles to the north. He had travelled to Fort Monro by road to attend the annual *djirga* convened by the Pakistani District Commissioner. All the tribal chiefs of the area sat in *djirga* for a week or longer, and cases of inter-tribal conflict or crime were heard and adjudicated according to tribal law. The Commissioner was then responsible for deciding the sentence of a convicted man.

A number of criminal cases would be tried in the course of the session; the chief told us there was no death penalty, but a murderer received fourteen years in jail at Multan, after which time he could return to his tribe. Only the adulterer could not return to his own tribe, for if he did he would almost certainly be killed. He himself had succeeded his father only the year before and was attending the senior *djirga* for the first time; his son-in-law, who was with him, was his nominee at the junior *djirga*, which took place in the smaller of the two tents we had seen in the main square.

The chief was a most interesting and well educated man. He spoke fluent English and was a devout Mohammedan; he broke off our conversation at six o'clock while he prayed. He was a greater admirer of Persian poetry and emphasised that Omar Khayyam does not rank with great poets, Sa'adi and Ferdowsi, except in the eyes of the English. He had written poems himself and offered to recite to us, but we had to confess that our Persian was not really enough for us to benefit. He had a degree in law from Peshawar University and modestly admitted that as he was the only member of the

djirga who was educated the onus of ensuring correct judicial procedure fell largely on him. The conversation covered many topics, ranging from British rule in the last century to elementary philosophy; he thought the Westerner could not grasp the true concept of soul and he believed in the possibility of communication with the souls of people who have died.

At eight we left him, though not before we had promised to breakfast with him the following day and he had instructed one of his servants to ensure that we found accommodation at the *dak bungalow*.

When we arrived at eight next morning we were again regaled with eggs and tea, but the chief did not eat. He explained that he usually had his breakfast at his second prayer of the morning, at five o'clock, and was not now hungry. If we would stay at Fort Monro till the end of the *djirga*, we could accom-

pany him to his home and shoot duck with him. We had to apologise that time, the bane of our western civilisation, was valuable to us and we had to be back in England by the end of September. We were already behind our schedule. We thanked him for all his hospitality, loaded our belongings into the car and set off for Quetta.

The rest of the journey was uneventful. We were not shot at by anyone, we gave some tribesmen a lift as far as Loralai and made Quetta by ten the same evening. Though the tourist is usually advised to take the southern route between Quetta and Multan (by Shikarpur), we did not feel we had been in any danger, and the spectacular scenery and saving of time had fully justified our decision to cut across tribal territory. One must only choose the time of year with care, for in spring the dried-up river beds become torrents that even a Land Rover may find impossible to negotiate.

SPORTS NEWS

Viewpoint

TO BE CONSPICUOUS by one's absence can mean one of three things—one has staged a gesture of defiance, one has simply forgotten or one remembers but apathy has won the day. In the case of the captains and secretaries of certain sports clubs it is this last that applies. There seems to be a curious reluctance amongst them to report on their teams' exploits (and, perchance, their own); and yet these are the selfsame people who are the first to criticise other members of the college and hospital for not supporting them. This, of course begs an obvious question—it will remain unanswered!

Mañana may be an excellent policy at certain times and in certain climates, but we would beg the people concerned not to apply it too rigidly when asked for reports, however scrupulously they apply it to their own lives.

Sports Day 1961

THE FINE SHOWING of the sun heralded a good start to Sports Day.

The standard of athletics through the afternoon was very keen and the highlight was the final of the 100 yds. M. Freeth managed to pull back on a good start by C. Richards to win in a time of 10.2 secs., recorded by the first three runners M. Freeth, C. Bridger and C. Richards, which equals the existing record. M. Freeth went on to win the 220 yds. and on the strength of these two performances was awarded the President's Cup.

T. Foxton ran two good races to win the 800 yds. and the mile in times of 2 mins. 1.7 secs. and 4 mins. 48.8 secs.

In the field events the shot and the javelin were the attractions. The javelin was won by M. M. Orr and the shot by T. Herbert, who also won the discus.

C. Bridger recorded 54.3 secs. to win the 440 yds. and P. Littlewood kept his 3 mile championship.

The introduction of a new event, throwing the cricket ball, was made by request of the Cricket Club, but was won by a member of the Athletic Club, C. Richards, and it is hoped that this feat does not go unnoticed.

D. Williams deserves mention for winning the hurdles and the long jump, S. Harris taking first place in the high jump.

Although the prize giving was delayed by an hour due to the heavy programme the dance afterwards was a great success.

The club hopes that this enjoyable day is a good omen for future years.

Cricket

1st XI v St. Edmund Hall, Oxford, May 18th, 1961—Won by 6 wkts.

Quick wickets by Harrison soon had a mediocre Teddy Hall side in trouble. A hat-trick by Niven accelerated their downfall and Delany completed the collapse. With only 87 runs required the Bart's batsmen set about their task with abandon, but all played second fiddle to Delany whose hard-hit 50 in almost as many minutes was the feature of the innings.

Scores: St. Edmund Hall 86 (Niven 4-41; Harrison 3-24).

Bart's 87-4 (Delany 54 not out).

1st XI v Brasenose College, Oxford, May 19th, 1961—Lost by 81 runs.

"Isis . . . to patient science dear" (Wordsworth).

Undisturbed by the raucous shouts from the adjacent towpath B.N.C. steadily acquired 216 runs by mid-afternoon against an uninspired Bart's attack. The Hospital batting was conspicuous only for its lack of patient science and in close succession the established batsmen got themselves out on an easy wicket against innocuous bowling, to record the season's first defeat.

Scores: B.N.C. 216 (Delany 4-26; Harvey 3-53).

Bart's 135 (Pagan 30).

1st XI v Romany, May 21st, 1961—Won by 2 wkts.

A fine catch by Pagan at gully in the

opening over stimulated a big stand by a competent Romany side's second wicket pair. However when Delany broke this partnership wickets fell steadily to trundlers Harvey and Niven, leaving Bart's to score 208 in 160 minutes. Warr and Jeffreys contributed their accustomed good scores but with half an hour left 57 runs were still required. Jailler gave his wicket hitting out but with 8 wickets down Harvey and Niven prodded and pushed impudent singles and this combined with Harvey's judicious use of the "cowshot" produced the season's best victory to date in the last over.

Scores: Romany 207 (Niven 4-46).

Bart's 210-8 (Harvey 58 not out, Jeffreys 41, Warr 31).

1st XI v Streatham Wanderers, May 29th, 1961—Won by 10 wkts.

On an easy-paced batting wicket Harrison produced one of his more aggressive spells and proved too fast through the air for the majority of the opposition. Warr and Jeffreys opened for Bart's and 90 minutes later they were still unbeaten with the necessary runs scored, the former having driven and pulled his way to within four runs of a century and the latter pushing and glancing delicately off his legs in a subsidiary role.

Scores: Streatham Wanderers 143-9 dec. (Harrison 5-54).

Bart's 144-0 (Warr 96 not out, Jeffreys 35 not out).

1st XI v King's College Maniacs, May 28th, 1961—Won by 19 runs.

A fine knock by opening bat Davies provided the basis of the Bart's innings, interrupted though it was by a downpour. Supporting roles came from Warr—going on from where he finished the day before—and Delany, but there seemed hardly time to dismiss the opposition when the declaration came. However, lack of application by the King's batsmen produced quick wickets and, despite a stubborn 7th wicket stand, careless running between the wickets ensured their ultimate defeat.

Scores: Bart's 146-3 dec. (Davies 74, Warr 42 not out).

King's College Maniacs 127 (Niven 3-31).

1st XI v Queens' College, Cambridge, June 10th, 1961—Drawn.

By early afternoon Bart's had done well to have captured 6 Queens' wickets for 135 runs on a hard wicket. However an unbroken

century stand ensued, assisted by loose bowling and arthritic fielding. For the Hospital, Jeffreys again batted well, but his partners changed frequently and it was soon apparent that victory was out of the question. Cannon, at number nine, responded to his captain's pleas of caution by clearing the long-on boundary with ease, and Savege, similarly instructed, hit seven fours in his unbeaten 41 to elevate the score into the realms of respectability.

Scores: Queens' College 249-6 dec. (Niven 3-68).

Bart's 188-8 (Jeffreys 62, Savege 42 not out).

1st XI v Parkfield, June 11, 1961—Drawn. Economical medium-paced bowling and keen fielding restricted the Bart's run machine and even Warr was rendered unusually placid. Harvey contributed a valuable innings but despite this the total of 136 seemed inadequate. However, the Parkfield batsmen resolved to take no risks against Harvey and Niven with the result that the loose balls went unpunished and a verdict unconsummated.

Scores: Bart's 136 (Harvey 37, Warr 26, Jeffreys 26).

Parkfield 121-8 (Niven 4-53).

1st XI v Arawak, June 17, 1961—Won by 5 wickets.

Runs came slowly to the openers of Arawak, a West Indian side, and maiden followed maiden. Where were the traditional flashing wrists of a Weekes or the crashing drives off the back foot of a Sobers? Harvey beat the bat repeatedly and was mainly responsible for Arawak's low total of 140. The recognised Hospital batsmen all seemed to succumb just when set but their added contributions ensured a 5 wicket victory. Merry's innings in particular, after a hesitant start, progressively ripened under the stimulus of his countrymen's bowling.

Scores: Arawak 140 (Harvey 4-39).

Bart's 141-5 (Merry 30, Jeffreys 29).

1st XI v Horlicks, June 18, 1961—Lost by 14 runs.

Merry put the opposition in to bat on the closely bounded Horlicks ground always sympathetic to seam bowling. As usual the Horlicks batsmen went for their strokes and when all out for 163 the situation appeared nicely balanced. Five Bart's wickets down for 61, Jailler and Harvey set about repeating their rescue act of the previous year. At 95

Harvey just edged a lifting ball and Phillips joined Jailler. 40 runs later Jailler was caught going for his ninth four in 38 runs and the result was back on the fulcrum of uncertainty. Shortly afterwards the weight fell finally on the Horlicks side as the last three Bart's wickets fell in close succession.

Scores: Horlicks 163 (Niven 4-57, Merry 3-42).

Bart's 149 (Jailler 38).

Swimming

BART'S WERE UNABLE to topple St. Mary's Hospital from their pedestal of success on June 22nd, coming second to Mary's in the United Hospitals Swimming Championship for the third successive year. Bart's took more than their share of the first three positions in each event but the great depth of talent in the Mary's team accounted for the vital lower places in the final.

Results:

FREESTYLE RELAY

1st. Groves, Shorey, Shand, Ruoss, Brunner, Anderson.

100 YDS. BUTTERFLY

1st. B. Shorey, 6th. D. Shand.

DIVING

1st. C. Ruoss. 2nd. D. Shand.

100 YDS. BREASTSTROKE

2nd. B. Shorey.

MEDLEY RELAY

3rd. Hillyer, Lask, Shorey, Ruoss.

100 YDS. FREESTYLE

4th. R. Groves. 6th. C. Ruoss.

440 YDS. FREESTYLE

4th. R. Groves.

Recently C. Ruoss representing London University came second in both the Highboard and Springboard Diving events in the British University Championship at the Empire Pool, Cardiff. First place in each event was taken by D. Rapkins of Loughborough College.

D. Shand has been awarded his London University Half Purple for his continued success in diving for the University. This brings the total of Purples in the Bart's Swimming Club to four, the award in previous years having been made to R. Groves, B. Shorey (Team Purples), C. Ruoss (Full Purple).

ALPINE CLUB

THE WHITSUN MEET in Snowdonia proved a delightful blend of the aesthetic and athletic, the langorous and the energetic. Guided by minute instructions from the ground ("Oh well, if you can't put your foot on the ledge, swing up your behind and sit on it") a party scaled Mur y Niwl, one of the steeper routes outside the Llanberis Pass. Indeed, after a traverse above the roof of an overhang, coils of nylon rope drooped six feet out from the base of the cliff.

Another day we scrambled to the top of Tryfan to bask in the sun and watch the antics of the climbers as they sweated over the lip of the East face. So balmy was the weather that one brave soul was inspired to dive into the waters of Llyn Bochlwydd. Her enthusiasm was tempered by the coolness of her reception and the plunge was a snailspace

Monument Underground ramp before this weekend, followed Alan Baker up the Direct Start of Overlapping Wall, one of the harder Llanberis routes.

At nightfall pleurous libations were poured to Bacchus, cut short only by the meagre hours ordained by the high priests of the Caernarvon Beach.

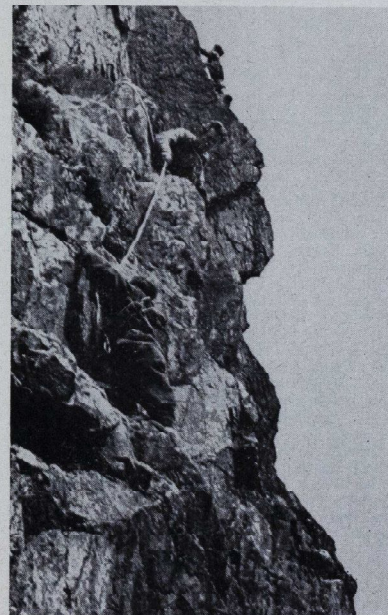
But perhaps the climax of the trip was the ascent of Main Wall on Cynr Las. Here one can revel in the glory of the position, secure on the bucket-like holds yet perched 400 ft. above the floor of the valley. The exhilaration of the climb is mingled with the serenity of the surrounding hills.

N.P.

RECENT PAPERS BY BART'S MEN

Continued from June Issue

- *PARTINGTON, M. W. The early symptoms of phenylketonuria. *Pediatrics*, 27, March 1961, pp. 465-473.
- *— Observations on phenylketonuria in Ontario. *Canad. med. Ass. J.*, 84, May 6, 1961, pp. 985-991.
- *PERKINS, E. S. Behcet's disease—ophthalmological aspects. *Proc. roy. Soc. Med.*, 54, Feb. 1961, pp. 106-107.
- FRANKERD, T. A. J. (and Bowdler, A. J.). Primary myeloid metaplasia. *Brit. med. J.*, May 13, 1961, pp. 1352-1358.
- *ROBERTS, D. C., and TREVAN, D. J. Cell division in an ascites tumour *in vitro*; with especial reference to abnormalities of cytoplasmic cleavage. *Brit. J. Cancer*, 14, 1960, pp. 716-723.
- *— and TREVAN, D. J. A versatile microscope chamber for the study of the effects of environmental changes of living cells. *J. roy. micr. Soc.*, 79, Feb. 1961, pp. 361-366. — see also TREVAN, D. J., and ROBERTS, D. C.
- SCOTT, Mary J., see DALY, M. de Burgh, and SCOTT, Mary J.
- SHARIH, A. see LEHMANN, H., and SHARIH, A.
- SMITH, M. A., and WATERWORTH, Pamela M. The bacteriology of acne vulgaris in relation to its treatment with antibiotics. *Brit. J. Derm.*, 73, April 1961, pp. 152-159.
- SPENCER, A. G. The renal action of chlorothiazide. *Proc. roy. Soc. Med.*, 54, April 1961, pp. 257-259.
- *TAYLOR, G. W., and others. Operations for primary lymphedema of the lower limbs: results after 1-9 years. *J. cardiovasc. Surg.*, 2, Jan. 1961, pp. 27-36.



beside the rebound to the shore.

John Watson, who was reputed not to have set foot on rock steeper than the Bank-

- *THEOBALD, G. W. The importance of placenta-tion evidenced by denervation of the internal iliac vessels. *J. Obstet. Gynaec. Brit. Commwltth*, 68, April 1961, pp. 197-204.
- THORNE, Napier. The skin clinic. *Brit. J. Clin. Pract.*, 15, April 1961, pp. 373-376; May 1961, pp. 477-478.
- THOULD, A. K. Lead encephalopathy. *Proc. roy. Soc. Med.*, 54, March 1961, pp. 228-229.
- *TREVAN, D. J., and ROBERTS, D. C. Sheet formation by cells of an ascites tumour *in vitro*. *Brit. J. Cancer*, 14, 1960, pp. 724-729.
- , see also ROBERTS, D. C., and TREVAN, D. J. TUPPER, R. see DENNES, E., TUPPER, R., and WORMALL, A.
- TURNER, J. W. Aldren. Obituary: Conrad Meredyth Hinds Howell. *Lond. Clin. med. J.*, 2, April 1961, pp. 51-52.
- WATERWORTH, Pamela M. see SMITH, M. A., and WATERWORTH, Pamela M.
- *WEBER, F. Parkes. *Miscellaneous notes (Eleventh series)*. 1961.

WESTON, P. A. M. Pathology and treatment of urethral stricture and its complications in Jamaica. *Ann. roy. Coll. Surg.*, 28, April 1960, pp. 203-222.

*WINNICOTT, D. W. Integrating and disruptive factors in family life. *Canad. med. Ass. J.*, 84, April 15, 1961, pp. 814-818.

*WINSTOCK, Donald (and Ingram, G. I. C.). Dental extractions in haemophilia: plasma therapy without dental splints. *Brit. med. J.*, March 11, 1961, pp. 719-721.

WINSTONE, N. E., and BROOKE, Bryan N. Effects of steroid treatment on patients undergoing operation. *Lancet*, May 6, 1961, pp. 973-975.

WORMALL, A. see DENNES, E., TUPPER, R., and WORMALL, A.

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

BOOK REVIEWS

A Synopsis of Ophthalmology. 2nd Ed. J. L. C. Martin Doyle, M.R.C.S., L.R.C.P., D.O. John Wright & Sons, Bristol. Pp. 236. 27s. 6d.

To write a readable and comprehensive synopsis is indeed a difficult achievement and particularly is this so when the subject matter is not relieved and helped by illustrations. Mr. Martin Doyle has undertaken this task efficiently and if his "Synopsis of Ophthalmology" is used, together with an atlas of diseases of the eye, the medical practitioner, diploma student, eye house-surgeon and undergraduate student will acquire an adequate clinical knowledge about the commoner ocular disorders. The synopsis is well balanced and up to date. There is a valuable chapter on modern therapy particularly concerned with antibiotics, corticosteroids and chemotherapy. There is a brief account of the commoner eye operations. Advice is given about the care of the blind and National Health Service procedures for the examination of patients. It is important in this country, where 92 per cent. of the people have their eyes examined by medically unqualified persons and where the undergraduate teaching of ophthalmology is the least in the civilised part of the world, that doctors with little available time for reading should have a book concisely written to aid their awareness of serious eye diseases. The tragedy of delay in appropriate treatment and of misdiagnosis leads too often to the saddest of human afflictions. John Wright and Sons are to be congratulated on their admirable production of this book.

H.B.S.

Essentials of Neurology by John N. Walton, M.D., M.R.C.P. Pitman Medical Publishing Co., Ltd., London. Pp. xvi + 422. 30s.

Dr. Walton, from the Royal Victoria Infirmary, Newcastle-upon-Tyne has written a first class, fairly short text book of neurology which should be valuable for senior students. The book is written on conventional lines and is well up to date. It is remarkable how much information he has got into the text and my major criticism

would be that he has mentioned too many rare and esoteric conditions when the space would have been better used in expanding his account of some of the more common disorders. The references which he gives are in general to review articles rather than to original papers and seem well selected, and the index is good, an important consideration in a book of this type. There are some line diagrams but no clinical or pathological illustrations, which is no real defect and no doubt accounts for the very reasonable price of the book. J.W.A.T.

Synovial Joints, Their Structure and Mechanics by C. H. Barnett, D. V. Davies and M. A. MacDonaill.

Jean Riolan, writing many years ago, called passionately for a study of the joints while their capsules were still intact: that is of the joints as organs and not merely as the meeting places of the end of bones. He would have the dry bones live, and cried out against those who confined their studies to what had been boiled and dried. The distinguished authors of this book, Anatomists all, acknowledge Riolan as the founder of their work on joint function, and in 200-odd pages bring the joints from structure to life and cover the dry bones with clear and detailed description of the tissues and of the mechanical arrangements which give them use. The book is divided into four sections. First, a necessary account of the structure and components of joints: then the physiological processes which enable them to live and function. The third section presents an unproved theory of joint function owing much to the work of John Goodsir and based on the belief of joint lubrication by so-called hydrodynamic or full-film lubrication. In the fourth section the function of joints as organs of posture and movement within the living body is carefully considered and described.

The book provides an essential base from which to begin any real study of the pathology of joints. W.D.C.

A Synopsis of Children's Diseases by John Rendle-Short, M.A., M.D. (Cantab.), M.R.C.P., D.C.H. 3rd Edition. John Wright and Sons, Ltd. Pp. 672. 42s.

There are some for whom the very word "synopsis" is anathema, but to the less sophisticated majority such books can be very useful. "A Synopsis of Children's Diseases" is a particularly good example of how such a book should be arranged and set out. But, let it be made clear, this is no slim pocket edition to be mugged up the night before an exam. Its price and the number of pages it contains should be sufficient testimony to that. This is good, solid stuff, and the scope is considerable.

Professor Rendle-Short has extensively revised and rewritten much of this edition. He has also included a limited number of references to recent review articles, which, in this type of book, is so infinitely preferable to vast lists of references to abstruse original papers. The lay-out is excellent: the printers must have been kept busy sorting out the many varieties of type employed.

This volume makes no pretence at being a textbook, but it is rather in the approach than in the contents that the difference lies. It is aimed at the General Practitioner and the Paediatric House Physician, to whom the appendix on drug dosage should be especially useful. It should also prove valuable to those preparing for examinations, whether Finals, the Diploma of Child Health, or Membership of the Royal College of Physicians. A.M.P.

Whillis's Elementary Anatomy and Physiology by Roger Warwick, B.Sc., Ph.D., M.D. Pp. 275. 5th edition. Churchill. 24s.

This is an interesting book which presents a well written and attractive account of the fundamental facts. The text is lavishly illustrated and includes a fairly comprehensive survey of the essential subjects.

A concise narrative of the nervous system and a readable chapter on metabolism give the book a unique place among others of its kind. Circulation is given a reasonable assessment, but extra space could profitably be used for more detail in such subjects as excretion, respiration and reproduction.

This book would be of greater value had the authors not been so intent on maintaining the elementary viewpoint. Disastrous misconceptions are inevitable. This criticism is particularly applicable to a number of the illustrations—the courses of nerves and bloodvessels are shown completely devoid of important relating structures. The other extreme is reached by overcrowding of labels; the final result is confusing and inaccurate.

Such errors should be avoided by the medical student whose concept of these subjects is, of necessity, more complex; but for others requiring an initial picture of the human body this book is ideal. It provides a sound, reasonable basis on which to build further knowledge.

C.R.M.

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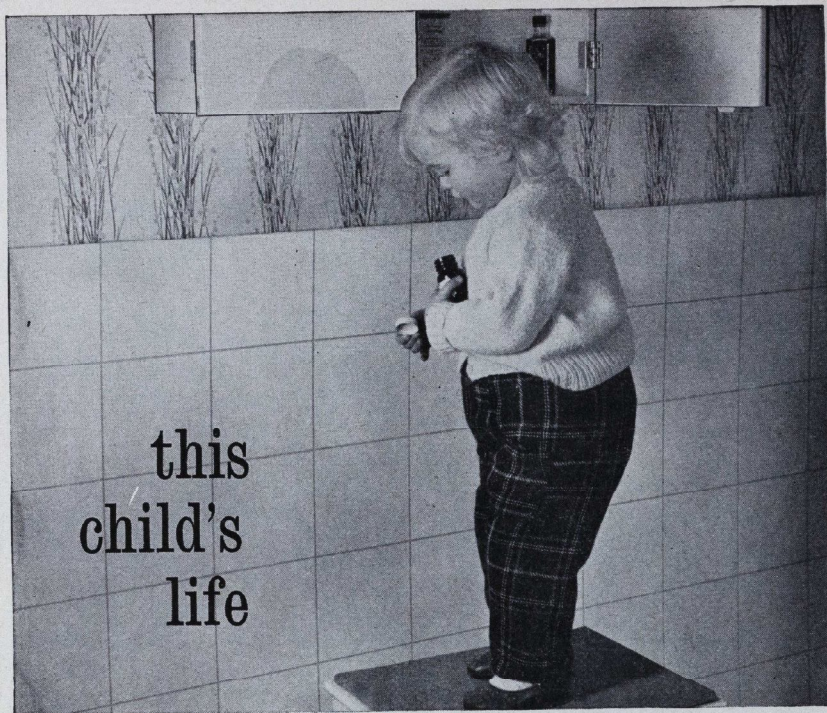
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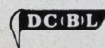
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ST. BARTHOLOMEW'S HOSPITAL JOURNAL



Vol. LXV, No. 8

AUGUST 1961

Editorial

WE QUOTE AN EXTRACT from one of a series of recent articles in *Time and Tide* on Britain's Health Service. *T. & T.'s* Medical Correspondent suggests ways and means of improving the N.H.S. so that the patient may get better value for his money. "... a re-orientation of medical teaching—along the lines taken so far by the London Hospital, Guy's, and even Bart's—so that students are taught to treat the patient as a whole person—to take a comprehensive view of both the somatic and psychical factors within the patient's social setting in contrast to the specialist." (The specialist's social setting, or his somatic and psychical factors, or his, presumably, uncomprehensive view?)

We confess that the italics are ours, but just into who, or what, has the author got his knife? It is the "*and even*" that really smarts. Is Bart's so immersed in the dust of antiquity and tradition that any innovation

(which, incidentally, this is not) is such an outstanding event? We have already had one letter from an outraged Bart's man demanding to know how his beloved alma mater can lie down under such an insult.

However, perhaps we have misconstrued *T. & T.'s* Medical Correspondent's meaning. It may be that he was only serving a pretty vicious backhander at the sacred cow of St. Thomas's.

We regret that this month's *Journal* is so slim. Whether it be the balmy season of the year, or just an increase in the ever prevailing reticence of Bart's men to write for their own journal, sufficient material has simply not been forthcoming in spite of begging, cajoling and even threatening.

The editor feels rather like the sower who went out to sow. For every twenty letters written inviting contributions five are

Editorial—Continued

devoured by the birds and no more is heard. Ten more fall on stony soil and the invitation is refused. Of the remaining five that are promised four are choked by thorns and never materialise.

Some seed, however, falls on good soil and brings forth grain, and we are particularly delighted to publish this month Mr. Donald Fraser's controversial article on the maternity services. This is a subject about which lay feeling has been running fairly high recently, and this is a most suitable moment for a senior obstetrician not only to acknowledge the problems, but also to examine them and suggest where the faults lie and how they may be remedied.

We are also very grateful to our other contributors this month whose articles belong to that all too rare and, to the editor, heaven

sent category which have turned up out of the blue.

At long last the elegant new swimming pool in the basement of Gloucester House is now open. The provisional time-table provides an interesting example of social segregation with separate timings for each strata of the hospital hierarchy. It also poses some delicate questions. For instance, are the Sisters entitled to use the pool in the time allotted to Nurses, or would this constitute a grave breach of etiquette? Or again, may a Night-Nurse who misses her appointed hour be allowed to join the category merely labelled "Women"? However, doubtless all these problems will resolve themselves, and let us all be thankful for our ninety minutes a week progressively called "Mixed". We will publish the full time-table in the *Journal* as soon as it becomes finalised.

Engagements

CUNNINGHAM—CORBETT.—The engagement is announced between Geoffrey Allan Brockman Cunningham and Alison Mary MacRae Corbett.

PRICE—JOHNS.—The engagement is announced between Richard Nigel Wyndham Price and Glenys Mary Johns.

Marriages

HOPPER—HENDERSON.—On June 29th, Dr. Peter Kennedy Hopper to Dinah Constance Milne Henderson, M.B., Ch.B., D.M.R.D.

SIMS—HARTLEY.—On July 8th, Robin Sims to Jennifer Hartley.

Births

HILL.—On July 6th, to Mary (née Bladon) and Dr. Pascoe Hill, a sister for Jonathan.

McCOLL.—On July 25th, to Jean (née McNair) wife of Ian McColl, M.B., B.S., a son (Alastair James).

McKENZIE.—On July 21st, to Sally (née Wade) wife of Dr. Alexander McKenzie, a son, brother for Miranda and Tessa.

MARSTON.—On July 18th, to Elizabeth (née Nicholson) and Dr. Michael Marston, a son (Hugh Michael).

ROSSITER.—On July 28th, to Jane (née Luckin) and Dr. James Rossiter, a son (Benjamin), brother for Penny, Gage and David.

Deaths

MAXWELL.—On July 25th, Prof. John Preston Maxwell, M.D., F.R.C.S., F.R.C.O.G. Aged 89 years. Qualified 1896.

PHILLIPS.—On July 15th, Alfred Percy Phillips, M.R.C.S., L.R.C.P. Qualified 1910.

TRAVERS.—On July 11th, Ernest Frank Travers, M.D. Qualified 1904.

Appointments

University of London

The title of Professor emeritus has been conferred on Dr. L. P. Garrod, professor of bacteriology at St. Bartholomew's Hospital Medical College since 1937.

University of Oxford

Dr. J. G. Widdicombe has been appointed University Demonstrator in Physiology from October 1, 1961, to September '30, 1966.

Royal Institution

Prof. R. J. Harrison has been elected Fullerian Professor of Physiology, Royal Institution.

Change of Address

SIR CHRISTOPHER ANDREWES, Overchalke, Coombe Ressett, Salisbury, Wilts.

MISS D. J. BERRY, 1, The Byeways, Sutton Drove, Seaford, Sussex. Seaford 2056.

MR. AND MRS. RUPERT CORBETT, Katrina, Beaumont Hill, St. Peter, Jersey, C.I. South 316.

DR. AND MRS. M. CROSFIL, Inyning View, Freshford, Bath. Limpley Stoke 3143.

DR. WILLIAM SECRETAN HAYNES, Perth Chest Clinic, 17, Murray Street, Perth, West Australia.

DR. AND MRS. R. A. STROUD, 42, Mitcham Park, Mitcham, Surrey.

Calendar

AUGUST

Sat. 12—On duty: Dr. G. W. Hayward
Mr. A. W. Badenoch
Mr. R. W. Ballantine

Sat. 19—On duty: Dr. A. W. Spence
Mr. E. G. Tuckwell
Mr. T. B. Boulton

Sat. 26—On duty: Medical and Surgical
Units
Mr. G. H. Ellis

SEPTEMBER

Sat. 2—On duty: Dr. R. Bodley Scott
Mr. A. H. Hunt
Mr. F. T. Evans

Sat. 9—On duty: Dr. E. R. Cullinan
Mr. C. Naughton
Morgan
Mr. R. A. Bowen

Fifty years ago

THE PRZMBGNZANSZKI-ZUT REACTION

TAKE 10 c.c.s. of the serum of a Greenland Whale, which has been harpooned by a Scotsman, and heat to 32.65°C. at a pressure of 32 lb./sq. in. To this add 10,000,000 lymphocytes of a tubercular frog. Incubate for 48 hours at 37°C. Prepare a second tube containing 5 c.c. of the cerebro-spinal fluid of a cab horse from Northern Hackney, which has had repeated injections (m.v.) of hydroxy-amnio-ethyl-diamido-ortho-β-phenyl-oxybutyric acid. Incubate under similar conditions with 0.5 c.c. of a suspension of *B. coli* from a pneumonic rat.

Mix the contents of the two tubes and add the serum of the patient to be investigated. A positive reaction, i.e. agglutination of the *B. coli* and the formation of a green fluorescent ring of Barium oxy-butyl-ortho-phenate, will indicate the presence of pseudo-brilliant enlargement of the pituitary body.
A.B.P.S.

The Eric Benjamin Strauss Library

IT SEEMS THAT few students are aware of the existence of the Eric Benjamin Strauss Library, which was formed to commemorate the retirement of Dr. Strauss from the staff of the hospital in February, 1959, having served twenty-one years as Physician in Psychological Medicine at Bart's.

When Dr. Strauss retired a collection was made amongst the members of the Psychiatric Department to buy him a suitable leaving present. After the gift had been purchased there was a surplus sum of money which, at Dr. Strauss's suggestion, was spent on buying the books which formed the original nucleus of the Library.

When Dr. Strauss died in January of this year he left in his will all his medical books to the Library. Now that his estate is cleared Dr. Louis Rose, who is Honorary Treasurer and Librarian, has moved all these books to Bart's, and they are now housed in the Department of Psychological Medicine. The Library, which is open to students, contains between two and three hundred books on Psychiatry, which may be taken out on loan.

Tenth Decennial Club Dinner

The Tenth Decennial Club will hold its annual dinner on Wednesday, October 11th, at 7 for 7.30 p.m. at the English-Speaking Union of the Commonwealth, 37, Charles Street, Berkeley Square, London, W.1. Dr. F. H. Young will be in the Chair.

The Committee has decided not to circulate the three hundred members of the Club, but to write individually to those who have attended any or all of the dinners over the last five years, and to all overseas members. It is, however, hoped that any member who is not so included and who would like to come to this year's dinner, will write to Dr. Geoffrey Bourne, 20, Harley House, London, N.W.1, enclosing his cheque for £2 5s.

OBITUARY

**R. C. Davenport, M.B., B.S.,
F.R.C.S.**

The many friends of Robert Davenport are saddened by his death at the age of 67 but will for ever rejoice in the memory of a man and a doctor who possessed so many admirable qualities of heart and mind.

He was at one time house surgeon, Eye house surgeon, Chief Assistant to the Eye department, and Demonstrator of Physiology at Bart's. He was a lucid teacher with infinite patience and a tolerance for stupidity and the frailties of human nature which was remarkable.

Patients of all ages and types were comforted by his warm humanity, genuine sympathy and his understanding of their background and likely behaviour. His gentleness in breaking the unpleasant news of some irremediable eye disorder which must lead to the saddest of all human afflictions softened the hard blow of such adversity. In such a case he was at his best at St. Dunstan's during the 1939-45 war when young soldiers, sailors and airmen had to be told of their plight, be guided, supported and encouraged by Davenport in the difficult stages of early training and the acceptance of blindness. Characteristically he went further and interviewed their wives and families to ensure an appropriate supporting background. In sympathy he mastered Braille.

When he retired after serving the Moorfields Medical School as dean for 20 years tributes came to him from 63 countries, from Chile in the west to the Phillipines in the East. To generations of students from all parts of our dwindling Empire and others of many races and colours he was the ideal dean, always an approachable friend, a kindly counsellor and a father confessor to whom they went not only for advice about their studies but brought to him their domestic problems and their homesickness in a foreign land. Few men have done so much for good Imperial (Commonwealth) and international relations. For this and his admirable work at St. Dunstan's he so richly deserved some public honour or decoration but to such he would have attached, quite characteristically, little importance.

His honesty and integrity were transpar-

ent, as was his dislike of showmanship and political manoeuvres. His friends, his colleagues and a legion of students and patients will always remember him with warmth and genuine affection as a very lovable man and a doctor who brought to his way of life and the practice of his chosen branch of medicine and surgery all that is best of human qualities. Our sympathy is extended to his widow and family.

H. B. STALLARD

Bart's Golfing Society

It is apparent that a number of students who qualify from the Hospital are unaware of the existence of this club. It was started in 1928 for all past and present students of the Hospital who are on the Medical Registry.

If there are any people who are so eligible and would like to join the club, they can do so by writing to the Secretary enclosing a 5s. subscription for life membership.

The club meets twice a year at courses close to London.

The last meeting was held at Denham Golf Club on June 21st, 1961. The Gordon-Watson cup (best Stapleford score under handicap) was won by Mr. L. Gracey with 42 points. The runner-up was Dr. A. Dossetor with a score of 33. The Corbett Cup (the best Stapleford score under handicap for those with a handicap over 18) was won by Dr. P. Borrie with a score of 27. The three sealed holes were won by Mr. L. Gracey with a score of 8 and the runner-up was Dr. H. Bevan-Jones, with a score of 7.

Mr. L. Gracey went round the course with a gross score of 68 (S.S.S. for course, 72), giving him a net score of 66 which is a club record.

The next meeting will be held at Addington Palace Golf Club on Thursday, September 14th, and it is hoped that as many new and old members as possible will attend. The June meeting next year will be on Wednesday, June 13th, at the Berkshire Golf Club.

J. O. ROBINSON,
Secretary,
149 Harley Street,
London, W.1.

Last Month

ON JUNE 28TH the preclinical summer term ended for the majority, the unfortunate remainder having to take 1st and 2nd M.B. during the most glorious weather. Many of the preclinical students will undoubtedly be taking jobs for part of the thirteen week vacation.

There was recently an editorial in this journal deploring the average medical student's cry for more financial state aid. Needless to say this criticism did not amuse a good many students in Charterhouse Square. Obviously not all medical students have to work during their vacations and of those who do there are some who do so only to pay for continental holidays, but there are others who work because they must if they are to lead reasonably sane and social lives throughout the subsequent term.

There can be no end to the variety of jobs taken by medical students in the summer vacation, from those which involve toiling in the sun picking fruit for a mediocre wage and poor keep to that which paid a Cambridge man £50 a month to play the piano on a luxury liner of a famous shipping line. This was exclusive of keep, cheap cigarettes, drink and tips! It seems that ideally one should aim to get hold of a job which offers full board, as well as the prospect of commission or tips on top of a flat wage.

In the jobs that I have had I have been much amused to hear dreary old platitudes from customers and fellow employees, all eulogizing the didactic advantages of "meeting the other half"! The other half teach one nothing except that they are dishonest to a man, the customer constantly being the mug. For example: nearly all the West End sales are rigged, the time sheets of a nationalised organisation are fixed and many of the drinks served, especially in seasonal establishments, are not those ordered by the customer.

My present work is behind the bars of a north country village pub. It has confirmed me in the view that a lot of people have little clue as to what they are drinking, but drink expensively because they think it looks big. They will accept French Vermouth for Cinzano Bianco, ordinary brandy for Cordon Bleu, light ale and lime for lager and lime

and even a single Scotch with plenty of ice for a double! And so it goes on. Madame wants a Pimms No. 1 and there is none left. Madame must not be upset so a Pimms is manufactured with gin, Dubonnet and all the other paraphernalia. Madame is quite happy and remarks on the quality of her drink while fumbling in her purse for a shilling.

S.C.S.

Correspondence

Dear Sir,

In connection with the very interesting articles by John Newton in your June issue, on "Wanderings through medieval London", I thought your readers might like to know that Clerks Well, which was for long lost sight of, was uncovered during excavations under the premises now 14/16 Farringdon Road, and may be seen without charge on application to the Finsbury Borough Librarian, Skinner Street, E.C.1.

Clerks Well is so called because the ancient Company of Parish Clerks used to meet here annually for the performance of miracle and mystery plays. This well was mentioned by Fitzstephen in 1174, and in 1603 Stow spoke of it as being "not far from the west end of Clerkenwell Church, but close without the wall that encloseth it".

Yours sincerely,

C. O. S. BLYTH BROOKE.

Medical Officer of Health,
Metropolitan Borough of Finsbury.

from Sir Adolphe Abrahams.

Dear Sir,

It gives me a thrill (albeit somewhat nostalgic) to see some excerpts of "The Chronicles of Christopher" which I wrote for the *Journal* fifty years ago when I occupied the editorial chair.

I trust that you are more fortunate with contributors than I—compelled at that time to write fully 90 per cent of every issue!

Yours sincerely,

ADOLPHE ABRAHAMS.

THE MATERNITY SERVICES—ARE THEY HUMAN?

Donald B. Fraser

FEW READERS OF this journal can have avoided propaganda in the press, on radio or television, suggesting that all is not well with the maternity services. In one breath the results were never better, judged by maternal and perinatal mortality figures, but the means to this end—so it is said—leaves much to be desired; patients are treated by numbers and man's inhumanity to man is the watchword of the service.

An "Association for the Improvement of Maternity Services" has been formed to publicize the matter and make constructive suggestions toward reform. A white paper on human relations in obstetrics has been circulated from the Ministry of Health to all maternity departments. This somewhat gratuitous effusion has caused resentment at the working level and emphasizes the grave responsibilities of the Ministry's advisors.

The matter is sometimes presented as though the defect were of recent development. This, on the face of it, seems odd. Senior Staff changes gradually and slowly. Juniors, both midwives and doctors, take their line by example from their seniors. It seems unlikely that people who have made midwifery their life's work can have failed to gain some knowledge of the psychology of the pregnant woman. Her fears are common knowledge—fear of being left alone—fear of death—fear of a malformed or injured baby—fear of pain and physical damage. These are all well-known and maternity units have their individual methods of dealing with them. We have a proud heritage in British Medicine handed down in trust from our predecessors that the practice of it is, and shall be, humanistic—with a tinge of applied science to make it efficient. This does not change in a generation.

With so much smoke, there must be some fire. What is the explanation? In the writer's opinion, it is naively simple—the obstetric hospital services are inadequate to the demands made on them. Every unit is overbooked to start with and the inevitable emergencies tax capacity to breaking point. Chronic overwork over the last five years in

particular, in an effort to meet the problem, has resulted in a deterioration of quality in an effort to deal with quantity. The midwives, who are particularly under fire for the simple reason that they deliver the majority of patients in these Islands, are unable to cope with the numbers involved—their standards are lowered—the maternity units are tending to become "factories", with babies the by-products of labour.

The activities of lay bodies in matters medical are always suspect, particularly by doctors. They tend to be classed with antivivisectionists and other quack societies. This is historically unfair, for the concept of prophylactic ante-natal care needed, and received, strong lay support in the face of medical reactionaries 50 years ago. The observations and recommendations of A.I.M.S. must be taken seriously. They will have achieved the purpose of their agitation when the Ministry have established adequate hospital maternity services and provided incentives to an adequate number of midwives to staff them. It is on the last point that the future depends; for the maternity services, good or bad, will stand or fall on the recruitment of these dedicated women.

Some of the lay misconception about the conduct of maternity units is due to medical people themselves. A vociferous minority have plugged the idea of natural childbirth into a caricature of reality. The safety factor has been over-emphasized and false sentimentality has crept in to confuse the issue. The modern layman's picture of childbirth is that of an enthusiastic back-rubbing husband cheering his wife through her finest creative hour. The silent majority of obstetricians know that human reproduction is a relatively crude process, potentially dangerous and, for most mothers, pretty uncomfortable to put it mildly.

The discipline of the labour wards and lying-in wards, so meaningless to the patient, is the means by which relative safety has been achieved, particularly in relation to puerperal sepsis, and it must be maintained.

The Ministry have made an effort to assess hospital requirements in the country

and the Cranbrook report suggested the magic figure of 70 per cent. of deliveries to take place in hospital. This figure was out of date for the London area at the time of the report over 80 per cent of deliveries were already taking place in hospital. The birth rate has gone up since then, and the tendency of women to want their confinement in hospital—note by the Royal College of Obstetricians and Gynaecologists in 1954—has increased. Few obstetricians would quarrel with this idea for they know that the normal midwifery case is normal only in retrospect. The intelligent woman also knows that complications are more readily handled in hospital surroundings than at home. The necessity for flying squads to support domiciliary midwifery is an expression of compromise with the obviously better arrangement, at least with regard to the safety of mother and child, which is our fundamental consideration.

In the present situation, patients, particularly multiparae, are subjected to a medical "means test" and the same woman who was delivered naturally in her first pregnancy, may find the hospital door closed to her because of the normal result last time; a result that may have been related to the excellence of her ante-natal and intranatal care. The psychology of this rebuff to a patient conditioned by successful primiparity is thoroughly bad. This brushing back of the multipara into her home until she is gravida five has historical parallel in King Canute's effort with the tide.

The Emergency Bed Service is a voluntary organization entirely apart from the National Health Service, founded to help London doctors to find accommodation in hospital for urgent cases. It is of proven value and, of course, unforeseen obstetrical emergencies do occur, but the numbers of obstetric cases handled by this service have steadily increased to the figure of some 4,000 a year. This is a glaring abuse of the original purpose, because many of the obstetric cases are not medical emergencies at all, but social problems, in that facilities at home are quite unsuitable for confinement and a hospital booking has not been possible. Their experience emphasizes the necessity for more hospital beds and the problem has now reached the proportion of a major social scandal.

Recent immigrants from the West Indies have aggravated the London problem. They

tend to book "late", their standards of nutrition and crowded living accommodation make a social if not a medical booking in hospital imperative. Many are instructed to contact the Emergency Bed Service in labour for last minute arrangements for hospital confinement. The perinatal mortality of their babies is considerably higher than that of their English counterparts and they need expert attention. No racial discrimination is intended in these remarks and the balance is more than made by scores of excellent Negro midwives who are helping to bolster the tottering maternity services.

How do patients fare at St. Bartholomew's Hospital in this controversy? We are now equipped to look after properly about 800 patients a year and many of our cases are grossly complicated. We have to refuse booking to a similar number. The district, where so many young Bart's students achieved medical manhood almost overnight, has been irretrievably lost. It has been lost simply because midwives could not be found to run it. The Governors have recently increased our bed complement from 40 to 46 in order that the responsibilities to mothers in our own geographical vicinity may be reasonably discharged.

At the instigation of the director of the department, Mr. John Beattie, the Governors have also opened in recent years an eight-bedded ward "HARLEY" for admission of cases of abortion. This ensures that no booked case in trouble in early pregnancy is ever sent elsewhere.

Our out-patient department is obsolete and, in many ways, an insult to human dignity. It is particularly unsuitable for the reception of the only healthy patients in the hospital and the attendances at ante-natal clinics are three times as many as they were 25 years ago in the same department.

We score rather better on in-patient facilities. The arrangements for premature babies are excellent. The lying-in wards are pleasant and efficient. The first stage rooms and labour wards are adequate to present numbers and patients are closely attended in labour. We have skilled midwives of the highest quality as might reasonably be expected, but under-staffing is a feature from time to time. These midwives constitute the important close contact with patients and the reputation of the hospital is safe in their hands.

The "ten year" plan for Bart's envisages

a new maternity unit of 100 beds with modern out-patient facilities. This will maintain the advantage of integration, enjoyed by the present department, with the medical, surgical and pathological services of the hospital. It will involve the establishment of

a Teaching School for Midwives—the only way to staff it, and will remedy the present defect that 20 per cent. of our medical students receive no practical training in midwifery in their own hospital.

MEDICINE OUTSIDE HOSPITAL

G. H. Abercrombie

DR. J. L. STRUTHERS, of Southampton, who qualified in 1955, chose this title for his lecture on General Practice on June 7th, 1961.

Bart's serves a local population of about 20,000 people. Six or eight general practitioners would care for about that number, but would not see anything approaching the proportion of unusual cases to be found in the wards of a teaching hospital. When you leave Bart's, you should spend at least six months in general practice, whatever your future may be, to learn what patients want when they go to see a doctor, and what doctors want when they send patients to hospital. Of your 2,500 patients, you will see an eighth in any one month, a half in any one year, nine-tenths in three years; but the number on any one day is unpredictable. In winter, a G.P. may work seventy hours a week; in summer perhaps only thirty. Surgeries dominate the picture. During the winter on three evenings a week, family life and social life mean supper, stoking the boiler, putting the dog out, and bed. Surgeries are to the G.P. what ward-rounds are to the hospital; home visits are perhaps equivalent to out-patient Clinics.

The doctor's wife has to be a remarkable woman. She has to tolerate your erratic hours as well as tolerating you! She must have a good telephone manner, assuring each individual caller that his troubles matter without ever committing the doctor to any precise line of action. She answers the phone to save the doctor from being involved in long and fruitless discussions, and from being tempted to prescribe treatment without seeing the patient.

In hospital you see approximately equal numbers of what you tend to call male and female patients. Outside we call them men and women, but we see far more women, whether we like it or not, for three reasons: first, they have their own troubles with menstruation and pregnancy; second, they have the care of children; third, at the other end of life, they suffer from the chronic disabling diseases—rheumatoid arthritis, non-fatal strokes and osteoporosis—and need repeated visits at home. You may not be charmers, perhaps it's just as well if you are not, but you should start now to cultivate the manners which women like, to understand a woman's point of view, and to learn about those things which most affect her daily life, e.g. the baby's nappies. If the mother sees that you understand her difficulties, she will be more likely to accept your advice on the prevention of illness and anxiety. If you want to improve your skill in these matters, go visiting with a good, down to earth, social worker, and see how she fits into the surroundings, whether in her own office or in a one-room tenement; see how she gets the information she needs, and how she gives the advice the patient needs.

While you are still here, make the most of your last chance of studying Medicine as an academic subject. Your stock of academic knowledge must sustain you through your whole professional life. It will be gradually eroded by forgetfulness and hurry, but may be increased by experience, by reading books and journals, especially *The Practitioner*, by attending the meetings of your local medical Society, and by sharp-

ening your wits on your colleagues and partners over morning coffee, when the visiting list and clinical problems are discussed.

In general practice you are likely to find yourself in a mutual admiration society. People whom you don't like will usually sense it and leave you; only those who like you will remain your patients. Even if you gradually become less and less safe by the standards of academic medicine, these patients will remain blissfully ignorant, and will still call you a good doctor. Don't delude yourselves as to your powers—most patients would recover eventually without treatment.

STOP, LOOK AND LISTEN

What matters to the patient is that someone, important in his eyes, has stopped to listen to him. This gives him confidence to tell you more, and to tell you what you need to know to make a diagnosis. The history

is the important thing. Take it as it comes; it may need encouragement, but come it will. It is instructive to consider how often you are really stumped for want of some piece of apparatus. The stethoscope, symbol of a doctor in the public eye, is not indispensable. The sphygmomanometer could be lost for a week. A haemoglobinometer is far more valuable and half the price, and yet is missing from many surgeries. You need an ophthalmoscope only once or twice a week. The instrument whose loss would be really serious is the auroscope: you must have one and learn to use it. If you will stop and look and listen, most of your diagnosis is done before you touch the patient. Try it now while you still have no responsibility, no need to do anything about what you discover. Thus you may prepare yourselves to be what your patients need and want—a good doctor.

MEDICAL STAFF APPOINTMENTS

The following appointments to the medical staff take effect from the dates mentioned:—

DEPARTMENT OF OBSTETRICS AND GYNAECOLOGY

Consultant: Mr. Gordon L. Bourne. August 1st, 1961.

EAR, NOSE AND THROAT DEPARTMENT

Consultant Surgeon: Mr. R. F. McNab Jones. August 1st, 1961, to succeed Mr. Jory, retired July 27th, 1961.

Registrar: Mr. L. N. Dowie. July 1st, 1961.

CARDIOLOGY DEPARTMENT

Consultant Physician: Dr. D. Weitzman. July 1st, 1961, new appointment.

DEPARTMENT OF ANAESTHESIA

Consultant Anaesthetist: Dr. T. B. Boulton. July 15th, 1961, to succeed Dr. Langton Hewer, retired June 6th, 1961.

Senior House Officers: Mr. C. J. White. August 1st, 1961.
Mr. R. W. Gabriel. August 1st, 1961.

DR. CULLINAN'S FIRM

Registrar: Dr. G. M. Buckle. September 1st, 1961 (but has already begun work): to succeed Dr. Parrish.

DR. BODLEY SCOTT'S FIRM

Registrar: Dr. G. H. Fairley. August 1st, 1961, to succeed Dr. J. Q. Matthias.

MR. HUNT'S FIRM

Senior Registrar: Mr. P. Knipe returns on September 1st, 1961.
Mr. T. Early leaves on July 31st, 1961.
Mr. N. G. Rothnie locum during August, 1961.

RHEUMATIC DISEASES

Medical Registrar: Dr. R. L. Hewer. July 24th, 1961.

PRE-ECLAMPTIC TOXAEMIA

A review of the 327 cases of pre-eclampsia treated at the Peterborough group of Hospitals during 1959-1960, out of a total number of 2,425 deliveries.

by G. B. Jackson

Introduction

The toxæmias of pregnancy have been defined as a group of diseases which are encountered frequently during gestation and the early puerperium, and are characterised by one or more of the following signs: hypertension, oedema, proteinuria, and in certain severe cases convulsions and death (Eastman).

Eastman has also suggested the following classification:

1. Acute toxæmia of pregnancy (onset after 24 weeks).
 - A. Pre-eclampsia.
 - (i) Mild.
 - (ii) Severe.
 - B. Eclampsia (convulsions or coma, usually both, when associated with hypertension, proteinuria or oedema).
2. Chronic hypertensive (vascular) disease with pregnancy.
 - A. Without superimposed acute toxæmia.
 - (i) Hypertension known to have antedated pregnancy.
 - (ii) Hypertension discovered in pregnancy before the 24th week (and with post-partum persistence).
 - B. With superimposed acute toxæmia.
3. Unclassified toxæmia (insufficient data to differentiate the diagnosis).

Pathology and Aetiology

A FULL DESCRIPTION of the pathology and aetiology of pre-eclampsia may be found in any text book; it is sufficient to mention here that the major amount of the pathological study of this disease has necessarily been carried out in fatal cases of pre-eclampsia. Little is known, therefore, of the presumably reversible changes in non-fatal cases of pre-eclampsia which may or may

not be similar to those in the fatal cases.

The aetiology of pre-eclampsia is also unknown although there are many theories, but it is generally held that the final cause lies between disordered endocrine and maternal enzyme functions.

The clinical course of pre-eclampsia

It is a characteristic of the disease that the patient is often well during its early stages and no symptoms are noticed until the disease is well advanced. The first sign is usually a rise in the blood pressure. Figures of 130 mm. systolic and 90 mm. diastolic are usually taken arbitrarily to be significant (F. J. Browne). This rise in blood pressure occurs after the 24th week of pregnancy and is soon followed in most cases by a rapid rise in weight with obvious oedema; the weight gain may, however, precede the hypertension. Excessive gain in weight, moreover, may be due to an actual gain in "flesh", a fact of some importance since it has been shown that pre-eclampsia is commoner in patients showing an excessive gain in "flesh" during pregnancy.

Although the order of events may vary, the next sign to appear is usually proteinuria, which varies greatly according to the severity of the disease. In the Peterborough group of Hospitals, proteinuria is not found to be a frequent sign in pre-eclampsia; hypertension, weight gain and oedema being more usual.

In mild pre-eclampsia the blood pressure does not exceed 160 mm. systolic or 100 mm. diastolic, oedema and proteinuria being minimal or even absent. In severe pre-eclampsia the blood pressure may be grossly raised to levels of 180-200 mm. systolic and 110-120 mm. diastolic; associated with this the oedema and weight gain are marked and

proteinuria may be very severe. If the disease is allowed to progress, the patient begins to complain of frontal headaches, visual disturbances, loss of appetite and vomiting; progressing to twitching of the extremities and finally to the convulsions and coma of true eclampsia.

Of the 327 cases reviewed 68 were not booked for hospital confinement; the patients fell into five main groups:

1. 105 cases with hypertension alone, of whom 82 had a maximum diastolic blood pressure below 100 mm. and the remaining 23 cases with a maximum diastolic pressure between 100-110 mm.
2. 78 cases with hypertension and oedema but no proteinuria. In only 8 cases was there marked pitting oedema.
3. 68 cases with hypertension and proteinuria but no noted oedema. In none of these cases was there more than a trace of proteinuria.
4. 73 cases with hypertension, oedema and proteinuria, of whom 49 had mild proteinuria (less than 1 gramme per litre), 20 had moderate proteinuria (between 1 gramme and 5 grammes per litre) and 4 had severe proteinuria (more than 5 grammes per litre).
5. 3 patients with eclampsia.

Of these 327 cases seven were known to have essential hypertension, two of whom had proteinuria before pregnancy. One other essential hypertensive was also a known case of diabetes mellitus.

Perinatal mortality and foetal maturity

The perinatal mortality in pre-eclampsia is to some extent dependent upon the severity of the disease. In its milder form the figure is low, but in severe pre-eclampsia and eclampsia the perinatal mortality is of the order of 300 per 1,000 deliveries.

Foetal maturity plays an important part in determining the foetal mortality and a high proportion of foetal deaths are attributable to immaturity. But the foetal mortality is also proportional to the duration of the disease and rises considerably after the 37th week of pregnancy. The highest degree of survival is therefore obtained by inducing delivery near the 37th week of pregnancy.

In fact, in this series 98 births were induced, 16 deliveries were by Caesarean section and the remainder were spontaneous deliveries. The maturities are shown in the table below:

Duration of pregnancy in weeks	Induced births	Spontaneous births	Caesarean sections
40-Term	58	115	11
39	12	38	0
38	11	27	2
37	5	14	0
36	6	8	1
35	3	3	1
34	1	3	1
33	1	2	0
32	0	0	0
31	1	1	0
30	0	1	0
29	0	0	0
28	0	1	0

totalled 22, or 64 per 1,000 births. Figures vary for the perinatal mortality in pre-eclampsia, but figures between 10 and 15 per cent (100-150 per 1,000 births) are usually given (Theobald).

The perinatal mortality was composed of 20 stillbirths and 2 neonatal deaths, the incidence of the stillbirths being:

(i) 38 weeks-term	...	...	9
(ii) 36-38 weeks	...	...	2
(iii) 32-36 weeks	...	...	5
(iv) before 32 weeks	...	...	4

Foetal abnormality was present in three of these cases, namely, hydrocephaly, anencephaly with spina bifida and hydramnios; in the third case the foetal abnormality was not stated.

The remaining two perinatal deaths were of twins delivered by lower uterine segment Caesarean section at 35 weeks of pregnancy; they died on the first and second days of life.

Maternal mortality

In large series the maternal mortality in pre-eclampsia is low (0.2-0.4 per 1,000 cases); in eclampsia, however, the mortality is far higher and is variously stated to be between 1 and 10 per cent. In this small series the maternal mortality was nil.

Associated abnormalities

Pre-eclampsia is commoner in cases of

multiple pregnancy; in this series there were five cases of twins, an incidence of almost 1 : 60 cases. Hydramnios is also said to be associated with pre-eclampsia, but only 3 cases were found in the series.

Other abnormalities also noted were: 18 forceps deliveries, 9 breech deliveries, 3 manual removals of placentae and two cases each of ante-partum haemorrhage, post-partum haemorrhage and puerperal pyrexia.

Maternal and perinatal mortalities in eclampsia

As previously mentioned, the maternal and perinatal mortalities in eclampsia are considerably higher than those in more moderate stages of toxæmia. From 1951 until the present time 34 cases of eclampsia have been treated at the Peterborough Group of Hospitals: of these 18 were not booked for hospital confinement. There was one maternal death, that of a patient with congenital polycystic kidneys, who died as a result of anuria.

Four deliveries were by lower segment Caesarean section, eight deliveries were by forceps; there was one case of triplets and one of twins, the remainder were normal. This resulted in a total of 37 births with a perinatal mortality of 5, or 135 per 1,000 births. The perinatal deaths are listed below:

- (i) A stillbirth delivered by lower segment Caesarean section at term.
- (ii) The neonatal death of a triplet born at 39 weeks of pregnancy; this was due to congenital oesophageal atresia.
- (iii) The breech delivery of a macerated stillbirth at 31 weeks of pregnancy.
- (iv) A neonatal death following normal delivery at 32 weeks of pregnancy.
- (v) A stillbirth delivered normally at 33 weeks of pregnancy.

The treatment of pre-eclampsia

The most important factor in the treatment of pre-eclampsia is early detection of the disease. This entails regular attendance at the ante-natal clinic with a careful watch for a rise in blood pressure, excessive weight gain (due either to oedema or an actual gain in "flesh") and the appearance (or exacerbation) of proteinuria. Any rise in the blood pressure above 130 mm. systolic or 90 mm. diastolic, or a weight gain exceeding 1 lb. per week is suspicious. The appearance of proteinuria is checked with either a clean specimen or a catheter specimen of the urine.

Treatment is largely symptomatic and can be divided into the treatment of weight gain and the treatment of hypertension. At the ante-natal clinic in Peterborough the importance of actual gain in "flesh" is stressed and any patient showing excessive weight gain is asked to follow a diet sheet which is reproduced below. Any patient who, at her first attendance, is thought to be obese is put on this diet immediately as it has been found difficult to make patients lose weight late in pregnancy. This type of diet is also used for patients actually admitted with pre-eclampsia.

The oedema of pre-eclampsia is due partly to a raised hydrostatic pressure and partly to water and salt retention, there being an increase of 10 per cent in the total exchangeable sodium (Dieckmann). Oedema of the legs is to some extent relieved by bed-rest, therefore; water and salt retention, however, require treatment with diuretics and a salt-reduced diet. Most of the patients in this series requiring diuretics were treated with Saluric (chlorothiazide) 0.5 gramme twice daily, together with a diet in which no salt was added. In the severer cases larger doses were needed and a salt-free diet was necessary.

Other diuretics have been used: Esidrex (mearsalyl), Hydrosaluric (hydrochlorothiazide), Aprinox (bendrofluzide) and the latest preparation to be used is Navidrex K. The chlorothiazide derivatives are particularly useful because of their added hypotensive action.

Hypertension in pre-eclampsia is partially of neurogenic origin, but Assali has shown that there is a toxic factor acting directly on the arteriole to produce spasm. Light sedation is often sufficient in the mild case; sodium amytal 1.5 grains three times daily was most commonly used. In severer cases small doses of hypotensive drugs, such as 0.5 mgm. daily of Reserpine, have been claimed to be of value, although this is by no means sure. Beck has stated that their prolonged use is successful in reducing the foetal mortality.

Hospital treatment for the milder case of pre-eclampsia was rarely necessary, and as a rule was not possible. These patients, therefore, were told to rest as much as possible and to avoid over-exertion; this combined with sedation, diet and diuretics was often enough to control the pre-eclampsia. Any worsening of the hypertension or gain

YOU MAY DRINK

1½ pints milk per day.
Tea, coffee, water, lemon juice—all without sugar.
Saccharin can be used for sweetening.

YOU MAY EAT

BREAKFAST

2 eggs or 1 large grilled chop.
1 thin slice bread with little butter.
Tea, coffee or milk.

MORNING TEA

1 orange.

LUNCH

Meat, eggs or cheese.
Vegetables (salad or cooked).
1 thin slice bread with little butter
1 piece fruit.
Milk.

DINNER

Large serving meat or fish.
Very little gravy or sauce.
1 small boiled potato.
2 vegetables.
1 piece fruit.
1 thin slice bread with little butter.
Tea, coffee or milk.

SUPPER

Milk or milk coffee.

DO NOT ADD SALT TO YOUR FOOD AT TABLE.

(Calories 1800 . . . Protein 85-90 g.)

DO NOT TAKE

Sugar, glucose, Dextal.
Honey, jam, syrup, sweet spreads.
Sweets, chocolates, cocoa.
Chocolate beverages such as Milo, Ovaltine, Bourn-Vita, Aktavite.
Soft drinks, cordials, milk shakes.
Alcoholic drinks.
Biscuits of any kind (no Sacs. Vita-Weats, Ryvita, etc.).
Cakes, puddings, pastry, scones.
Ice cream, cream.
Dried fruits, tinned fruits, grapes.
Porridge, cereals — cornflakes, Weetabix, etc.
Spaghetti, macaroni, vermicelli.
Rice, sago, tapioca.
Baked beans, split peas, barley.
Fried foods — chips, etc.
Fatty meat, sausages, bacon, ham.
Olive oil, peanut oil, olives.
Dripping, lard.
Nuts, peanut butter.
Extra bread and butter.
Extra fruit.

Diet sheet for patients with excessive weight gain in pregnancy.

in weight usually necessitated admission to hospital for complete bed-rest and more vigorous treatment.

Any rapid deterioration in the course of the disease was usually treated with heavier sedation, morphine, grains one-sixth to one-quarter, four-hourly being most effective. When this failed to have any effect the pregnancy was normally terminated.

Termination of pregnancy

Milder cases of pre-eclampsia were often allowed to reach term, but post-maturity was seldom permitted. Induction of labour near the 36th week of pregnancy, to avoid the risks of prematurity and of intrauterine death, was often necessary in the more severe cases.

Induction of labour was usually obtained by digital sweep of the membranes, or, failing this, by rupture of the membranes.

Pitocin drips for induction were not used because of the vasopressor action of this drug. Labour was often induced before the 36th week when the pre-eclampsia was worsening in spite of treatment, when the systolic blood pressure remained consistently above 160 mm., and in the face of persistent severe proteinuria. Failure of induction to succeed, or a very rapid and severe deterioration in the course of the disease, were often considered sufficient indication for Caesarean section. In all, 98 labours were induced and 16 deliveries were by Caesarean section, or a total of almost 35 per cent of the whole series.

The result of delivery was to produce a fall in blood pressure and a decrease in proteinuria, normally within the first week after delivery. The hypertension and proteinuria were normally absent at the post-

natal examination 6 weeks after discharge.

Selected case reports

1. Mild pre-eclampsia.

Mrs. Phyllis D—, aged 31, was pregnant for the second time, having had one previous ruptured ectopic pregnancy. When seen for the first time at 26 weeks of pregnancy her blood pressure was 145/80 mm. and she had gained 1 stone in weight. At 34 weeks the blood pressure was 150/105 mm. but there was no further weight gain and no proteinuria. She was treated as an out-patient with rest, diet and mild sedation. When admitted at term her blood pressure was 140/100 mm., and there was still no oedema or proteinuria.

Treatment continued with complete bed-rest, 1,800 calorie diet, and sodium amytal, grains 3, three times daily, with saluric, 1 gramme, twice daily. In four days the blood pressure dropped to 130/80 mm. and she lost 4.5 lb. in weight. On the fifth day after admission a digital sweep of the membranes was performed and she was delivered normally 24 hours later. At discharge on the tenth day the blood pressure was 130/90 mm. and six weeks later was 140/80 mm.

2. Severe pre-eclampsia.

Mrs. Winifred G—, aged 26, was pregnant for the third time; she had severe pre-eclampsia in the previous pregnancy. At 24 weeks the blood pressure was 150/84 mm., there was no oedema and no proteinuria; at 30 weeks the blood pressure was 170/110 mm., there was moderate oedema and proteinuria (1 gramme per litre), she was complaining of headache and spots before the eyes.

She was admitted and was given morphine, grains one-sixth intramuscularly, immediately. Shortly after admission the blood pressure reached a peak of 210/110 mm., but this soon decreased. Subsequently she was treated with bed rest, 1,800 calorie diet, and sodium amytal, grains 3, three times daily, with Aprinox (bendrofluazide), 1 tablet, twice daily. A fall in weight of 1 stone, to 11st. 5lb. was recorded, together with a fall in blood pressure to 170/110 mm., proteinuria (6 grammes per litre) persisted.

At 35 weeks labour was induced by a digital sweep of the membranes and she was delivered normally of a living baby weighing 3 lb. 5 oz. By discharge the blood pressure had dropped to 140/95 mm. and the proteinuria to 100 mgm. per litre. Six

weeks later the blood pressure was 145/90 mm., and the proteinuria 30 mgm. per litre.

3. Essential hypertension with added pre-eclampsia.

Mrs. Blanche R—, aged 33, pregnant for the third time, was a known hypertensive. At 20 weeks the blood pressure was 180/110 mm., there was no oedema and no proteinuria. She was told to rest and was given phenobarbitone, $\frac{1}{2}$ grain, twice daily. She continued through her pregnancy with a blood pressure of 180/110—160/100 mm. until admission at the 38th week; there was now severe oedema but no proteinuria.

After admission she was treated with bed-rest, 1,800 calorie diet and sodium amytal, grains 3, three times daily, and with Saluric, 1 gramme, twice daily. On the day after admission the membranes were ruptured with a Drew-Smith catheter and she was delivered normally the next day. At discharge the blood pressure was 170/100 mm. with no oedema and no proteinuria; there was no change from this at the post-natal examination six weeks later.

4. Severe pre-eclampsia with intrauterine death.

Mrs. Alice B—, aged 39, was pregnant for the eighth time, her previous seven pregnancies had been normal. When seen for the first time at 24 weeks her blood pressure was 140/80 mm. and there was no oedema or proteinuria. At 30 weeks, however, the blood pressure was 160/90 mm. and there was considerable oedema. The patient was admitted and treated with bedrest, 1,800 calorie diet and sodium amytal, 1 grain three times daily with Saluric, 1 gramme twice daily. She was discharged very much improved after one week of this treatment.

At 32 weeks examination showed no increase in foetal size, foetal movements were no longer felt and the foetal heart could not be heard; X-ray confirmed foetal death. The blood pressure was now 160/105 mm. The patient was readmitted one week later for induction of labour, her blood pressure now being 130/90 mm.

Digital sweep of the membranes was attempted, but was not possible because of non-dilatation of the cervix; an intravenous ergometrine drip was then set up, but this too failed to induce labour. Hysterotomy was therefore performed and a bilateral Irving's operation was carried out at the same time. At operation a macerated foetus was

found of approximately 26 weeks' maturity.

This patient was discharged after three weeks, feeling considerably improved and with a blood pressure of 150/70 mm.

Summary

Three hundred and twenty-seven cases of pre-eclampsia were treated with rest, diet, sedation, diuretics and, where necessary, with induction of labour. There was a perinatal mortality of 64 per 1,000 births. The maternal mortality was nil. In 34 cases of eclampsia the perinatal mortality was 135 per 1,000 births, and there was one maternal death.

The Bishop's Bonfire *Mermaid*

The Irish, we are told, believe that Ireland is "a little bit of Heaven". That, however, is not the impression one gets from Sean O'Casey's "The Bishop's Bonfire".

The play is the story of the preparations for the visit of the Bishop to his home town Ballyoonagh, and the people involved. It shows the conflict between the ideas of youth and age in a country where, as the programme note informs us, "chastity has become one of the worst vices, the marriage rate the lowest in the world and the birth rate too, accompanied by the alarming emigration of young people". The reasons for this are obvious if Mr. O'Casey has painted a true picture of communal life in Ireland, where he sees the Roman Catholic Church as the true government. The Church, with its clerical authority, puritanical outlook, piety and, above all, its tradition engrained since birth, has blinded and brainwashed the ignorant peasants into accepting without question its doctrines.

It would seem that the subject matter is heavy. Far from it; with tongue in cheek the author has said all he needs to say. Irish wit abounds, the subtle and the ridiculous blended to poke fun at the Church, Irish drinking habits, the army and even the Russians who, one character maintains, will transport them all to a New Siberia on the Isle of Man.

Acknowledgments

I would like to thank Mr. N. K. B. Kimbell and Mr. J. C. Spry-Leverton for their permission to publish this review and also for their interest and encouragement in its preparation.

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Amidst the comedy and slapstick is pathos in the figure of a young priest, who sees the folly of the feudal system created by his fellow clerics and tries to rebel. "The Bishop's Bonfire" is good entertainment and good comedy with a difference its "Oirish"!

J.W.

Ladies' Hockey Club

At the Annual General Meeting of the Club, held on Monday, June 26th, 1961, the following officers were elected for the 1961-1962 season:—

Captain: Alethea Coates; *Vice-Captain and Fixture Secretary:* Janet Thoroughgood; *Hon. Secretary:* Sheila Minns; *Match Secretary:* Catherine Lloyd; *Treasurer:* Parveen Kumar; and *Committee Member:* Elizabeth Knight.

We regret that there were the following errors in last month's teaching supplement. Dr. Harris has a Ward Round at 10.30 a.m. on Thursdays. Mr. Birnstingl holds his Surgical Out-patients' Clinic at 9 a.m. on Mondays. Mr. Tuckwell no longer holds a Monday morning clinic.

SPORTS NEWS

Viewpoint

It must have happened to all of us sometime, whatever the game; to have committed some glaring mistake—missing a sitter (unknown aetiology—but apt in that one usually ends up in a rather undignified posterior position), whether it be the dropped final pass in Rugby, the missed open goal at Soccer, or the smash straight into the net at tennis. But perhaps the most embarrassing, in that you remain in the limelight for a long time, is the dropped dolly at cricket.

However, it is not the drop itself that is so interesting, but the reaction of the fielder afterwards (self-analysis can be very revealing sometimes!). There would seem to be three main groups, depending partly on how good a player you are but also on personality.

1. Mr. Average—very keen, but not very good—indulges in a profusion of apologies and a veritable quagmire of self-criticism continuing for the rest of the innings and on into the pavilion, until the shades of kind alcohol creep over his hyperaesthetic cortex.

2. The Expert makes excuses—"It was difficult, wasn't it; did you see the wind get hold of it, and I lost it against those trees? No, it definitely wasn't on." Oh foolish one—the truth is not in thee and thou deceiveth thyself (but not anyone else, alas . . . alas . . .).

3. The A. N. Other—picked to fill the No. 11 spot—cannot bowl, cannot bat (cannot field either, for that matter). "Goodness, what a duffer I am! (Laughs.) Still, it leaves the game open. (More laughs.) Didn't want us to win too easily. (Hysterics.)" Later in the bar (after they have won) the captain

of the opposition comes up to our skipper: "Fine chap your No. 11—best I've played against; and those stories—that one about . . ."

Heigh-Ho, it's a fine game.

Athletic Club

THIS SEASON HAS provided greater scope for Bart's athletes in competition and in preparation for University Championships than in the past. The team has returned victories against King's College Hospital, St. Thomas's Hospital, Guy's Hospital, Northampton College and Imperial College Athletic Clubs. The two most enjoyable fixtures, both competitively and socially, against the Westminster Bank A.C. were closely fought.

The team's success has been mostly due to a very keen nucleus of athletes. In the sprints M. Freeth has strengthened our claims and is rewarded with a trip to Sweden with the United Hospital's A.C. in September, as is also T. Foxton. C. Bridger and A. Knox have run well in the 440, particularly the former who has recorded many good wins. In the 880 and the mile Foxton has run consistently well and has been ably supported by P. Littlewood and A. A. Lewis.

In the field events T. Herbert has shown greater concentration in the shot and discus. M. M. Orr and C. J. Richards have been a formidable combination in the javelin and have taken maximum points in all fixtures. Goodall has produced a welcome return to form in the triple and long jumps. S. Harris and B. Marsh have gained important points in both the high jump and the long jump.

It is hoped that this enthusiastic team can be retained as the club can then be assured of a successful future, which may attract otherwise dormant athletes to participate before "sans eyes sans teeth" doth us part.

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BOOK REVIEWS

The Principles and Practice of Surgical Nursing by D. F. Ellison Nash. Edward Arnold. 36s.

The revision of this large textbook for its second edition has been thorough; there are few chapters which remain unchanged. Additions include mention of steroid therapy as it affects the surgical patient; open heart surgery; the artificial kidney; the treatment of cardiac arrest; protecting staff against radiation hazards; urinary ileostomy; fluothane, and many others. The book is rather larger (1032), contains more illustrations, and is a little dearer (by 6s.).

The publication of this book was a notable event in nursing education; no other surgical textbook is anything like it. It only claims to describe the principles of surgery, but these are supported by careful reasoning, and with full application to practice. Detailed practical advice is never lacking, and vague allusions to watchfulness and care, which are so irritating to anyone who wants factual information, are never made. The nurse is recognised and addressed as an adult practitioner of a craft. Many authors who write of a subject in which practices differ as widely as they do in surgery are content to give generalities with which no one will disagree. This is not Mr. Nash's way, and he is committed on every subject he discusses. His book is that of a great educationalist with well-marked opinions. Inevitably some will not agree with all of these, but his beliefs are well supported and must command attention.

The index remains the only weak part of the book. An exhaustive index is a great help when one is looking for information in a hurry, and there is a great deal more in Mr. Nash's book than might be thought by looking at the last pages. W.E.H.

Drugs in the treatment of disease. British Medical Association. Ed. H. Clegg. 1961. pp. 516. 35s.

New drugs make their appearance every day on the market and the physician is faced with the dilemma that if he treats his patient with one of the new proprietary drugs, the complications of the treatment may be worse than the disease. In among this great collection of new drugs are some that represent an unqualified advance such as the phenothiazine drugs in mental disease or hypotensive drugs such as guanethidine.

This book is compiled from a series of therapeutic articles that were published in the British Medical Journal in the last two years. These were written by eminent members of the profession and have again been revised before being published in book form so that the problems of delay in this rapidly changing field have been largely overcome.

There are 65 articles, some of them written by consultants to this Hospital, and all aspects of simple therapeutics have been covered with the possible exception of cytotoxic drugs. The high standard of these articles is guaranteed by the fact that each one has already been published before a critical audience.

A fresh approach has been made to such traditional subjects as tonics, antacids and cough mixtures whilst recent advances in steroid therapy are also concisely described. Very little of the pharmacological basis of therapeutics is included in this book but it should prove a very useful handbook for undergraduate and postgraduate therapeutics and also for the G.P. who finds it difficult to decide between the genuine and misleading advertisements which he receives.

Little need be said in criticism of this book except possibly that the inclusion of three chapters related to the control of blood pressure has led to a certain amount of repetition, and attention could be drawn to the curious omission of spironolactones from the chapter on diuretics. J.C.C.

A Short Textbook of Haematology by R. B. Thompson. pp. 306. Pitman Medical Publishing Co. Ltd. 30s.

There are several excellent text books of haematology. Some deal with clinical aspects, whilst others approach the subject from a pathological angle. However, these books are alike in that they contain a large amount of subject matter, and, although essential for clinicians interested in blood disorders and haematologists, are too comprehensive and bulky for the average medical student.

This new book may therefore be of considerable value. It is concise, of a convenient size, reasonably cheap, up-to-date, and, on the whole, clearly written.

It is unfortunate that, in places, unnecessarily long and complicated sentences mask the authors true meaning, but it is usually possible to grasp his intentions without undue trouble. For instance, on p. 107, we read of the reticulocyte response in a case of iron-deficiency anaemia under treatment. "The height of the response varies inversely with the initial degree of anaemia". This statement is obviously misleading, but most people are likely to make the correct interpretation.

The majority of the book is most informative, but certain points are particularly clearly explained, and are more easily absorbed than in other, far larger books.

The passages on the distinction between the warm and cold antibody types of acquired haemolytic anaemia, the significance of absolute values and the inherent errors of the red cell count, porphyrin metabolism and iron metabolism are all to be highly recommended. A wide variety of disorders is mentioned, including so uncommon and recently discovered a disease as thrombotic thrombocytopenic purpura.

On the whole this book is to be thoroughly recommended, as an easily assimilable source of a great deal of information on haematology. It should prove ideal for the medical student, and may well be of value for recent information on blood disorders to the qualified practitioner. A.J.S.

Bacteriology and Immunity for Nurses by Ronald Hare M.D. Longmans. 17s.

Those asked to review a book may be experts in the particular field involved, or members of the reading public for whom the book is intended; this reviewer belongs to the second group. A nurse has no ability or desire to assess the scientific accuracy of a Professor of Bacteriology, but may suitably answer certain questions. Is the material selected by the author from his immense subject what she needs? Is it presented in a way that she can understand?

The answer to both these questions is yes. The book is attractive in appearance from the type to the dust jacket, and is well illustrated with photographs, microphotographs, maps and line diagrams. The language used is not unnecessarily technical but is never condescending, and the style is lucid and readable, detached and cool, with a tendency to negatives — "not unusual", "not very surprising". The facts are well marshalled and presented, as for instance in the section on the control of infection. Professor Hare says that the chain of causation can be broken in three ways; by controlling the sources of micro-organisms, by cutting their lines of communication, or by rendering the population refractory to infection. These methods he applies to each infection he describes.

The criticisms that one might make of this book are that condensation has occasionally led to ambiguity. It might appear, for instance, that the only commercial method of milk pasteurization is the long-time one, and that there is only

one site for the appearance of the primary sore of syphilis.

The section on staphylococcal cross-infection in hospitals is as disturbing as this topic always is. Bacteriologists doubtless realize the burden of anxiety carried by the conscientious nurse in this respect, and exemplified in Professor Hare's trim little diagrams. We rely on them to show the solution. W.E.H.

Baillière's Pocket Book of Ward Information Marjorie Houghton, M.B.S., S.R.N., S.C.M., D.N. Published by Baillière, Tindall & Cox Ltd. Price 6s. 6d. Tenth edition.

That a further edition has become necessary shows that there is a continued demand for this handy little book. Indeed it does contain an amazing amount of information in so small a volume which really is pocket size. Sometimes I would suggest that in some sections there is an excess of what is required by those for whom the book is designed and this may deter some would-be users.

Though most keen ward sisters compile their own book or card index of useful information and routine preparations and treatments approved by their own physicians or surgeons and in conjunction with the hospital's own special departments, this should prove a useful volume for those who do not, and has many helpful sections for all users, in particular the first section on weights and measures and their equivalents, the concise account on hormones and glandular secretions and on fluid and electrolyte balance.

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To be of real use the nurse should make herself familiar with all sections so she can use it as a true reference book.

B.F.C.

Textbook of Physiology by W. W. Tuttle, Ph.D., Sc.D. and B.A. Schottelius, Ph.D. 547 pp. 14th edition. Mosby. 52s. 6d.

Like so many American textbooks the presentation is excellent. The paper is expensive, the double column print is large, clear and quick to read, the diagrams and pictures helpful and the layout of chapters, headings and sub-headings sensible and useful for reference purposes. So many English medical books, although better written and spelt are left standing in matters of first impressions. In textbooks these first impressions are important, since the well balanced student is more likely to visit the theatre than stay at home to read his physiology in forbidding close print unrelieved by pretty pictures for several pages at a time. His reading must be easy.

The continuity and background writing in this book make for interesting reading. The book is clear and easy to read, although this is not to say that the writing is good, for it is sometimes stilted, and a few of the American-type visual training aids are a trifle tiresome. Chapters on metabolism and nutrition are quite as good as similar sections in Biochemistry textbooks and better expressed. Each chapter leads the reader into its subject from basic principles, and especially useful are those on muscle and nerve physiology, circulation and respiration. The account of renal secretion is a

little thin, saying nothing of GFR and RPF and how they are measured.

Establishment textbook traditions die hard and anyone would hesitate to suggest that this book should replace the standard physiological textbook at Charterhouse, especially since it is a pound more expensive. However it is the much better book. S.C.S.

The Penguin Handbook of First Aid by A. C. White Knox and J. E. F. Gueritz. Price 3s. 6d.

This Penguin written by two eminent and knowledgeable members of the St. John Ambulance Brigade is a small, sensible manual for the lay public. It is well written and clear, keeping instruction to the minimum, but avoiding nothing that is essential.

The chapter on accidents and how they can be prevented holds something for everyone and puts forward the necessity for knowledge where prevention is impossible. Bodily functions are explained simply, basic care in recognition and treatment of shock and haemorrhage is clear, but enough stress is not laid on the early calling of Medical Aid.

Practical advice on unusual conditions are welcome, for example jelly fish stings, farm injuries and adder bites. Simple methods of transport and the importance of the individual in Civil Defence end this little book. It seems excellent for the lay public, but the medical student and nurse would be wiser to consult a more comprehensive standard book.

R.E.B.

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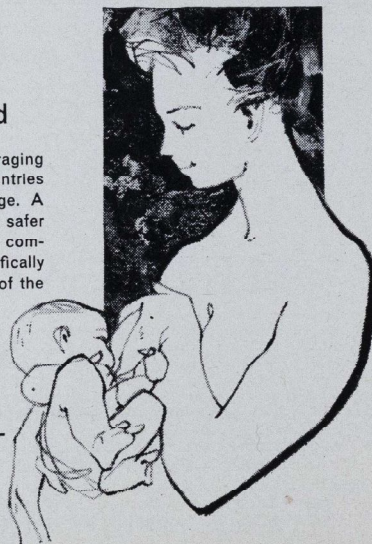
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Editorial

MANY STUDENTS WHEN they start their clinical must be mildly scandalised by the apparent offhandedness with which patients are treated on occasions. As the ponderous diagnostic machine of the hospital lumbers into action symptomatic treatment is so often waived. Time is at a premium and explanations of the rationale behind diagnosis and treatment tends to be cursory. In the Foreword of a recent book by Anne McGhee from the Nursing Studies Unit at Edinburgh* Professor Brotherton, the professor of Public Health and Social Medicine at Edinburgh University writes: "When we come fresh to work in hospitals for the first time we are all disturbed by some of the things we find there, but our prolonged apprenticeship as nurses or doctors conditions us to the peculiarities of the hospital world. We gain experience but we lose some of our sensitivity. We are apt to forget what a bewildering and sometimes frightening place the hospital can be for our patients."

There is a natural tendency to be suspicious of any attempt at objectivity of something in which temperament, emotional liability and

sensitivity play a great part. However, Mrs. McGhee has contrived to produce a business-like and analytical report on the reactions of nearly 500 patients to varying periods of confinement in an Edinburgh Teaching Hospital. All the patients were interviewed both in the wards and again afterwards when they were at home. This could only be achieved by contact and co-operation with the nursing staff. The study is divided into a number of sections which include the patients' reactions to Nursing Care, Medical Care, Structure and Equipment, Amenities, etc. The terms of reference of the report are necessarily limited but this was only intended as a pilot study preliminary to a more comprehensive undertaking yet to be achieved. Nevertheless, it would make illuminating bedside reading to many members of both the medical and nursing professions. The sad truth is that those most likely to benefit are the least likely to read it.

**The Patient's Attitude to Nursing Care—Anne McGhee.* E. & S. Livingstone, Ltd. 10s. 6d.