batted very correctly and R. Jeffries then added 40 runs for the fourth wicket. Finally H. Ross hit the winning run off the third ball of the last over of the day.

Present 180 (J. Harvey 49; D. Goldie 26; D. Delany 21).

Past 184 for 5 (M. Brambridge 43; J. Stark 37; J. Tomlinson 35; R. Jeffries 29 not out).

#### SWIMMING CLUB REPORT

Since the last Swimming Club report we have had only two engagements. We won the London Hospitals' Invitation Relay Cup after Guy's had been disqualified for swimming one of their men twice.

Then a week later we entered a team for the United Hospitals' Water Polo Knock-out Competition. We had small hope of doing very well, particularly when it became apparent that we were going to have difficulty in raising a satisfactory team. The first round was against Charing Cross. Some sound tactics amidst the confusion of our opponents allowed us to win 2.0

In the next round we met the London. B. Shorey promptly knocked out one of our opponents when trying to get the ball and this probably helped towards our slender 1-0 victory. We thus advanced to the final where we met our familiar rivals, St. Mary's. Once again their shooting and passing were too good for us and we lost 4-0.

It was a pleasant evening for the team (including two of our American colleagues) who were better satisfied than they either deserved or hoped! We look forward to another successful season in the United Hospitals' League, but unless more keen swimmers appear, we may have a lean time.

#### Teams

Rclay—B. Shorey; D. Shand; B. Lask; P. Quinn. Water Polo—B. Shorey; D. Shand; J. Britton; B. Lask; G. Haig; K. Steinhouse; M. Kurtz.

Colours have been awarded to: B. J. Britton

•

From the day you qualify . . .



# THE MEDICAL DEFENCE UNION

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#### **EDITORIAL**

At a loss

Every well equipped hospital journal office has twenty-seven subjects jotted down on a precious piece of paper. They are boring subjects about which a desperate editor can quite successfully write nothing at all for a page or more.

Medical Education: if ever little children have grown fat and happy at mummy's breast then the sucklings of this one are gross indeed. An Ameri can writing on the subject in last week's B.M.J. used such Orwellian terms as the "'total' patient" and "physician-scientist". God forbid the day when doctors do anything but treat sick

The New Morality: the Daily Telegraph and its laughable-last-generation conservative-progressive readers did fair justice to this theme. It is a pity in this age of liberalism that the British must natter incessantly about sexuality instead of getting on with enjoying it.

Medical Student Selection: which includes that impossible five minute face-to-face gamble where a dean trusts his judgment and his luck to sort out the good chaps-the nice types-from the cads.

#### Face to face

Recently and quictly the Selection Committee here have included several students in their invitation list of those asked to assist in the interviewing of prospective doctors.

Doubtless there are those who are important in their new roles as arbiters of the right type of student entry. However, the fact remains that it is insupportable that juveniles of twenty or so should play any part whatever in the selection of boys a mere three or four years their junior. It is an insult to the interviewees and can serve only to throw an element of farce into a scene already light, if not comic.

#### Consultants' Page

Already this page has lapsed. If past and present senior staff saw its form in the July and August issues, liked it and would like to ensure its permanence perhaps they will send contributions to the Editor.

#### Correspondence GRASMERE AND ALL THAT

Dear Sir,

If the writer of your August editorial really believes that "People pollute", then surely he should leave the practice of medicine to those who retain some respect for their fellow men.

Yours faithfully, R. A. STROUD, Mitcham, Surrey.

16th August. Out of context the comment is even more matter of fact. It is sad that people must scatter their excreta (more precisely—rubbish) about the countryside. People do pollute.—Editor.]

Births, Engagements, Marriages and Deaths etc. are on page 255.

#### Calendar SEPTEMBER

Sat. & Sun., 14th & 15th: Dr. E. R. Cullinan Dr. C. Naunton Morgan Mr. J. N. Aston Dr. R. W. Ballantine Mr. Fuller

16th September: Copy Date for October Journal. Sat. & Sun., 21st & 22nd: Dr. G. Hayward Mr. Badenoch

Mr. I. N. Aston Dr. I. Jackson

Mr. Cope Sat. & Sun., 28th & 29th: Dr. A. W. Spence Mr. E. G. Tuckwell Mr. J. N. Aston Dr. T. B. Boulton

Mr. McNab Jones Physician Accoucheur on duty for the month of September is Mr. J. Beattie.

#### OCTOBER

Sat. & Sun., 5th & 6th: Prof. Scowen Prof. A. W. Taylor Mr. J. N. Aston Mr. F. T. Evans

Dr. R. A. Bowen Mr. Hogg

7th October: Pre-clincial term begins. Sat. & Sun., 12th & 13th: Dr. R. Bodley Scott

Mr. Alan Hunt Mr. J. N. Aston Dr. Ř. A. Bowen Mr. Fuller

14th October: Copy date for November Journal. Physician Accoucheur on duty for the month of October is Mr. D. Fraser.

## THE WINE COMMITTEE—NEW DATE

The 1963 Smoking Concert will be on Tuesday, 29th OCTOBER. Gentlemen with ideas of scripts or sketches please see Mr. Graham Chapman before Friday, 4th October.

#### WESSEX RAHERE CLUB

The Autumn dinner of the above Club will take place at The White Hart Hotel, Salisbury, on 19th October, under the chairmanship of Dr. Alan Grant. It is hoped that, as usual, a member of the Staff will be present as Guest of Honour. Further details will be circulated or can be obtained by any Bart's graduates who are not already members from the Hon. Secretary, Mr. A. Daunt Bateman, F.R.C.S., 11, The Circus, Bath.

The Annual Dinner of the 10th Decennial Club will be held at the English Speaking Union, 37, Charles Street, London, W.1, on Thursday, 10th October, at 7 for 7.30 p.m. Dr. Eric Catford will be in the chair. Guests from the eleventh Decennial Club may be invited. The cost, with two wines, exclusive of drinks before and after, will be £1 15s.

#### **OBITUARY**

#### Mr. A. E. ROCHE

The death of Alex E. Roche came as a sad shock to all his friends. He was a man of many parts, was absolutely honest and fearless in his honesty, yet for all who knew him had a kindness and friendliness which was outstanding. He was a magnificent raconteur (as was his father before him) and he was a wonderful mimic. Those who heard him after dinner at the Cambridge Club gatherings will remember his mimicry of L. B. Rawling and J. E. H. Roberts and other members of the consultant staff. He was gay and had a pretty wit, but he was never acid. Even when in a moment of frustration he told someone his candid opinion of their behaviour (and he could be very forthright on occasions) they became firm friends until his untimely

Roche's career was distinguished both at school and Cambridge and he continued in like manner after he came to Bart's. He became H.S. to the Green firm in the days of L. B. Rawling and J. E. H. Roberts and afterwards became Chief Assistant for five years. He was also an R.S.O. at St. Peter's Hospital for Stone. He obtained his M.D., M.Ch. and became F.R.C.S. in 1924. Until his retirement two years ago he was surgeon in charge of the Urological Department, West London Hospital and Royal Northern Hospital. He was also consultant urologist at the Hounslow Hospital. He was an excellent and careful surgeon, vet even in this field his wit would break through. I well remember him saying, "The only thing that I can say of my surgery is that I don't throw things about the theatre, they are too expensive!"

He was responsible for three books on his specialty, but found time to publish three more in lighter vein: Medical and other verses, An anthology of wit, and in 1959, More medical and



other verses. Roche was also a good musician and a keen Mason. He was a past President of the Section of Urology of the R.S.M. and of the West London Medico Chirurgical Society and a past President of the Hunterian Society.

In 1932 he married Cicely Mary Briggs who was trained at Bart's and was a Theatre Pink at the time of her marriage. To her and their four children comes the sincere sympathy of all their friends at Bart's.

F.T.E.

## **FIVE MINUTES FROM BARTS: 3**

by our Drinking Correspondent. (Photographs by B. C. P. Lee)

I thought this month that I would select three places which are not well-known to Bart's people, but which in their way offer something which justifies a visit.



Queen's Head, known to habitués as " Peggy's".

The Queen's Head, Crutched Friars, known to its habitués as "Peggy's", is used by a few Bart's drinkers in search of draught Guinness and a game of darts. It was re-discovered recently by a small band of pilgrims who, overcome with the mental strain imposed by the Bart's course, named themselves "Depressives Anonymous" and resolved to stay at Peggy's until closing time and then hurl themselves off Blackfriars Bridge. The Guinness and the darts and the general atmosphere of goodwill generated

by Peggy herself prevented them from taking the final step and they continue to return there often.

You do not need to be a would-be suicide to enjoy the pleasures which Peggy has to offer. The sandwiches are good, too. If Peggy has one fault it is her devotion to the Licensing Act which is reflected in the speed with which she throws you out after "Time" has been called.

Nevertheless, visit Peggy's for I think you will find it amusing.



General atmosphere of goodwill generated by Peggy.

Come out of Peggy's, if possible, and walk down to Ludgate Circus. In front of you you will see the Albion resplendant in its new coat of paint. This pub has an interesting history



Somewhere to get a cold beer.

since until six years ago it was a dull and completely unsuccessful place. It was then taken over by Mick Barnett and his family who cleaned it up and applied a few sound business principles to its management. The first thing that Mick discovered was that there were hordes of Australian and American journalists working in Fleet Street who were looking for somewhere to get a cold beer instead of the usual tepid variety served in most of the Fleet Street pubs. Mick bought a large refrigerator, filled it with light ale and since then he has never looked back. Earlier this year the pub was completely remodelled so that it now has a first-class restaurant upstairs, a snack-bar downstairs and very comfortable appointments throughout. Lunch is a little more expensive than most pub lunches, but is extremely well presented and slickly served. This is a friendly place and it seems a pity that more Bart's men do not know about it.

After leaving the Albion and turning into Fleet Street, two minutes walk brings you to Johnson's Court on the right-hand side, dive down this alley-way and into the Cheshire Cheese. For many years the Cheshire Cheese has

been something of a tourist trap much beloved of visitors who want to see sawdust on the floor and the seat where Dr. Johnson is alleged to have sat. Owing to this it is always overcrowded at lunchtime and there is not much hope of getting a seat unless you book in advance. Nonetheless, it is certainly worth visiting once since the cooking is good in an honest English sort of way. The pub specialises in roast beef, chops, game-pie and that sort of thing and there are a number of small bars where the beer is drinkable, but not outstanding and the shorts are extremely expensive. It is for small private dinners that the Cheshire Cheese excels itself. You can eat in the magnificently stocked wine cellar, lit by candles, for as little as a pound a head and emerge more than satisfied. It is a shame that the small dining room only seats up to forty people for if it were larger I feel sure many more of the Bart's clubs would go there for their annual dinners; as it is, the smaller clubs may enjoy the pleasures of this historic spot, while the larger clubs are forced into the few City clip-joints which deign to remain open for dinner. If you are looking for a drink at night, remember that the Cheshire Cheese closes at nine.



First-class restaurant upstairs.

## UP TO THE MINUTE, IN A MOMENT

On 3rd August, Dr. Stephen Ward, a gifted osteopath, died, "a victim of British hypocrisy". At once Misses Keeler, Rice-Davies and the others again joined the ranks of the common or garden tarts. Last week it became obvious that Superintendent Axon is determined to keep Miss Keeler in the public eye just a little longer. Although long since glazed, that eye may light up when it sees the ex-girl friend of the great in the dock as opposed to the witness box.

On 22nd August, Lord Nuffield died and the profession lost a supreme benefactor. The tributes spoke for themselves; only Mr. John Freeman found fit to crab.

During the last month the police have been searching for some two million pounds which was hijacked from a mail train on 8th August. The humourless small mindedness of officialdom is always quite funny: Mr. Bevins said he had no admiration for the audacity of the thieves.

As we go to press it looks as if Lord Denning's report will be the final chapter in the present pornographic saga. That is, of course, if it is not too obscene to publish.

Life has been full enough at Bart's in that slack season after Goodwood. Since 14th August, Mr. Graham Chapman (in his first clinical year) has been appearing in the Footlights' latest review, Cambridge Circus, at the Lyric, Shaftesbury Avenue. The show seems certain of a successful run.

The Editor was invited to the World Premier of John Huston's "Freud-The Sccret Passion". He writes: "Freud's family cavilled considerably at this film and more especially at its sexual theme. It is hard to see why, since there is positively no wanton sexuality, what there is being strictly relevant to Freud's unpopular theory of infant sexuality. The film may interest medics. It can have no appeal to the general public. Anyone, misled by one or two salacious posters, who wants only an evening of cinematographic sublimation should stay away."

The Students' Union Council has now set up a Teaching Committee, elected Dr. Lehman an honorary member of the Students' Union for his unflagging interest in student affairs, and bought a snooker table for the new A.R. which is already nearly completed. The table must be on the ground floor since the building is not designed to be particularly permanent.

On 3rd September the Students' Union Wine Committee held a Barbecue Ball in Charterhouse Square to mark the first anniversary of the College Hall bar being taken over by the Union. The first year's profits were about £500. Some of this went towards subsidising the evening of 3rd September. (A social correspondent will report this function in our October

Rowing and cricketing are at an end and the rugger scason has begun (writes our sporting correspondent). For the past five weeks the Rugger Club has been training twice a week at Charterhouse. By tackling some really tough circuit training in the newly-decorated gymnasium all the players have improved their fitness. Although competition for some positions will be severe many of last year's players are still with us. Mr. Christopher Smart, the new captain, should be able to build a successful team.

From August 4th to the 9th the Cricket Club were on their annual tour. In good weather they lost to St. Andrews of Burgess Hill, Rottingdean, and Seaford Seagulls and beat Barcombe, Ditchling and Ferringon-Sea. In the Ditchling match Mr. Raymond Powles, playing for the opposition, dodged and stodged at No. 11, scoring 7 runs in 30 minutes and nearly losing the game for Bart's. Fortunately in spite of his treacherous efforts No. 10 was dismissed by the penultimate ball of the game as the result of a pretty dickey l.b.w. decision given by an old and inebriated umpire. The team's bank holiday Monday jinks included a fight with some negroes, swimming expeditions in the buff and several interrogations by the Brighton police-also in the

On their final short tour, 31st August to 1st September, the team beat Arkesden in a twenty over game and Clavering by a single run thanks to a six on to the pavilion executed by Mr. Colin Richards off the last ball of the game. By way of celebrating a successful game as well as a good season (16 won, 13 lost and 5 drawn) the team pulled down the Clavering pavilion for the second year running.

(9th September)

#### IN PECTORE ROBUR

## The Life and Works of SIR HAROLD GILLIES (1882-1960)

by Richard Petty

#### 1930-1939

"Whatsoever a man soweth, that shall he also reap."

The year of Gillies's knighthood also saw his election to the post of consulting plastic surgeon to St. Bartholomew's Hospital. This must have been a most moving experience for him; here at last was the recognition for which he had struggled so long; recognition not only for himself, but also-of far more significance to him-for plastic surgery. The new science had been officially accepted into the ancient preserves of surgery; of this Sir Harold was proud.

The first years at Bart's were by no means easy years. Sir Harold was allocated four beds, these eventually being increased to a total of eight. He was compelled to rely upon the kindness of his colleagues for the accommodation of any extra patients. It was a tribute to the con fidence with which his fellow surgeons regarded him that he was rarely unable to find the addi-

tional beds that he needed.

In 1930 Sir Harold's cousin, A. H. McIndoe, had arrived in England from America. McIndoe had, since his emigration from New Zealand, worked with the Mayo brothers in Rochester. It had been a year previously that Lord Moynihan\* had visited the Mayo Clinic and had remarked upon the promise shown by McIndoe, the young registrar working in gastric surgery. Lord Moynihan had told him of the opportunities that were open in England to good surgeons, and had advised that he moved to London and attempt to secure a post with the then expanding Postgraduate Medical School. Without due consideration McIndoe had taken this advice and had sailed for England, only to find that London was already overcrowded with young surgeons seeking similar jobs. He had had no alternative but to appeal to his cousin, Sir Harold Gillies, for help.

Sir Harold, who had, in fact, never met Mc-\* Berkley George Andrew Moynihan, 1st Baron Movnihan, 1865-1936. Qualified Leeds, 1887. Surgeon to Leeds Infirmary, 1906. Professor of Clinical Surgery in the University of Leeds, 1909. Knighthood, 1912. Baronet, 1922. Vice-Chancellor, Leeds University, 1924. Appointed consulting surgeon. Leeds Infirmary, 1926. President of Royal College of Surgeons, 1926-1932. Raised to peerage as Baron Moynihan of Leeds, 1929.

Indoe (and who always insisted he had never heard of him either!) took pity and used his influence to find him at least a temporary job. Sir Philip Manson-Bahr\* advised that McIndoe try for the post of lecturer in surgery at The Hospital for Tropical Diseases.

When McIndoe had secured the position, Sir Harold offered him an assistantship within his practice. For a year their relationship was one of chief and assistant, but, in 1931, Sir Harold proposed that McIndoe should join him on a permanent partnership basis, having ascertained that his cousin was indeed a brilliant and

imaginative surgeon.

They operated together regularly at Bart's, Dollis Hill and at the London Clinic, and the older man taught McIndoe the techniques and methods used in plastic surgery. Sir Harold gave him, in fact, his full support and it helped the unestablished surgeon immensely to have his name associated with that of one whose professional status ranked so high. Together they produced papers, the younger man preparing the manuscripts for publication, and the name of McIndoe was for the first time brought before the eyes of the medical profession.

There was now a loose partnership of three men, Gillies, Mowlem and McIndoe, which was

to remain intact until 1939.

In 1932 Sir Harold developed a severe phlebitis of his right foot and was, as a result, confined to his bed for eight weeks. The "Daily Express" published a report intimating that he was in fact on his death bed, the article taking a form suspiciously reminiscent of an obituary. This provoked a strong protest from Sir Harold, who, despite his incapacitation, was very far from being moribund. The paper published an apology the following day with an air of injured inno-

He did find the illness most aggravating, and, to fill the many hours of immobility, took lessons in draughtsmanship and painting. Before his discovery of Professor Tonks in 1916 he had had tuition in sketching but had found no time in his full life to pursue this. In the course of his work he had come across many problems con-

Sir Philip Manson-Bahr., Eng. D.S.O. Qualified London Hospital, 1908. Consulting Physician, Hospital for Tropical Diseases.

cerning facial form and dimension, and had often sought the services of professional artists and sculptors, especially those of F. Derwent Wood, R.A., who had helped to solve the problem of aesthetics in the satisfactory construction of facial prostheses. It irked Sir Harold that he had not the technical knowledge to express his own ideas in graphic form, and he tackled the acquisition of this knowledge most seriously.

On his recovery he found great pleasure in painting and it was evident that he did have a decided feeling for composition and colour. He also found that many others of the medical profession sought relaxation in painting and he organised the Medical Art Society for their use.

The first meeting was held in his Club, The Garrick, during that year, the senior member being Sir Leonard Hill the physiologist. The Society henceforward have held annual exhibitions within the premises of the Royal Society of Medicine at 1, Wimpole Street.

In 1934 Sir Harold was elected Honorary Fellow of the American College of Surgeons, and, whilst in the United States to receive his Degree, gave the Charles H. Mayo Lecture with the title, "The Development and Scope of Plastic Surgery".

The private practice was by now well-established and Sir Harold could afford to leave much of the work to his assistants and partners. He was able to indulge in all the pursuits he loved so well, in golf, in painting and in fishing.

During the years between his knighthood and the Second World War, many celebrities consulted him; notably Leopold, King of the Belgians. In 1934 Sir Harold had removed two impacted wisdom teeth which were thought to be affecting the King's sight. This operation was performed with the utmost secrecy in the Manor Court Nursing Home in Folkestone. In 1935 they met again as a result of the tragic car accident outside Lucerne in which Queen Astrid had been killed. King Leopold had sustained injuries to his face and left arm on that fateful day in August, and, in December, after the wounds had healed, consulted Sir Harold in his rooms at the London Clinic. The scars were excised and all visible evidence of the crash removed from the person of the King.

Another case which reached the columns of the daily press was that of the small boy in the Royal Infirmary, Stoke-on-Trent, who had lost an ear. Sir Harold removed the corresponding ear from the boy's grandmother and grafted it onto the tissue around the exposed external auditory meatus. This transposition was highly successful but not as miraculous as the press would

have wished their readers to believe. Sir Harold had, in fact, completed considerable research into the use of maternal cartilage for the reconstruction of the auricle, and was to publish his findings in 1937.

Sir Harold was undoubtedly the darling of society and many socialites came to him for the repair of injuries sustained in car crashes and hunting accidents. The newspapers were only too anxious to report such cases as Daisy Kennedy, the violinist wife of John Drinkwater, whose scars Sir Harold had removed at the St. Mary Abbott's Hospital in March, 1937.

Despite the magnitude of his private practice, Sir Harold managed to publish original papers with regularity. In 1938 he produced a paper on the reconstruction of the syphilitic nose, a problem which had held his interest since 1923. It was to speak on this subject that Professor Sauerbruch invited him to a meeting of the Medical Society of Berlin.

Sir Harold had observed with distaste the rising tide of Nazism and had first hand knowledge of Hitler's professional purges from German colleagues who had taken refuge in England. It was one of these colleagues who translated into German the address which he was to give in Berlin. This was recorded onto gramophone discs at the Blind School in Regent's Park and synchronised to the proposed order of the slides that were to be shown. Sir Harold hoped sincerely that the voice of the exiled German would be recognised.

However, with the aid of Siemens, the electrical engineers, the address was uneventful. The account of the reconstruction of the syphilitic nose and a brief addendum denouncing unqualified beauty surgeons, delivered by the recorded voice of his German friend and mimed by Sir Harold, was heard by the unsuspecting audience in an atmosphere of quiet concentration.

At the dinner in his honour after the meeting, Sir Harold was presented, after a long speech singing his praises, with a bronze bust of Virchow, for which he produced one of the few German words that he knew, "Danke".

The last paper produced before war was declared concerned techniques in mammaplasty. Morestin, as early as 1915, had described methods for the reduction of breast tissue by operative means, and Sir Harold had discussed briefly the problems of breast surgery in *Plastic Surgery of the Face* in 1920. But, in many quarters, this new paper met with a bad reception; as Sir Harold said, "When I first began to undertake breast reductions I was almost burned at the stake": the dictum "What God hath given,

let no man take away" was obviously widely misapplied. Gillies and McIndoe defended their techniques with the words, "Today there is little need to justify plastic surgical procedures on the pendulous breast. It is a field as genuine as any other in reconstructive surgery provided its limitations are recognised and the cases are carefully selected".

#### 1939-1945

"Silence is the soul of war;
Deliberate counsel must prepare
The mighty work which valour must complete."
Matthew Prior.

At last the almost unbearable tension that had built up since the Munich crisis had been broken. The Nazis invaded Poland, and Britain and France declared war upon Germany.

In 1938 plans had been laid by the War Office for the deployment of the medical services in the event of hostilities breaking out that year or in the near future. Sir Harold, in his capacity of Consultant Plastic Surgeon to the Army at Home and the Ministry of Health, had been asked to develop proposals for the expansion and organisation of the plastic surgery service in case of a national emergency.

With the fear of immediate attack from the air, all units were to be evacuated from London and dispersed throughout the Home Counties to safe but accessible hospitals. Sir Harold had selected the possible sites for the units, and the surgeons who were to lead them were permitted to inspect their prospective establishments. McIndoe, with great foresight, had chosen the Queen Victoria Hospital, East Grinstead, and it was to this small hospital that he and Jayes moved on the declaration of war.

Kilner stayed with his Ministry of Pensions unit at Roehampton, but Mowlem and Barron travelled to St. Albans.

Sir Harold had chosen for himself the Park Prewett Hospital, a former mental home outside Basingstoke. Within the grounds of the hospital stood Rooksdown House which had previously been the private block, and it was in this building that he established himself and his unit. The lounge was converted into operating theatres and the separate rooms into wards.

The Rooksdown House unit consisted at this time of the chief assistant, James Cuthbert,\* a former registrar at Bart's; the dental surgeon, Martin Rushton; the anaesthetist, Patrick Shack-

\* J. B. Cuthbert, F.R.C.S. Qualified S.B.H., 1937. Plastic Surgeon i/c Johannesburg Hospital.

leton, and a newly qualified nurse, Dorothy Whiteside, as Matron.

For the first months of the war Sir Harold was rarely at Rooksdown. The casualties as yet were few and there was still much work to be done by him in London in policy making and in organising new plastic surgery units in Birmingham, Liverpool, Manchester and Leeds. In addition to creating units, Sir Harold instilled new life into existing establishments and helped the expansion of those in Newcastle, Stoke-on-Trent and Gloucester. This labour was achieved with the aid of Sir William Kelsey Fry.

By the time the first great influx of casualties arrived during the withdrawal from Dunkirk, there was an efficient and fully-staffed organisation prepared to give immediate treatment: a very different situation compared with the circumstances of plastic surgery during the First World War!

A unit had been sent with the British Expeditionary Force to France under Richard Battle, a surgeon who had been trained by Sir Harold. This was the first of the Army plastic surgery units that were to travel with and operate behind the line of battle.

The idea of mobile plastic surgery units had been conceived by Sir Harold, having memories of the First World War when surgeons had been so thankful to receive well dressed and healed wounds from Kazanjian's Jaw Unit in France. But the role of these units was not to be that of mere primary dressing stations, they were to act as self-sufficient and independent entities, treating and repairing as many soldiers as possible without reference to hospitals in England.

Unit No. 1 was rescued from the beaches of Dunkirk and was later redeployed during the North African Campaign at Alexandria. Unit No. 2 under Oldfield was sent to work in Cairo to lielp with the influx of casualties from the bitter fighting in the desert.

Unit No. 3, under Heanley, travelled to India to receive casualties from the Burma front and was later joined by a unit organised by the In-

dian Army Medical Corps.

At the beginning of the war there had been a total of six full-time plastic surgeons and the pressing urgency for more specialists in this field was a great problem. Rooksdown House was the main training centre for the leaders of the units, but the training of a plastic surgeon was necessarily an extended process, and there was a relatively long period of inefficiency whilst the team that made up the unit settled down in active service. Sir Harold appealed to the War Office to allow each group of personnel to train to-

gether. The idea met with approval and the first team to be produced as such, Unit No. 4, was sent to Africa to accept casualties from Tunisia in 1942, and eventually moved, with Unit No. 1, to the theatre of war in Italy.

Eventually Units No. 5 and No. 6 were to land on the beaches of Normandy, and Sir Harold was to visit them in Holland before they crossed in the wake of the main thrust across the Rhine in 1945.

By the end of the war each unit was to have treated an average of 3,000 patients, of which only 18% of the face and jaw cases and 20% of the burns cases were sent back to Rooksdown. Sir Harold kept in touch with the leaders of the units by letter, problems were discussed and new procedures explained, and morale was generally kept high by cheerful anecdotes of wartime England.

Casualties which did arrive in England had been labelled by the Units abroad and were either flown to R.A.F. Wroughton and thence by ambulance to Rooksdown, or were transported to Rooksdown's own station by train. A great variety of cases were received from both the Scrvices and the civilian population, unlike the unit at East Grinstead which specialised almost exclusively in airmen's burns.

In 1941 America was still uncommitted in the European struggle and was observing with anxiety the uncomfortable stale-mate between England and the all-conquering Germany. In October the American Government invited Sir Harold to visit the United States to lecture on plastic work and the British war effort.

Sir Harold spoke first in Chicago and then spent some weeks touring South America. On his return to North America in December he atended a luncheon given (in his honour) by the American Asociation of Oral and Plastic Surgeons. He met again the colleagues of the First World War days, many of whom he had not seen since 1919. Here, to pay homage to the old master, were Ferris Smith, John Straige Davies, Fulton Risdon, G. M. Dorrance, Vilray P. Blair and Robert H. Ivy. It must have been very gratifying for the doyen of plastic surgery to perceive that he had retained the friendship and loyalty of so many of his fellow surgeons.

Sir Harold returned to England in the bomb bay of a Liberator aircraft of the U.S.A.F. in time for a Christmas fraught with the anxieties of the pending German invasion.

Meanwhile the battle in the air had developed, and burned airmen were filling the plastic surgery units in England. East Grinstead took the brunt of this work, but Rooksdown also received

many of the casualties. It was one of these pilots who introduced into Rooksdown the A-12 strain of haemolytic streptococcus.

McIndoe had already experienced the devastating effects of the haemolytic streptococcus. The germ destroyed within hours the vulnerable tube pedicles and they melted away like snow in the sun, wasting many hours of work and much valuable tissue. It was for this reason that McIndoe had adopted the less susceptible free skin graft for the repair of burns.

Sir Harold asked Colonel L. Colebrook,\* Director of Pathology for the Army at Home, to visit Rooksdown and devise some method of eliminating the germ.

Colonel Colebrook typed the streptococcus and enforced rigorous aseptic discipline in the unit. Special dressing rooms were set aside in which no-touch technique was used by gowned and masked nurses; sulfonamides were used to quell the infections as they broke out; no wound dressings were allowed to take place until fully two hours had elapsed after bed-making and sweeping. After a prolonged battle it seemed as though the streptococcus had been eradicated. A celebration was held to mark the occasion and Colebrook was congratulated on his achievement. However, it was only a few weeks later that the A-12 haemolytic streptococcus re-established itself this time resistant to sulfonamides. The germ plagued the unit thenceforward until its final extinction on the introduction of penicillin.

The atmosphere engendered by Sir Harold in Rooksdown was that of informality and tolerance, and there existed an absolute trust in the relationship between the surgeons and their patients. These factors contributed greatly towards the high morale of the unit. Not only were the operations a success, the recovery of the patients was rapid in their happy environment.

Sir Harold had given much thought to the preoperative nursing methods to be used in the cases of serious injuries to the face and neck. In these patients there were great risks of respiratory obstruction due to debris and blood and the sequel of lung damage and infection. As much use as possible, therefore, was made of chemotherapy, early suction, expectorants, postural drainage and physiotherapy. The recovery of a casualty was as much due to this careful nursing as to the skill of the surgeon who, indeed, would have been powerless without its aid.

In 1941 the free Danes living in England presented Sir Harold with the sum of £3,000 which he was asked to expend upon the building of a badly-needed recreation pavilion for Rooksdown. The money was offered with the thanks of the Danish people for the work which Sir Harold had performed after the Geysir disaster in 1924. In January of the following year the Oueen Alexandra Pavilion was opened by Lady Louis Mountbatten in the presence of the Countess of Malmesbury, the Danish Ambassador and the subscribers to the fund. The pavilion stands today and sees much use as weekly dances are held in it for the patients and staff of Rooksdown. Sir Harold said, "Here it is common to see a surgical student dancing with a forehead flap and nurses waltzing with tube pedicles" (1957). During the war the pavilion also acted as the headquarters of the Red Cross.

Between the years 1944 and 1946 Sir Harold built up the Rooksdown Club, an exact parallel of McIndoe's Guinea Pig Club, and it was eventually to have a total of a thousand members. It was registered under the War Charities Act, and played a large part in the rehabilitation of the more seriously disabled of Rooksdown's previous patients. It had its first meeting in 1947.

After D Day, Queen Wilhelmina and Princess Juliana of the Netherlands paid Rooksdown an informal visit as the unit contained many Dutch among its cosmopolitan inmates. The two mem bers of the Dutch Royal family were most moved and impressed by the work being performed, work which is carried on to this day: Rooksdown is a lasting testimony to the pride and affection with which Sir Harold Gillies regarded the art of plastic surgery in the relief of suffering humanity.

#### 1945-1960

"Sleep after toyle, port after stormie seas,

Ease after warre, death after life, does greatly
please"

Spenser.

After the war Marshal Tito had appealed to the U.N.R.R.A. for help in the repair of the many mutilated invalids from his armed forces. Sir Harold was asked to visit Yugoslavia to determine the extent of the aid which would be required.

He perceived that the Communist authorities' only interest was in a British team performing the entire work: this would have been impossible as there was sufficient reconstructive surgery in England alone to occupy the time of all plastic units for many months to come. Sir Harold

explained the situation, and, on behalf of the U.N.R.R.A., offered to arrange for a plastic surgery unit to visit Yugoslavia on the understanding that it would instruct Communist surgeons in technique and method with a view to the foundation of a permanent civilian service.

This arrangement did not appeal to the Yugoslavian government at all, but, after much hesitation, it was accepted.

Sir Harold returned to England and James Cuthbert; Rushton, the dental surgeon; Shackleton, the anaesthetist and Matron Whiteside, were dispatched to Yugoslavia. The unit worked for many months with changes of staff and Sir Harold said, "This friendly gesture, at a time when Yugoslavia was far from happy, may have had a small part in her drift towards the West" (1957).

When Sir Harold was again behind the Iron Curtain on a lecture tour in 1948, Marshal Tito invited him to his home. Marshal Tito had, in fact, attended Sir Harold's lecture in Belgrade in 1945 on his first visit to Yugoslavia. Sir Harold told the story, "while proudly displaying his private fruit grove, he (Marshal Tito) plucked a lemon and presented it to me. Whereupon he was requested to sign the fruit; this was the Order of the Lemon, First Class" (1957).

In 1946 Sir Harold was one of the instigators of the formation of the British Association of Plastic Surgeons. The aims of the organisation, were to propagate the art and science of plastic surgery within the framework of surgery itself, and to stimulate understanding and co-operation between plastic surgeons and the medical profession and public. Sir Harold was honoured by being the Association's first president.

The problem of the relationship of the plastic surgeons with the profession and the public was, and still is, very great. There is an inherent distrust, indeed a strong prejudice, in many of the older members of the profession which leads them to believe that plastic surgery is both unchical and unnecessary. As a result of this, many unhappy and deserving patients are denied the services which plastic surgery can give to them. Today the Association is powerful, and it is able to defend its members in any action brought against them by the General Medical Council or in a court of law.

Recently it may be remembered that several distinguished plastic surgeons were accused by the G.M.C. of advertising in the public press. Through the able and successful defence put forward by the Association on behalf of its members weight was added to the appeal for the modernisation of Clause 5B of the General Medical

<sup>\*</sup> Leonard Colebrook, F.R.S., F.R.C.S., F.R.C.O.G. (Retired). Qualified St. Mary's, 1906. Late Hon. Director, Research Laboratories Queen Charlotte's Hospital/Medical Research Council Burns Unit Birmingham Accident Hospital.

Council regulations. Sir Harold's particular part in this appeal will be discussed later.

1948 saw the institution of the National Health Service. Sir Harold had played a major part, in his capacity of consultant to the Ministry of Health, in the determination of the role plastic surgery was to take in the Welfare State, and it is mainly due to him that plastic surgery today is fully integrated into the functioning of the Service.\*

Rooksdown had been, during the War, of a truly cosmopolitan nature and many foreign plastic surgeons had been trained by Sir Harold during that period. It was for his work in the training of Norwegian surgeons that he was created, in 1948, Commander of the Order of St. Olav.

Sir Harold had, since 1916, been much concerned with medical photography, and between the wars had been responsible, in conjunction with Kodak, Ltd., for the first colour film of a plastic operation to be taken. In 1950 he was therefore invited to become Chairman of the Medical Group of the Royal Photographic Society in succession to Sir Cecil Wakeley. He took a great interest in the proceedings of the Society, never failing to attend the monthly meetings, and was elected Fellow of the Royal Photographic Society in 1952.

In was in 1951, whilst he was still holding office within the Royal Photographic Society, that he showed publicly for the first time his paintings of Iceland: he produced them to illustrate the chairman's address entitled, "Surgery, Sagas and Salmon". He had visited Iceland for the first time in 1950 and the country was to become just as much an inspiration for his painting as Scotland.

In 1952 his work appeared for the second time in the Royal Institute of Oil Painters' annual exhibition. He had made his *début* at the exhibition in 1940 when his depictions of the peaceful river Test made a sad contrast with the bomb-blasted galleries.

Painting, in fact, was now his main pastime, and wherever he travelled in the course of his

\* Before the Second World War the following constituted the plastic surgery service:

Two training hospital appointments.
One London County Council unit.

Two units outside London.

Now there are a total of thirty six units distributed throughout the United Kingdom. Sir Harold Gillies supervised the organisation of the service within the Welfare State and was responsible for the establishment of one or two units of up to a hundred beds each in every N.H.S. region.

H.D.G., Med. In. London, 7, 1953.

work he was accompanied by his paints and canvases. His regular visits to the Strathcaro Hospital near Edinburgh always marked an opportunity to paint, as well as to fish the famed salmon beat at Shotley Bridge.

At the age of seventy it was with great regret that he had to retire from Rooksdown. Although he had found the long operating sessions with the unit too much for his failing health (he had for some years been suffering from arteriosclerosis), he still undertook private work and consulted regularly at the London Clinic.

Sir Harold now had the leisure to concentrate on a task which had occupied his mind for some time: this was the writing of a work on the development of plastic surgery. He had always taken great pains to keep accurate records of all cases that had passed through his hands, and had aggregated over the years a unique collection of photographs illustrating not only the immediate results of his operations, but also the mature appearance of the grafts and implants. In conjunction with Ralph Millard,\* who had been his pupil in 1948, he assembled a mass of informative and illustrative material. By 1954 all that remained was its arrangement for publication, and in this Sir Harold planned an entirely novel approach to the presentation of a textbook.

His conception, which indeed suits the crystallisation of a life's work, was that of autobiographical informality. The text was to be eminently readable, the photographs and illustrations appearing, unnumbered, beside the appropriate descriptive print; in fact Sir Harold's (and all students') ideal of a good textbook—not a mere volume of reference but a book which would make light work of the acquisition and assimilation of knowledge.

With these ideas in mind several publishers in England were approached. From many there were polite refusals to handle the work and from others a shocked response, indeed one firm complained bitterly that its appearance would either irreparably damage the reputation of its publishers, or that of British surgery!

It began to look as though the book would never find a sponsor, and it was not until 1956 that Little, Brown and Company of Boston, U.S.A., accepted the responsibility.

Two years of work were involved in setting up the material for printing. Theodore Phillips, who was publisher's editor for Little, Brown and

\* D. Ralph Millard, Jr., M.D. Diplomate, American Board of Plastic Surgery, Assistant Clinical Professor, University of Miami School of Medicine; Consultant in Plastic Surgery to St. Joseph's Hospital, Asheville, North Carolina/United States Naval Hospital, Key West, Florida.

Company at that time, tells of the arrival of the manuscript, part hand-written, part typed, with 3,500 photographs in three shaped suit cases which he was later to discover were from the fitted boot of Sir Harold's Bentley car which had been sold to cover initial costs.

Gradually The Principles and Art of Plastic Surgery took shape while caustic letters from Sir Harold expressing disapproval of the editor's work regularly crossed the Atlantic. At last, in May, 1957, the proofs were finished and the book published; it met with enthusiastic approval from its critics, especially in America. It's appearance was exactly as Sir Harold had envisaged, two volumes attractively laid out in a form which would engage the attention of the reader at all times: to others it meant more than this, The Principles and Art of Plastic Surgery was to them the history of the speciality written by its instigator and greatest exponent, a book with a unique place in the history of surgery.

In 1955 the first meeting of the International Society of Plastic Surgeons was held. There gathered in Stockholm surgeons from all the world over, many of whom had been Sir Harold's pupils, and all of whom owed him their gratitude for the foundation of their speciality. They expressed their thanks by unanimously electing him their first president, and gratified him further by electing to posts on the executive committee many of his protégés including Sir Archibald McIndoe and Dr. Ralph Millard.

Sir Harold's visit to Sweden was followed by an invitation from the Government of New Zealand to give a series of lectures in Australasia. This was to be the first time Sir Harold had visited his homeland since 1904, his second year at Cambridge.

Sir Harold and Lady Gillies determined that they should take this opportunity to visit the three members of their family, who, on marrying, had left England. They first flew to Nairobi where lived one of their two daughters, and then travelled further into Africa to see their youngest son, an entomologist working on the problems of disease transport in Tanganyika. The third member of the family living abroad was their eldest son in New Zealand itself.

The visits and travelling occupied four months, and, before his return to England, Sir Harold was invited to read a paper to the Royal Australasian College of Surgeons in Sidney and was there elected to an Honorary Fellowship of the College.

In March, 1957, Sir Harold exhibited his pictures with the United Society of Artists at the R.B.A. Gallerics. The catalogue had unfortun-

ately been misprinted and Sir Harold was introduced as, "Sir Harold Gittins, the plastic surgeon, whose sure and steady hand employs pigments in a brush-mark-less technique that produces a silky finish". This annoyed intensely the art critic of the *Star*, who, having demolished Sir Harold's picture, "Sunrise Loch Boisdale" (35 gns.), with few but damning words, commented, "The adulatory attitude towards the pictures of amateurs distinguished in fields other than painting is ridiculous when it comes from an allegedly serious society of painters... Sir Harold's pictures... are frankly bad".

However, two years later, in June, 1959, a most successful exhibition of his work was held in Foyle's Art Gallery. Many of his paintings were sold, at an average price of £21, to colleagues and collectors. In fact, there was a minor scandal when J. Paul Getty attempted to buy "Calm Fjord, Laerdal", a picture which had been lent for the occasion by a friend. Mr. Getty did not see any other picture which pleased him and he left soon after.

In May, 1957, Sir Harold's first wife had died and in September of that year he remarried. His second wife was Miss Marjorie E. Clayton, who had been his surgical assistant since 1937.

In November of the same year, Sir Harold travelled to India on the invitation of the Government to operate and lecture. He was away from England for ten weeks.

In December, whilst Sir Harold was still in India, the Sunday Times published an article under his name entitled, "Sex and Psyche". This was a discussion of the problems occurring in the treatment of humans of indistinct gender, a controversial topic much in the public eye due to the recent case of Robert/Roberta Cowell. Sir Harold, who had not, in fact, been involved on this particular occasion, had had experiences of a similar nature\* and was well qualified to write upon the subject.

The article was of no particular intrinsic importance but was the precursor of the chain of events which led to the writing of the letter "The Price of Ethics", published in the British Medical Journal in April, 1959.

In 1948 Sir Harold's cousin, Sir Archibald McIndoe, had been elected Councillor of the Royal College of Surgeons and was voted to the position of Vice-President in 1957. The college, after ten years of State medicine, was in dire financial straits, and £3,000,000 had to be raised to meet the costs of maintenance and planned expansion. Sir Simon Marks, who had been a generous benefactor of medical research and

<sup>\*</sup> Vide; "Works",

learning, advised Sir Archibald to launch a pub-

lic appeal.

The College Appeal Committee which was formed had as its chairman Lord Kindersley and as its vice-chairman Sir Simon Marks himself. It was decided that publicity for the appeal should be obtained through the media of newspapers and television. Press conferences were held and the nature of the appeal was explained.

The weeks that followed culminated in the following leader of the British Medical Journal editorial of 25th April, 1959:

#### Top Surgeons

A photograph in a Sunday newspaper a few weeks showed the President and the Council of the Royal College of Surgeons of England (and others) listening to the Hunterian Oration. Leaning forward earnestly from a solitary column of type was the orator himself. The names of those in the two front rows were given in full so the reader should be in no doubt as to their identity. Not long after this, gossipcolumn writers described with glee a party in Lincoln's Inn Fields where stars of the Emergency Ward 10 film drank cocktails with the College's famous skeletons. Photographs again. As the President of the College of Surgeons is the most unassuming and modest of men, it was obvious there must be something desperately wrong with the present state of the College for him to assent to this kind of publicity. Like many a private doctor suspected of advertising, it wanted, and wants, money-and apparently quite a lot. The College deserves it. It is a national institution built up by the labours of famous men. But many national appeals for money have been launched before this without attempts to publicize the persons behind the cause of the appeal. The College of Surgeons could probably raise the money it wants without losing its dignity and without giving publicity to the members of its council. No one could have felt at all happy at seeing the full-page advertisement in last week's New Statesman and Spectuator announcing the presentation by "Granada" on I.T.V. of SUR-GEON—printing the names of the President and six members of the College Council (two of them also members of the B.M.A. Council), complete with degrees, diplomas, orders, and honours. And then, last Sunday, a picture in a Sunday newspaper of a rather perplexed P.R.C.S. rehearsing for this Thursday's

This Journal has a great respect for the present President of the Royal College of Surgeons of England. No one who knows him can doubt that his first concern is for his college and the last is for himself. He is not in private practice, and therefore does not stand to gain any professional advantage from the present series of publicity stunts of which he is the unwitting centre-piece. Doubtless they are as disasteful to him as they may be pleasing to the ingenious minds which have thought them up. We hope the College will raise the money it needs. We hope too, that the President will look a bit more critically at the advice he is receiving from the promoters of the various schemes for raising it. It would be a pity if the College, in achieving its target of £3m., found that in the process it had lost something more precious

The voicing of official disapproval of the publicity campaign (and the thinly veiled hint that it was thought that certain Fellows of the College were advertising) unnerved many of its backers, not the least Sir Archibald McIndoe, who had been its chief sponsor.

Sir Harold was incensed by this attack on the College and on McIndoe in particular, and wrote the following letter to the British Medical Journal (13th June, 1959):

#### The Price of Ethics

Sir,—How anyone can complain of the ethics of that wonderful photograph of the College Council passes comprehension (\*\*Top Surgeons", Journal, April 25, p. 1100). X's only complaint is that X wasn't a good enough surgeon to be included. After all, we voted them there, and good cess to them.

At 76+ I hope there are still a few friends who will credit me with a life that has been devoted to surgery, and to a particular branch—the surgery of the maimed, the wounded, and the burned. It is unfair but inevitable that through the thrust of the press the limelight should be thrown on such subjects as hole in the heart, insulin, penicillin, psychiatry, or even plastic surgery. Having had a hand in developing the present plastic surgery service of our country, of which the Health Service may well be proud, I can speak with feeling of the encouragement given to this young subject in the 1920's, not only by the great medical journals but also by such dedicated individuals as Lord Northcliffe, Beaverbrook, Owen Seaman, Squire Sprigge, and, later, Lord Nuffield. Their press, their approval helped on the work, educated the public and obtained facilities necessary to its progress to the benefit of many disfigured folk and to the credit of British surgery.

Some body outside the profession has got to put it across, some body or bodies inside the profession have to be utilized, even against their interests, to further these aims by explanation and interview. One small note in the press may influence in a few days the trend of medical treatment which otherwise might take years to percolate. Far quicker and more potent is the television technique. It educates the public in the truths of our lovely profession, and what harm if one or two men get a tiny puff? Cannot we be tolerant as well as clever and ethical? Unfortunately Mr. A, who is written up by some thrustful journalist, may be one of our worst qualified and shadiest of practitioners, while Dr. B, with less glamour and more ability, stays hidden under his bushel of ethical modesty. Is not the answer to be found in educating

the press to our standards?

I wonder whose pocket and whose dignity suffers from such an excellent television programme as that recent one depicting an operation for hare-lip. It could hardly have been more sympathetically shown, and must have given a great deal of comfort to parents and of instruction to their medical practitioners. There seems to be a false idea that as a result of such publicity all the hare-lip babies in Britain would immediately be rushed off to the operator televised. My own experience of this type of publicity is that only a few rather hopeless individuals seek an appointment without a doctor's reference and impecunious to boot. As a form of successful advertising it is there-

fore a wash-out. But as a means of spreading among the populace, including the medical profession, the great advances in British medicine and surgery, publicity properly controlled should be welcomed with an open heart.

I think it is magnificent that the President of the Royal College of Surgeons and his councillors and counsellors should devote so much time and energy to raise money for the good of surgery and not for their own gain. These men have all deserved great credit for the unselfish work they have done, and is it not preposterous that they should be called to account by a vociferous group of people who appear to enjoy criticizing the ethics of others? Are not the Peter Mays and the Denis Comptons of our profession better than the press critics?

On a Sunday soon and for the following five Sundays The Sunday "X", ambitious to capture the doctors as readers, had proposed to publish my lifestory written by myself about golf and fishing, and all sorts of things I've enjoyed with my medical pals, and of course my efforts at surgery. These articles would have been quite harmless, the offer prodigious —£6,500. On advice and after much brain-washing, I have wistfully turned it down. Am I right, or a fool? Could the G.M.C. be persuaded to modernize Clause 5b? —I am, etc.,

London, W.1.

HAROLD GILLIES.

This helped to encourage the members of the Appeal Committee, and no more than a year passed before the sum of £2,000,000 had been raised towards the fund. The remaining money, however, was obtained in a more discreet manner.

The last trip abroad that Sir Harold was to undertake took place in August, 1959. He was invited by the Colombian Government to visit South America to lecture and to receive an honorary degree.

Sir Harold and Lady Gillies flew to Bogata, the capital of Colombia, which, standing 9,000 feet above sea level, is the highest city in the world. He spent some weeks sightseeing and painting between his various commitments and was especially enchanted by the Gold Museum, a complex of vaults containing many of the treasured heirlooms from past civilisations of South America.

On his return to England he retired from private practice to his home at Church Oakley near the town of Basingstoke.

The last occasion upon which the public was to hear of him was during the July of 1960. Geoffrey Griffin, the South African fast bowler, had been continuously accused by umpires of throwing during the Test match series. Griffin's arm was, in fact, bent due to bad setting of the humerus after fracture. Sir Harold had suffered himself from a similar accident when he had been

playing golf for England, and had designed an aluminium splint to keep his left arm straight whilst driving. On reading of Griffin's plight he found his splint in Edward Holdright's golfing school in Regent's Park and took it to Lord's where the South African Test team were playing. Griffin did use the splint in the nets and during several County matches, but never, unfortunately, during the Tests themselves.

After a short illness, the result of his arteriosclerosis, Sir Harold Gillies died on 10th September, 1960, at the age of seventy eight, in the London Clinic.

He left assets totalling £20,179, and he willed that each of his four children should receive £250 and that the residue should become the property of Lady Marjorie Gillies. The revenue from the royalties and the sale of copyright was to be equally divided between his family.

#### **Epilogue**

"His life was gentle; and the elements so mixed in him, that nature might stand up and say to all the world. This was a man'."

William Shakespeare.

In 1961 the British Association of Plastic Surgeons founded "The Gillies Memorial Lecture". The money with which the lectureship was endowed was also to provide grants to foster education, study and research in plastic surgery.

In the Spring of 1960 the American Society of Plastic and Reconstructive Surgery had invited Sir Harold to receive in person their Special Honorary Citation in recognition of his work in the advancement of plastic surgery. The ceremony of presentation was to take place at the President's Banquet during the 29th Annual Meeting of the Society on 6th October, 1960, at Los Angeles, California.

Sir Harold had accepted this invitation in a letter to Dr. Kenneth Pickrell. On his death Lady Gillies wrote to Dr. Pickrell:

"... I am certain that it would be Sir Harold's wish that nothing should be altered or changed at the meeting and that it should proceed as if we both were there. Please offer my sincere thanks to all of the members of the American Society of Plastic and Reconstructive Surgery.

Yours sincerely, Marjorie Clayton (Sam)." (27th September, 1960.) Mr. Patrick Clarkson, Sir Harold's pupil and protégé, travelled to America to receive the Citation on behalf of Lady Gillies. It read:

SPECIAL HONORARY CITATION TO SIR HAROLD GILLIES IN RECOGNITION OF HIS DEVELOPMENT OF THE SPECIALITY OF PLASTIC SURGERY, AND HIS OUTSTANDING SCIENTIFIC CONTRIBUTIONS TO THE ADVANCEMENT OF ITS PRACTICE. Presented by the American Society of

PLASTIC AND RECONSTRUCTIVE SURGERY

6th October, 1960, LOS ANGELES, California.

During the meeting itself Dr. Jerome Webster paid tribute to Sir Harold Gillies in the reading of a memorial paper. He concluded his tribute with the words, "Gillies' name might perish, but his influence will be immortal".

Obituaries appeared for many weeks in the public and medical press of England and America. The contributors, personal friends and colleagues of Sir Harold, all found the task of describing his sporting and professional achievements an easy one, but many had great difficulty in capturing the character, the essential moving spirit, of this mercurial genius.

All were agreed that Sir Harold had, in fact, achieved an incredible amount in the short span of a human life, but none, except probably Mr. Rainsford Mowlem, really captured his true nature; he wrote: "(Sir Harold)...had a restless, imaginative and ingenious mind which was completely untrammelled by any preconceived ideas as to how things 'should be done'."

In 1933 a sporting correspondent, on meeting Sir Harold, had remarked, "He never takes the most ordinary things of life for granted and is always wondering how they can be improved".

It was the combination of imagination, ingenuity and restlessness with boundless curiosity and energy that gave Sir Harold his success. He had a strength of mind and body which enabled him to pursue his many interests and to carry out his many duties with a zeal that would have broken a lesser man both mentally and physically.

He had never allowed himself to be weighed down by responsibility, and retained a sense of humour during the most difficult periods of his life. He was renowned for his appreciation of the practical joke and his colleagues could never foretell in what direction his puckish sense of the ridiculous would find vent. He could never resist an opportunity for a "leg-pull" and there are a legion of stories concerning his discom-

fitted enemies—and friends, many of them told by himself, often to his own detriment.

Probably the most famous story is that of his "Dr. Scroggie". On this occasion he refused an invitation to spend a golfing holiday with a group of colleagues, but told his hosts that a Dr. Scroggie, a South African, would be taking his place. He disguised himself behind a luxuriant grey beard, donned knickerbockers and cap, and arrived at Westward Ho! to join the party. None of his friends recognised him and they spent a most uncomfortable first day debating whether this odd character was indeed Dr. Scroggie. It was at dinner that night that one of the company "took the bull by the horns" and approached the solitary figure sitting at an isolated table. Sir Harold's plan was to get into the game the next day with a handicap of six and "clean the house", but, as was a usual occurrence, the joke misfired: he was recognised. His mannerism of holding his cigarette between his second and third fingers had given him away.

Many people never quite forgave him for his often misplaced and mistimed jokes at their expense. One of these in particular was Sir Archibald McIndoe, who was unmercifully ragged during the first year with his cousin. One of his favourite tricks was to describe a most complicated operation to a distinguished audience of visiting surgeons, and then to turn to a most inexperienced assistant with a benign smile and say, "Will you cut the graft that I have just been describing, please, Mr. So-and-So".

Despite this disregard for the feelings of others, he was well-loved by his close acquaintances who understood the quirks of his nature. Dr. Rainsford Mowlem said, "He was capable of evoking an enormous though sometimes unwilling affection in all those who knew him well".

Towards the end of his life he gave free rein to his bizarre wit, and was dubbed by many "eccentric". Many times he jeopardised his reputation and embarrassed his friends with his sallies. On the occasion that he made public speeches he would always include risqué and irreverent tales irrespective of the gravity of the function: no doubt he revelled in the sight of the red faces in the audience. Whatever criticism one might level at Sir Harold, nobody could accuse him of being pompous or "arch".

His frankness, although an admirable trait, often discredited him in the eyes of those who were the butt of his criticism. This characteristic, however, qualified by a streak of deep humility, would just as often act in his favour: combined with his infectious enthusiasm, it was

this that had impressed his superiors in the early days of his career.

He was always sensitive to any deep hurt that he may have inflicted and was in the habit of apologising for his rudeness. He expressed surprise that he had any friends at all and was particularly amazed by the request of the Danish Government to treat the injured from the Geysir. The representative that had watched him operate at Sidcup the year before had had particularly large feet and Sir Harold, noticing this, had passed ostentatious remarks about their generous size. Despite the fact everybody agreed that his rudeness was "unforgiveable", he was nearly always forgiven.

One person who was anathema to him was the fool; he could not tolerate presumption or ignorance, and those unfortunates suffered the cruellest form of his wit. He did, however, freely forgive mistakes made through inexperience and would always have a kindly word of advice for those who brought their troubles to him.

Many facets of his character were paradoxical. His generosity was well-known and many of his pupils, on entering private practice, were financed by Sir Harold. On the other hand he would just as readily refuse some small request for aid with the excuse that he could not afford it. People, in fact, accused him of being "pound foolish, penny wise".

He never allowed his patients to discuss the question of fees with him and would always refer them to "my secretary, Mr. Seymour". Mr. Seymour would tell the patient after consultation the fixed fee that Sir Harold charged for their particular operation, and any question of a reduction would be fully discussed and Sir Harold eventually informed of the financial position of his patient. There were many occasions on which patients were treated in return for a nominal fee or even entirely free.

The approach to a new private patient played an important part in the eventual psychological, if not physical, result of treatment. Sir Harold advised, "When a patient comes for the first consultation, put him at ease—a cigarette is offered and a bit of polite fencing usually gives an opening. Of course, the family doctor may have told or written you about the case already. If not, it may be amusing to conjecture on your own what the patient needs, but let him approach and unfold his reason for coming in his own way; do not interrupt the story. Avoid breaking into the conversation with, 'and what would you like me to do to that huge nose, Sir?' just as he is about to show you his Dupytren's.

"Once it has been made clear that the patient

desires a nasal reduction, no matter how many chins she has, refrain from the temptation to lift her face with your fingers while you are discussing her nasal problem. As soon as the patient's wish has been divulged, try to ascertain the reasons for the desired change. This is important in helping to determine the justifiability of the surgery. If the patient frankly admits, 'Vanity', I am pleased to tell them, 'You could not have a better reason. There is a responsibility in this tricky operation, and if you are not going to be vain about the nose I'm going to give you then I have no interest in doing it?"

Sir Harold did take immense pride in his work and would allow no patient to leave his care until he was perfectly satisfied with the results of the operations.

He would never permit his inherent enthusiasm to overcome his better judgment. Each operation was treated as a specific entity—a new problem deserving original thought and action. Before tissues were disturbed, the details of the method to be used were worked out at length and exhaustively. Photographs and plaster casts, in the case of a facial operation, were the maps upon which the campaign was planned. Exact patterns of the skin areas to be grafted were cut from linen and the precise dimensions of the tube pedicles to be raised were evaluated. This information was draughted carefully onto the skin of the patient before the operation started, with a pen and Bonney's Blue.

As an operator Sir Harold showed great artistry. That is not to say that his technique was florid or mannered: his every movement was deft and controlled, and his handling of tissues was supremely gentle.

His assistants often found him exasperating to work with. Time would lose all meaning during an operation and his only thought would be for of satisfactory final result. An absolute apposition of skin edges was demanded, and should he have discovered, after the meticulous insertion of dozens of minute stitches, that this compliance had not been met, or, alternatively, that he had seen a better way of arranging the flaps, the work would be undone and started afresh.

His patience was proverbial and unsurpassed, and he always maintained that the true test of the temperamental suitability of a surgeon to plastic work was his willingness to destroy hours of work to the advantage of the final result of the operation.

His dictum was "Never do today what can honourably be put off until tomorrow". He would never be persuaded to make a hurried decision or perform a hurried operation, both of which could have irreparably damaged the final appearance of the patient.

Sir Harold was a brilliant and inspiring teacher. He devoted much thought to his teaching technique and had the opportunity to develop his methods to the full. Teaching revolved around the preoperative planning clinics where patients would be seen and the nature of the lesions to be repaired demonstrated. The discussion of the cases, however, did not take place in the restricting presence of the patients, and the courses to be pursued surgically were debated at length in a separate room.

He was one of the few teachers who practised what he taught. He stressed always the absolute necessity of handling tissues gently, the extreme importance of accurate edge apposition and the imperative need for careful dressing. In fact, he never failed to apply pressure dressings and bandages himself, for he had learnt through hard experience that badly dressed grafts failed to thrive and sloughed with alarming rapidity.

It was this first hand experience in plastic surgery that gave him his unique position as a teacher: he was truly the fountain-head of knowledge regarding his speciality.

To describe the face that Sir Harold Gillies presented to the world is not hard. His idiosyncracies and appearance made an indelible im-

pression on all who knew him. He was sometimes irascible, always unpredictable: he was a "bon viveur" in the true sense of the phrase and loved his club life at the Garrick and the Junior Carlton: he had an inexhaustible capacity for "doing things" and was never happier than when painting, fishing, motoring, playing the violin (at which he was most proficient), or working.

His ingenious mind found expression not only in his surgery, but also in the production of innumerable inventions. He patented a revolving car seat, an electric suction razor (in his own words, "a cross between a dermatome and a vacuum cleaner") and a coat hanger. The coat hanger was most successful financially; many were sold in the West End stores during the Christmas shopping period of 1959. Its principal was based on the fact that one always dons one's trousers before the jacket!

He was always known as Giles by his friends, and Giles could always be found in the centre of a laughing group or traced by an endless succession of cigarette stubs. He smoked incessantly even whilst performing minor "finishing" operations: when patients complained about the impending drop of the accumulated tube of ash, he would say "Don't you worry, it's perfectly sterile "!

His hand writing was absolutely illegible and the story of a patient who used one of his prescriptions for everything from a season ticket on the London buses to a free pass to cricket games, boxing matches and horse races and which terminated its distinguished career by inspiring the patient's daughter in the writing of the opening phrases of an original piano concerto which won her a two-year scholarship at the London Conservatory of Music, is famous.

His suite at the London Clinic where he consulted every Tuesday displayed evidence of his varied interests and activities. The walls were decorated with a stuffed 12-lb. Laerdal salmon, the insignia of the Orders of St. Olav and Dannebrog, the certificate of Honorary Fellowship of the American College of Surgeons, a signed photograph of Earl Beatty accepting the surrender of the German Grand Fleet in 1918, an etching by Henry Tonks, a photograph of himself on the links whilst playing golf for England and one or two of his current paintings.

The floor staff of the London Clinic always looked forward to his Wednesday operating sessions in Theatre No. 3 when his anaesthetist was invariably Sir Ivan Magill.

He was habitually late for appointments and would think nothing of leaving a waiting room full of patients in favour of a game of golf or the promise of some good fishing.

He was devoted to his children into whom he instilled much of the zest for life that he enjoved.

His eldest son, John Gillies, M.B.E., played squash for Cambridge and England. He was a fighter pilot during the Second World War and was shot down during the Battle of Britain to spend until 1945 as a prisoner of war. He is now an accountant practising in South Island of New

His younger son, Dr. Michael Gillies, who followed his father's footsteps at Caius and Bart's, is qualified in entomology and tropical medicine and is now working for the Colonial Medical

Of his two daughters, one married Professor Harrison, Professor of Anatomy at the London Hospital, and the other is the widow of the late Bill Travers, the oil magnate, and lives mainly in Burma and India.

This was Sir Harold Gillies, the man and the surgeon, loved and respected by all who knew

His colleagues recognised his many talents and forgave his few weaknesses. He was set apart from them by the broad spectrum of his experience and Mr. Patrick Clarkson acknowledges this in writing, "He was a member of a bigger and wider world than that enjoyed by most consul-

He left us secure in the knowledge that he is likely to remain "the greatest world influence of any British surgeon this century".

Sir Harold Gillies' name might perish, but his influence will be immortal."

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12. The help of the following is gratefully acknowledged:

The Librarians of-The Royal Society of Medicine The Royal College of Surgeons St. Bartholomew's Hospital Wellcome Historical Museum The Guildhall Library The Director, Dept. of Statistics, S.B.H. The Steward, S.B.H. The Director, The Registry, S.B.H. The Staff, Dept. of Medical Photography,

(To be continued)

## BEHIND THE SCENES: 3

#### OCCUPATIONAL THERAPY

by Pamela Anderson



Patient with Still's Disease.

#### Our Aim

THE aim of an Occupational Therapist is to I treat each patient by means of work and assessment so that he or she may return to normal or near- normal life as soon as possible. This treatment is, of course, carried out in close cooperation with all the other departments in the hospital.

#### Lack of space at Bart's

At Bart's, however Occupational Therapy so far has been extremely limited due to lack of space and has mainly consisted of general work with patients in the wards and department and a small amount of specific treatment and assessment. At the present time a great deal of craft work is still done as we have no facilities for more practical forms of therapy using treadle lathes,

bicycle fretsaws and so on.

A Functional Assessment Unit (F.A.U.) has been planned for the department where patients will be assessed in all the everyday activities involved in running a home. This unit will be run in conjunction with the Physiotherapy Department. Patients will be advised in such activities as walking up stairs and climbing into a bath. They will also be assessed for return to work or change of job and where necessary practice will be given in coping with public transport. The patients requiring this form of therapy are mostly the arthritics, hemiplegics, amputees and neurological cases.

#### Patients referred to Occupational Therapy

All the patients referred for Occupational Terapy should be made to work and move to full capacity and this is particularly necessary with the rheumatoid arthritics. When these patients have to stay in bed for any length of time they become very stiff and work should be provided which encourages a maximum range of movement. In the later stages of treatment these patients would benefit from practice in the F.A.U., and could build up their work tolerance before returning to look after a home or to their job. Where there is any doubt about a patient's ability to return to work he should be assessed while still in hospital and before referral to the Ministry of Labour. Where there are only slight difficulties at work, an Occupational Therapist can often advise and suggest alternative methods for doing the same work.

#### Hemiplegies

Treatment of hemiplegics should be started as soon as their condition allows. They should be encouraged to do things for themselves and make things even if, at first, they can only work with one hand. Initially these patients are very frightened, especially when there is speech involvement, and anything they can achieve helps to restore their self-confidence. As soon as there is any sign of recovery of function in the hand and arm the patient is made to use the limb to its fullest capacity even though he may only be able to steady his work. Later on he is given work to do which needs the co-ordination of both upper limbs. At this stage the patient should be made to use both a knife and a fork and can be supplied with easy grip cutlery as a temporary

If there is going to be a permanent disability or even very slow recovery the patient should be assessed fully with regard to dressing and every day chores and self-help aids supplied if necessary. This is where the F.A.U. would be such an advantage as the patient would be able to practise working methods in homelike conditions.

#### Neurotic and Psychotic patients

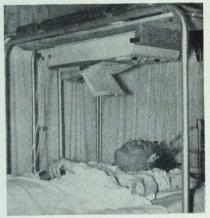
Occupational Therapy also plays a large part in the treatment of neurotic and psychotic patients. Most mental hospitals and psychiatric day centres have a large staff of Occupational Therapists and treatment is aimed at the resocialisation of patients with special emphasis on the return home and to work. Light industrial work is brought into the hospitals and even chronic patients of 20-30 years standing appear to respond well and take a pride in earning a wage again. Many of the patients who will be returning home, especially those with anxiety neuroses, are encouraged to work in the kitchen unit, do housework and shopping to build up their selfconfidence.

All these patients are encouraged to take a pride in their appearance—dressmaking is a big item in an Occupational Therapy programme. The Occupational Therapists also organise the sporting and social activities which include drama, musical evenings and dances. Here at Bart's the psychiatric cases referred for Occupational Therapy are usually the depressions on E.C.T. and the occasional out-patient referred for some specific reason.

#### Tragic lack of accommodation here

At the moment the Occupational Therapy service at Bart's is tragically inadequate and until we get accommodation which will permit Functional Assessment and proper treatment it will remain so. If patients could get immediate and intensive therapy their time in hospital would be greatly reduced, thereby helping the economy of the hospital. It would also be possible to save on local welfare services if patients were sent home knowing that they could cope with the everyday activities.

Photographs by kind permission of the Medical Photographic Dept. of St. Bartholomew's



Patient with cervical fracture and quadraplegia.

#### LAST MONTH

#### From our Charterhouse Representative

Now it was in the sixth month of the year that the Great Exam began, and the camp of the scholars was divided in two. For some had taken it before, and some had not. And in the time before the Exam the scholars discussed one with another what questions they would be asked. But when the Exam came they saw that the questions were unlike those they had talked of. And they were depressed and cried together, saying, "Why have we worked so hard that the questions are so general?"

Now it is tradition that after the papers the practicals follow, and the duration of the exam is about three weeks. And at the end of that time the elders gather together, and the fate of each scholar is decided. And after the meeting

the chief elder, who is the Dean, comes forward to the scholars and tells them one at a time what the result shall be. And those that have passed are exceeding joyful, but those who have failed are full of sorrow.

It came to pass that of the scholars who had taken the exam before all but one was successful, vea even the Catholics passed; and they were amazed. And they asked themselves is this not a miracle? So great was the wonder thereof that some had refused to believe; for many had arranged after the Exam to go elsewhere, and follow other pursuits. But as time passed they became accustomed to the fact and rejoiced

Now I heard and saw all, and was moved.

## COULD YOU HAVE BEEN A SOLICITOR?

By a Solicitor of the Supreme Court

A NUMBER of similarities between doctors and solicitors spring to mind.

To start with, we both belong to the few great original learned Professions.

We earn our living by providing services rather than goods. We are disciplined by governing bodies we ourselves elect, to preserve the highest standards of conduct in serving the community. We may not advertise and we can be "struck off" the Roll or the Register.

Our life is not as exciting and full of sensational moments as the telly-beguiled public would think.

The service we provide involves giving confidential advice to all men; you, in relation to their bodily needs in their environment, we, in relation to their legal position.

Both doctors and solicitors are always meeting people, diagnosing their problems and helping to solve them. Most solicitors think of some of their clients as "patients",



The Law Society's Hall.

and I am sure that most doctors are frequently asked for, and give, a lot of good advice to their patients on matters not strictly clinical and possibly legal.

Before he qualifies, a medical student or solicitor's articled clerk has to undergo a long and (virtually) unpaid training period, learning Medicine or Law and their practical application to particular cases. After qualification, both have to gain hard practical experience and subsequently keep up to date; our consciences can be nagged by just as large a pile of unread Solicitors' Journals and Law Reports as doctors' Lancets and B.M.Js.

What makes a good Solicitor? To quote from a booklet put out by the Ministry of Labour-" A Solicitor . . . must be able to grasp quickly the facts of a complicated situation . . . have a knowledge of human nature and understanding of the motives of human conduct . . . combine his interest in people with impartiality . . . be able to win his client's confidence in his knowledge and soundness of judgment . . . the foundation of his dealings with colleagues and with clients must always be complete integrity of character". This-with respect-seems sound sense and, transposing "patient" for "client" must surely apply equally to doctors.

Without confidence, the patient or client will not come for advice in the first place,

nor follow it when given.

By way of elaboration of the passages quoted, one could add that the patient/client must trust you to regard what he tells you as entirely secret—no after dinner stories about his cirrhosis or his divorce. Probably the greatest modern medical myth is that all doctors swear the Hippocratic Oath. He ought also to be able to feel that you are interested in him, not merely as tomorrow's fourth appendicectomy in Theatre 2, or fifth on the list of Undefended Divorces in the Queen's Bench Division, Court 12, but as Mr. Jack Jones, feeling very apprehensive despite your re-assurances. Every doctor and every solicitor only has one patient or client—the one of the moment.

Both Professions have to combine interest with impartiality; to do so in the right proportion is not always easy. How much involvement? With too little, a solicitor can feel very bored with Mr. Jones' endeavour to avoid bankruptcy, death duties or an affiliation Order-just as I suppose the doctor can find Mr. Jones's dermatitis or dyspepsia very wearisome.

With too much involvement, both doctor and lawyer cease to be able to give sound objective advice. Perhaps this is the reason why the doctor or solicitor is always wise to get a colleague to treat or advise himself or his wife. The old adage is "A Lawyer who acts for himself has a fool for a Client". I think one could probably transpose again here.

There are, of course, many differences between the two professions and one gets the impression that the Medical Profession stays more esoteric than the Legal, maybe because the doctor is only one step removed from God.

The patient puts himself in the hands of his doctor, but he only consults his solicitor.

The doctor may not deem it advisable to explain the why and wherefore of the treatment, but the solicitor, of necessity, spends a lot of time explaining the operation of the Law and the meaning and purpose of the documents he prepares. There is some legal aspect of virtually every activity which people undertake and the solicitor's job is to advise their clients how best to manage their affairs.

Medicine is far more dynamic than Law. New techniques and discoveries have transformed it in the last forty years. Law is static and conservative by comparison. The Law is universally regarded as being inevitably five, ten or twenty years behind the times. Pure medicine, exemplified in scientific research, is always at least ten vears ahead.

If, in your beliefs and your character, you have the qualities I have mentioned, and which are needed for both professions, the answer to the question in the heading is "Yes"-you could have been a Solicitor of the Supreme Court of Judicature.

An Historical Review

# **RAILWAYS**

and

## **HEALTH**

by

Gervase R. Hamilton



#### RAILWAY UNDERTAKING

Touter: "Going by this train, sir?"

Passenger: "Mm? Eh? Yes."

Touter: "Allow me, then, to give you one of my cards, Sir."

(Reproduced by kind permission of Punch.)

"None of the consequences have ensued from the use of steam in land carriage that have been previously stated. The horses have not started, nor the cows ceased to give their milk, nor have ladies miscarried at the sight of these things going forward at the rate of four miles and a half an hour." These words, spoken by a Mr. Joy before the Parliamentary committee investigating the Liverpool and Manchester Railway Bill of 1828, reflect the common concern of the time that the new-fangled railways were a source of harm to the physical and mental health of the public at large. Though the unfounded statements of quacks and pseudo-scientific charlatans were soon proved wrong, the Victorians were always more than unusually aware of the dangers to their health of rail travel, and the scientific and medical journals of the period were filled with sensible but at times curious advice.

It was not the thought of ill-health, but rather the fear of maining or death that loomed large in the mind of the early railway traveller-an attitude amply confirmed by the reports of the Board of Trade on early railway accidents. It was not in fact until the fascination of the new form of travel had worn off that the Medical profession made any serious attempt to put the investigation of the subject on a scientific footing. One of the pioneers in this field, Monsieur Devilliers, chief physician to the Lyons railway of France, published in 1857 a treatise entitled "Statistics and Scientific Researches", in which he showed that one fifteenth of the drivers and firemen employed by that railway suffered from diseases ranging from disorders of the brain and nervous system to lumbago and spinal trouble. Five years later Monsieur Gallard read a paper to the Academy of Sciences in Paris in which he proved without doubt that train crews suffer no occupational diseases. He quoted figures showing that the death rate among railway workers in the twenty to fifty five age group was less than half the normal death rate of the ordinary population of Paris of corresponding age group. In this country at about the same period, the medical officer to the G.P.O., Dr. Waller Lewis, made a similar investigation and found that railway workers suffered no harm from their travelling and, in fact, that the work was beneficial to their health. He personally examined between sixty and seventy sorters who had been working on G.P.O. trains between six and eighteen months and found they were all in sound health—indeed, many said they had never felt so well in any other work. He also noted rather curiously that young sorters who had previously been thin became fat and vice versa!

If it was shown that the railway worker had little to fear for his health, what about the ordinary passenger? "If," we are informed, "a season ticket holder be young and healthy he has nothing to fear from his journeys, but only if suitable precautions are taken". What the precautions involved we shall see in a moment. A doctor writing in the medical press stated that if the traveller rose late in a flurry and rushed to the station, "It was peculiarly dangerous to persons with diseases of the heart". Another, writing on the same subject, added, "I have known sudden deaths and several aggravations of valvular lesions to be caused in this way." Alfred Haviland in his "Hurried to Death, or a Few Words of Advice of the Danger of Hurry and Excitement especially addressed to Railway Travellers", of 1868, observed, "season ticket holders especially on the Brighton line age very rapidly "-a statement that has an element of truth in it to-day! He went on to give a cautionary tale. "Elizabeth Stainsby had been visiting some friends in the neighbourhood of the Metropolitan Railway; she had partaken plentifully of refreshment and then hurried up an incline to the station in order to catch the train. Shortly after she entered the carriage she was seized with difficulty in breathing and then died. The cause of the obstruction to her breathing was attributed to the impure atmosphere of the Underground Railway." However, at autopsy, "she was found to be tightly laced, to have a crude meal in her stomach and a constriction of one of the vessels leading from the heart which, after a chemical analysis of the air, was deemed sufficient to have caused the sudden death." The "Impure atmosphere" of the old steam underground railway at its most stygian and sulphurous between Gower Street and Great Portland Street stations, is frequently mentioned by Victorian travellers in the Metropolis. Although a fruitful field for the investigator no attempt seems to have been made to review the health of the train crews or the regular travellers on the Underground. The incidence of respiratory tract diseases, especially chronic bronchitis and emphysema, must have been phenomenal.

A frequently reiterated fear of the Victorian railway traveller was that of catching cold-a fear real enough when it is recalled that steam heating of coaching stock did not become common until the turn of the present century. Passengers were generally advised to keep the compartment windows closed as much as possible and wear warm clothing. Some doctors trying to preserve the balance between warmth and ventilation adopted the scientific approach. "In fast trains," one wrote, "with the outer temperature below 40 degs. Fahr., there is circulation of air through the ventilators and unavoidable chinks of the carriage sufficient to keep the air pure, even with six or eight passengers, without any window open. When the outer temperature is above 40 degs, and the carriage full, an inch or two of one or both windows open may be permitted with safety." The "unavoidable chinks" were the subject of a letter to the "Leeds Mercury" in the early days of railways. "A passenger by the second class carriages on the Manchester and Leeds complains that himself and a female relative have caught a severe cold from the holes in the floors of the carriages which admit currents of air to the legs of the passengers; he asks if there is any use or object in these holes, except to drive passengers into the first class carriages. We cannot answer him."

The dangers of stuffiness, however, were not altogether ignored. A Dr. Angus Smith allayed the public's fears in this direction by proving the air in the carriages normally harmless, except in hot weather when he thought the woollen coverings of the seats in first class carriages were a source of danger to health, especially if they were not kept clean.

Even if the traveller had succeeded in avoiding catching a cold, he might have cause to fear the "vibratory illness". Arguments on the subject filled the pages of medical journals for a short time but were soon forgotten. It was alleged that if organic disease were present, it would undoubtedly be accentuated by the motion and fatigue of a journey taken twice daily. Railway companies were advised to pad their carriages better to avoid vibrations and "concussions" since the shaking of the carriage was felt most keenly on the back, loins, waist and head, and such vibrations badly upset those who were "sensitive in the ear or membranes of the head". A Dr. Williams advised the use of air cushions

to lessen motion and noise. A small horse-hair cushion around the neck of the traveller and another of larger size around the loins would "wonderfully intercept the noise and jarring motion of the carriages". An invalid, "air collared and air girt with the legs on an easy footrest and a pillow or cushion or two to prop against the rolling or lateral motion may generally travel better in a first class carriage than in the special invalid beds".

Not only were the vibrations of the carriages harmful, but the eyes were liable to be fatigued by the "dizzy rapidity of passing objects". Travellers were recommended to refrain from looking out of the windows particularly in fast trains, but if they were bored on no account to read cheap badly printed books as this was stated by an eminent oculist to be "very injurious to

A subject approached without the usual Victorian embarrassment, indeed, covered with commendable thoroughness, was that of train sickness. Macarthy O'Moore in his "Tips for Travellers" of 1899 advises lady passengers to carry "a bottle of salts, even on a short journey"; sensitive stomachs are warned of the "perils of meat pies" bought in station buffets. If the worst happened and faintness or sickness supervened the sufferer could take Havilland's advice and find that, "a bit of hard sea or captain's biscuit (not the useless sweet or arrowroot variety) accompanied by a little weak, cold sherry or brandy and water, are the best means of appeasing a stomach likely to suffer". A veil was discreetly drawn over action in emergencies and the facts were only faced in more modern times as shown by this extract from a letter to an illustrated paper, "People who find it necessary to vomit whilst in a railway carriage should discreetly use their hats; this would come naturally to anyone properly brought up ".

Not everybody considered rail travel a danger to health and yet one wonders how many people to-day would agree with the words of a Dr. James Johnson, "a physician of first rate talent and deserved eminence", who, contrasting rail and coach travel wrote, "Rail travel equalises the circulation, promotes digestion, tranquillises the nerves and often causes sound sleep during the succeeding night; the exercise of this kind of travelling being unaccompanied by that lassitude, aching, and fatigue which in weakly constitutions is the accompaniment of coach travelling; and which so frequently in such constitutions produces sleepless nights.

The Railways bid fair to be a powerful remedial agent in many ailments to which the Metropolitan and Civic inhabitants are subject; and to thousands of valetudinarians in the Metropolis, the ride to Tring and back twice or three times a week would prove a means of preserving health and prolonging life more than all the drugs in Apothecaries Hall."

## FIFTY YEARS AGO

The "Clizabethan" Style, and how it might have affected Tennyson, had he been up for Mid wiferp.

## ON THE MANAGEMENT OF A CHARGE COMPLICATED BY THE FACT THAT SOMEONE HAS BLUNDERED

Number = 600. Distance=1½ leagues (5632.69 metres). Direction=Onward. Destination= (i) The Jaws of Death. (ii) The Mouth of Hell.

CAUSES OF PREMATURE RETURN AND DIMINUTION IN NUMBERS OF THE 600. A. Causes associated with Cossack and Russian.

(a) Disposition of cannon. (i) To right of them.

(ii) To left of them. (iii) In front of them.

(iv) (subsequent to complete version of

the 600.) Behind them.

(b) Storming.

(i) With shot.

(ii) With shell.

B. Causes associated with the 600 themselves.
Fall of (i) horse.

Three Golden Rules to be observed in the Management of a Charge.

Do not make reply.

Do not reason why.

(III) Do and die.

#### Engagements

HUNTER-THOROUGHGOOD. - The engagement is announced between David Laing Hunter and Janet Elsie Thorough-

PRICE-HORSNAIL.-The engagement is announced between David John Everard Price

and Patience Mary Horsnail.

RICHARDS-NORTON-The engagement is announced between Nicholas Christopher Guyon Richards and Wendy Geraldine Norton.

SMART-ELKINGTON.-The engagement is announced between Christopher James Smart and Janet Elizabeth Elkington.

WARD-JONES .- The engagement is announced between Anthony Milford Ward and Margaret Dorothy Jones.

#### Marriages

BAILEY-FISHER .- On 27th July, Alan Richard Bailey to Rachel Gay Fisher.

PHIPPS-SMITH.-On 27th July, Christopher Roger Phipps to Rosemary Alden Smith at Bromley Baptist Church.

SHARP-COLLINS .- On 6th July, Dr. Guy Thomas Sharp to Iillian Margaret Collins. SHEARMAN-SLATTERY .- On 29th June, John Shearman to Diane Slattery.

#### Births

ATKINSON.—On 12th August, to Veronica (née Filler) and Dr. R. S. Atkinson, a son, brother for Janet, Michael and Ruth.

CHARLTON.-On 31st August, at St. Bartholomew's Hospital, to Jennifer (née Price) and Clive Charlton, a daughter, Clare Louise, a sister for Simon Rupert.

COTES (by adoption).-By Patricia (née Beck ingham) and Dr. John Cotes, a son (Simon John), a brother for Peter and Lucy.

DUNKERLEY .- On 30th July, to Jill and David Dunkerley, a son (Hugh).

IND .- On 13th August, at the Westminster Hospital, S.W.1, to Dorothy (née Bishop), wife of Dr. John Ind, a son (Charles Thomas Mcssiter)

JOHNSTON .- On 20th July, to Penny, wife of Dr. E. Neville Johnston, a son (Robert).

JUNIPER .- On 31st July, to Jane (née Griffiths) and Dr. Colin Juniper, a daughter, sister for Susan.

KENNEDY .- On 21st July, to Jill, wife of Dr. Robert Kennedy, a daughter, sister for James and Fiona.

MORGAN-HUGHES .- On 11th August, to Wendy (née Footitt) and Dr. John Morgan Hughes, a son (Nicholas John)

MYERS.—On 20th July, to Anne (née Clifford) and Dr. David Myers, a daughter (Sally).

STEPHENSON.—On 6th August, to Carolyn (née Garnham) and Dr. Charles Stephenson (both soon of British Columbia), a son (Ashley), brother for Justin.

VANDY .- On 7th August, to Monika (née Preuss) and Dr. K. W. Vandy, a son (Jan

#### Death

ROCHE.—On 25th July, Alexander Ernest Roche, M.A., M.D., M.Chir, Cantab., F.R.-C.S. Qualified 1922.

#### Appointments, etc.

Empire Rheumatism Council.

A Geigy Travelling Fellowship has been awarded to Prof. W. G. Spector for a study visit to Australia.

#### Royal College of Physicians, Edinburgh.

At a meeting of the College on July 16, Prof. E. F. Scowen was elected to the membership.

#### Changes of Address

- Dr. and Mrs. Harold Ball from White Horses, Marine Drive, Barton-on-Sea, Hampshire, to Fair Oaks, Shirley Holms, Lymington, Hampshire.
- Mr. A. Caplan to Ministry of Pensions and National Insurance, 10, John Adam St., London, W.C.2.
- Dr. Russell E. Frears from 14, Park Terrace, The Park, Nottingham, to 31, Bld. Tauler, Strasbourg,
- Mr. A. P. Fuller to 73, Harley Street, London, W.1.
- Dr. A. H. Gretton to 6911, Bow Crescent, Bowness, Calgary, Alberta, Canada.
- Dr. J. R. Hamerton to P.O. Box 372, Dar es Salaam,
- Mr. C. A. Horder from Avalon, Mawnan Smith, Falmouth, Cornwall, to 35, Lyonsdown Avenue, New Barnet, Herts.
- Mr. D. F. Ellison Nash to 95, Harley St., London,
- Dr. Ian S. Paterson to 1995, Sasamat Place, Vancouver, 8, B.C. Canada.
- Mr. A. B. Pavey-Smith from North Wood, Nailsworth, Glos., to Blake House, Springhill, Nailsworth, Glos. Tel. 340 (unchanged).
- Mr. C. Gordon Sinclair to Hatfield Mount, Norton, Worcester. Kempsey 267.
- Mr. Musgrave Woodman to Autumn Wood, Somerset West, Cape, S. Africa.

## CURRENT TRENDS IN PERIPHERAL VASCULAR SURGERY

by Martin Birnstingl

THE account which follows is an attempt to sum up the principles used today in the diagnosis and treatment of common vascular surgical conditions. The subjects to be considered are Vascular Trauma and Occlusive Arterial

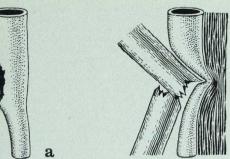
#### SURGERY OF VASCULAR TRAUMA

Injury to a major limb artery does not invariably imperil the limb, but is very liable to do so when combined with extensive muscle and bone damage, because of reduction in the pressure head through surgical shock and loss of the usual collateral vessels in the traumatised soft tissues. The importance of restoring flow through the main vessel is clear and it seems extraordinary today that surgeons have taken more than fifty years to apply techniques that have long been accepted as reliable in the experimental laboratory. The Russian surgeon Eck accomplished porta-caval anastomosis in the dog in 1879 and Alexis Carrel, in Bordeaux, published a reliable technique of arterial suture in 1902. He later joined Guthrie in Chicago where they accomplished successful vein grafts and, amongst other discoveries, achieved successful autografting of kidneys in dogs and cats. Although these pioneers had great hopes for the future of vascular surgery, arterial anastomosis was not introduced to the clinical field until 1945, when Gross inserted a segment of preserved human aorta when repairing a coarctation of the aorta in a seven-year-old boy. During World War II, ligation was the standard treatment in major arterial wounds and many limbs were amputated that might now have been saved. However, the Korean War witnessed the introduction of vascular surgical teams by the Americans, with the result that an amputation rate of 62 per cent. following major arterial ligation in 1952 was replaced by one of 7 per cent. after arterial repair in 1955. These figures speak for themselves.

Diagnosis: When a limb is severely injured in civilian life, the main artery may be cut, compressed, contused or put into spasm (Fig. 1). This causes a state of acute ischaemia and the limb becomes livid, cold, pulseless, anaesthetic and paralysed. Unless the arterial circulation is restored within about six hours from the time of injury, irreversible changes in the tissues of the limb

are liable to make recovery impossible. The cause of the circulatory arrest can only be determined by direct examination of the artery at operation. Normal arterial pulsation will then be apparent proximal to the obstruction, whilst distal to the lesion the vessel may appear considerably narrowed, because the absence of pressure within its lumen allows elastic contraction of its wall. Lacerations and compression by haematoma or bone fragments are easily recognised, but it is also important to be on the look out for an arterial contusion, since either haematoma in the wall of the vessel, or traumatic thrombosis within its lumen, will produce complete obstruction in the absence of external signs. However, the absence of arterial pulsation below the lesion will lead to its recognition. Arterial spasm may occasionally follow a traction injury on an artery or even be produced by rough dissection, but spasm is much less common than the forms of mechanical damage already mentioned, so that it should never be diagnosed until the suspect artery has been exposed at operation.

Treatment: The essentials of treatment are therefore rapid restoration of systemic blood pressure by transfusion, after which immediate operation should be undertaken. The attempt to restore arterial blood-flow may need to be done before the fractured bones are reduced and immobilised. Only when the circulation is clearly recovering within 6 hours of injury is it permissable to delay the decision to expose the damaged artery. As soon as the diagnosis is clear, the artery can be dealt with. In most arterial lacerations, direct suture of the rent is inadvisable, because it tends to narrow the lumen and lead to thrombosis within a few hours of operation. It should also be remembered that the artery wall is often damaged over a greater length than is evident upon external inspection. This traumatised portion should be resected, cutting the ends obliquely for subsequent anastomosis. Provided that the artery can be freed for several inches, an end-to-end anastomosis can be constructed, but in other situations a graft should be inserted. A length of saphenous vein gives excellent results, provided that it is removed by careful sharp dissection, tributaries ligated and the vein finally reversed to avoid blockage by the valves. An alternative method is to suture a patch of vein into

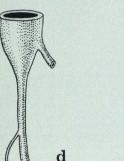


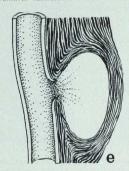
Common traumatic lesions of arteries.

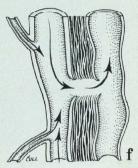
Laceration; note distal narrowing due to lack of pressure.

Compression by bone fragment.

Contusion, causing intramural haematoma and resultant thrombosis.







Traumatic spasm.

Pulsating haematoma, or false aneurysm. Traumatic arteriovenous fistula.

the arterial wound, after this has been accurately trimmed back to healthy vessel wall. The use of 6/0 arterial silk sutures, good haemostasis in the wound and a meticulous technique are essential if reliable results are to be achieved. Morcover, the importance of early exploration of a main artery, whenever vascular injury is diagnosed, cannot be over-emphasized.

Arterial spasm is rarely encountered and is best treated by forcible dilatation of the vessel by pinching off the lumen and injecting heparinised saline through a fine needle . This may be supplemented by application of 2.5 per cent. papa verine sulphate to the outside of the spastic vessel.

Other vascular lesions following trauma are pulsating haematoma and arterio-venous fistula (Fig. 1). A pulsating haematoma or false aneurysm results from a lateral hole in a major artery, in which the extravasation is restricted by the surrounding soft tissues, as in the axilla. In such a case an urgent arteriogram can be most useful. Although such a patient is not in immediate danger, early operation is advisable because of the difficulty in dissecting an artery when it has become bound to its surroundings through scarring. Conversely, in the presence of an arteriovenous fistula it is usually better to delay operation for two or three months, in order to allow a good collateral circulation to develop in the neighbourhood of the fistula. However, early operation is occasionally necessary, should heart failure or some other complication supervene.

Since ligation of a major limb artery does not always produce gangrene, a few patients are seen in which a limb has survived, but the patient has been left with a residue of severe intermittent claudication. Such cases form a particularly favourable group for arterial reconstruction, being often young subjects without atheroma or other arterial degeneration.

## SURGERY OF OCCLUSIVE ARTERIAL DISEASE

Many patients with degenerative disease are not only old, but show progressive lesions in several parts of their vasculature. It is perhaps surprising that worthwhile results can be gained by operating upon such poor material. Nevertheless, however widespread the disease, the patient's symptoms frequently arise from blockage of a single important artery and are therefore amenable to surgical relief. Ischaemic symptoms fall into two main groups, according to whether the reduction in blood-flow is moderate or severe, and these will now be discussed.

(a) Moderate Ischaemia: These patients complain mainly of intermittent claudication; less often there is coldness or paraesthesia in the feet. Intermittent claudication, or exercise pain, is caused by the accumulation of metabolites in the muscles at a rate faster than they can be removed by a reduced blood-flow. The patient is usually compelled to stop by the severity of the pain, at which point production of metabolites falls to a low level and the pain gradually dies away, only to reappear when he again exercises. The pain is thus constantly related to exercise and proportional to the amount of work, so that the claudication distance for a given patient seldom varies. These features are helpful in distinguishing true claudication from other types of skeletal pain due to osteoarthritis and related disorders. The actual site of the muscular pain is governed by the level of the arterial lesion. This is most commonly in the femoral artery, when the claudication is felt in the calf and leg. Claudication in the buttock and thigh suggest that the block is in the iliac artery or, if bilateral, in the aorta. The diagnosis can usually be decided by carefully feeling for absent pulses and by ausculatation with a stethoscope for a murmur over the appropriate arteries in the abdomen and thighs.

Many patients with intermittent claudication have an excellent collateral circulation, as shown at Bart's by a follow-up of 412 claudicant patients over periods up to 10 years, of which only 10 per cent. came eventually to amputation (Taylor and Calo, 1962). Selection for direct arterial surgery therefore needs care and thought. In sedentary patients and those with widespread arterial degeneration, the gain from surgery is

small and operation carries a slight but definite risk. Provided the collateral circulation is adequate for the nutrition of the limb, such patients can be reassured and advised to adjust their way of life within the limits imposed by their pain. On the other hand, a patient who has hitherto led an active life or who needs to walk in the course of his occupation, may be greatly incapacitated and should have an arteriogram with a view to relieving the obstruction, since surgery will usually restore the circulation and relieve the exercise pain (Fig. 2).

Symptoms of coldness and paraesthesia in the limb indicate that the circulation to the skin and superficial nerves is impaired. The trouble is worst at night, when the cardiac output is reduced. These symptoms may be relieved by a vasodilator drug such as Tolazoline hydrochloride, mgm. 25-50 at night, and they are usually cured by lumbar sympathectomy. Both methods increase blood flow to the skin, but in patients with arterial disease they have little effect on the total flow of blood to the limb. It is therefore rare for either sympathectomy or drugs to cure intermittent claudication and the patient should never be led to expect this.

(b) Severe Ischaemia is liable to occur when the onset of obstruction is sudden or when there is widespread vascular disease in the limb. Rest pain or "night pain" is characteristic, being often severe and intractable. Oedema of the foot is the result of ischaemic damage to the capillary endothelium; trophic lesions on the toes and heel and eventual gangrene are clearly due to severe, unrelieved ischaemia.

The patient with these symptoms should be assessed with a view to arterial surgery and arteriograms obtained. The alternative is usually early amputation. In a recent series of patients in which I was concerned, direct arterial surgery was possible in 63 per cent. of 71 limbs with actual gangrene. At the end of one year 30 of the 51 limbs operated upon in this way had been preserved, a salvage of 60 per cent. After successful restoration of blood-flow, a distal amputation can be performed at the level of demarcation, usually at the toes or forefoot. Without vascular surgery, most of these limbs would have required amputation at thigh level, to secure healing of the flaps.

Technical Considerations: The basic methods used at present in relieving atheromatous obstruction are thrombo-endarterectomy and by-pass grafting. Thrombo-endarterectomy (disobliteration or "rebore") is mainly used in shorter blocks, particularly in the aorto-iliac region. In selected cases it can be applied to more distal



Fig. 2.

(a) Detail of femoral arteriogram from a professional acrobat with intermittent claudication, showing

atheromatous obstruction near adductor opening.

(b) Arteriogram repeated one year after successful thrombo-endarterectomy shows that the segment remains

vessels, provided care is taken to avoid the least tendency to narrowing at suture lines. The greater part of the diseased media is removed, together with its containing thrombus, and this can be achieved either by open dissection or by passing a "ring stripper" through a small slit in the artery (Fig. 3). An ellipse of saphenous vein or fabric is preferably sewn into the resulting defect, to prevent narrowing (vein patch). Femoro-popliteal by-pass grafting has the advantage that long stretches of disease artery can be circumvented by two surgeons working simultaneously to perform the proximal and distal anasteroscepts.

Much thought has been expended in seeking the most satisfactory substitute for arterial replacement. Knitted Dacron is reasonable when a rapid flow through the graft is ensured, as in the aorto-iliac region; it is an unsatisfactory longterm substitute distal to the inguinal ligament in atheromatous patients. Arterial homografts removed at post-mortem are convenient to handle, but the supply of young cadavers is limited, sterility difficult to maintain and late degeneration in elastic tissue may result in aneurysm formation several years after insertion (Irvine, 1963). The patient's own saphenous vein, although tedious to remove, appears to be most suitable. Unfortunately, previous varices or other disease may preclude this autogenous material in a small proportion of patients, in which one of the alternatives must be used.

Buerger's disease (thrombo-angiitis obliterans) is rarer than atheroma and usually begins between 20 and 45 years old. It is seen exclusively in men, 90 per cent. of whom are heavy cigarette smokers. Since the lesions occur in the smaller limb arteries, symptoms usually begin distally

Fig. 3.

Technique of thrombo-endarterectomy.

(a) Incision over lower end of blocked segment.

(b) Dissection with appropriate loop-knife for size of artery.

Plane of dissection seen in transverse section.

Extraction of "core", including thrombosed lumen.

Saphenous vein patch to repair arteriotomy incision.

Final result, showing absence of narrowing at level of incision.

with intermittent claudication in the feet, chronic infections or necrotic patches on the toes or heels, coldness and paraesthesia. The femoral and popliteal pulses are unaffected, but the more distal pulses are usually lost. The upper limb is sometimes involved, and the disease has a tendency to phases of activity, in which migratory thrombophlebitis is common. The phlebitis may precede the onset of arterial changes.

Direct arterial surgery has little to offer these patients. A sympathectomy will usually improve skin nutrition and stimulate development of a collateral circulation. Every effort must be made to curtail smoking, but the majority of patients come to eventual amputation. Successful treatment of this disease must await further research into the basic disturbance responsible for thrombo-angiitis obliterans.

#### ACKNOWLEDGMENT

I am very grateful to Mr. Peter Cull, Medical Artist and to the Department of Medical Photography, St. Bartholomew's Hospital for the illustrations.

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## DO ALL YOUR OLD BART'S FRIENDS READ THE JOURNAL?

(PLEASE TURN TO PAGE 269)

#### SPECIAL DEPARTMENTS. III.

(In this Series the Journal will give space to the various Departments which students see less of during their clinical course. The series will give an indication of the work done in these Departments. It will also outline opportunities for those especially interested in a particular speciality.)

## DEPARTMENT FOR DISEASES OF THE SKIN THE WIDER ASPECTS OF DERMATOLOGY

by R. M. B. MacKenna

T the present time some authorities A confidently predict that before long there will be a shortage of specialists in many branches of Medicine; if this is true, it is reasonable to assume that there will soon be better opportunities for those who are interested in skin diseases than there are at present. Therefore it may be helpful to a few readers briefly to discuss the scope of Dermatology and the opportunities for research and investigation which are within the range of the dermatologist.

The first point to be realised is that a weekly attendance in the Skin Department for three months at classes where the cases have been selected, and where, so far as is possible, the teaching is integrated with the undergraduate's knowledge up-to-date only gives a brief glimpse of one elementary aspect of Clinical Dermatology, so that the student has no opportunity to discover the ancillary matters which are of great importance to the members of the Department.

Dermatology is a speciality placed between Medicine and Surgery, with a bias in favour of Medicine, and it goes without saying that if one wants to specialise one must first have a good working knowledge of both these subjects. Very few consultants in Dermatology have held a surgical diploma as their principal post-graduate guerdon, although some would regard it as here-tical, others would welcome a small influx of men and women with a surgical training and background into Dermatology, for their approach to many problems would be refreshingly different from that of their colleagues and might be very helpful. Further, seldom a day passes without a skin specialist having to undertake a biopsy or some relatively simple operation, and these routine jobs, as well as dermabrasion and other operations on the fringe of Plastic Surgery would probably be better done by a trained surgeon than by a physician. Therefore if a candidate decided that he would like to take the examinations for the F.R.C.S. instead of those for the M.R.C.P., I would not dissuade him.

But, if he wants to be a Physician and a Der-

matologist, what type of individual should he be? As the reader will see in a minute, there can be opportunities for persons with many types of interest, but whoever wishes to be particularly a clinical dermatologist, then he had best be of the type who is interested in physiological medicine and what have been called "physiological diseases". For example, the work of a physician interested in diabetes is very akin to our's. This physician has to regard the whole patient, and not only certain parts of his endocrine system; he has to have a lot of patience; he has to teach the patient how to live with his disease, and how to treat himself; he has to be prepared to adjust his therapy from case to case not only in accordance with the man's reactions to several varieties of insulin, or other hypoglycaemic, but with the fluctuations in drug responsiveness or resistance which develop because of every-day incidents such as emotional upsets, infections, surgical operations, the taking of steroids and so forth. In a few words, the budding dermatologist has to be a patient and vigilant doctor, not colour blind, and with a considerable interest in therapeutics.

Probably the best introduction to the speciality is, at a suitable time, and not too early in one's career (preferably after holding both an H.P. and an H.S. job) to become an H.P. in a big skin department, for this enables one to make a quiet survey of what goes on and allows time for discussion with several individuals to discover the paths which they have found most rewarding.

Besides the clinical discipline, the seeing of patients, the exploration of therapy, and undergraduate and postgraduate teaching, what else has Dermatology to offer?

It is early yet, but obviously the recent breakthrough in Genetics is going to have its repercussions, and, so far as is known, there are few Dermatologists working in this field. There is here ample scope for many investigations, and it is likely that, as the area is relatively unexplored, pioneers will achieve some quite dramatic advances without undue effort; it is those who follow who will have to toil for small rewards.

For very many years the skin defied scientific -as opposed to clinical-investigation, for the scientist was faced with a membrane which had length and breadth, and almost no thickness. He had therefore nothing to work on. But recently the biochemists have discovered methods of dealing with the skin and its secretions, and a good deal of this has been pioneered in this country at Bart's. There is still much which has to be learned, not only in relation to the skin itself, but also about the hormonal factors which so greatly influence its activities. There is much scope for biochemical investigation, and in the future those who really have a flair for this work will not have too much difficulty in obtaining suitable appointments, provided they have real

A few posts in Histo-pathology are available. The work here varies very much. There are still some discoveries to be made with the use of special stains and an old fashioned microscope, helped by much knowledge, a real ability in Histology, and patience. And no skin department can function without a good histo-pathologist for its routine work. But in recent years two things have happened; firstly by the use of special techniques including the use of special stains (and also isotopes) biochemical investigations of great importance, particularly in relation to enzymes, have been made, and there is considerable scope for extending this work. Secondly the use of the electron microscope has considerably increased our knowledge of the structure and activities of the cells and other components of the skin, and has been used to study such diverse matters as the formation of melanin and the inward and outward permeability of the integument to fluids. The application of electron microscopy to our work should be an interesting and rewarding employment for several decades at least.

It has been said that in about 30 per cent. of our cases emotional factors are of paramount importance in the origin and persistence of eruptions, and at Bart's we rather pride ourselves not only on having had for many years, excellent relations with the Psychiatric Department but also for having carried on our own dermatological staff two psychiatrists who have achieved internationad eminence because of their work in this field. For as long as one can forsee, all big skin departments will be the better if they can have a competent psychiatrist prepared to fully liaise with them, and if possible to sit in at some of the clinics to learn something of the skin specialist's point of view. Both parties gain thereby, for the dermatologist learns not to guess

about the patient's emotional state but to assess it from a proper standpoint, whilst the psychiatrist learns quickly to adapt his techniques to the special requirements of the dermatological patient, and his outlook is broadened too.

There are five more openings which may be briefly mentioned. Firstly, physiologists have begun to study the activities and functions of the skin with considerable interest. Those who feel that clinical dermatology is interesting but who would like to make their names as academic physiologists would find scope for liaison with us at many centres. Similarly liaison with bacteriologists is helpful for both sides. There are in England a very few posts for mycologists, most of whom have close and cordial relations with dermatological departments; in certain areas abroad where deep fungal infections occur there are better opportunities for them than at home. Entomologists and others interested in Ectoparasitology are too far apart from us, and most of us would welcome a much closer link with this branch of medicine, particularly in regard to work abroad. That brings us to Tropical Dermatology which is a great field with opportunities in many parts of the world, always provided that posts become available to attract men of good calibre; hitherto the only incentives in many areas have been clinical interest and benevolence, but in time this will probably change. There are indications that matters are stirring a little and we can note, firstly, that whilst hitherto there has been an oppressive dearth of books written in English on Tropical Dermatology, now a few good ones are available, and secondly, that I. Marshall working under the auspices of Stellenbosch University and the South African Council for Scientific and Industrial Research is conducting an enquiry into the epidemiology of skin diseases in the whole of Africa, so in that Continent at any rate the field is being surveved.

It is difficult adequately to summarize a paper such as this. A surgical colleague has a story that when he visited a university centre abroad he watched an operating session; after two hours the operations were finished and the Professor said, with great relief in his voice, "That finishes the patients, let us now go and look at the dogs", and set off at a great pace for the Research Block. It seemed, said my colleague, that because the animal work offered much promise for advances in his speciality, the dogs were of more importance to the Professor than the patients. Metaphorically speaking, we too have our dogs, and have paraded them here for your interest and inspection.

# SOME NOTES ON THE WORLD HEALTH ORGANIZATION

by Noel Chilton, D.M.

#### Introduction

TT is fashionable nowadays to blame the United A Nations when things go wrong. Those who do so sometimes forget that the U.N. does a lot of useful things, quite apart from its efforts to prevent war. It promotes international cooperation through a number of Specialized Agencies such as the International Labour Organization (ILO), the Food and Agriculture Organization (FAO), the United Nations Educational, Scientific and Cultural Organization (UNESCO), and many others including the World Health Organization (WHO), in which over a hundred countries are working together to improve the health of the world's population. Russia is a member of the WHO, and there are some Russians and Chinese on the staff at the Geneva Headquarters. The numerous consultations which take place in these Specialized Agencies between members of countries possessing widely divergent political views are all aimed at the promotion of human well-being, and thus contribute indirectly to the preservation of peace.

#### Histor

The story of international health co-operation goes back over 100 years. From 1851 onwards there have been conferences between nations aimed at protection against epidemics of infectious disease. By 1900 several quarantine agreements between countries had been signed. In 1902 the American republics created a Pan-American Sanitary Bureau (PASB) whose object was to eliminate disease and thus improve trade between the republics. In 1909 the secretariat of the Office International d'Hygiène Publique (OIHP) was established in Paris, with 55 countries represented on its governing body. The OIIIP acted as a centre for the exchange of epidemiological information, in which it collaborated with the PASB and other bodies until the 1914-18 war put a stop to most of these activities. In 1923 the Health Organization of the League of Nations came into being. It differed from its predecessors in that, in addition to the organizing of quarantine measures and the exchange of information on epidemic diseases, it began to produce international standards for vaccines, sera and certain important drugs, and also to study nutrition, housing and other international health problems. One of the latter was malaria which at that time was widespread in parts of Europe as well as in the tropical countries. This useful work was interrupted by the Second World War, during which the United Nations Relief and Rehabilitation Administration (UNRRA) was set up. UNRRA's Health Division was given the threefold task of restoring national health services, providing medical care for displaced persons, and reviving the mechanism of international exchange of information on epidemics.

Finally, in 1948, WHO was founded and took over the health work which had previously been done by OIHP, the League of Nations and UNRRA. During the years the scope of international health policy had been widened. It was no longer a simple matter of setting up local quarantine restrictions to prevent the spread of epidemics from one country to another. The new idea was that of basing knowledge, experience and resources on a world-wide scale and of giving active assistance to countries engaged in improving the health of their own peoples.

#### Aims

WHO works on three fundamental principles:

1. Health is indivisible, and no country (or group of countries, or family, or person) is safe in these days of rapid, frequent and widespread travel.

2. The means and skills now exist for the cradication of most diseases and for the promotion of positive health.

3. Therefore it is the joint responsibility of all nations to put an end to inequalities in disease control and to help all peoples to attain the highest possible level of health.

It must be remembered in this connection that two-thirds of the world's population still live under appalling conditions. WHO is trying specially to improve the health services and to solve the health problems of these backward regions.

#### Administration

WHO is managed by a Director-General who is in charge of a staff (including field workers) of about 2,000, of over 60 nationalities. The Headquarters is at Geneva in the Palais des Nations, the house of the old League of Nations, but these buildings have been found too small to contain the secretariat staff which numbers about 700 in 1963, and a new building is under construction. There are six Regional Offices, each

under a Regional Director, and each responsible for work done in its own part of the world; these Regional Offices are at Brazzaville (for Africa south of the Sahara), Alexandria (for Eastern Mediterranean countries plus Pakistan), Copenhagen (for Europe), New Delhi (for South-East Asia), Manila (Western Pacific), and Washington (for the Americas). The Washington office is the headquarters of the old Panmerican Sanitary Bureau, which has assumed the functions of a Regional Office of WHO.

#### Finances and Policy

The Regional Offices receive advice and financial direction from Headquarters, but in other respects they are autonomous. They initiate most of the national health projects, the plans being put up to Headquarters and included, if approved, in the Budget of the World Health Assembly which is held each year, usually in May, and attended by representatives of all Member Countries. The budget in 1963 amounts to about 39 million dollars. There are about 120 Member Countries, each of which pays a share, calculated on a fixed scale which takes into account both the size and the wealth of the country concerned.

Obviously, with a budget of 39 million dollars, WHO could not possibly undertake to do all the health work needed in the world. The policy is to send out WHO staff for only limited periods, to show how a problem is to be solved, and to train local workers. When WHO undertakes to start a job, it is always agreed beforehand that the government of the country concerned will carry it on to a satisfactory finish and will bear the major share of the cost. The idea is to help countries to help themselves. WHO cannot impose its will on any government, and it cannot interfere at all unless it has been asked by a government to give its help to some project. When such requests are received, WHO usually sends an expert, or a team of experts, to the country where they make a survey, decide on what should be done, and draw up a plan of operation. If money is made available, WHO then initiates the work and trains local staff to continue it. In 1961 WHO was involved in over 800 projects in some 130 countries or territories.

#### Offensive Action

In the sphere of epidemic diseases WHO's functions are both defensive and offensive. The defensive functions are an inheritance from the past. They are concerned with such things as international quarantine at seaports and airports. Some of the old quarantine regulations

were unnecessarily irksome, and they used to vary considerably from country to country. No less than six Sanitary Conventions were signed between 1912 and 1944. WHO has now established a single set of sanitary regulations, which have been adopted in the laws of most countries. These regulations are designed to ensure the maximum ease of flow of international traffic compatible with the safeguarding of health. WHO issues bulletins of infectious diseases occurring anywhere in the world. They are broadcast daily from four wireless stations and weekly from a dozen others. A weekly bulletin of infectious diseases is sent to all countries by airmail.

WHO's offensive measures against epidemic diseases are a comparatively new departure. Their object is to control the diseases themselves, or even to eradicate them where possible. The biggest eradication job, involving thousands of workers, is now in progress against malaria. This disease, which is the world's most expensive one, has for many years rendered vast areas unsuitable for habitation, with a resultant crippling of industry, agriculture and education. In 1955 over 1,400 million people were exposed to malaria. The eradication programme is based on some simple facts. The female mosquito, after sucking blood, sits on the wall of the house before flying off to lay its eggs. If the inside walls of all houses are sprayed with a residual insecticide the mosquitos will die before they are able to reproduce. The mosquito population eventually gets so low that there are not enough left to carry on the infection. If the spraying is kept up for three or four years nearly all the malaria in the population will have died out, and what remains can be found and cured by treatment. Then, although the mosquitos will come back, there will be no malaria left for them to carry. There are, of course, many difficulties in carrying out this programme. The human element is responsible for some of them, for example, when the spraymen fail to spray all the houses in a district, or the staff of malaria detectors fail to find and treat all the cases left over after the spraying has been completed. There is the danger of reinfection by spread from an adjacent country after eradication has been achieved in one country; for this reason it is advised that neighbouring countries should combine together in a single programme of malaria eradication. In some parts of the world there are still cannibals and head-hunters who would not make agreeable hosts to the malaria staff! Worst of all perhaps, is the development of resistance to insecticides by strains of mosquitos which have been subjected to them. This is a highly complex subject. In general it may

be said that malaria eradication is a very difficult operation, but that seven years after WHO's effort began some 329 millions of the world's population had been freed from malaria, and another 737 millions were already being protected by eradication programmes.

#### Yaws and Tuberculosis

Offensive measures against yaws are in progress. This crippling tropical disease which formerly covered half the world, is associated with poor living conditions. By 1962 WHO and UNICEF had already cured 38 million cases by improving living conditions and by giving penicillin. Research is being carried out on new antibiotics and it is hoped that yaws will be eradicated. The same cannot be said of tuberculosis as regards the immediate future, but the signs are hopeful. The slow advance brought about by the improvement of living conditions has been dramatically accelerated since the discovery of Isoniazid in 1951. BCG vaccination campaigns organized by WHO have protected 140 million people in 58 countries. Where hospitals are few, WHO has established large-scale methods of outpatient treatment. 360 million persons have been tuberculin-tested.

#### Other diseases

Among the other diseases which are being attacked in the less developed countries are leprosy, trachoma, venereal diseases, rabies, undulant fever, bilharziasis, the dysenteries, smallpox, yellow fever and typhus. In the more advanced countries, WHO is specially interested in research on such subjects as poliomyelitis, cancer, heart diseases and the prevention of accidents. It has also set up an international network of laboratories to warn the world of the appearance and spread of outbreaks of influenza and to determine the strains of virus. Cultures of the virus concerned are made available to countries wishing to prepare anti-influenza vaccines for use before the epidemic reaches them.

#### Other work and training

Other work of high priority is concerned with environmental sanitation (safe water, disposal of wastes, protection of milk and food, insect con-

trol, housing improvements, prevention of air pollution), mental health and health education of the public. Infant mortality is 4 5 times higher in some countries than in others; WHO conducts a number of child health projects in collaboration with UNICEF (United Nations Children's Fund). It works with FAO on nutrition and with ILO on industrial health, including the health of seafarers. It has programmes of training for doctors, nurses, midwives, sanitarians and laboratory workers; in 1962 no less than 95 visiting teachers were sent out at the request of 38 governments. Training is provided also through the granting of travelling fellowships to candidates selected by their own governments. Those who accept fellowships must undertake to work for three years in their own country after their return. Advice is given by WHO, when requested, on the improvement of teaching in medical schools. Facilities for the exchange of scientific knowledge are provided by the organization of conferences, seminars, study groups and training courses. WHO has a library of its own, and a library service which has helped to build up or replenish libraries in countries where such facilities were deficient, by supplying books, photo-stats and microfilms. It also distributes its own publications.

#### The future

The ultimate aim of WHO is to attain the highest possible level of health for all peoples. Whether this level can be reached depends on the support given by men and women possessing not only experience and skill in the various branches of public health, but also an understanding of the Organization's international obligations. Member countries may often be called upon to make sacrifices by releasing, temporarily or permanently, medical and technical personnel who are also of great value to their own administrations, for the common good of mankind. WHO depends, in fact, on the support of its members, and also on intelligent public opinion. That is why I am glad to have been asked to write these notes which, however brief, may be of some interest to those who have at heart the well-being of millions of under-privileged people in all parts of the world.

#### Case Report: SURGICAL EMPHY-SEMA FOLLOWING LABOUR

by C. C. Frears and K. M. Stephens

History

Mrs. P., a primagravida aged 19, was admitted to

Thorpe Coombe Maternity Hospital in early labour. She was 7 days postmature. Her pregnancy had been normal throughout, except for slight oedema of the fingers at 34 weeks, and an upper respiratory tract infection at 37 weeks which cleared up without treatment.

Her past history included only an attack of jaundice at the age of 9. There was no history of any

chest disease in her or her family, and a chest X-ray within the last year was normal.

On examination she was well, her blood pressure 120/80, pulse 80, and urine normal. The presentation was Vertex Right occipito-anterior with the head

The first stage lasted 27 hours, during which time the patient was quite comfortable under pethidine sedation. The second stage progressed slowly, the patient being encouraged to bear down vigorously throughout. Gas and air analgesia were used. After one hour forty minutes there followed the normal delivery of a live female child weighing 7 lb. 5 oz. The third stage was completed in 10 minutes with minimal blood loss, and she was returned to the ward in good condition: temperature 99°; pulse 80; blood pressure 125/80.

Six hours later, during a staff round, it was noticed that she had swelling of the right side of her face. On questioning, she complained of mild dysphagia, slight dysphoea, and of dull pain over the sternum and both sides of the neck on deep inspiration. She had no cough or sputum.

On examination, she was not cyanosed or distressed. Her face appeared markedly swollen and on palpation crepitus was felt, extending from below both zygomata, down the neck and over the front of the upper half of the chest. The trachea was central, the chest moved equally and the apex beat was not displaced. On percussion and ausculatation, it was found that the area of cardiac dullness was markedly reduced and the heart sounds were accompanied by a peculiar crunching noise heard over the whole precordium. Breath sounds were normal, the pulse 96 and the temperature 99.2°.

A chest X-ray the same day showed air in the mediastinum but normal heart and lung shadows. A diagnosis of pneumomediastinum was made, and to prevent a mediastinitis she was given 500,000 units Benzyl Penicillin b.d.s. for 5 days, during which time the crepitus and swelling gradually diminished, leaving the patient symptom free.

One month later she was seen again and showed no evidence of her previous condition.

#### Patho-Physiology

Acute mediastinal and subcutaneous emphysema may follow any sudden, violent and prolonged expiration against a closed glottis. It can thus occur during a severe bout of coughing or the straining of labour.

Machlin (1939), by over-inflating the lungs of cats, demonstrated the mechanism concerned. After sudden overdistension of the pulmonary alveoli, air escapes through a rent in the lung parenchyma to cause a local interstitial emphysema. If the intra-alveolar pressure is maintained, further air escapes into the interstitial tissue and tracks along the sheaths of the pul-

monary vessels into the mediastinum. Alternatively, the air from the interstitial tissue in the periphery may reach the mediastinum by dissecting off the visceral pleura.

The pretracheal and prevertebral fasciae are continuous at their lower ends with the anterior and posterior walls of the mediastinum respectively. The air is originally enclosed within these two layers, but with increased pressure it escapes through the loose connective tissue surrounding the great vessels into the posterior triangle of the neck and Burns' space. The air is now beneath the general investing layer of deep cervical fascia and can enter the subcutaneous space through numerous venous stomata.

The peculiar crunching sound heard over the precordium, the diagnostic sign with which Hamman's name is associated, is due to the heart contracting against collections of air lying between the parietal pericardium and parietal pleura.

#### Discussion

The occurrence of air in the subcutaneous tissues is an interesting and unusual complication of labour.

In 1927 Charles Gordon reviewed the 130 cases of "respiratory emphysema" recorded until then. With reference to these, our case seems typical. The patient—a young robust primagravida; the labour—prolonged and accompanied by strenuous bearing down. Typical also is the complete recovery within 7-12 days with subsidence of symptoms and signs.

Since Gordon's series, there has been little reference to the condition in the British and American journals. However, in such references as have appeared, the effort of bearing down seems to have occupied a definite place in the aetiology. It is interesting that, in one case, the patient became so distressed that it was necessary to release the air through an incision over the manubrium sterni.

The condition was probably not unknown to early medicine. Louise Bourgeois, midwife to the Queen of France, publishing her "Observations" in 1617, may have referred to it when she wrote:

"I saw that she tried to stop crying out, and I implored her not to stop, for fear her throat would swell."

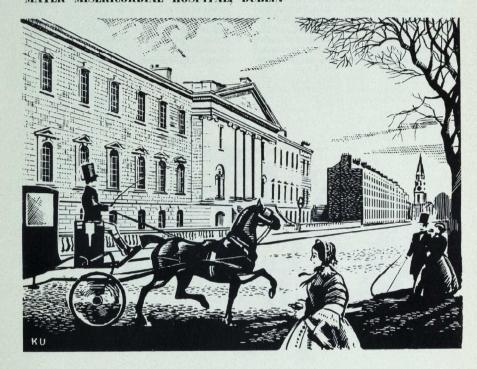
#### ACKNOWLEDGEMENT

We would like to thank Mrs. Bryson, consultant to Thorpe Coombe Maternity Hospital, for permission to publish this case.

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# OTHER HOSPITALS: 2 MATER MISERICORDIAE HOSPITAL, DUBLIN



In 1831 Catherine MacAuley founded in Dublin the Congregation of the Sisters of Mercy, now the second largest order of women religious in the world

In 1843 seven sisters set out for the new world to found the first American House of Mercy in Pittsburgh from which in turn was established the Convent in Chicago in 1846. In 1845 a convent was opened in London in Bermondsey. In 1854 fifteen of the sisters from the Irish House and six from Bermondsey went to the Crimean War where they served in the military hospitals under the direction of Florence Nightingale.

Within the next decade these three groups established hospitals, one in Chicago from which

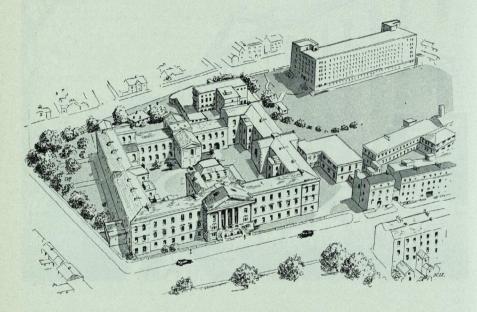
was derived the Mercy Hospital which attained world-wide recognition from its association with John B. Murphy: one in London, the Hospital of St. John and St. Elizabeth, and one in Dublin, the Mater Misericordiae Hospital.

The Dublin site was a remarkable one. It was fifteen acres in extent at the top of Eccles Street, then unfinished, and at the extreme north west end of the city which was enclosed at that time within the canals. It has provided space for expansion up to the present and foreseeable future.

At the end of the eighteenth century the Georgian architects and town planners were turning their minds from squares which were such a feature of their buildings, to curved forms, crescents and circles. These may be seen in great

magnificence in Bath. Francis Johnson, who lived in 64, Eccles Street, and who was the last of the great architects of the period, was entrusted with the plan for a large elliptical circus to round off the unfinished street and to complete Georgian Dublin with a magnificent prospect on this high northern ground. The union between Great Britain and Ireland, which transferred the seat of the Irish Government from Dublin to London made the financial success of the project doubt-

Anatomy and Surgery chiefly and had no definite hospital liaison. So the Dublin Hospitals at that time, and indeed down to very recent times, were separate clinical teaching units, teaching students from the private schools as well as those from the Royal College of Surgeons, from Trinity College and later from the Catholic University School. They provided resident accommodation for students as well as for house officers and this resident apprenticeship of students was a feature



ful and the growing popularity of the south side of the city put an end to the scheme.

In the eighteenth century and continuing down to the middle of the nineteenth century there were a number of private medical schools in Dublin, sometimes as many as six or seven teaching at the same time. Their students were qualified by passing the examinations of various Boards set up for ad hoc examinations to recruit surgeons to the Royal Navy and to the armies waging the Peninsular War and to the various county infirmaries in the country. They could also present themselves for the examinations of the Royal College of Surgeons in Ireland.

These medical schools were schools of

of Dublin clinical training until the internship of recent years crowded them out.

The fifth decade of the nineteenth century was a period of ferment and wide changes in the medical profession. In 1858 the first Medical Act to control the profession of medicine, to govern the education of future doctors, and to compile a register became law. The new hospital was built when these regulations came into force, and during the same period the establishment of a Catholic University under the Rectorship of Dr. Newman was being undertaken in Dublin

There were several private schools in the City at this time and amongst them was the school of the Apothecaries in Cecilia Street, which had been opened in 1837 and where Andrew Ellis was Professor of Surgery. In 1854 as its membership was falling off and its qualification was losing its attractiveness in view of the new legislation looming ahead it was decided to close the school and to sell its building and such equipment as it contained. It was bought by Ellis, who was then Senior Surgeon designate of the new hospital, as many thought to establish a private school, but actually on behalf of Newman.

The Mater Misericordiae Hospital was thus through Ellis and Thomas Hayden closely connected with Newman's Catholic University Medical School and after the failure of the University continued as a private school qualifying its stu-

dents through the Conjoint Board of the Royal Colleges and later through the Royal University.

The National University of Ireland was established in 1909 and Newman's school became the Medical School of University College, Dublin, one of the constitual Colleges of the University.

Some years ago the arrangement by which Dublin Hospitals were free clinical teaching institutions with loose affiliations to the qualifying bodies was seen to be out of place in the modern world. Consequently, a formal agreement was entered into between University College and the Hospital Authority by which the hospital became a part of the Medical School of University College, Dublin.

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# CHRISTIAN VIEWPOINT—An incurable cancer.

## The story of Dr. Jimmy Griffiths

by Revd. Dr. H. W. Guiness.

I received a telephone call one day from a lady asking me to go and see her son in Hospital. She told me I had met him years before at "King's School", Parramatta, when visiting Australia in 1930. He was about to undergo his third operation for spreading carcinoma which had now entered his spinal column. I told her I

would go at once.

The Royal Prince Alfred Hospital in Sydney stands close to the great west road leading to the Blue Mountains. I went round there during the day and was told that Dr. Griffiths would see me. He was sufficiently free from pain at the time and talked quite freely of the old days and his experiences of life since then, but explained to me quite frankly that he was an agnostic and found no comfort in any religious faith. After this I dropped in each day, usually at night and we got to know each other very well. His life story was most fascinating. At school he had been mainly interested in science and there had been no conflict between this and his Christian faith. Indeed at this time he had discovered Christ as a personal reality and had started to serve Him. But when he got to the University and started his medical course he found that the prevailing atmosphere of scientific materialism made faith impossible since he had none of the answers to the questions propounded by his professors. He graduated successfully and went into General

He was a very popular figure in the country town where he lived and worked as he took a great deal of interest in all social affairs. He would even be seen taking his projector to show some film to a Boys' Club or Old People's Home. He was in great demand everywhere not only for his professional skill, but also for his generous nature and love of humanity. His wife and children adored him.

Then came the discovery of carcinoma, his

first operation, and the period of a few years freedom. This was followed by a second operation. More freedom followed and now, three years later, he was facing what looked like his final operation with only a short expectation of life in front of him. As we spoke late one night of the Christian faith and Christ's ability to meet every need of the human personality he said to me with a rather despairing look, "But I do not believe in Him! I wish I could!" "Have you never read the evidence?" I said. "Which makes it a much more reasonable thing to believe in Christ than not to believe in Him." "What evidence?" he replied. "Why the evidence of the resurrection." "I have never heard of such evidence," he said. "Where is it?"

The next evening when I came to see him I brought with me a little book entitled "The Evidence of the Resurrection of Jesus Christ", by Professor Norman Anderson. He asked me to sit down by his bed and read it to him. After I had read several pages he stopped me with these words, "That's enough, I am absolutely convinced. There seems to be no doubt that Christ rose from the dead. What must I do to become a Christian again?" We talked together about repentance and faith, turning away from all known wrong, and the willingness to give up the right to oneself, and all that Christ did for us on the cross nineteen hundred years ago. He accepted the truth that Christ had carried his sins on the cross so making forgiveness possible, and he opened his life to the living Son of God in a simple act of surrender. We prayed together and I went home.

The next day Sister said to me, "Dr. Guiness what has happened to Dr. Griffiths? He is a changed person." He was. He possessed a serenity and peace which defied all analysis and never left him until a few months later when he passed into the presence of his Master.

I took the funeral myself and the whole town was there. The church was packed to the doors. In his death he gave his neighbours a more personal message than he had even done in his life. They cannot forget the story of his discovery of the One who said, "I am the resurrection and the life. He who believes in me will never die."

# BOOK REVIEWS NEW PENGUIN BOOKS

Cop Hater, The Con Man, The Pusher, The Mugger by Ed McBain, published by Penguin at 2s. 6d. each.

Ed McBain is a writer new in this country and these four paperbacks, which Penguin have published simultaneously, appeared in America in 1956 and 1957. It is impossible to review any one of them without reference to the others for each is an episode in a series in which the principal characters are the same and only the situation is different. In the blurb on the back of these books we are told that Mr. McBain has written material for television and one can feel this all the time when one is reading the books, for if there is one keyword which describes them, it is "graphic". This is a writer who is accustomed to producing fast-moving episodic dialogue, terse and racev. The central characters are a group of detectives in a precinct in an unnamed American city which is probably New York. Each book deals with one problem that they have to face, one crime which they have to solve. Factually and in detail we are shown how they work. The emphasis throughout is placed on the minute description of police method, even to the extent of the reproduction of fingerprints and sections from case-files. I have usually found this type of mystery writing tedious, for example, in the hands of Freeman Wills Crofts and J. J. Marric, but McBain does this with tremendous attack and vitality and one finds oneself fascinated and sometimes excited as the story un-

What distinguishes these stories is the feeling the reader gets that McBain's policemen and crooks and bystanders are real people leading real lives and not dilettante antique - collecting amateur sleuths or grizzled inspectors from Scotland Yard whose personalities reside largely in the outsize pipes that they clench between their teeth. These are real cops, doing a real job of work in a professional way. The feeling one gets is much the same as that produced by "Z Cars" and it is McBain's ability to deal with commonplace things in a vivid way that makes the books so real. His detectives remind one of that model described by that great master crimewriter, the late Raymond Chandler. They are poor, hard-working, comparatively honest, cynical and, above all, completely professional. Mc-Bain is also completely professional. I enjoyed these books very much. I hope there are more forthcoming.

T. J. McElwain.

One Day in the Life of Ivan Denisovich by

Alexander Solzhenitsyn. Penguin 2053. 3s. A sensation was caused by the publication of this book in Russia. It is rumoured that Kruschev himself authorised the publication of it. It is, as the title suggest, the story of one day in the life of Ivan Denisovich Shukov, who is an inmate of a long-term labour camp in Siberia in the time of Stalin. The camp life is described in minute detail, including the desperate efforts of the prisoners to live off the food they receive and their attempts to keep warm in the bitter climate of a Siberian winter. Their work on a building site is described also.

In a book of this nature it is obviously possible that the political significance is greater than any literary merit and that in assessing it as a work of literature one must be very careful. However, it is beautifully written in a terse crisp manner reminiscent of Hemmingway and it has been likened to Dostoievsky's Memoirs from the House of the Dead. The book shows the knowledge gained by the author during his stay in one of these camps and is more like an extended short story than a novel. One hopes that he will produce more works of this calibre.

The New Cold War — Moscow v. Pekin by Edward Crankshaw. A Penguin Special. 2s. 6d.

For over five years there has been a new Cold War simmering between China and Russia. Most commentators seem to have paid scant attention to this until now, merely dismissing it as something minor. Edward Crankshaw, the Observer's correspondent on Soviet affairs, has been writing about it for some time, and in this book he traces the development of the basic ideological differences from the fundamental attitude to Revolution in the two countries and follows the quarrel from the 20th Party Congress of 1956 to the two World Conferences in Bucharest and Moscow in 1960.

This is a particularly lucid account of the differences between Russia and China and Mr. Crankshaw leads us ably through the mass of Communist clichés and woolly thinking making some of the speeches sound almost interesting. At no time does he depart from his historical approach in order to speculate. He allows himself an occasional ironical reference to some of the Communist tenets of belief, but apart from this there is little relief from the intricacies of Communist dogma and philosophy. His conclusion that Communism can no longer be regarded as a single World Force has perhaps yet to be more fully appreciated.

Richard Swain.

#### **OTHER REVIEWS**

Manual of Obstetrics by Alan Brews. 12th Edition. 61 plates. 388 illustrations. 792 pages. J. & A. Churchill. Price 90s.

This book, which was first produced in 1906, remains a classic and a monument to the conservative approach to obstetrics in the British Isles. There have been twelve editions which have always been rewritten and revised by a member of the Consulting Staff at the London Hospital. Mr. Alan Brews has brought the present edition to the highest standard of efficiency and erudition and he is an illustrious successor to his colleagues of the past.

It is difficult to find fault with this volume. It is so large and full of detailed information that it should be purchased not only by the medical student but, also, by the general practitioner obstetrician. When the price has been paid, the possessor will have an excellent reference book for years to come for there is a good deal more in it than is necessary to pass the qualifying examination in obstetrics.

The general format is good and the standard of illustration and microphotography is very high. The text is easily understood and the type is excellent. There have been no radical changes in the practice of obstetrics since the last ediiton, but a great deal of new knowledge, new techniques and new therapy have been described which brings the book completely up to date. The section on the foetus and the neonate has been re-written by Dr. Richard Dobbs and comprises 130 pages which emphasises how rapidly knowledge about the newborn child is growing.

The book is highly recommended, based as it is on a traditional and conservative approach to obstetries which is refreshing to read in 1963 when the art of obstetrics seems to be disappearing in the face of a massive surgical onslaught.

J.B.

Modern Gynaccology with Obstetrics for Nurses by Winifred Hector and Gordon Bourne. Third Edition. 241 pages. Heinemann. 17s. 6d.

This book is well known to the nursing staff at St. Bartholomew's Hospital and in many other nursing centres. The familiar green dust cover is easily recognised on the desk and a lecturer attempts to keep on the straight and narrow path when he sees a nurse furtively refer to the book to confirm or refute what has just been said.

This edition is of special interest because it provides new knowledge in obstetrics and care of the baby in view of the three months' obstetric course which is now incorporated in the general training of nurses in many centres.

The book is kept up to date with added information about anuria, radiotherapy, cytotoxic drugs and venereal diseases.

The authors have done well to pack so much knowledge into 214 pages and it is up to the nurse to learn it all and so obtain a defensive knowledge of gynaecology and obstetrics to add to her nursing of the patient which is her most important duty.

Diseases of the Ear, Nose and Throat in Children by T. G. Wilson (Wm. Heinemann Medical Books, Ltd.). 75s.

Mr. Wilson's book is to be welcomed. It has filled a niche in English otolaryngological literature. It is well written and is intended for otolaryngologists in training. Drawing on his immense experience at the National Children's Hospital he describes in detail the problems peculiar to children. It is well bibliographied and this second edition has been brought up to date. There are new sections on cholesteatosis of the middle ear and speech defects. Although of primary interest to otolaryngologists, paediatricians and other workers with children will find it helpful.

It is always a pleasure to recommend a text book that is easy to read. This is the hall-mark of the care taken in writing. Dr. Wilde, the father of Oscar, was a distinguished otologist in Dublin and Mr. Wilson has clearly come in for both the literary craft and the professional skill of the Wilde's. There are very few misprints in this edition and the illustrations are very good, many being from the pen of the author.

The Prevention of Cervical Cancer by H. C. McLaren. 122 pages. 44 illustrations. The English Universities Press. Price 21s.

This is a short instructive book on the diagnosis of pre-invasive carcinoma of the cervix and the author relates to this, as an awful warning, the tragic 5-year survival rate of the more advanced cases of established carcinoma in this region. The emphasis is almost entirely on the diagnosis by the cytological smear technique although mention is made of the colposcope and the micro-colposcope—only to point out that this is an expensive, highly skilled and less satisfactory way of making the diagnosis in the pre-invasive state.

Professor McLaren writes in an ebullient and racy manner which is diagnostic of the man for those who know him. The purist might criticise the pictorial efforts of angels sprouting horns to depict an innocent cell becoming a malignant one but the micro-photographs and coloured pictures of cytological smears are of the highest order.

This small book is presumably written to stimulate the general practitioner to take an interest in the subject and to co-operate in screening the whole female population in this country if and when money is available, unless a simpler and cheaper method is forthcoming in the future.

Garrod's Inborn Errors of Metabolism. Reprinted with a supplement by H. Harris, Professor of Biochemistry, King's College, London. Oxford University Press, 1963. 207 pages. Price 42s.

Garrod's Inborn Errors of Metabolism is rightly regarded as a classic which has a special place in the history of medicine. It can properly be considered as one of the foundations on which our modern knowledge of both human heredity and biochemical genetics is built. A measure of its importance is that, although published over fifty years ago, the concepts formulated in it have served as a greater stimulus to medical research during the last decade than at any time since its publication.

It has long been out of print and difficult to obtain and the present re-issue under the editorship of Professor Harris is most welcome. It will be of special interest to Bart's people because Garrod was the first director of the Medical Unit here when it was established in 1919. Moreover, modern aspects of Garrod's work are continued as an important part of the research under the present director.

The interest and usefulness of the present reprint are greatly enhanced by the inclusion of the relevant portions of Garrod's key paper in the Lancet (1902) on alkaptonuria and by a sixty-page essay by Professor Harris on "The Inborn Errors Today". In spite of the modest disclaimer that this ". . . is intended simply as a rough guide to some of the avenues along which the study of inherited metabolic disease and of human biochemical variation have advanced since Garrod . . .", it is the masterly survey that we have come to expect from this well-known expert. One piquant piece of information remarked upon by Harris is that the inherited lack of the enzyme homogentisic acid oxidase postulated by Garrod as the cause of alkaptonuria was only demonstrated experimentally as recently as 1958 by La Du and his colleagues! In general Harris is mainly concerned to point out the wide application of the "recessive gene-missing enzyme" concept and to show how this can be generalised to include not only quasi-enzymic processes such as the idiosyncrasy in kidney amino acid transport involved in cystinuria, but also the variance in the synthesis of non-enzymic proteins such as occurs in the haemoglobinopathies. It is an important contribution to modern scientific medicine and well worth a reading by clinicians and biochemists alike

Scientific Books, Libraries and Collectors (by) John L. Thornton and R. I. J. Tully. Revised, second edition. The Library Association. London. Pp. 406-626. [516. to Library Association mambers.]

406. 68s. (51s. to Library Association members.) This new edition of an already well-established bibliography makes a welcome appearance in the world of scientific literature. It has been thoroughly revised and considerably expanded, containing a wealth of new and up-to-date material.

The book covers the development of scientific literature from earliest writings to the present day, and includes chapters on scientific books; scientific societies; scientific periodical literature; bibliographies and bibliographes; private scientific libraries and scientific publishing and bookselling. Most of the chapters have been rewritten and many more individuals included who were omitted from the first edition.

The profusion of footnotes and the extensive bibliography—covering fifty-six pages—give ample opportunity for further reading and study for those requiring authoritative literature. The index has nearly doubled in size to include many more subject entries.

Several new plates have been added.

This work "reveals a wealth of material on certain aspects, but also suggests 'bibliographical gaps' that await exploration and exploitation". It is to be recommended to students and collectors of scientific historical literature as a worthwhile addition to their book shelf.

S.R.M.

Courage Her Passport. The story of Marie Augusta Krauss (alias Mary Josephine Van Hauweart), as told to and written by H. A. Morton Whitby. 204 pp. Frederick Muller, Ltd. Price 18s.

204 pp. Frederick Muller, Liu. Frice 10s.

The subject of this book is obviously a most courageous woman, and the details of her exploits during the war remind us of the horrors undergone during that period by prisoners of the Nazis. It is similar to other accounts published during recent

years, although the excessive use of dialogue makes parts of it read as fiction. The subject of the book is the wife of Mr. H. A. Morton Whitby, who has recounted her story, which probably might have been better told in her own words. The facts are too dreadful to need any embellishment, and we wonder if anything is gained by their being frequently repeated. Possibly not, unless there are still people who are unaware of the bestial nature of war, and its terrible effects upon men and women of all nations.

Three Hundred Years of Psychiatry, 1535-1860.
A history presented in selected English texts.
(By) Richard Hunter (and) Ida Macalpine.
London (ecc.), Oxford Unversity Press. xavi,

1107 pp. 84s. Historical writings are primarily one person's interpretation of events, based on documentary evidence, the writings of other historians, the lives of individuals, contemporary evidence in the form of writings by other scientists, and the subsequent evaluation by successors. A good medical biography should condense the results of investigation into the biographee's pedigree, his background, education, training, professional career, writings, and their impact upon the contemporary scene and possibly upon the future. A general history of a medical subject condenses the lives and achievements of many persons between two covers, and the broader the subject the greater the condensation. This tends to conceal individual achievements, and important persons and events are frequently omitted altogether.

The history of pyschiatry has received little attention until recent years, and no attempt has been made to provide an adequate, documented survey of the entire field. The literature is vast, and is by no means confined to the writings of persons recognised as psychiatrists in the modern sense of the word. This fact has been appreciated by the authors of this monumental tome, covering a period of three hundred years, and entailing several years of intensive research in libraries, record offices, among wills, parish registers, death certificates and other manuscript material. It has involved investigating dates of birth and death and other biographical material, and bibliographical searches into dates of publication, issues and editions. This selected readings in the history of psychiatry contains writings by cranks and quacks, laymen and clergymen, as well as by physicians and surgeons, many of them containing germs of theories to be aired later. Many of the extracts when the appetite for more, and this book contains material and ideas to fill several more volumes.

The headings include authors' names, dates of birth and death, qualifications and chief appointments. Extracts from their writings follow short introductions, and facsimiles of title-pages, letters, certificates and similar illustrations add enormously to the value of the text. We meet several unexpected characters in the psychiatric arena: John Hunter, William Withering, Erasmus Darwin, Jeremy Bentham, Charles Dickens and John Snow, for example. Several Bart's men noticed include Peter Turner, William Harvey, George Kerr, Sir William Lawrence, Charles West and Robert Gooch, while there is also William Salmon, "who practised at one time near St. Bartholomew's Hospital to catch patients who could either not be admitted or were discharged uncured".

A Modern Textbook of Personal and Communal Health for Nurses by M. A. Priest. Published by Heinemann. Price 15s.

This useful book, in a revised edition, with an improved if rather longer title, is welcomed by nurses and their tutors. It is the textbook of choice for so many because it gives the information that nurses necd, with a simple but sound explanation. The text also covers their syllabus for Part I of the General Nursing Council's Preliminary State Examination, and this book should prove popular when the proposed new General Nursing Council syllabus is brought into effect.

The changes and additions throughout this second edition, especially with regard to Domiciliary Health and Welfare Services bring these sections up-to-date. There is need for constant revision here bringing the attention of the nurse to the changing needs of individuals and groups in the community.

All readers will appreciate the giving of temperature readings in Fahrenheit and Centigrade scale and measurements in Metric and English systems.

M.M.E.

Principles of Rehabilitation by W. Russell Grant. Publishers, E. & S. Livingstone, Ltd.

The number of people with physical handicaps seems likely to increase, since more now survive congenital misfortunes, cerebro-vascular accidents and traffic mishaps. Decreasing their dependence on others must therefore increase the sum of human happiness for the patients and their families, and Dr. Russell Grant's work in this sphere is well known.

Nothing is too large or too small for attention, from purpose-built houses to gadgets for turning keys, and for all but the least items the cost is given. All the voluntary organizations and the statutory sources are listed from which assistance can be obtained for infants, schoolchildren and those in need of resettlement.

The chapter on aids to personal independence is excellent, and the patient's needs in each respect are carefully analysed, and helpful ideas put forward. He writes, "It is not sufficiently appreciated how embarrassing it is for a person to be dependent on the help of others for the evacuation of howels and bladder. Approximately a thousand times a year such an individual is subjected to the indignity of asking some-body else to help, and in my experience no other form of independence is more appreciated by patients than in this matter". This is undoubtedly true, and that Dr. Russell Grant expends four pages of his small book on this topic shows that he has the problems of the handicapped in true focus.

W.E.H.

The Nurses' Dictionary, revised by P. J. Cunningham. Published by Faber. Price 7s. 6d.

The new binding of the 25th edition of "Honnor Morten" is a pleasure both to the eye and the hand. The lettering, and the proportions of the design both on the front and on the spine are excellent, and will doubtless help to sell many copies of this old favourite which has been modernised by Miss Cunningham without changing its familiar format.

Aids to Medical Nursing by Marjorie Houghton and Mary Whittow. Publishers: Ballière, Tindall and Cox. Price 8s. 6d.

This paper back has two new authors, both well-known in their own fields. One is an educationalist

and the other is a ward sister, and this seems a very good combination to write a book for student nurses.

The sixth edition has been completely re-written, and provides a sensible non-academic book at a reasonable price for the student nurse. It is very hard to decide what to leave out when writing on such a big subject, and one should not complain if the choice is not similar to one's own preferences. It does, however, seem unduly cavalier to dismiss the physical treatment of psychiatric disorders in two lines.

Proof-reading has been well done, and only one error was noticed (page 196, line 3). The book opens far more readily than most paper backs, and though the type is small it is not hard to read.

W.E.H.

Medicine for Nurses by W. Gordon Sears, M.D. (Lond.), M.R.C.P. (Lond.). Publishers: Edward Arnold, Ltd. Price 24s.

Dr. Gordon Sears has issued nine editions of this medical textbook in the last twenty-eight years, and he has certainly written a winner. His work is conscientious, carefully and frequently revised, conservative in outlook and encyclopaedic in scope. He began writing textbooks for nurses when there were very few authors in this field and has remained a household word ever since. This new edition does not differ in any major way from the last, and will be just as successful.

WEH

A New Way With Old Leg Ulcers by Stanley Rivlin Publishers: Pitman Medical. Price 10s. 6d.

This is a booklet written by an enthusiast who believes firmly that any leg ulcer is curable provided the patient will co-operate in his method of treatment. It very closely resembles the Bisgaard treatment, about which much enthusiasm is felt by physiotherapists.

Since the author is mainly addressing the district nurses who see most ulcers, his easy unacademic style may be an advantage. His instructions are clear, detailed and practical, and are reinforced with some excellent diagrams. He does not hesitate to recommend proprietary brands of bandages, shoes and stockings. General practitioners ought to read it as well as nurses, for even if not everyone gets the same results as the author, his methods are rational and offer hope to all ulcer patients.

Aids to Clinical Pathology by M. G. Rinsler. Third Edition. Publishers: Baillière, Tindall and Cox. Price 12s. 6d.

This little book bears evidence, at least in the first chapter or two, of being inadequately thought out. The author fails to stick to the subject, tending rather to overdo the morbid pathology and physiology; on the kidney alone there are four pages of pure physiology. Some important subjects are not accorded the space they deserve. Diphtheria, for example, is given three times the space allotted to chronic bronchitis, and almost as much is written on phenylketonuria as on acute glomerulonephritis. A little judicious pruning would not have been amiss.

In spite of these drawbacks I learnt a lot from this book and consider it well worth reading—but as an introduction to the subject rather than for revision.

Nursing Care of the Anaesthetized Patient by Frank Wilson, M.B., B.S., F.F.A.R.C.S., D.A., D.C.H. Publishers: Blackwell Scientific Publications. Price 10s. 6d.

The aim of this small book is the safety of the patient undergoing anaesthesia through knowledge and understanding by the nurse.

It is well set out and clearly illustrated but very expensive (10s. 6d.) and only covers very simply the basic care taught the student at an early stage of her training. The sections that might prove particularly valuable are on care necessary in the use of diathermy and the nurse assisting with infant induction.

The suggestion that a nurse should support both sides of the jaw until the patient can talk is not practicable, in transit yes, but one nurse has frequently to observe and care for a group of post-operative patients.

Shold the student nurse try to carry out the technique illustrated in Fig. 27, I feel disaster may result from insecurity of balance.

This booklet might have been more valuable if points regarding the post-operative care of patients following the use of hypotensive or muscle relaxant drugs had been given.

B.F.C.

The editor will be pleased to have the name of anyone who would like to be considered when the Journal distributes books for review.

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#### SPORTS NEWS



[The Captain of Boats does not know a great deal about the splendid cup in this picture, but it is quite certain that it was not won by the rugger eight!—Sports Editor.]

A BOAT CLUB TIE

The Boat Club undoubtedly boasts the most handsome tie of any Club in the Hospital. The pride with which its members wear it is both sporting and sartorial. Its wearers—as is well known—have to adhere to a code of ethics at least as strict as that of Hippocrates and in addition they must prove their physical courage in such fearsome initiation ceremonies as the U.H. Bumps and the Head of the River.

To Mr. Jack Gallagher—a native of Denver, Colorado despite his name, and lately registrar to Mr. Badenoch—it was the second of these requirements which proved insuperable. For by the time he had discovered that in Britain a tie is not only an adornment but an important physical sign, the rowing season—so far as the Bart's Boat Club was concerned—was over.

The silly season, however, was just beginning, and if Mahomet could not go to the mountain, then obviously the mountain must be brought, by force if necessary, to Mahomet. The Grand Challenge Trophy for Tub Fours was thereupon instituted and scheduled for Saturday, 27th July, at Putney.

On arrival at the London Rowing Club they found first that all other competitors had unaccountably scratched and were nowhere to be seen. Secondly, the massed fleets of Enterprises and G.P.14's preparing for the Tideway race made it impossible even to go for a swim, let alone launch a boat.

To Chiswick then, where the stoutest and most stable tub four was selected, and, with due regard for its age and dignity, reverently laid on the water. Watched with commendably little alarm by Mrs. Gallagher and her two energetic children, they set off in bright sunshine and perfect calm to position themselves for the row-over.

"You find ruptured tendo-achillis in sheep trying to be lambs," Mr. Farrow had said. If they thought such thoughts, they kept them to themselves, paddling firm with increasing confidence and ever-diminishing ataxia. The cox—his stentorian roar mellowed by compassion and a faint desire to laugh—made appropriate noises, "pour encourager les autres". The final effect was one of counterpoint with a marked cross-rhythm every four bars (or strokes).

Turning at the gasworks, they gathered themselves for a full rowing start—several times in fact—and finished the course in a record time for the event. Justly proud, they drove in procession to the City Barge, where victory was celebrated and Anglo-American relations firmly cemented.

Mr. Gallagher has his tie, and the Boat Club has another member. It was suggested that he should wear the tie only in those lands not under the dominion of Her Britannic Majesty and her heirs, apparent and presumptive. Alas, the passage of time would make such a condition only too easy to observe.

Crew: Mr. J. Gallagher, Bow; I. H. Wan Ping, 2; D. L. Hunter, 3; K. M. Stephens, Stroke; C. L. Brewer, Cox.

Many congratulations to the Tennis Club for reaching the final of the United Hospitals Cup competition for the first time. Guy's managed to beat us—but only after six close-fought matches. Last year Bart's reached the semi-final, and lost narrowly to King's College Hospital. This year the team beat St. Thomas's Hospital, last year's eventual winners, on the way to the final. Guy's have now won the cup eight times, and St. Thomas's twice. Credit must go to the hard work and sound play put up by the team. Cup Team: A. Edelstone; A. Frank; D. Latham;

M. Fryer; E. Carden; S. C. Kohli; P. Mitchenere.

#### ATHLETICS CLUB REPORT UNITED HOSPITALS CHAMPIONSHIPS, 12th-15th JUNE, 1963

This year the championship was won by St. Thomas's Hospital with Bart's 3rd. This result was very satisfactory since it was the highest Bart's have been since 1950, when, with the help of Olympic gold medallist A. S. Wint, they won the Shield for three successive years.

Unfortunately, we had no Olympic runners to call on, but D. Tunstall-Pedoe and P. Littlewood, who are currently running for London University, gained victories in the three miles and one and a quarter miles steeplechase respectively. These were very good wins and both athletes ran superbly against strong opposition. Although they were the only first places gained by Bart's athletes, they were nevertheless encouraging. We gained places in the final six of every event, except the 100 yards, 220 yards and 400 yards.

On the Wednesday evening, which was hot and sunny, it became apparent that while we had failed to secure any qualifiers for the finals of the shorter distances, we were in a much stronger position than previous years. This was emphasised by D. Tunstall-Pedoe's fine win in the three miles in 14 mins. 43.2 secs., supported by

T. Foxton in 5th place.

Saturday afternoon was also fine, and started with the useful performance of B. Scott in the 440 yards hurdles. He came 4th in a personal best time of 57.8 secs. Scott, who had already gained 5th place in the high hurdles on the Wednesday night, has proved to be a versatile athlete. As the afternoon passed on, Bart's position in the competition became very precarious. Westminster and St. Mary's were very close and fighting for third place, Guy's and St. Thomas's being 20 points ahead, jostling for first place. At one stage, Bart's had dropped back to fifth place and despite a fine time by P. Littlewood in the steeplechase (6 mins. 24 secs.) with T. Foxton 3rd in 6 mins. 43 secs., and also an excellent performance by K. Rawlinson who came 2nd in the javelin with a throw of 171 feet 8 inches, the issue was still in doubt. The medley relay was the event which was to judge who should take 3rd place in the Championship.

D. Tunstall-Pedoe started in grand style, with the 880-yard leg, and gave us a 10-yard lead. In the next two legs (220 yards cach) this lead was reduced in spite of some fine running by Niven and Goodall. B. Scott, in the last leg, 440 yards, had a small lead, and although he ran his best time for the quarter-mile, he was unable to hold it. Nevertheless he held off a challenge from St. Mary's and ensured third place.

Mention must be made of the Tug of War team which, under the able leadership of J. Gibson, did very well against St. Thomas's, the eventual winners.

. .

#### Results

T. Foxton:

3rd Steeplechase, 6 mins. 43 secs. 5th 3 miles, 15 mins. 43 secs.

4th Mile, 4 mins. 25 secs.

D. Tunstall-Pedoe: 1st 3 miles, 14 mins, 43.2 secs. 2nd 880 vards, 1 min. 56.9 secs. 2nd Mile, 4 mins. 19.5 secs.

P. Littlewood: 1st Steeplechase, 6 mins, 24 secs.

D. Goodall: 6th Long Jump, 19 feet 2 ins.

T Herbert: 5th Shot, 38 feet 1 in. 6th Hammer, 67 feet 9 ins.

T. Bates:

5th Discus, 106 feet 6 ins.

K Rawlinson:

2nd Jayelin, 171 feet 8 ins.

B Scott:

4th 440 yards Hurdles, 53.8 secs. 5th 120 yards Hurdles, 17.2 secs.

4th Long Jump, 19 feet 11 ins. 6th Triple Jump, 40 feet 3 ins.

RELAYS

 $4 \times 110$  vards 5th B. Scott, I. Smith, D. Goodall, J. Niven. Medley 3rd

B. Scott, D. Tunstall-Pedoe, D. Goodall, I. Niven.

#### MEN'S TENNIS CLUB

#### Thursday, 6th June. U.H. Cup Match. 1st VI v. St. Thomas's.

St. Thomas's, last year's winners of the Cup, were automatically placed at the top of this year's draw, and Bart's were drawn to play them. Thomas's were only left with two of their winning team while this Hospital was in the more fortunate position of having four of last year's cup team. However, because they possessed a very strong first pair, one of whom was the University of London Captain, it was decided that Bart's would have three moderately strong pairs rather than two strong and one relatively weaker. After the first round Thomas's led two matches to one, this result largely being due to the failure of Mitchenere and Kohli to beat a pair whom two weeks earlier they had easily outplayed. After the second round the score was level at three matches all and the outcome of the fixture therefore depended upon the final round and, in particular, whether Carden and Latham could defeat their second pair. This they succeeded in doing which gave Bart's a final win of five matches to four.

Team: Carden, Kohli, Edelstone, Mitchenere, Latham, Fryer.

Saturday, 15th June. 1st VI v. St. George's.

As a result of a large number of regular first six players being unable to play, the Bart's team did not, on paper, appear to be very strong. However, this presented the opportunity of trying new players and also giving them first team experience. During the course of the afternoon only one match was lost by the Bart's team. The good result was mainly attributable to very steady and consistent play by every member of the team. Result 9-1.

Team: Mitchenere, Fryer, Bowen, Cantrell, Roy, Smiley.

#### LADIES' TENNIS CLUB

This has been an encouraging season for the Ladies' Tennis Club on the whole. We had a good response to our tennis trials in April at College Hall, and among those who came were many of the preclinical students, who showed a promising standard of play. We were all hoping to start the season with a flourish but our first fixture against the Royal Dental Hospital had to be cancelled because of rain.

Thereafter we sustained a succession of losses, with a different team playing each week. It took several weeks to sort out our best partnerships for this year we virtually had to build a new

On 4th May we lost against University Col lege in the first round of the University tournament. The only redeeming feature about this was that we were able to play on our own lovely courts at Chislehurst.

Those who played were: R. Smiley; J. Spring; S. Hereward; E. Webb; E. Sykes; M. Newbold.

On 8th May, View Day, we were able to put out two teams. The first played the Royal Free Hospital in the U.H. Tournament, which they lost 1 5. Many of our team were sadly lacking in practice, and after the deceptive knock-up thought that victory was on their side too early in the game. The opposition played a somewhat disinterested game, but won fairly easily.

Team: S. Hereward, R. Smiley; J. Sykcs (capt.); W. Rostron; E. Burgess; J. Pitt.

18th May. The First Team played the School of Pharmacy at home. This was a most enjoyable match. The second couple did not pair up together very well. But the games on the whole were very close and a 3-6 defeat was an honourable one:

Team: J. Sykes; J. Spring; E. Webb; E. Munro; E. Sykes; M. Newbold.

22nd May. The match against St. Mary's Hospital was away. This was our first win of the season, and here I must mention how glad we were to have Ruth Smiley in the team. Having played for Oxford University, she raised the standard of the team tremer dously. The 1st and 2nd couples on this occasion played extremely well together. We won 5-4.

Team: R. Smiley; S. Hereward; A. Wallacc--Greig; E. Burgess; J. Sykes; D. Evans.

Then followed the annual Cambridge tour from 31st May-2nd June. This was highly successful-not only from the tennis point of view. The Sunday morning was memorable for a very wet attempt at punting down the Cam. During the whole weekend the weather was extremely hot, almost unbearably so, as far as long sets were concerned. On Friday, the match against Newnham was a 5-4 win for Bart's. This was in fact the most enjoyable of the three matches. On Saturday we played a Cambridge University team, which was originally intended not to be their top grade team. In fact, two "Blues" decided that they wanted to play. We lost the match 2-7. Against Girton on Sunday, we reversed the score of the previous day to win 7-2. Those who went were:

E. Webb; W. Rostron; A. Wallace-Grieg; E.

Burgess; E. Sykes; D. Evans.

12th June. A match against Bedford 2nd tcam was cancelled. The 1st team match against Bedford 1st on that day was played away. We showed up rather badly against the girls' college. However, the 1st couple won all their games, and we lost the match 3-6.

R. Smiley; J. Fielding; J. Sykes; E. Webb; E. Sykes; P. Kumar.

17th July. We lost against West Heath Lawn Tennis Club 1-5. The match was played in the evening and drizzle prevented us from playing until 7.15 p.m. We therefore played the best of eleven games to race dusk.

We all hope that next year the Club will be well supported and perhaps, with luck, we may have better weather so that fewer matches have to

be cancelled.

#### BOAT CLUB CAPTAIN'S REPORT: APRIL-JUNE, 1963 U.H. BUMPING RACES

The Bumps were held on 14th, 15th and 16th May, and of the twenty crews entered, five were manned by Bart's men. In the first division the 1st VIII was still third with the 2nd VIII six places behind, and in the second division the 3rd, 5th and 4th boats were in line astern in that order.

The 1st VIII re-assembled after Easter and trained six days a week during the month preceding the Bumps. D. Macfarlane's unexpected departure left us without a stroke, but fortunately M. F. MacKenzie was available (having resigned from the University 2nd crew) and he was invited to stroke the Bart's VIII. John Curry coached the crew for a fortnight, concentrating mainly on co-ordination and basic technique, after which Chris Hudson took over for the last week and ruthlessly but skilfully worked us into a racing crew capable of starting comfortably at a rating of forty.

Thomas's, Mary's and Bart's were the leading crews in the first division, and all rowed over each night well ahead of the rest of the field. The second night was probably the most exciting when Mary's, with Bart's only a length away, got within a canvas of Thomas's at about half-way. Mary's, however, were unable to bump Thomas's and after a hard race Bart's finished less than half a length behind Mary's. This occasion proved the points of those who want the Bumps course lengthened to Kew Railway Bridge, if only for the first division. The longer course would give good crews a better chance of bumping each other, whereas at the moment a relatively untrained crew such as Thomas's can get away with experience alone. An alternative, of course, would be to start the crews closer together.

The 2nd VIII, with two changes in the crew since the Head of the River Race, started training regularly again after Easter and were coached by Tom Stoyle, Andy Robertson and Dai Lloyd. They continued to improve, but were hampered by their lack of weight.

On the Saturday preceding the Bumps the 2nd VIII rowed at Hammersmith Amateur Regatta where, after a hard row in extremely unpleasant conditions, they were beaten by Hammersmith

R.C. by three lengths.

The crew were determined to make up for this in the Bumps, and on the first day, having scored a technical bump over U.C. & H., they went on to bump the next crew ahead, Thomas's II. Unfortunately, the democratic rules of bumping do not permit two bumps in one day, but the following day it was a relatively easy matter to bump Thomas's again, so that on the final day Bart's had to catch Mary's II in order to win their oars and to become the highest second boat. These prospects added to the excitement of a tremendous race in which Bart's got off to a flying start and were within a canvas of Mary's by half-way. The latter made a desperate effort to get away, and Bart's, already at full speed, did not have the strength to make the kill. The

chase continued at full spate all the way to Kew Bridge, but Bart's had given all and finished half a length behind.

The 3rd VIII, consisting mainly of old-timers, had four outings with various coaches before the races, and went out with cool determination to chase Westminster II down the river. On the first day Bart's made a lot of water on them, but not enough to bump them, and on the second day the prev escaped by bumping the Royal Dentals. The latter, having seen our crew in action, did not turn up on the last night, giving Bart's III a technical bump.

The 4th VIII, the Rugger Boat, was stroked by Mr. Gilmore in stern with Mr. Chesney in the sharp end. We were most impressed when they went out for several outings before the Bumps "to get the feel of the boat", and although their technique was somewhat crude, she rapidly responded in the right direction. On the

Start

1. St. Thomas's

St. Bartholor

St. Mary's I

Westminster

U. C. & H.

7. St. Thomas's

9. St. Bartholor

11. Royal Denta

12. Royal Veteri

13. Westminster

14. St. Bartholor

15. St. Bartholog

16. St. Bartholog

17. St. Thomas's

18. St. Mary's I

19. St. Thomas's

20. Westminster

10. Guy's II

2nd Division

2. St. Mary's

Guy's

1st Division

first night the Rugger crew were chasing Bart's

The 5th VIII was the Gentlemen's Boat, which noble men assembled for the first time on the day of their first race. Unfortunately a mechanical fault made them too late for the start and the Rugger Boat was given a technical bump, much to the annovance of Thomas's Rugger boat which was chasing them. On the second day the Gentlemen fell victim to the powerful Thomas's crew, while the Bart's Rugger Boat rowed over; and on the final day our Rugger men were bumped by their rivals from Thomas's after a gruelling battle. The Gentlemen rowed over.

The results of the bumps are summarised below. Of the Bart's crews, two finished where they started, two went up, and the one that went down is still in a good position. Our thanks are due to all the men who help on bank, and without whom the races could not have been held. The Bumps were very well organised by D. L. Hunter, who has been U.H.B.C. Secretary for the past year.

	Tues.	Weds.	Thurs.	
				St. Thomas's
				St. Mary's
ew's				St. Bartholomew's
				Westminster
	<u> </u>			Guy's
				St. Mary's II
II				St. Bartholomew's II
	L _	><		St. Thomas's II
ew's II				Royal Veterinary
			><	U. C. & H.
		$>\!\!<$		Westminster II
ary				Guy's II
r I		$>\!\!<$		St. Bartholomew's III
ew's III			><	Royal Dental
ew's V				St. Thomas's III
ew's IV	$>\!<$		$>\!\!<$	St. Bartholomew's IV
III		$>\!\!<$		St. Bartholomew's V
[				St. Mary's III
IV				Westminster III
II	><			St. Thomas's IV

The Bumps Crews were :-

7. H. C. Coleridge Str. M. F. Mackenzie	3. G. Libby 4. B. Bennett 5. C. Sykes 6. P. McArthur 7. D. Robins	3rd VIII B. K. Gilsenon 2. J. Merrill 3. M. Revill 4. R. Morris 5. T. MacElwain 6. R Bark 7. R. Husband Str. D. Macfarlane Cox R. Weller.	4th VIII B. D. Chesney 2. M. Waterworth 3. E. Dorrell 4. C. Smart 5. S. Harris 6. I. Gibson 7. P. Thornback Str. G. Gilmore Cox R. Wilson	5th VIII B. T. Dutt 2. C. Church 3. J. Wales 4. C. Clarke 6. D. Jones 7. J. Clayton Str. I. Aaronson Cox J. Pilling
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Allom Cup Regatta, 18th May

Bart's 1st VIII, with A. B. Avers rowing in place of M. G. Kettlewell, as usual drew Imperial College in the first heat of the senior event. Both crews started well, and I.C., striking a higher rating, took a half-length lead in the first minute. Bart's fought back and both crews went hammer and tongs over the course with I.C. never leading by more than half a length. Towards the finish Bart's, who were rowing better than ever, started going up, but I.C. spurted hard to win by 3/4 length. In the final I.C. beat University College, who had beaten Mary's and Thomas's in the first round.

Bart's 2nd VIII raced against St. Thomas's II and an I.C. crew in the first round of the Junior VIII's event, and after a hard race, won by two feet from I.C. In the final a strong King's College Crew beat Bart's by 21 lengths.

At this stage we had to decide whether or not to send a crew to Henley, and very reluctantly we decided to break up the first eight and to train a coxless four for Henley instead. There were many reasons for this, not the least being the fact that for the past two years Bart's has sent an eight to Henley only to be beaten in the Eliminating Heats, and we had no positive results to suggest that the same fate might not befall us a third time. Another factor was that two men did not want to continue rowing in the eight after the Bumps. The activities of the coxless four will be recounted in the next report.

The 2nd eight also stopped rowing after the Allom Cup and a crew was formed from the remaining members of the 1st and 2nd VIII's. This crew had only one outing together before their first race, but their enthusiasm kept the eight going although they knew the odds were against them.

At Chiswick Regatta on 25th May, Bart's drew St. Paul's in the first round of the Junior Eights event, and beat them convincingly. In the semifinal Bart's tried hard but lost to a good Mortlake crew, who went on to win the event.

Crew: B. Lee, bow; P. Needham, 2; C. Sykes, 3; B. Bennett, 4; G. Libby, 5; J. Silverton, 6; D. Parr, 7; C. R. Anderson, Stroke; J. Pilling, Cox.

Twickenham Regatta, 2nd June. Bart's Junior VIII might have won the first heat had not a crab lost them their initial lead, and some confusion as to where the finish was upset them at the end. As it was they lost to Walton R.C. by only ½ length.

At Reading Regatta, on 16th June, R. M. A. Sandhurst beat our eight by just over a length. Bart's did not row their best and although it was a close chase, they could not get ahead. D. Macfarlane replaced B. Bennett in the crew, and I. Cole coxed.

A scratch Gentlemen's Eight rowed at Horseferry Regatta at Kew on 23rd June, but lost to Haberdasher's School, the eventual winners.

Crew: T. Dutt, bow; J. Clayton, 2; K. Gilsenon, 3; N. Greenwood, 4; R. Swain, 5; P. Needham, 6; D. Parr, 7; C. R. Anderson; Stroke; I. Cole, Cox.

The summer holidays then intervened, and with the exception of the Henley four there was no further organised rowing. Although we only won three events during the year (Junior Eights at U.H. and U.L. Winter Regatta and Senior Fours at Huntingdon), a large number of people were able to row and enjoy the effort which is, after all, the main thing. D.A.L.

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#### **EDITORIAL**

Our Bread and Butter

That the professions are often considered rather superior to commerce is typical of the Englishman's hypocrisy. In fact they are the most thriving trades of all and their members-without knowing it-the shrewdest of business men. In our own profession the bread and butter is assured. Sick people are our business just as corpses are the undertaker's business. The Ministry of Health can guarantee the medical profession a sufficient supply of unhealthy people. There are other problems for our friends in the

Overnight, in 1948, the population became aware of its rights to free treatment, disease and disablement. Initial sillyness aside this was a good thing, but since that time the male medical student intake has dropped by 12.5 per cent., Lancet, Dec., 1962.

emigrating doctors have increased to 30 per cent. of the number qualifying and the population has increased. The N.II.S. still staggers on-saved by a generous and fortunate influx of our coloured brothers from beyond Calais. There being no prejudice against the colour of one's skin in Great Britain, the junior posts of most of the provincial hospitals have been more or less filled. One or two of our brighter Ministry friends have thought about the situation that will arise when the number of immigrant doctors no longer balances the emigrants.

The disastrous recommendations of the Willink Committee, in 1955, are gradually being reversed and over the next few years the male medical student intake should increase. What of our industrious medical women? If we could guide the Ministry's myopic eye to them the profession might be saved, without too much difficulty, 200 doctors and the Ministry £1,000,000 each year.

Natural Maternal Feelings Many medical men hold no brief for the entrance of women into the profession. Their objections are no less valid for being instinctive rather

than reasoned. "Many (women) in active practice emphasised the importance of retiring for only a reasonable perinatal period, and not resigning their work . . . at a time when natural maternal feelings were strong."\* This sentence contains the nub of a problem. Nature meant "natural maternal feelings" to be "strong". She did not intend young mums to go skipping out to scrub floors, wrap toffees or treat the sick while the kiddies bawl in day nurseries. The women of the emancipating 20s did not realise that a mother is the greatest

force for good in the family unit. That force exists only so long as she is in it.

No one should be surprised that amorality, juvenile delinquency and crime are increasing when the nation's mothers, especially those of Social Grades III-V, are climbing on the bandwagon of affluence. During term time, in the afternoon, their latchkey offspring return to an empty house and an absence of discipline; during the holidays they roam the streets unwatched, and often, unloved. In the evening both parents, two exhausted bread-winners, are short-tempered with their children. After a sulky and skimped high tea they all bury their irritability in a darkened room, one corner lit by a square of flickering blue light. Reading is impossible and conversation is difficult, consequently the minds of the viewers are filled with a great emptiness. Who can blame the more rebellious of the older \* The Fate of Oxford Medical Women by A. H. T. Robb-Smith, M. J. Low, F.R.C.P., p. 1158. The

young ones if they creep out from that vacuum to find life-to seek love in the lust of frequent fornications and vainglorious death astride twohundredweight of vibrating steel?

It is sad that the family unit no longer exists in an age when the economy could afford to employ all men (assuming the absence of married women) and pay them a decent wage. This serious social corruption has been caused by the advent of the working mother by day and television by night. A very similar line of thought is applicable to mothers in Social Grades I and II.

The Oxford survey shows that since 1921 the incidence of marriage amongst medical women has increased from about 25 per cent. to 75 per cent. Over the same period their clinical activity has steadily declined, until now it is only 25 per cent. of their full-time potential. This may be an indication that medical women, or rather women, are regaining their sense of values and realising their greater worth as mothers and wives. Certainly the reasons they gave for giving up or reducing medical work bear this out; marriage, pregnancy, bringing up a family, the incompatability of general practice with family life and lack of domestic help make up 60 per cent. of those reasons-first things first.

"... For a variety of reasons the clinical effectiveness of women doctors is less than that of men." Evidently Dr. Robb-Smith thinks the chief reasons are three: the difficulty of finding jobs in the face of administrative obtuseness and male prejudice, the anxieties of returning to a profession after several years of child bearing and the inadequacy of the local authority day nurseries. She feels, quite rightly, that it is ridiculous for the medical schools to be increasing their intake of women in accordance with the recommendations of the Goodenough Committee, so that they now constitute over a quarter of the country's medical students, while the Ministry of Health, aided and abetted, perhaps, by the profession and just a soupçon of prejudice, makes it thoroughly difficult for them to practice.

Since 1948 boards of governors and regional boards have shown no enthusiasm for part-time junior appointments analogous to those in the medical-assistant grade recommended by the Platt Committee. Such posts would be ideal for married women with small children. The Ministry could force the regional boards' hands on this issue and then go on to work out a scheme for retraining women who wish to return to the profession. Such a scheme would consist of trainee appointments, each tied to a subsequent established post.

Fifteen Million Pounds Wasted\*

Of Great Britain's 12,000 women doctors about half are not working at all, even part-time. The same survey suggests that about half of these, or 3,000, want to work either part or full-time. (At this point the reader and selection committees may wonder whether an expected and irretrievable loss of 25 per cent. from the female medical intake is tolerable.

In other words the Ministry of Health, sanguine as it is about emigration by nearly a third of its recruits, is also unconcerned that a quarter of the 400 women doctors qualifying a year are being unnecessarily lost. Each year the profession is losing 100 willing women doctors who could reasonably be expected to be retrieved at a tenth of their training cost. If the profession is to have women-and that is a moot point here, where they did not arrive until 1947—they must be given better opportunities to practice.

\* It costs £5,000 to train a doctor.

#### Correspondence **ERRATUM**

Dear Sir,

I wonder whether you need have troubled to put in the erratum slip in this month's Journal which explains that a certain illustration is inverted. Certainly you need not worry as much as the publishers of a very glossy book on plant diseases which had an illustration of tomatoes standing erect on top of their stalks!

Yours sincerely, JOHN L. STRUTHERS. Maybush, Southampton. 22nd September.

CAMBRIDGE GRADUATES CLUB

Dear Sir.

The Club was founded in 1876 with the object of holding an annual "supper" at which Cambridge graduates already at the Hospital might make the acquaintance of the newcomers each year. Except for the interruptions of war, a dinner has been held every year since. The 73rd Annual Dinner will take place on 1st November at 7 p.m. for 7.30 p.m. at the Connaught Rooms, with Mr. John Beattie in the Chair. We would be grateful if any Bart's Cambridge man who has not received an invitation would kindly inform Professor R. A. Shooter, Department of Bacteriology, St. Bartholomew's Hospital. Many past Bart's men make a point of coming every year, and younger men are particularly welcome. Yours faithfully,

H. JACKSON BURROWS, R. A. SHOOTER,

Honorary Secretaries.

St. Bartholomew's Hospital.

#### Calendar

OCTOBER

Sat. & Sun., 12th & 13th: Dr. R. Bodley Scott Mr. Alan H. Hunt Mr. H. J. Burrows Dr. R. A. Bowen Mr. A. P. Fuller

14th October: Copy date for November Journal. Sat. & Sun., 19th & 20th: Dr. E. R. Cullinan Mr. C. Naumton

> Mr. J. N. Aston Mr. G. Ellis

Mr. J. W. Cope 22nd October: Drama Society A.G.M. 5.45 p.m. Sat. & Sun., 26th & 27th: Dr. G. W. Hayward Mr. A. W. Badenoch Mr. H. I. Burrows Dr. R. W. Ballantine Mr. R. F. McNab Jones

The Physician Accoucheur on duty for the month of October is Mr. D. Fraser.

29th October: Wine Committee Smoking Concert.

NOVEMBER

Sat. & Sun., 2nd & 3rd: Dr. A. W. Spence Mr. E. G. Tuckwell Mr. I. N. Aston Dr. I. Jackson

Mr. I. C. Hogg Sat. & Sun., 9th & 10th: Prof. E. F. Scowen Prof. G. W. Taylor Mr. H. J. Burrows Dr. T. B. Boulton Mr. A. P. Fuller

11th November: Copy date for December Journal.

The Physician Accoucheur on duty for the month of November is Mr. J. Howkins.

THE WINE COMMITTEE - The 1963 Smoking Concert will be on Tuesday, 29th OCTOBER.

FILM SOCIETY—OCTOBER 21st October "Waltz of the Toreadors".

#### Births

CHARLTON.-On 31st August, to Jennifer (née Price) and Clive Charlton, a daughter (Clare Louise).

CHITHAM.-On 29th August, to Heather and Dr. R. G. Chitham, a daughter.

CUNNINGHAM.—On 2nd September, in Mombasa, Kenya, to Alison (née Corbett) and Dr. Geoffrey Cunningham, the gift of a son (Allan Geoffrey).

DOBSON.—On 25th August, to Sheila (née Davey) and Dr. John L. C. Dobson, the gift of a son (Simon Charles Lindsay).

GODRICH.-On 12th June, at Lichfield, to Chloe, wife of Dr. John Godrich, a son (William), a brother for Angela and Jeremy. HUCKSTEP.—On 3rd September, in Kampala, Uganda, to Ann (née Macbeth) and Ronald Huckstep, a son (Michael).

WHITEHOUSE.-On 19th August, to Jill Rosemary (née Clarke) and Dr. Michael Whitehouse, a daughter (Rachel Louise), a sister for Sarah and James.

#### Deaths

FREETH.—On 20th August, James Wilmot Owen Freeth, M.R.C.S., L.R.C.P., aged 57. Qualified 1931.

TAIT .- On 28th August, Greville Brend Tait, I.P., T.D. Qualified 1925.

#### Appointments

University of London

Dr. Patricia J. Lindop has been recognized as a teacher of the University in Radiobiology. Mr. H. B. Stallard has been invited to give the Middlemore Lecture for 1963 at Birmingham.

**Changes of Address** 

Dr. M. Besser, 47, Finborough Road, S.W.10, and St. Bartholomew's Hospital Medical College, Charterhouse Square, E.C.1.

Dr. A. E. Fraser-Smith, The Cottage, Yealand Conyers, Carnforth, Lancs.

Dr. and Mrs. A. H. Gretton, 6911, Bow Crescent, Bowness, Calgary, Alberta, Canada.

Dr. P. A. Johnson, The Pound Cottage, Westcott,

Dr. G. H. Lunn, 121, Harley Street, W.1.

Dr. W. Radcliffe, "Longacre", 26, Welshwood Park Road, Colchester.

Mr. Douglas Robertson, Dormy House, Burnstones Close, Sheffield 10.

Dr. Sturton, S.D., Hong Kong Sanatorium and Hospital, Happy Valley, Hong Kong.

Births, Engagements, Marriages and Deaths etc. are included free of charge.

DEMONSTRATIONS Pathology (in the Museum):

OCTOBER 1st-9th Heart Blood vessels 9th-16th Urinary system 16th-23rd

Respiratory system 23rd-30th Bones and Joints 30th-6th Nov. NOVEMBER

6th-13th

Reticulo-endothelial system 13th-19th Liver

Alimentary system and 19th-26th Gall bladder

26th-3rd Dec. Nervous system

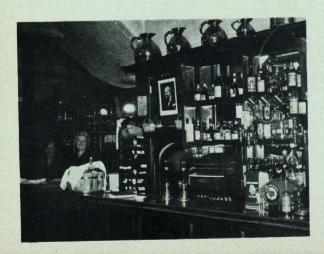
DECEMBER

Ductless glands and 3rd-10th Generative system



## **FIVE MINUTES FROM BART'S: 4**

by our Drinking Correspondent. (Photographs by B. C. P. Lee)



If you stand on the corner of Aldersgate Street and Carthusian Street, you are facing Coltman's. You may not notice it at first since behind its plain frosted glass from it looks more like a warehouse than a restaurant, but once inside things are different.

Although Coltman's is a restaurant and not a pub, it is recommended since it has a bar at the front where you can get a drink without having to eat. The atmosphere is pleasantly plushy and the restaurant is very popular and always full of business people at lunchtime.

If you feel like a meal after your pint of bitter (served, incidentally, in a silver tankard), the restaurant is good in an unpretentious sort of way and the prices are very reasonable. The sort of meal you can expect to get is of the prawn cocktail, roast beef, cheese and biscuits type and is brought to you quickly and with a minimum of fuss. An average lunch would cost about 8s. Your drinking is done at pub prices.

Come out of Coltman's and turn right up Aldersgate St. At the corner of Aldersgate St. and Clerkenwell Road is the Hat and Feathers. Three years ago the Hat enjoyed a well - deserved reputation among people from Charterhouse since it was run by an affable and generous landlord who was good for a free pint now and again and would even extend limited credit. The main draw, however, was the bar billiards table and many were the 2nd M.B. candidates who spent their time playing billiards in these relaxed surroundings.

Unfortunately, all has changed. The brewers, Ind Coope, decided that this pleasant gin palace should be streamlined and have turned out all the fumed oak and old benches and replaced them with a curious combination of Twentieth-Century Coffee Bar and fake Empire furniture. The result is bizarre to say the least. The main attraction is that the Hat sells draught lager at 2s. a pint, which is as cheap as you will get it and therefore for lager fanciers it might be worth a visit, but it cannot be recommended with much enthusiasm since the atmosphere is chilly and the landlord does not seem anxious to see Bart's people.

A short walk from the Hat down Clerkenwell Road towards the back gate of the Medical College brings you to Berry Street. If you turn down here you come to the Sutton Arms. This is a small and unpretentious place, but the landlord is friendly and well-disposed towards Bart's people and serves quite a good counter lunch. Upstairs there is a large room which he will hire to clubs for their annual booze-ups and he does not object to songs, recitations and the occasional figure seen flying down the stairs without his trousers.

On no account must this Sutton Arms be confused with the Sutton Arms in Carthusian Street. On the few occasions I have visited that pub I have found the sandwiches stale, the beer warm and the juke-box noisy.



Top left: You are facing Coltmans. Bottom left: Bitter served in a silver tankard. Above: The Hat sells lager at 2s. a pint. Below: A small unpretentious place.



# UP TO THE MINUTE IN A MOMENT

As the leaves brown and drop from the trees, party political bayonets are fixed for the final assault, a new academic year begins and the publication date of the St. Bartholomew's Journal creeps nearer to the beginning of the current month.

We go to press before the season of party conferences is quite over. Pre-election conferences are bound to be that much more noted for carrot dangling. Mr. Grimond's carrots looked pretty good-trouble was, like meringue, they disappeared in one's mouth on sampling. After the Brighton gathering on 11th September, many must have wondered whether the Liberals are fit to hold the balance of power let alone power itself. On 30th September the Socialists went to Scarborough. Mr. Harold Wilson's carrots were tasteless. He made a pie in the sky speech about the technological age and the party bosses managed to keep all controversial issues off the agenda-a notable achievement. Plans were mooted for no less than five new government departments-Economic Planning, Overseas Development, Higher Education, Science and Disarmament (is the C.N.D. to become respectable

In Alabama on Sunday, 15th September, four negroes were killed by a bomb while praying. The next day the inception of the federation of Malaysia was announced amid some rather indigenous behaviour, which culminated in the burning of the British Embassy in Jakarta two days later, on 18th September. On the same day, the 16th, Buckingham Palace announced Her Majesty the Queen's contribution to N.P.Y. On 19th and 20th September the concept of Empire took two minor knocks in the form of reports of the feasibility, even inevitability, of the Channel Tunnel (Chunnel for the benefit of tabloid readers) and decimal coinage.

On 26th September, thirteen people were charged, in an Aylesbury court, in connection with the great train robbery. To date the police liad found only a tenth of the money stolen. The very next day another gang(?) snatched a further £90 without much difficulty. Crime does pay. On 2nd October Miss Keeler was again in court, only six days after the publication of Lord Denning's report. The style of his report would have delighted the eye of Mr. Raymond Chandler; its content we had already gleaned in toto from Scandal '63, an excellent book by three journalists. Again we learnt that five ministers had been gulled, but then Mr. Profumo was glib.

As promised there is a report of the Wine Committee's Barbecue Ball on page 304. Another social correspondent reports on the Nurses' Swimming Gala, page 320. Dr. Geoffrey Bourne's book, We Met at Bart's is reviewed on page 324.

On 27th September, Mrs. Board left; she was the women students' cloakroom attendant for sixteen years, in fact, ever since the Royal and Ancient let them in. That day the new preclinical intake was shown round the College and Hospital by Students' Union workers. It was an astute remark from the Students' Union Chairman, Mr. Trevor Powles, that informed one group of students that whereas it took 35 minutes to reach Chislehurst by car, only 25 were required for coming home. It is now common knowledge that Mrs. Gibbins, the College Hall housekeeper, will be leaving on 18th October. Opinions blow strong about this remarkable woman. The Journal has found two relevant quotes: "Signs of activity and efficiency in the new C.H. housekeeper. She hopes for improvements in the food. . . . She may have to be careful. Being at Bart's her efficiency will fall heavily on her seniors' toes, who will hastily look to the security of the money bags and their old peace and quiet." (Broadsheet, 29th May.) And: "It is easy to buy popularity with the students if you give them £10 worth of living at £4 10s. a week." (Reliable source, 4th October.)

At the end of the cricket season we find that Mr. Colin Richards achieved the best bowling average with 14,76 runs an over, although he bowled only 54 overs, writes our sporting correspondent. Mr. Steve Thomas averaged 38.7 runs in 27 innings during the season.

The Autumn sports have begun. The Hockey Club started training on 28th September with a number of interested freshmen. Apart from the likelihood of running two teams regularly, the First looks strong with the return of Mr. Patrick Kingsley to the Hospital and the forward line, as well as the addition of one or two useful players of previous rugger fame. The Boat Club began training a week later, on 4th October, when the First Rugger XV were surprised to lose 6-0 to R.M.A. Sandhurst. The Bart's pack, with improvisations in the second row, was less effective than their heavy forwards. A week before Trojans had been beaten 8-0 in an away game, and on Wednesday, 2nd October, when our line was moving particularly well, Reading was beaten 21-0, Messrs. Sidebottom and Harris scoring two tries apiece.

(7th October.)

## A HISTORY OF PLASTIC SURGERY

by Richard Petty

## BEING RELEVANT TO THE DEVELOPMENT OF THE WORK OF SIR HAROLD GILLIES

"The love of life is next to the love of our own face and thus the mutilated cry for help."

Sir Harold Gillies's early work was based almost entirely on methods described in medical texts spanning the years from 600 B.C. to the present day. It is therefore appropriate to briefly consider the sources which were specifically acknowledged by Sir Harold to have been his inspiration.

#### INDIAN SURGERY

St. B.H.I., October, 1963

There are written texts in existence recording operations for the repair of noses by flaps taken from the cheek. This technique in rhinoplasty is the oldest known to man and its origin is obscure.

Eventually there evolved a method based on free skin grafts from the glutcal region. The part of the nose to be covered was patterned with a leaf; a graft of the requisite size was cut from the skin covering the buttocks, and a metallic frame was inserted, with two tubes, into the nostril to support the graft. "And then, scraping the border (to which the graft is to be joined) and making the surface fresh (to make the graft successful the flap is to be carefully sutured. When the graft has been properly made, a powder composed of ptercarpus santalinus, glycyrrhiza glabra and sulphate of antimony, should be sprinkled over the part, and then it should be covered with lint, which is to be kept moistened with oleum sesamum until the complete graft has taken place".

This is the operation as described by Sushruta Samhita, the great Hindu surgeon, working in the 5th century B.C. Originally the method had been practised by tile-makers (surgery was a lowly profession in early India), who would have used potters' earth in place of the adhesive powder described by Sushruta. The primitives would also use the mouth parts of black ants to approximate the skin edges, whereas Sushruta was versed in the use of horsehair, hemp and flax for the suturing of wounds and incisions.

Sushiruta described operations for the repair of lips by means of cheek flaps and fifteen methods of restoring split or mutilated ear lobes. Of the cheek flap method for restoration of the nose, he writes:

"The careful doctor takes (as a pattern) the head of a plant the size of the nose, cuts a flap from the cheek according to the pattern laid upon it, but leaves the flap attached at one place. He quickly puts the (new) nose in place. After he has incised the edges he fastens it in the proper position with a good bandage, carefully inserts two small tubes of appropriate size, elevates it and strews over it dust of red sandalwood, sweet wood and antimony. Then he covers it with white cloth and moistens it often with the oil of sesame. . . . When the transplanted flap is united the pedicle is divided. If the nose is too small one attempts to make it grow; if it is too large, one reduces it to the proper size."

Rhinoplasty was an operation much in demand in ancient India as nasal mutilation was the punishment for many crimes including adultery. Sushruta describes yet another method of nasal restoration, utilising the classical forehead flap. The base of the pedicle was situated at the junction of the eyebrows and the flap extended upwards and laterally to one of the temporal regions. The resultant scars of this operation were striking and the pedicles frequently necrosed due to kinking of the stem on its descent from the forehead.

Sushruta was also aware of the finer points of surgery. He writes, "... the incision of a surgeon's knife should never have a distorted or an improper shape. ... An incision ... not mada as directed may give rise to extreme pain, prolonged granulations and condylomatous growths"

The first printed account of the Indian methods of rhinoplasty is to be found in the anatomical textbook of Alexander Benedictus, 1497.

#### ROMAN SURGERY

The work of Aulus Cornelius Celsus (25 B.C.-50 A.D.) was based on Indian and Alexandrian surgical teaching. In Book VII of De Arte Medica, he describes two methods of covering tissue defects. He written

"The method of the cure is this; to reduce that, which is mutilated, into a square; from its interior angles to cut in transverse lines, so as to divide the part, that lies within these lines, from that beyond them; then to draw together the parts we have thus opened. . . .

... If they (the edges of the wound) do not fully meet, then beyond the lines we have

St. B.H.J., October, 1963

made before, to cut in two places in a lunated form, so as only to separate the surface of the skin; for by this means what we draw together will be more at liberty to follow.

. . . Which is not to be forced together but gently drawn, so as it may easily follow, and when let go, not recede far."

Celsus also describes for the first time operations for the relief of ectropion. In old age he states that ectropion can be cured by "burning the excrescence with a slender piece of iron and then anointing with

#### ITALIAN SURGERY

Gaspare Tagliacozzi (1546-1549), Professor of Surgery and Anatomy at the University of Bologna and Chief Surgeon to the Grand Dukes of Tuscany and Mantua, placed plastic surgery on a secure scientific footing.

Tagliacozzi had been introduced to the speciality through the work of the Brancas, the family of surgeons practising in Sicily during the first half of the fifteenth century. The Sicilian rhinoplasty is mentioned in a letter of the poet, Elisio Calenzio, to a friend:

"Orpianus, if you wish to have your nose restored, come here. Really it is the most extraordinary thing in the world. Branca of Sicily, a man of wonderful talent, has found out how to give a person a new nose, which he either builds from the arm or borrows from a slave. When I saw this, I decided to write to you, thinking that no information could be more valuable. Now if you come, I would have you know that you shall return home with as much nose as you please. Fly !"

Antonio Branca is mentioned as performing plastic operations by Peter Ranzano, Bishop of Lucerne, in his Annals of the World (1442) and by the German surgeon Heinrich von Pfolspeundnt, writing in 1460.

The secrets of their technique in reparative surgery were well-kept by the Brancas, and it is not known how Tagliacozzi learnt of them. However, in 1597 he published De Curtorum Chirurgia, the result of many years of practice of and experimentation in the transfer of grafts.

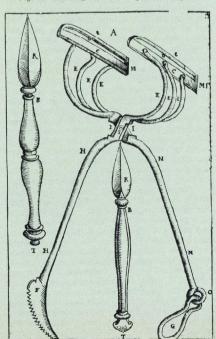
This beautifully illustrated book is the first treatise on plastic surgery and holds a unique position in the history of the art. It describes in detail methods for the reconstruction of the nose, ear auricles and lips.

In 1586 Tagliacozzi wrote to a friend of his rhinoplastic operation, describing the method reiterated seven years later in De Curtorum Chirurgia (from which the illustrations are taken):

. . . You see, Pareus, Groumelinus and

others have written that a hole or cavity is made in the arm, in which the mutilated nose is buried, until flesh grows onto it; that then the flesh is polished off into the shape of a nose. This, notwithstanding my respect for such eminent men, is far afield from the techniques of the skill; and we are far from making use of any flesh (if they interpret muscular tissue as flesh) or from digging out a hole or cavity in the arm, but rather that an incision, made in the arm, consist only of a smooth piece of the epidermis, equal in size to the nose that is to be refashioned, and no use of the flesh beneath is made in the operation, but only the skin of the arm is taken in joining it to the nose by the same method of grafting, which the professors of agriculture have been wont to call grafting by means of a sprout plucked out of its own matrix, just as we are stating in our treatise in a clearer and more illuminating way. . . . "

Fig. 1. The Tagliacozzi Forceps and Scalpels.



He then proceeds to detail the procedure, which is summarised thus:

After proper preliminary measures had been taken regarding the general health of the patient, he was seated in front of the surgeon and supported by an assistant. The surgeon closed the broad blades of a specially designed pair of forceps (Fig. 1) onto an area of skin overlying the biceps muscle of the left arm. A double edged knife was then passed through horizontal slits in the forceps' blades, detaching a generously proportioned strip of skin from the underlying subcutaneous tissue. This area of skin, on removal of the instruments, was left as a bridge pedicle. A piece of lint soaked in oil was then placed under the flap to prevent reunion.

The dressing was left for four days after which time (if infection had not supervened) the pedicle was severed from the arm at its upper end (Fig. 2). The flap was then carefully dressed until the under surface had granulated and the skin had contracted to its minimum size.

This usually took a fortnight and the patient was then considered ready to undergo the main operation. He was purged and shaved, and he donned a hooded leather jacket. The edges of the flap and the nasal aperture were freshened and one sutured to the other. The arm was kept in a semi-flexed position by the straps attached to the leather jacket (Fig. 3).

The patient was kept in bed and the ligatures removed on the third to the fifth day. The pedicle was severed from its arm root on the twentieth day (Fig. 4 overleaf). The new nose was then covered with a special dressing until final trimming (Fig. 5).

The operation was first performed on Conti Brachetti Di Moderna in 1580 after luetic destruction of the nose. It was, as may be imagined, an extremely painful process: in 1612 Paulo Zacchias (1584-1659), physician to Popes Innocent X and Alexander VIII, wrote, "If a malefactor was condemned to lose his nose and thereby lost it, it was legal to have it restored by the operation of Tagliacozzi; because the operation could be considered a punishment on account of the time required to perform and the pain oc-

In De Curtorum Chirurgia, thirteen chapters are taken up with the discussion of the rationale behind plastic operations. In the fourteenth chapter, donor sites are enumerated; the best for the nose and lips, the arm, and for the ear, the skin behind it. Chapters fifteen and sixteen contain directions regarding the dimensions of the grafts and the ways in which the grafts are united with the recipient areas: Tagliacozzi states that too

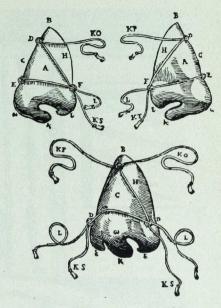


Fig. 5. Icon Undecima from "De Curtorum Chirurgia".

much skin should be raised, rather than too little. The seventeenth chapter discusses the factors of age, constitution and season in the surgical risk. In the eighteenth chapter he maintains that there is no reason why the skin of one person should not unite with that of another. The nineteenth chapter summarises the ancient techniques in reparative surgery, and in the twentieth, twentyfirst and twenty-second, he defends rhinoplasty against the charges of cruelty levelled against it. In the twenty-third chapter the advantages and disadvantages of different techniques are discussed in the repair of nose, ears and lips, and in the twenty-fourth the points in which the new nose differs from the original are described. Chapter twenty-five cantains a resumé of the whole subject. Tagliacozzi concludes by writing:

"We restore, repair and make whole those parts of the face which nature has given but which fortune has taken away, not so much that they might delight the eye but that they may buoy up the spirit and help the mind of the afflicted "-an extraordinarily

enlightened sentiment.



Fig. 4. Icon Decima from "De Curtorum Chirurgia".

Stress has been laid upon the work of Tagliacozzi for it is on this that Sir Harold Gillies based many of his rhinoplastic techniques evolved during the First World War.

After his death, Gaspare Tagliacozzi was buried in the Church of St. Giovanni Batista, Bologna, but his body was later exhumed after the Roman Catholic Church had posthumously excommunicated him. The Church, in fact, had adopted strong views against the practice of plastic surgery, maintaining that mutilation, whether by disease or by trauma, was the will of God.

Plastic surgery fell into disrepute and was not revived in Europe until the closing years of the eighteenth century.

#### **EUROPEAN SURGERY**

In the October edition of the *Gentleman's Magazine*, 1794, appeared the following description of the Hindu operation of rhinoplasty:

Cowasjee, a Mahratta, of the caste of husbandmen, was a bullock-driver with the English army in the war of 1792 and was made a prisoner by Tippoo, who cut off his nose and one of his hands. In this state he joined the Bombay army near Seringapatam and is now a pensioner of the Honourable East India Company. For about twelve months he was wholly without a nose; when he had a new one put on by a Mahratta surgeon, a Kumar, near Poonah. . . . Two of the medical gentlemen, Mr. Thomas Cruso and Mr. James Findlay, of Bombay, had seen it performed as follows: A thick plate of wax is fitted to the stump of the nose so as to make a nose of good appearance; it is then flattened and laid on the forehead. A line is drawn around the wax which is then of no further use; and the operator then dissects off as much skin as it covered, leaving undivided a small slip between the eyes. This slip preserves the circulation, till a union has taken place between the new and the old parts. The cicatrix of the stump of the nose is next pared off; and immediately behind this raw part, an incision is made through the skin, which passes round both alae, and goes along the upper lip. The skin is now brought down from the forehead; and being twisted half round, its edge is inserted into this incision; so that a nose is formed with a double fold, above and with its alae and septum below, fixed in the incision. A little Terra Japonica is softened with water and being spread on slips of cloth, five or six of these are placed over each other, to secure the joining. No other dressing than this cement is used for four days; it is then removed, and cloths dipped in ghee (a kind of butter) are supplied. The connecting slip of skin is divided about the twenty-fifth day; when a little more dissecting is necessary to improve the appearance of the nose. For five or six days after the operation, the patient is made to lie on his back; and on the tenth day, bits of soft cloth are put into the nostrils to keep them sufficiently open. This operation is always successful. The artificial nose is secure and looks nearly as well as the natural one; nor is the scar on the forehead very observable, after a length of time."

This awakened wide interest in plastic surgery and, in 1814, Joseph Constantine Carpue (1764-1846), an English surgeon, reported the successful completion of two rhinoplastic operations following the Hindu methods, but improving on them by adding a septum nasi.

Carpue later wrote a paper (1816) discussing the various known methods of transferring tissue and points out the misconception in Tagliacozzi's claim that the skin of one person will unite with that of another.

John Hunter had worked on the transplantation of tissue in animals and Dieffenbach (1792-1847) continued the experiments. The foundations of the rationale behind the grafting of bone were thus elucidated.

1809: Carl von Graefe (1787-1840) described a successful case of blepharoplasty. He repaired the lower eye-lid by means of a pedicle flap from the cheek based on the Hindu method.

1814: William Balfour published his paper, "Observations on adhesion with two Cases, Demonstrative of the Powers of Nature to Reunite Parts which have been, by Accident, Totally Separated from the Animal System". He wrote,

"I am convinced that had Taliacotus at once separated from the system, the flaps of skin with which he repaired mutilated parts, his operation would have been equally successful, infinitely less troublesome to himself and distressing to his patients. . . Attempts at reunion of divided parts may be successful."

1816: Von Graefe introduced the first surgical techniques for the repair of the soft palate (staphylor-rhoplasty).

1821: F. L. G. Fricke (1790-1842) published Die Bildung neuer Augenlider-Blepharoplastik, an extensive treatise on the use of pedicle grafts from the parietal and cheek region to supply skin for the reconstruction of deformed eye-lids.

1824: A case of rhinoplasty as perfomed by a Mr.

Travers was reported in the Lancet. The account concludes, "This operation is called the Taliaco-

1827: "A Case in which a Lost Nose Was Restored" appears in the Edinburgh Medical and Surgical Journal (Vol. XXVIII). This article concludes, "This curious operation is occasionally practised in India by the native practitioners. Dr. M. Whirter, who paid great attention to their surgery during a long journey in the East . . . informs us that these operators are in the habit of pummelling

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the integuments of the forehead with the heel of their slippers, so as to excite the circulation before performing their incisions."

1838: Malgaigne described cleavage lines of the skin in his textbook on surgical anatomy and experimental surgery. Langer investigated this pheno-

1840: Robert Liston (1794-1847) described Indian methods of rhinoplasty in his Elements of Surgery.

c.1840: Conrad Martin Langenbeck (1776-1851) described methods for repairing cleft palates.

c.1850: C. Nélaton (1807-1873) described a total rhinoplasty utilising costal cartilage for the formation of the new septum.

1858: Louis Ollier (1825-1900) reported an experimental work concerning bone grafts.

1869: J. C. F. Guyon (1831-1920) first reported the success of pinch grafts to a granulating defect.

1869: Jacques Louis Reverdin (1842-1928) demonstrated that a completely detached piece of human epidermis could continue to live and grow when placed on a properly prepared recipient area. Bulletin de la Société de Chirurgia, Dec. 15th,

1872: Ollier announced a novel method of skin grafting. The Bulletin de L'Academia de Medicine

"Instead of grafting small pieces of 2-3 cm., and 4 mm., square, as is done by M. Reverdin, M Ollier takes large pieces from 4 to 8 cm. square and more, including not only the superficial layers of the skin but the whole dermis."

1874: Carl Thiersch (1822-1895) first suggested the use of a razor in cutting grafts and emphasized the necessity of shaving the fat underneath the graft. (Verh. Deutsch. Gessel. F. Chirurgie, 1874.) HENCE THE OLLIER-THIERSCH

1875: I. R. Wolfe of Glasgow described methods for grafting of conjunctiva in 1872, and, later, methods for repairing eye-lid defects, including ectropion, with full-thickness grafts and devoid of Fedor Krause subsequently modified the

HENCE THE WOLFE-KRAUSE GRAFT.

1891: D. F. Keegan described his rhinoplastic operation in the *Lancet*:

"I generally allow at least a fortnight or three weeks to elapse after the mutilation before attempting to restore a new nose. A day or two before the operation I prepare a pattern of the forehead flap by cutting it out first in a piece of a leaf of the plantain (Banana tree). A piece of stout brown paper, cut to the exact size of this pattern is rendered adhesive on one side by smearing it with litharge plaster, and at the proper stage of the operation is stuck firmly on the forehead in a slanting direction.'

He recognised the importance of lining the new nose to prevent the withering that otherwise takes

Vercher described his mammaplastic technique. He reduced the breast substance by the excision of a quadrant in toto.

1903: Morestin described his mammaplastic technique. A curvilinear incision was made in the sub-mammary fold and the breast tissue exposed. Adequate quantities of tissue were removed and the reshaped breast anchored with deep cat-gut sutures to the pectoral fascia.

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The help of the following is gratefully acknow-

The Librarians, St. Bartholomew's Hospital, Wellcome Historical Museum, The Guildhall Library.

## **BEHIND THE SCENES: 4**

## THE MEDICAL COLLEGE AND ITS ADMINISTRATION

by Cecil Morris



The new research library-completed September, 1963.

#### Past and Present

In contemplating the administration of any organisation there is a tendency to consider the present as being the last word in efficiency and the past as being the opposite, but on reflection one realises that this is not the case. In the old days the Medical College was conducted on easy-going lines, much like a family business, and on the whole it was generally well administered, with due regard to economy and efficiency. Nowadays the administration of the College is a complicated business, and not the least difficult part is to bring into it the leading principles of a well-managed business without losing too many of the humanistic characteristics of the past. The changes which have occurred in the College's relationship with the State, the University of London, and other outside bodies has necessitated an acceptance of increased obligations, and as a consequence it now demands higher powers of organisation and management, and a greater knowledge on the part of its committee members.

The Medical College started as a voluntary

association of teachers who devoted some of their spare time to the instruction of students and prepared them for the various examinations; the first record of students attending medical and surgical practice go back to 1662. In 1834 the Medical Staff Committee was formed to deal with matters concerning the Medical School as distinct from the Hospital, and in 1839 the Medical Officers Committee signed a petition asking for recognition of the School by the University of London. This was agreed.

#### Constitution

In 1921 the College obtained a Charter of Incorporation and although modifications to the original Charter have been made, including a Supplemental Charter to admit women students, this document still forms the basis of the College administration. By virtue of the Charter the following powers were granted :-

(a) To take over the Medical School and its Library and Museum, together with any property held in trust for the use of the Medical School.

(b) To carry on the educational work of the Institution.

(c) To receive any property, gifts or endowments which may be made from time to time.

Governors of the Medical College were elected with certain powers, amongst them being the nomination of members of the College Council. This latter became the supreme governing body of the Medical College.

The Council of the College consists of the President, Vice-President, Dean and Warden of the College, ex-officio, together with representatives of the College Governors, the Hospital Governors, the Medical Council and the University of London. In addition, certain representatives are elected by the College Committee. The duties and powers of the Council consist in conducting the general business of the College, and the control and management of its real and personal estate. The College Council delegates its duties to an Executive Committee.

The College Committee is the Academic Body which is responsible for the general arrangements concerning teaching, and the nomination of Professors, Lecturers and Teachers for appointment

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St. Bartholomew's Hospital Journal, St. Bartholomew's Hospital, London, E.C.1. by the College Council. The College Committee consists of the members of the Medical Council together with the Professors and Lecturers of the College.

#### The Dean

The senior administrative officer of the College is the Dean, who is appointed for a term of five years, and who is ultimately responsible to the College Council for the whole of the administrative procedures. It is unnecessary to enlarge upon the important influence which a Dean, who has the ability for wise and inspired leadership, can exercise on the life and progress of the College. He is responsible for selecting the student entry, no easy matter when over 2,000 applications are received for approximately 100 places, and he must have constantly under review the medical curriculum, so that by its nature the training provides a student with an education on broad liberal lines. A further responsibility of the Dean is to maintain the friendly relationship which exists between the College and the Hospital, and to see that the Hospital does not lose sight of the fact that the student body forms an important part of the population of the Hospital.

Charterhouse Square

In 1933 the College purchased the site formerly occupied by the Merchant Taylors' School in Charterhouse Square, and this was formally opened as the pre-medical school in October, 1935. Unfortunately, two-thirds of the school was destroyed by bomb damage in 1941 and the College was faced with almost complete reconstruction. Temporary repairs were carried out in 1945, and the pre-medical school returned to Charterhouse Square from Cambridge where it had been during the war, in May, 1946. The rebuilding programme which started in 1948 with the construction of College Hall has continued without cessation to date. The new laboratory block contains accommodation for the departments of Physiology, Pharmacology, Physics, Zoology, and Radiobiology, together with an animal house, library, staff common-room, and accommodation for the M.R.C. Air Pollution Unit. An extension of the laboratory block which is nearing completion will house the linear accelerator unit and a research library. This building programme has been superimposed upon the normal administrative activities and has involved many members of the College staff in a vast amount of additional work.

The College's association with the University

of London, which started in 1839, has continued until the present time. Prior to 1930 Government funds for university education were allocated quinquennially by the University Grants Committee direct to the Schools, but by the Statutes made for the University of London, under the University of London Act, 1926, a new body was created called the Court of the University, and this department has the responsibility of allocating all funds at the disposal of the University.

In order that the College may obtain its share of the Government Grant to the University of London a Development Policy has to be prepared covering a period of five years, and the submission of the Policy is followed by a Visitation by a Committee of the University Grants Committee. The Policy has then to be interpreted in financial terms, and in due course the College receives notification from the Court of the amount of the grant awarded for the ensuing five years. The recurrent grant received from the University in 1930 was £17,750 compared

with £336,000 in 1962.

Due to rising costs the Exchequer grants have not always been adequate to meet the needs of the College, and many proposals put forward have not been implemented because of this lack of funds. The difficulties with which the College has been faced owing to insufficient funds being made available by the University have compelled many of the scientific departments to seek financial assistance from outside sources, and in addition to the normal income the College is at the present time administering the sum of approximately £60,000 p.a., including a grant of £30,000 from the B.E.C.C., for research purposes. The College has also to apply to the Court Department for capital funds for building purposes, and although the College received £803,000 towards the cost of College Hall and the new laboratories during the period 1949 to 1962, the building programme is far from complete.

Day to Day

Many of the administrative functions which have to be carried out to-day are the results of government legislation; these tasks are very timeconsuming and in no way contribute to the wellbeing of the College.

The day to day administrative activities can be divided broadly into two categories, (1) academic, and (2) management. The academic activities start a considerable time before a student enters the College; of the applications received for entry some hundreds are interviewed and from these the final entry is selected. The administrative work involved in the student entry is a continuous process. A current record of a student's progress through the College is maintained and examination schedules, reports for local authorities and pre-registration certificates dealt with, academic statistical requirements of the University of London are completed, clinical appointments organised, lecture and demonstration programmes arranged both for undergraduates and postgraduates, scholarship and prize examinations planned, the agenda for the various College Committees prepared and the Minutes recorded.

Management may be divided into two headings, financial and domestic. Under the heading of financial comes the collection of students' fees, University grants and other income, the payment of salaries and wages, the payment of all expenses incurred by the College, the preparation of financial returns required by the University of London, the issuing of student's

grants, which at present number 1,500 a year, the preparation of monthly accounts for the College Hall and refectories, maintaining the financial records of the Students' Union, and the preparation of the College Accounts for audit purposes. Under the heading of domestic comes the appointment of staff, the general maintenance of the College property, the management of the Hall of Residence, the refectories, the consultants' dining room and the sports ground, and the arrangements necessitated by the ever-increasing use of the College accommodation for meetings of professional societies.

No assessment of an administration can be complete without reference to the personnel involved, and the College is fortunate in having an administrative staff who perform their duties both efficiently and willingly, and at the same time try to maintain a good standard of public relations with all members of both the Hospital and the College.

## Case Report: FOOLED AGAIN

by A. J. Lines

A boy, R.T., aged 7 years, was brought by his parents to the Accident Service late in the evening, with the complaints of pain on micturition and apparent pain on trying to walk.

The history was that on the previous day he had ridden his new bicycle straight into a wall, and bruised his right groin on the handlebar. The morning after the event he had complained of pain in the site of the bruise, made worse on walking and micturition. He had been off his food all day and had vomited once. There had been no bowel action since the event, contrasting with his usually regular daily stool.

On examination the child was pale and apprehensive, T. 102°, P. 156/min. regular with normal volume. The respiratory rate and excursion were markedly increased during examination, but

fell to normal afterwards.

The tongue was clean and moist. The chest was clear. The abdomen was soft, with slight fullness of the right supra-pubic region. There was tenderness over the whole lower abdomen most marked at the site of a bruise, two inches in diameter, centred over the middle of the right inguinal ligament. No bowel sounds were heard. There was no perineal bruise. The left testis was normal. The right was smaller and was lying at the neck of the scrotum. X-ray of the pelvis showed no bony lesion.

He was admitted for observation.

Three hours later he was examined again. There were now guarding and rebound tenderness supra-pubically, and some tenderness in the recto-vesical pouch. He had passed no urine since admission.

The patient was taken to the theatre, and under a general anaesthetic further examination of the abdomen revealed nothing abnormal. A catheter was passed easily and a clear urine obtained. After gentle manual expression of this, some sterile water was injected via the catheter, and

the measured quantity was returned.

A transverse suprapubic incision was made. It was found that there had been no extra peritoneal extravasation of urine, and almost no bleeding. The peritoneum was then opened, and a trace of pus was seen. The appendix was found to be acutely inflamed, with a gangrenous tip. Routine appendicectomy was carried out with a sucker in the pelvis. The wound was closed without

Post-operative progress was good.

Conclusion. This case is reported to highlight a common pitfall, namely that of failing to bear in mind one of the most common abdominal dis-

I am grateful to Mr. L. W. Plewes for his encouragement to write this case up.

# AN INTRODUCTION TO CARCINOCHEMOTHERAPY with particular reference to arterial administration

by C. A. C. Charlton

CHEMOTHERAPY is the most recent addition to the armamentarium in the battle against neoplastic and related diseases.

This therapy is often employed as a form of palliation in some carcinomas following the use of, or in conjunction with, the more conventional types of treatment of this disease—those of surgery, radiation and hormone therapy.

One of its great advantages is that it may provide relief of pain by a relatively simple method and so postpones the use of the more powerful analgesics with their associated state of semistupor and "partly living". It does not necessarily prolong survival, but does make the remainder of the patient's life more comfortable.

The drugs and their activity

There are two main groups of chemotherapeutic agents at present in clinical use in the treatment of cancer. The first group consists of the biological alkylating agents, which act mainly by altering the essential cellular constituents such as nucleic acid, proteins and enzymes and so lead to cell death.

Amongst these agents are thiotepa (an ethylenimine), nitrogen mustard, which was the first drug used in localised chemotherapy for tumours by Klopp of Washington, U.S.A., in 1950, melphalan (phenylalanine mustard), and endoxan (cyclophosphamide-phosphamide derivative of nitrogen mustard).

The second group comprises the antimetabolites which interfere with the synthesis of nucleic acids by acting as fraudulent substrates, products and co-factors. Examples are 6 mercaptopurine, 5 fluoro-uracil and methotrexate (amethopterin).

It follows from the above, that the alkylating agents are effective if they are in contact with the tissues for a short time, whereas the antimetabolic drugs must be exhibited for a period of days before maximal benefit occurs. This fact determines, to some extent, the method of administration of the drug.

The susceptibility of cells to cytotoxic compounds depends on the rate at which the cells divide. The more rapidly dividing cells (physiologically and pathologically) are the most vulnerable. The effectiveness of these drugs is increased by raising both the temperature of the tissues (by accelerating the chemical changes)

and the oxygen tension of the target cells (which is believed to potentiate drug activity).

The normal tissues most liable to damage are haemopoetic tissues, gastro-intestinal mucosa, germinal epithelium and skin. It is this factor which limits the dose of the drug administered, although in the case of the anti-metabolite methotrexate, these tissues can be protected to some extent by injecting intramuscularly a specific antagonist like folinic acid.

One of the most favourable features of carcinochemotherapy is that the course of drugs may be repeated many times, the length of each course being limited by the toxic manifestations. During therapy it is important to have repeated white cell and platelet counts done, the drug being withheld if the levels fall below certain arbitrary figures (2,000 cells/cu. mm. for the white cells and 100,000/cu. mm. for the platelets). Evidence of infections, bleeding tendencies, diarrhoea, erythema and blistering of the skin, may also indicate termination of the course of treatment.

Once the patient has recovered from one course, there is no reason why the drug should not be repeated, and as large, or even a larger amount of the drug may be given on this second occasion with no marked ill effects. The dose of the drug is initially adjusted to correspond to the patient's general condition. If previous radiation therapy has been given, a smaller dose than normally prescribed is indicated.

Individual drugs tend to show a specific activity with regard to the different types of carcinoma treated. It has been shown (Hurley et al) that 5 fluoro-uracil is superior to thiotepa, cyclophosphamide and nitrogen mustard in the treatment of breast cancer, and is the most satisfactory drug in the treatment of carcinoma of the pancreas and colon. In some cases maximal effect has been obtained by using a combination of drugs, such as nitrogen mustard and thiotepa for carcinoma of the hepatic biliary area.

Carcino-chemotherapy also proved of value as an alternative form of treatment to X-ray therapy in inoperable adenocarcinoma of the colon. This lesion is relatively insensitive to X-ray therapy, but objective remission was obtained in 20 out of 45 cases of this disease treated with 5 fluorouracil (Vaitkevicius).

Administration and results

These drugs may be applied locally at the time

of operation. The peritoneal cavity may be bathed with a solution of the drug following removal of a tumour, the chest wall swabbed following mastectomy and the mucosa of bowel ends cleansed prior to anastomosis. The value of this is well documented in the case of the last example since the incidence of recurrence of tumours at the suture line has been drastically reduced (Cole et al).

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Intracavity administration of carcino chemotherapeutic agents is also in common use for the treatment of peritoneal and pleural metastases. The effusions may be temporarily increased following injection of the drug, as a result of mesothelial reaction, but this is commonly followed by a decrease in the production of fluid. The object of this form of treatment is to make the patient more comfortable and does not lend itself readily to statistical measurement of cure rates, since the effusions are usually a manifestation of advanced disease, with an extremely poor prognosis.

There are various ways of administering these drugs parenterally. A method of localised chemotherapy for tumours by an arterial route has been the subject of much recent work and has been termed regional chemotherapy. Three different methods of delivering the drug through an artery exist; perfusion, infusion and intermittent injection.

In the case of perfusion, the circulation of the region is isolated from the general circulation by cannulating the afferent artery and efferent veins (applying a cuff proximal to this), and is maintained by a pump and oxygenator, the drug being introduced into this circuit. In the limbs isolation of the circulation is virtually complete and is therefore known as isolated perfusion. This procedure is employed in the treatment of malignant melanomata. In the upper limb 45 to 60 mg. (depending on the weight of the limb) of melphalan is perfused for one hour, being added in aliquots and then the drug is washed out, since it is active for some hours. In the lower limb up to 90 mg. of melphalan is used. It is often convenient to remove the primary lesion with or without the regional lymph nodes at the time of perfusion, or this may be done later, by which time the tumour should have regressed in part at least. Soft tissue sarcomas of the limbs have also been treated by perfusion with nitrogen mustard or melphalan. Creech et al have treated 240 limbs by the above method and obtained a complete cure with no evidence of recurrence at 4 years in 25 per cent. of the melanomas and in 34 per cent. of the sarcomas. Of the melanomata, total or partial disappearance of the lesions occurred for varying periods in 80 per cent. of the patients. Mortality was

approximately 6 per cent. Regional perfusion is when complete isolation of the circulation is not possible and leakage of the drug into the general circulation occurs. When perfusing the pelvis, cannulae are introduced retrogradely through the femoral vessels up to the level of the common iliac vessels, the aorta and inferior vena cava are exposed and occluded proximally and thigh tourniquets applied. By this means tumours of the rectum, genito-urinary tract, perineum, buttock and iliac lymph nodes may be treated. Creech et al used thiotepa and nitrogen mustard for this treatment, and abolished the pain caused by the disease in 36 per cent. of cases for four months or more. Eradication of the disease at these sites is extremely rare, but palliation may be achieved. This last is one of the main indications for regional perfusion in carcinoma of the breast and although it is obviously difficult to prevent the escape of the drug (melphalan and thiotepa being used in these cases) into the systemic circulation, objective improvement was obtained by the same workers, in 50 per cent. of patients so treated.

Continuous intra-arterial infusion is of value when using anti-metabolic agents, since a steady blood level of the drug may be maintained over a period of days, and it will be in contact with the cancer cells at the particular stage in mitosis at which it is effective, namely when the synthesis of the nucleic acids is occurring.

The regional artery to the tumour area is cannulated directly or by securing a catheter into a branch artery. To check that the catheter is correctly positioned, dye is injected along it and it is seen whether the stained area includes the tumour. To deliver the drug into an artery, a pressure greater than the systolic blood pressure is required. This is achieved either by means of a pump or by gravity feed, having the solution suspended high above the level of the patient. At the termination of treatment the catheter may be withdrawn, or if a further course of drugs is contemplated, it is sealed off (the catheter is first filled with heparanised saline to prevent its blockage by blood clot). Westbury (1963) treated 43 patients with head and neck cancer by this method and 34 of these obtained complete or partial regression of the tumours. Methotrexate was the drug used and in 16 of the patients 2-4 mg. per day was given for 1-2 weeks, whilst in the remainder large ordinarily lethal doses were given with the specific metabolite folinic acid (6 hourly I.M.) to protect the body from the toxic effects. The results were much the

same in both groups. One of the advantages of the intra-arterial infusion form of administration is that the course of therapy may be temporarily interrupted to allow any toxic manifestations to wear off and the tissues to recover, before proceeding further. This method of treatment is also employed in treatment of pelvic disease.

The third way of delivering the drug in regional chemotherapy is by intermittent intra-arterial injection. The advantage of this method is that the patient is not anchored to a drip, but only alkylating agents are truly effective given by this method. Commonly an indwelling arterial catheter is introduced by percutaneous puncture (if into the femoral artery) or at open operation. There is a danger of thrombosis of the common or internal carotids if an indwellings catheter is used in the treatment of cerebral tumours and so repeated arterial puncture is preferred.

At the Westminster Hospital, 11 patients with brain tumours were treated by internal carotid injection of thiotepa, given 45 to 90 mg. of the drug over 4 to 5 minutes (the positioning of the catheter is first checked by arteriography or instilling 10 per cent. fluorescein); up to 300 mg. of this drug was given. Objective remission (relief of headache and diminution of papilloedema) was obtained in 7 of these patients. The same workers have treated 11 patients with pelvic cancer by 2 or 3 injections of nitrogen mustard (20-30 mg. on each occasion) through a catheter placed at the bifurcation of the aorta by percutaneous transfemoral catheterisation. Relief of distressing symptoms was obtained in 7 of the patients.

The intravenous route of administration has also been employed. To compare the results of continuous administration of the drug by this means with the intra-arterial route, Sullivan et al treated 27 patients with various types of neoplastic disease with methotrexate and intermittent folinic acid. In two-thirds of these patients, the arterial route was chosen and over half obtained partial or total objective tumour regression, whereas in those receiving the drug intravenously only a third obtained a slight and transitory regression. There was also an increased incidence of toxic symptoms when the venous route was employed.

Widely disseminated melanoma have been treated by intravenous melphalan and although the dosage approached haematological tolerance, only occasional temporary benefit was obtained (Newton).

The oral route is now being employed for the administration of some of these drugs, but no reports are available to date as to the efficacy of this method.

# Summary

A number of carcino-chemotherapeutic agents in common use are described and the methods of administration and results are reviewed. The alkylating agents may be applied locally or intracavitarily, or used systemically by either the perfusion or intermittent arterial injection techniques. The anti-metabolic drugs are best employed by continuous intra-arterial infusion. There seems to be little to recommend the intravenous route of administration, other than its technical simplicity.

Finally, Hurley at Milwaukee has treated over 500 patients with advanced carcinoma by chemotherapeutic agents and 1 in 3 have obtained varying degrees of palliation.

# ACKNOWLEDGEMENT

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Date ....., 1963

Half past seven o'clock, and a mercifully rain-free evening. The skirl of the pipes echoed crisply around the Charterhouse precinct (but was the piper so unsure of himself or of his audience that he had to start his recital in the car park?). Still, the sound gave added urgency to the cleansing rites in College Hall bathrooms. The men shaved a little closer, and wiped away the blood with a barely muffled curse.

Simultaneously the lights went on. Happily, they illuminated not the angular façade and dreary fenestration of C.H., but the trees and the architectural bouillabaisse of Sutton's Hospital. Percy, the Hospital mascot, stood in splendid, green-lit isolation on the lawn; rotund, shining, and reminiscent of Easter Island. Surely this was—in the strictest sense of the phrase—son et lumière?

Although the tickets suggested that dancing would begin at eight, the piper called the tune until 8.30 without any competition. Meanwhile, Mr. Tubby Isaacs set up his stall (a touch of genius on the part of the organisers). The following morning, the myriad pathetic corpses of scampi bore silent witness to its popularity.

Rather slowly, people materialised and the bands began to play. The smoke from the braziers (another touch of genius) drifted across the lights in technicolour clouds. The steel band clanked away melodiously on the lawn, but dancing was not easy and they eventually went indoors.

The outside bar was another excellent feature—and a very necessary one, for the C.H. bar, although well sited, is too small for such occasions—and it was pleasant to stand drinking round the fires. The piper returned to the fray and a number of brave souls tried their hands



# BARBECUE BALL

From A Social Correspondent

(feet?) at Scottish dancing. They revealed great enthusiasm, but for the most part, this correspondent noted sadly, a certain ignorance of the exact procedure.

Back indoors, the steel band alternated with one of more orthodox materials in the refectory. Mr. Birnstingl appeared to prefer them to the well-patronised twisters in the recreation room, and who can blame him? He is, after all, a musician. Certainly

the refectorians had more room, and at the candlelit tables, with a projected image of a Greek temple in the background to set their minds on higher things, they had an atmosphere more conducive to vocal, as well as tactile communication.

Came the food; and amazingly, 350 people were fed with little fuss and clatter. I suppose that for 30s., one must not expect Strasbourg pâté and the finest Sevruga, but at any rate, nobody starved. Despite all the cheap

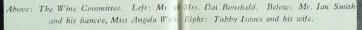
liquor (spirits were 1s. 6d. a nip at the bars), private caches of wine were revealed, and the popping of corks punctuated the quiet roar of conversation. Junior staff were there in abundance, and one or two more august figures were to be seen. Dr. Balme, eyes a-twinkle, circulated freely, while Mr. Ellis smiled urbanely at everyone.

At this stage, the pig, which had been turning happily on its spit for more than half a day, was declared open, so to speak. A suitably garbed high priest cut up the animal, and a number of smartly-clad acolytes distributed the pieces. Now here let me confess my almost total ignorance of the art of pig-roasting, and my unbounded admiration for anyone who undertakes such a difficult task. This having been said, it must be admitted that although the crackling was excellent, the flesh was at best a trifle rare. Nonetheless, many people did eat it; and if not for gastronomic reasons, then perhaps, as someone said of Mount Everest, because it was there.

And so to the cabaret. "House Full" would have been an understatement, but somehow everyone was able to see. It is true that some of us had seen a number of the sketches before, but most had not. And anyway, funny stories retold by Messrs. Chapman, Oddie and Cleese are not the same as funny stories retold by lesser mortals. Nobody was disappointed, and if it seemed brief, it had that in common with most worthwhile experiences.

Well, the bandmasters eventually cried "time" and slowly the party broke up. People walked more or less unsteadily to their cars, and drove off more or less skilfully. Percy watched all, inscrutable. The lights went out. And so to bed.









# "ROUND THE FOUNTAIN"

Have you read the latest edition of "Round the Fountain", a highly entertaining anthology of verse and prose extracted from past editions of The Journal.

A note to the Manager of the Journal enclosing 5s. 9d. will ensure that a copy is posted to you immediately.

Students in the October 1963 entry may be interested in the above publication obtainable from their respective cloakrooms at only 5s. per copy.

The important article on leprosy published in your June issue reminds me. . . . In 1942, while serving in the Middle East Command I spent ten days in a hotel outside the walled city of Harrar, which takes its name from Mount Harrat nearby. This, the Abyssinians claim, is where Noah's ark touched ground. Harrar is said by some to be the most ancient walled city in the world. Outside it is a leper settlement which I visited twice. There was a sentry at the entrance, but no other boundary to hinder visitors! Though I saw many with

# A LEPER AS WHITE AS SNOW

by R. Ogier Ward

shrivelled hands and missing fingers I saw no one "as white as snow", nor anyone of the terrible appearance depicted in your recent and interesting article.

# **IERICHO**

Harrar closes its gates every night after the cattle and goats have been driven into it, as no doubt Jericho did. I explored Harrar a good deal and saw that the walls had been undermined by the goats during their leisure hours. The walls are made of rough hewn stones crudely placed in position and fixed only by dried mud. A track runs along the top of the fifteen to twenty foot wall. Walking on it, I could easily see how much it was out of true in places. In this way I became fairly sure as to the manner in which Joshua captured Jericho, without the aid of any earth tremor, as has been suggested.

Joshua's orders to his spies were to make contact with Rahab the harlot in the city and find out where the walls were most undermined by the goats. Joshua could see for himself from the outside where any tilt was considerable. It was arranged that Rahab would hang a garment of some agreed colour where the outward or inward tilt or undermining was most marked. Then for six mornings the Israelites marched round Jericho in silence except for the priests' trumpeting. The inhabitants must have been amazed by the strange ritual, but by the seventh day they had lost interest, especially as on the seventh day the procession with The Ark compassed the city seven times. When the procession arrived opposite Rahab's garment the "priests blew with the trumpets at the command of Joshua and all the people shouted". Naturally the inhabitants all rushed to the top of the wall to see what was happening. This was too much for the wall and it collapsed and the armed men entered the city and took it. (And in 1942 when I was there seeing the lepers I could have undertaken to arrange for the capture of Harrar by the same means!)

# GEHAZI

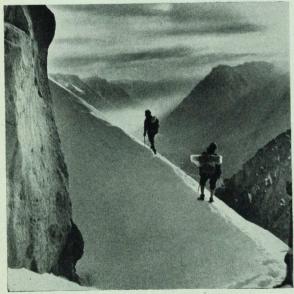
Now let us go to Canterbury Cathedral where, in 1170, three knights rid Henry II of that turbulent priest Thomas à Becket, whose body was left in the North Transept. The monks, terrified, had run away, but after a while they felt easier and returned to the body. They were astounded, for Becket's face, usually ruddy no doubt, was now as white as snow. Becket was a holy man and wore, as proof of his holiness, a horse-hair yest which had never been washed. The monks realised that the whiteness of his face was due to lice leaving the chilling body.

With this phenomenon in mind, let us again refer to the Bible—2 Kings, Chapter 5, "Naaman captain of the host of the King of Syria" learnt from his wife's Israclitish maid that in her country was a man who might cure him of his leprosy and so Naaman sought Elisha the prophet. Elisha was a cautious man and merely sent a servant to Naaman telling him to "go and wash seven times in Jordan and thou shalt be clean". Naaman was annoyed at his brusque reception, but was persuaded to do so, and was cured. Elisha seems to have lived near the lower Jordan where it was already, no doubt, very saline and sulphurous. Elisha prudently refused all gifts and Naaman departed. This was more than Gehazi, Elisha's servant, could tolerate, so he ran after Naaman saying that two young men had arrived and that Elisha asked for "a talent of silver and two changes of garments". Gehazi, having received these, went home and, no doubt, changed into the best of the suits before standing in front of Elisha who rebuked him and Gehazi "went out from his presence a leper as white as snow". A little poetic license here—the lice which had not fed since they were packed up for the journey from Syria now got busy not only on Gehazi's warm body,

# ST. BARTHOLOMEW'S TOWER by a Special Correspondent

We claimed our right as makers of the first ascent and named the loads to the edge of the plane. mountain St. Bartholomew's Tower. This stands at the head of the As if they had been empty Lang Glacier in the Staunings Alps of East Greenland, its twin cigarette packets the slipstream battlements standing out above the whiteness of the glacier.

Perhaps I should explain how I came to be there and why we spent the Summer 500 miles above the Arctic Circle instead of swimming on the Riviera. The few expeditions to neighbouring areas had spoken of almost continuous sunshine, by night as well as by day, of magnificent spires of tawny granite in a setting of virgin snow between the Arctic Ocean and the Greenland Ice Cap. The prospect of unclimbed peaks on an Alpine scale in surroundings like these was worth a year of concentrated planning and the organisation of a scientific programme to help in the raising of £3,000. In the Spring the Cambridge East Greenland Expedition, 1963, was still short of a medical member and wrote to ask if I would like



At the foot of "Metacarpal" on the ascent of Attilaborgen.

Until August the pack ice off this part of Greenland effectively them as snowshoes — and an blocks the approach of shipping and we wanted to arrive in early arduous grind was changed to July, so we had to charter a plane from Icelandair. To save carrying a delightful mountain journey. our food and equipment for the Summer across the backbone of the range we decided to parachute it onto the Sefstroms Glacier on pass which separates the Berour way to Mestersvig.

Like a glimpse through the back of Dr. Stephen Ward's infamous up a snow-filled recess. Here mirror we were given a preview of the excitements before us from the slope is too steep for skis the plane. At this range rock walls and peaks looked impossibly so we changed our footwear steep. Firmly anchored by our waists we heaved the parachute once again and climbed it in

tore them away, the static line opening the parachute slammed against its stanchion and we watched the circles of orange nylon drifting down to the glacier. Only one of the twentyeight failed to open and we were well pleased as we flew round the coast to Mestersvig, where the glacial deposits of gravel have been bulldozed into an airstrip. It was early in the morning when we landed and a good moment to broach our bottle of whisky.

From a point above our Base Camp beside the Sefstroms Glacier to Mestersvig took half an hour by plane. On the return we journeyed for seven full days. Chaotic heaps of boulders mud and gravel soon changed to rounded heather-clad hills. Green shoots were appearing close behind the melting snow. It was the beginning of July and Spring was here. We climbed a low pass and dropped into the Skeldung to find the entire valley floor awash with melt water. There was no alternative but to walk, probing with ski sticks to keep our balance, water swirling round our knees.

The Bersaeker Glacier winds into the heart of the Staunings, the huge slag heaps above its snout giving way to granite towers and snow peaks as we neared its source. When the ice highway underfoot gave way to snow we put on skis-using

The way to Col Major, the saeker and Gully Glaciers lies

crampons.1 On a fine Winter day in Scotland it would have been an easy climb. Here the weather had broken and little slides of powder snow covered the steps of the man in front. With skis added to our loads we were glad indeed to find pieces of the fixed rope left by Hunt's party two years before. The Col was bleak. The wind was driving flurries of snow into our faces and all but the nearest rocks were blotted out by cloud. It was pointless to start blindly down so we pitched the tents and retired to our sleeping bags for a day and a half.

It was a welcome excuse for a rest. Only one person had the foresight to bring a book, but he was persuaded to tear it into pieces and circulate it among us. We melted snow to hydrate our freeze-dried meat and to make tea, a process which took so long that the end of one meal almost overlapped the beginning of the next. Though it was an enjoyable way of passing time, we were glad when the cloud broke up and we could at last ski off down the gully.

For all but the experts, downhill ski-ing with a pack is an crratic form of progress. Speed builds up until one's courage falters or one loses control. Then the next five minutes are spent unclipping ski bindings, digging out self and pack, putting skis back on and cautiously starting all over

At last we rounded a corner and Alpfiord came into view, a limpid blue-green, speckled with icebergs spawned off by the glaciers which nose out into its waters. Behind was the edge of the Ice Cap itself, a thin rim of white above a tottering black cliff which dropped thousands of feet to the fiord. Beyond this tip the ice is thought to

<sup>1</sup> Crampons — steel spikes strapped onto the under surface of be almost two miles deep, its weight forcing the bedrock below the level of the sea. This was to be the backcloth to our Base Camp, which we reached three days later. It was a delightful place, a clearing in the boulder field far above the fiord, where Alpine flowers and heather found a precarious hold in the gravel.

We were amused at first and later much annoyed by the activities of a kleptomaniac Arctic fox We never decided whether he was incredibly foolhardly or a good enough psychologist to know that we were too softhearted or too scared of regulamargarine tins over the hillside. He became less popular when he grew bolder and car ried off a camera. We imagined him chuckling quietly to himself as he photographed the entire expedition combing the boulder field for his new acquisition.

It was late in the Summer when we climbed Attilaborgen, unofficially named by an Austrian party although they had been driven back by the weather when short of the summit. It was now too cold to climb on rock when the sun was far below the horizon. We decided to bivouac on a high



St. Bartholomew's Tower from the Lang Glacier.

tions in the hunting shires ever to shoot him. The only food he stole was a plastic bag of egg powder which he perforated in several places and sprinkled round the camp. Like a jackdaw he preferred bright shiny things, distributing our empty

ridge at the foot of an obelisk which we called the Metacarpal in polite circles. Slowed by food and sleeping bags in our packs we plodded interminably up the snow slope leading to the ridge. Hours later we reached it and were rewarded by the setting sun over the Ice Cap—beautiful behind tiers of fiery clouds. For a moment we were tempted by the idea of a dash to the summit before the weather broke, but we were already tired and there was a long way to climb. Reluctantly we agreed that it was prudent to wait. We built a wind-break from a monster polythene bag, spread out our sleeping bags and settled down for the night.

Next morning the sky was leaden and heavy with snow. Though the neighbouring peaks were masked by cloud, Atrilaborgen was still clear and we could always retreat if the weather became too bad. Failing to think of a good enough reason for postponing the start we armed ourselves with bando liers of ice screws, strapped on our crampons and set off.

While the angle was easy we could move together, kicking steps in the snow. Higher up it had an alarming tendency to slide away underfoot, leaving a menacing sheet of hard blue ice. There was nothing for it but to cut steps and climb in pitches, each man protected by an ice screw belay. Veils of cloud were blowing across the face and it was very cold, but the summit was now so close that a retreat was unthinkable.

The top appeared quite suddenly out of the mist and with the memory of how we had dispatched the summit cornice of Pembroke into the valley the week before, we did not venture quite to the highest point. Our stay was just long enough to measure the temperature (-8.6°C.), the wind speed (916 ft./min.) and the altitude (8,440 ft.) though we needed none of these figures to tell us that this was no place to linger.

If the climb had been mildly harrowing at times, the descent was patently unpleasant. We

<sup>2</sup> Belay—A fixed point through which the stationary climber is secured to the mountain. hewed out buckets for our feet and cowered deeper into our down jackets, like robins in the middle of an English Winter. When we came to rock pitches we rapelled<sup>3</sup> down the rope and rejoined our tracks to the glacier.

We almost ran down the morraine as it was important that we reach Base Camp before Alouette, the Canadian satellite passed overhead, as we wanted to make ionospheric recordings at the exact time of the crossing. This measurement



Dentistry by the expedition's doctor.

of naturally-occurring very low frequency electromagnetic activity formed the main part of our scientific programme, the justification for visiting Greenland. At hourly intervals we switched on the tape recorder to pick up the crackles and hissing emanating from the ionosphere. When the tapes are analysed they will yield information about the upper atmosphere and the earth's magnetic field.

Many weary hours were spent drilling holes in the glacial ice to plant stakes whose rate of movement could be measured

<sup>3</sup> Rapel—To slide down the rope which is doubled over a fixed point so it may be recovered from the bottom.

from survey stations at the side of the glacier. We calculated that it flowed 80 metres a year. Geologists attacked the Staunings granite with a sledge hammer since nothing smaller will chip off a piece when the rock is as hard as this. I made myself unpopular by subjecting half the expedition to the Harrod Step Test. This involves counting their pulse as they recover from stepping up and down a boulder of standard height at a rate too fast for comfort. Not surprisingly after a month of carrying loads around the mountains everyone became fitter.

We named our peaks after Cambridge colleges, a system which worked well until we ran out of colleges. As a concession to the medic, St. Bartholomew's Tower was christened and we were left with an impressive snow peak, a bald and shining dome in the sunlight, with a fringe of black rock curtaining its lower slopes. In view of its Scandinavian flavour, Erik's pate was suggested. The Danish Government is trying to prevent the map of Greenland becoming a European telephone directory and names commemorating contemporaries are not accepted. We fell back on Snetoppen,4 the name given from acrial photographs.

The Arctic Summer is short. By mid-August one could hardly read at midnight, flecks of white were appearing in the fox's bush and bilberry leaves were splashing the lower hillsides with patches of red and yellow. On the last day of the month snow fell at Mestersvig and the Danish meteorologists announced that winter had come. We had climbed twenty-eight new peaks between us and finished our scientific programme.

With reluctance we left this extraordinary country and flew off to the South.

4 Sne—snow, toppen—top.

# THE DEPARTMENT OF PSYCHOLOGICAL MEDICINE AT BART'S

by W. Linford Rees, Physician-in-Charge

THE field of psychiatry is varied and extensive. It not only includes the severer forms of mental illness and subnormality which account for 46 per cent. of all hospital beds in England and Wales, but the less severe psychiatric disorders which form 10-20 per cent. of patients seen in general practice. Psychiatry in many ways is a generality as well as a speciality and has been referred to as the "other half of medicine" as so many medical and surgical patients are found to have important psychological aspects. The modern trend is for more and more patients to be treated at out-patient clinics and for greater provision for community care for psychiatric patients. It is the policy of the Ministry of Health to develop psychiatric in-patients units in general hospitals for early treatment of mental illness. In future every new general hospital will have a large psychiatric unit. The Mental Health Act of 1959, which abolished certification and removed legal differences between general and mental hospitals together with the forward plan-ning programme of the Ministry of Health constitutes a major revolution in psychiatric care in this country which now in many respects leads the world.

# THE PSYCHIATRIC DEPARTMENT AT BART'S

The functions of the psychiatric department include:

1. Diagnostic and treatment services to outpatients and in-patients.

Teaching.
 Research.

Personnel:

The staff of the department work as a team and consist of doctors, nurses, a psychologist, psychiatric social workers, secretarial and administrative staff.

Medical Staff:

There are two consultants, a senior registrar and a part-time senior house officer post shared with the department of neurology. In addition, experienced psychiatrists of consultant status work part-time as Associate Chief Assistants and help in psycotherapeutic and other treatment clinics.

Nursing Staff:
A psychiatrically and generally trained Sister who has had special experience in group and family therapy provides invaluable help in the smooth running of the department and also maintains full liaison with the nursing staff of other parts of the hospital. Psychologist:

The functions of a psychologist include psychometric testing for assessing intelligence level, personality and intellectual deterioration. The treatment of

congenital dyslexia (word blindness) has been especially developed at this hospital and specialized individual treatment is provided.

Psychiatric Social Workers:

A senior psychiatric social worker and three psychiatric social workers work in the department.

Social aspects are important in many diseases, but none more so than psychiatry. Students are taught not only to regard their patients as a psychosomatic unity, i.e. with a body and mind acting as one, but also the importance of regarding the interaction between a person and his environment as a continuum.

Psychiatric social workers deal with environmental and family aspects such as employment, housing, use of social agencies and give important therapeutic help to the patients and their families. A psychiatric social worker often has to take on one or more members of the family in order to help them to accept, understand and cope satisfactorily with the patient.

# TREATMENT SERVICES

The following forms of treatment are provided:

1. Psychotherapy:

Psychotherapy in some form is an essential part of all forms of psychiatric treatment. It may be given individually or in groups.

(a) Individual Psychotherapy: Varies according to the needs of the patient. It may range from supportive and short-term therapy to

intensive long-term psychoanalytic therapy.
(b) Group Psychotherapy: This method has principally developed since World War II. The group usually consists of some eight patients with similar clinical problems and of similar age. Group therapy can be carried out in many different ways depending on the experience and preference of the doctor and the patient's need. It is not only economical in doctor's time but has greater therapeutic advantages than individual therapy for some patients. The essential requirement is that patients evolve into an actual dynamic group which facilitates expression and subsequently a better understanding of their problems and interpersonal relationships.

2. Pharmacotherapy:

The drug treatment of psychiatric illness has developed dramatically in recent years, with the discovery of the major neuroleptic drugs for treating schizophrenia and other severe psychiatric disorders, and the advent of drugs for treating depressive illnesses and, more recently, highly effective drugs for treating anxiety and tension.

3. Electroconvulsive Therapy (E.C.T.):

St. Bartholomew's was the first hospital in the world to use E.C.T. for out-patients and it is now given in all major general hospitals. The treatment is given under general anaesthesia with intravenous pentothal. A short acting relaxant (scoline) is used to reduce muscular action and so eliminate risk of

body injury. E.C.T. remains the treatment of choice for severe endogenous depressive illnesses.

Social Therapy:

Environmental and family problems are dealt with by psychiatric social workers. Rehabilitation and other facilities of the Ministry of Labour and other authorities are called upon when indicated by the patients' needs. A social club to promote social rehabilitation of some patients who have difficulties in mixing socially has operated from time to time.

Treatment of Children: The Child Psychiatric Clinic provides the following

therapeutic services:

(a) Play therapy.
(b) Guidance to parents by psychiatric social

workers.
(c) Psychological advice and training for

selected patients.
(d) A special clinic operates for treating adolescent problems.

7. Miscellaneous therapies:

When indicated, abreactive techniques, narcoanalysis, hypnotherapy and other therapeutic methods

**OUT-PATIENT CLINICS** 

The work of the out-patient clinics has doubled in the last seven years. In 1962 there were 9,077 attendances compared with 4,580 in 1954. The clinics

(i) Diagnostic clinics which are now held through-

(ii) Emergency clinics held daily to deal with psychiatric emergencies from the Casualty department or other parts of the hospital and from general practitioners.

Treatment clinics for adults and children as

described above.

#### **IN-PATIENT BEDS**

At present six beds only are available, three female and three male and are a part of a general medical ward. It has been agreed that as soon as possible the number of psychiatric beds should be increased with the aim of forming a separate unit within the hospital in order that nursing and other staff can be specially trained to meet the particular needs of psychiatric patients. When the larger number of beds is available it will be possible to arrange for students to undergo clerking and supervised clinical work with these patients and to follow their progress for a sufficiently long period of time.

# DAY-HOSPITAL CARE

In recent years an important development has been the establishment of Day Hospitals which can provide all the treatment facilities available to in-patients and avoids the danger of hospitalisation. The patient attends in either or both the morning and afternoon.

The Ministry of Health in the Ten Year Hospital plan has agreed that a special Day Hospital shall be established at St. Bartholomew's for treatment of patients of all ages and special facilities for teaching and research. This will be a major advance in the services of the hospital and will be invaluable for teaching and research as well as providing first class facilities for treatment and rehabilitation of patients.

# COLLABORATION WITH OTHER DEPARTMENTS OF THE HOSPITAL AND WITH DEPARTMENTS OF THE MEDICAL COLLEGE

In the past psychiatry tended to suffer from its traditional isolation. In Bart's we are fortunate in having close collaboration and full interchange of ideas with colleagues in every part of the hospital and Medical College. If staffing permitted there would be enough work for a parttime psychiatrist to be attached to most special departments and clinics of the hospital.

A combined clinical conference is held monthly for the Departments of Neurology, Neurosurgery and Psychiatry. Patients presenting special problems are presented and discussed. The conference has proved both valuable and stimulating.

We also enjoy collaboration in research with departments of the Medical College including Pharmacology and Biochemistry and with the Medical Statistical Department.

TEACHING

Undergraduate:

Clinical teaching and clinical clerking is carried out on out-patients. This is supplemented by systematic lectures, demonstrations and visits to psychiatric hospitals. The proposed new curriculum at Bart's provides much more time for the teaching of psychiatry in the first as well as the second clinical years. Furthermore, when the Day Hospital becomes available and the number of in-patient beds increases, there will be opportunity for greatly increased range of clinical teaching and supervised clinical work with better opportunities for students to follow the patient during the stages of the illness.

Postgraduate:

Postgraduate training in psychiatry is provided for clinical assistants, registrars and senior registrars as well as postgraduate overseas students.

# RESEARCH

One of the important functions of a University is to carry out and promote research. This is not only important for the advancement of medical knowledge with the possibility of improved care and treatment but also because active research work stimulates personnel, keeps them on their toes and provides a valuable opportunity for training post graduate students in research methods.

A list of current research projects was recently published in the Clinical Supplement.

# MEDICINE IN THE PUBLIC HEALTH SERVICE

by Herbert D. Chalke, O.B.E., T.D. M.R.C.P., D.P.H.

The Early Days of Public Health

**S**INCE its beginnings in 1847, the public health service in this country has expanded steadily and its present structure and scope bear only a superficial resemblance to those of a century ago.

The first medical officers of health fought the adverse environmental conditions brought by the industrial revolution. These doctors stood for "the sanitary idea" based on the belief that disease came from "miasmatic exhalations" in filthy, damp, overcrowded homes.

# Personal health

Unfortunately, the setting up of a communal hygiene service was not accompanied by a system of state medical care; the poor-law and the charity of voluntary bodies still dominated the medico-social scene at a period when life was cheap and cruelty, ignorance and poverty abounded. The need of help and health teaching for individuals became apparent, and towards the end of the century the seeds of personal health were being sown by voluntary agencies. The untrained visitors to poor homes have become the highly-qualified health visitors of today.

Although some provision for physically and mentally defective school children had been made carlier, it was not until 1907 that the school medical and school meals services arrived. Their influence has been tremendous. District nursing, notification of births and infectious diseases, registration of midwives, and, later, the creation of a tuberculosis service, were other weapons in the war against disease. So was the health insur ance scheme of 1911, but it applied mainly to working-class adults and not to children. The Maternity and Child Welfare Act of 1918 was another landmark.

#### Public health in the post-war world

Since the first Public Health Act in 1848, there has been a profusion of legislation about environmental and personal health, in connection with food, housing nuisances, clean air and noise. The care of mothers and children, infectious diseases, school and industrial health, mental illness and mental deficiency, were also dealt with. The incidence of the major infections has declined during this period and maternal and infant deaths have diminished progressively. School children are taller, heavier and healthier. The expectation of life has been extended by thirty years (but, paradoxically, longevity has itself brought new problems). This progress has been brought about by the conjunction of many forces-educational and social improvement, immunisation and, latterly, effective treatment—which must be the partners of social medicine. As many of the public health tasks of vesterday have been lightened. a changing world brings others which present new challenges and need a fresh approach.

The year 1948, with its new health service, marked the end of an era, characterised at first by apathy, ignorance and squalor, with malnutrition and outbreaks of dangerous infection. In the atomic and electronic age of the welfare state, raised living standards and well-organised health and community services contribute to better health, but the level of health conscienceness is still variable. There is a new focus on mental illness and on non-communicable illnesses, such as bronchitis, which cause so much absenteeism, disablement and death.

#### The National Health Service Act, 1946

The Act took some duties away from local authorities (or restricted them), notably, hospital administration, and tuberculosis and venereal diseases diagnosis and treatment. Other functions, most of which had been generally under taken before, were made obligatory and their scope extended. These concerned the care of expectant and nursing mothers and pre-school children, domiciliary midwifery and nursing, home visiting by health visitors, vaccination and immunisation, and the prevention of illness.

The local health authorities created by the Act were able to break new ground. Health visitors were able to take in the whole family as a unit. and now better trained for this purpose, are well fitted to play their part in the domiciliary team headed by the family doctor. Home helps have become indispensable for the care of the sick and the aged at home. More are needed, but often there are recruitment difficulties when and where domiciliary aid is required most.

Despite the establishment of a free medical service for all, children included, the activities of the child health services of local authorities have not been restricted. The centres are as well attended as ever, but there is a gradual change of function and a broadening of outlook. Early ascertainment of physical and mental defects enables treatment to be arranged and special educational facilities to be provided. Health teaching of parents, together with the inculcation of good habits at an early age, is being undertaken with vigour at clinics and schools by doctors and health visitors. Besides the prevention of disease, the promotion of good health by every available means is the main thread running through all public health work. This is no easy task when staff and funds are limited and commercial "anti-health" advertising has to be fought.

It will be seen that public health practice today owes its pattern not only to statutes and regulations but to social and environmental changes and new attitudes towards the disabled and handicapped, which can exert their influences long before the legislators take them into account.

# Liaison in the health service

It is agreed that for maximum effect the essence of a successful health service is co-ordination of effort. The new service, with its three main branches under separate administration, has been criticised for its inco-ordination, but in fifteen years there has been steady progress towards a homogeneous whole, thanks largely to determined individual efforts and a generous outlook

The medical officer of health, acting as a sort of middleman, has done much to help this conesion. As adequate community care is demanded increasingly, he and his staff will play an even bigger part in providing and mobilising domiciliary services—including those from voluntary sources—in consultation with general practitioners and hospital authorities. This will aid patients awaiting hospital admission, and in many cases will allow earlier discharge or even make hospitalisation unnecessary for some patients. These matters are stressed in a government circular (July, 1962).

# Some of the tasks of the public health team today

Infectious disease control still demands constant vigilance. Immunisation projects need planning, analysis and continuous propaganda. When, as still happens, there is a break-through of typhoid, diphtheria, dysentery or smallpox, an intricate control operation must be set in motion. Food poisoning incidents require prompt investigation and surveillance of food premises and food sampling are more necessary than ever. The new insecticides have facilitated insect control, but scabies and louse infestation have not yet been eliminated.

The public health department has a close interest in housing. The housing shortage, and the occupation of sub-standard dwellings, lacking baths and other amenities, present difficult pro-

blems for all age-groups. The Medical Officer of Health has no easy task in attempting to assess medical priorities when waiting lists are bulging. A fresh assault on sub-standard housing, including houses in multiple occupation, is now possible with the help of new legislation. Domiciliary care, particularly of the handicapped and aged, is also tied up with suitable home conditions. Many of the needs of the sick and the elderly are being met by home meals and home bathing services, employment centres, clubs, chiropody, and holiday schemes.

The drive against atmospheric pollution is beginning to yield results, as was shown during last winter's fogs; wise administration and expert staff are needed for the creation of smoke control areas. Noise abatement is also receiving some of the attention it merits. Home accidents, which now outnumber infectious diseases as causes of morbidity and mortality, call for propaganda, investigation and attention to possible causative factors. The Medical Officer of Health has duries under the Factory Acts, and he acts as the occupational health officer to a large staff of council employees.

#### Mental health

The Mental Health Act (1959) was the inevitable outcome of forward thinking about men tal health, with its emphasis on community care rather than incarceration. It lays the foundations of a new type of service based on the enlightened concept that, as far as possible, the care of the mentally disordered should be brought into line with that of the physically ill. Hostels, training centres and facilities for sheltered employment are part of the plan which is only just beginning to be put into practice. This new outlook on mental health calls for understanding and participation by the public, so good public relations must be established and maintained.

# Other local authority functions

It must be emphasised again that local authorities have important health assignments outside the national health service. These embrace sanitation, housing, food and drugs, and port health, which are among the many subjects detailed in the Public Health Acts and analogous legislation. The school health service, which has done so much to raise health standards, is administered by the education authority. The welfare services, under the National Assistance Act, are frequently controlled by a separate department. Fortunately, the medical officer of health is almost always the principal school medical officer and in about half the authorities the health and welfare services

are combined. The children's department has its own chief officer.

This complex and uneven structure, perplexing to so many, is administratively unsatisfactory. Yet one of the biggest assets of a public health service is its lack of standardisation, which permits of the evolution of special patterns according to local circumstances and needs.

# The future

The medical officer of health is charged with the duty of "acquiring an accurate knowledge of the influences, social, environmental and industrial, which may operate prejudicially to health, and of the agencies, official and unofficial, whose help can be invoked in amelioration of such influences". No mean task, and one with heavy liabilities, but of great variety, offering the community physician scope for originality, epidemio logical research and forward thinking.

Whatever the future pattern and organisation of public health work will be, its development is inevitable. Recognition of this is made in the command paper presented to Parliament in April, in which a fifteen per cent. increase in medical staff is envisaged in the next decade, with large capital programmes to include accommodation for the elderly and handicapped, and training centres for mentally subnormal adults. The national health service, with its emphasis on sickness rather than health, will benefit from this stimulus.

# **FIFTY YEARS AGO**

# B.N.A. TERMINOLOGY

To the Editor of the 'St. Bartholomew's Hospital Journal'.

SIR,—There is one class of the medical population, and that the largest, who ought to be considered before any drastic change is made in anatomical terminology. I refer to the general practitioner. His time for reading is limited, and if he is to keep himself up to date he cannot afford to waste any of it.

What will be his feelings on first reading an article in which the Basle terminology is used? He will find structures mentioned of which he has never heard, and unless he happens to remember that there is a new terminology, he will naturally conclude that the evolution of the human body has been making great strides since his student days. When he discovers that the new names belong to familiar structures he will be annoyed, and will want to know why he is called upon to spend his scanty leisure in learning anatomy over again, with new names for most of the structures.

He will be told that the new names will be world-wide, and that they are an improvement on the old ones.

But will the new terminology be world-wide? There have been many attempts to establish artificial universal languages. Not one of them has been successful.

Even Esperanto, the most successful of them, is very unstable, and Esperantists are divided into camps, some using the original language, the others "improvements" on it.

What is to prevent the same thing happening to anatomy?

Even if the new terminology be an improvement on the old—and the general practitioner may have his own views on this point—that is a dangerous reason for adopting it. Like other human inventions it is not perfect, and no doubt it can be improved upon.

If we adopt the Basle terminology because it is an improvement on the old, who can guarantee that in a year or two we shall not be asked to adopt another, because it is an improvement on the Basle terminology?

Until he is quite sure that the new terminology has come to stay, the general practitioner will do well not to waste his time in learning it.

Yours truly,

# CHRISTIAN VIEWPOINT: "In relation to chronic disfiguring and sometimes mortal disease"

"True courage is that which listens to what God is saying to us through disease and the threat of death; sickness and death take on a new meaning and help us to revise our scale (Paul Tournier.) of values."

Even before the drama of Job was written many thousands of years ago the spirit of man has always been disturbed in the presence of illness, tragedy and death. One of the most salutary exercises, when one is disturbed in mind in the presence of chronic disease and ill-health, is to go back to this book and see how Job meets

the problem.

It is unfortunate but man's average reaction to the presence of calamity or disease is to ask the question, "What have I done to deserve this?" Many a man, under these circumstances, cries out with Job, "Oh that I knew where I might find Him that I might come even to His seat. I would order my cause before Him and fill my mouth with arguments, I would know the words which He would answer me and understand what He would say unto me". (Job 23, 3-5.) Under these circumstances it is absolutely imperative that a Christian should be able to give an answer to the universal cry, "Why should I have to suffer like this ?"

I have been dealing for close on thirty-nine years with leprosy-a disease in which the advanced sufferers in the old days, and to some extent today, could be described, again in the words of Job, as "those which long for death but it cometh not; and dig for it more than for hid treasures; which rejoice exceedingly and are glad when they can find the grave?" (Job 3, 21, 22.) And it was my privilege, yes, I call it a privilege, to have to preach for ten years of my life, every fortnight, to an audience of leprosy patients, some of whom would be dead before the year was out; others would be blind; and still others would have to have a tracheotomy and wear a tube for the rest of their lives. Today, thanks very largely to the work of medical missionaries, such experiences are becoming a thing of the past but, nevertheless, I well remember the awful problem with which I was faced, when, under these circumstances I was called upon to speak words of comfort to my patients, many of whom could be described as being "with death as their companion". What could I say to these people? Could I say "Cheer up, old fellow, it wasn't your fault?" I could not, and cannot, accept the belief of many that they suffered because of sin, not perhaps in this life but more often, it was claimed, in a past life. I got the answer

before he died I said to him, "I am afraid that your throat is in rather a bad way and I think we should put in a tube in order to help you to breathe, and make you more comfortable ". The patient replied, "Will it help, Doc, to get better?" And I said, "No, it won't help you to get better. We have done all we can for you; but it will help you to live more comfortably". And he said, "Well, Doc, if that's all, I prefer not to have it". About a year later that patient was dving of slow suffocation, for he had persistently refused operation. I sat by his bedside but I could do very little. I could hardly even speak, for under these circumstances no words of comfort came to my lips. I daren't give him morphia or a sedative because that would have depressed his breathing still further. It was in the days when we did not have modern drugs which would help under these conditions. All I could say, in rather a futile kind of way, was, "Are you all right?" and, from a throat which could hardly utter the words-and I had to bend right down to hear what he said-the patient replied, "Yes, Doc, I'm all right, Jesus Christ is with me". In those words I had my answer. I realised more than ever that disease is never God's will; it is never the will of God that any of us should suffer. While disease is not due to personal sin it is a manifestation of a world in rebellion, and as the rain falls on the just and the unjust, so the Christian is as liable to suffer from disease, accident and misfortunes, as the non-Christian. There is, however, one difference. Whereas the one who does not know Christ has to bear the burden of suffering alone, he who knows the Lord knows full well that, no matter how hot the furnace of suffering is heated, even if it is heated seven times hotter than it is wont to be, there is one walking with him whose form and countenance is that of the Son of God. If I did not believe that I could not do my work; if I did not believe that, the problem of suffering would be absolutely insoluble. My reply to the question, "Why should these things be?" is that Christ has the answer and it is in Him I trust. Once we accept Christ as the focal point of our lives we find that, as with Daniel's companions, so with us, He walks in the flames of suffering, and in His company we experience His love and compassion, and the words of the Apostle John become true for us-" This is the Victory that overcometh the world, even our faith". (I John,

Without this knowledge I certainly could not

SPORTS NEWS

# CRICKET CLUB

St. Bart's v. Incogniti C.C. Saturday, 13th July. Match Drawn.

Incogniti batted first and scored rapidly against the Hospital bowlers and finally declared

at 275 for 5 wickets.

After a disastrous start, Pagan and Abell batted well, aided by R. Wood, and the Hospital score reached 174 for 6, when three quick wickets put paid to our efforts to win and C. Richards and C. Vartan saved the game. Incogniti 275 for 5 wickets.

St. Bart's 189 for 9 wickets. D. Abell, 51. W. Pagan, 39. R. Wood, 25.

St. Bart's v. Hampstead. Sunday, 14th July. Won by 5 wickets.

Hampstead batted first and, after a slow start against some accurate bowling by Smart and Vartan, built up a very respectable score of 226 for 6 wickets, leaving the Hospital 160 minutes to score the runs.

Yet another disastrous opening was saved by R. S. A. Thomas and N. Offen, the former scoring 139 not out, and aided once again by R. Wood, the Hampstead score was passed after 146 minutes' batting time.

Hampstead 226 for 6 wickets.

St. Bart's 229 for 5 wickets. R. S. A. Thomas 139 not. N. Offen 33. R. Wood 31.

St. Bart's v. Dartford C.C. Sunday, 21st July. Lost by 5 wickets.

After a promising start, Phillips was unluckily run out, and there followed a familiar collapse, steadied by D. Delany and the resolute batting of R. Thomas. At 108 Abell and Harrison struck at the opposition bowling and a final score of 158 was reached.

Dartford started shakily against the Hospital attack, and C. Smart, bowling well and economically, was unlucky not to obtain more wickets. With such a small target to reach, Dartford slowly attained that score for the loss of 5 wickets.

St. Bart's 158. R. S. A. Thomas, 50. J. R. Harrison, 43. D. Goldie, 28. Dartford 162 for 5 wickets.

St. Bart's v. Old Cholmeleians C.C. Saturday 27th July. Won by 2 wickets.

Old Cholmeleians, on a fine day at Chislehurst, slowly built up a score against the Hospital bowlers. P. Niven, brought out of retirement from Luton, bowled well and was supported by Vartan.

R. Powles and T. Herbert opened the batting for the Hospital, and set a firm foundation to the innings, with some fine batting from R. S. A. Thomas, ably assisted by Phillips and Vartan, the Hospital reached the required score for the loss of 8 wickets.

Old Cholmeleians 197 for 8 wickets. C. Vartan

St. Bart's 198 for 8 wickets. R. S. A. Thomas, 79. C. Vartan, 29.

St. Bart's v. R.N.V.R. Sunday, 28th July. Won by 7 wickets.

R.N.V.R. batted first on a dry fast wicket at Chislehurst, and were soon in trouble with the accurate bowling of Vartan. Aided by Niven and later by Abell, the Naval Reserves were finally all out for 130.

Despite a poor start, a fine partnership by Thomas and Vartan safely saw the Hospital home

to a comfortable win.

R.N.V.R. 130. D. Abell, 5-41. C. Vartan, 3-33. St. Bart's 131 for 3 wickets. R. S. A. Thomas, 49 n.o. C. Vartan, 48 n.o.

# SUSSEX TOUR

St. Bart's v. Ferring-on-Sea. Sunday, 4th August. Won by 4 wickets.

Lively bowling by Vartan and Harrison soon had the Ferring batsmen in trouble, and Smart bowling first change dramatically tore through the middle order, and Ferring were all out for

After a disastrous start and being 20 for 4 wickets, Thomas and Sidebottom batted well and sensibly and the opposition total was passed for the loss of 2 more wickets.

Ferring 93. C. J. Smart, 6-24.

St. Bart's 96 for 6 wickets. R. S. A. Thomas,

St. Bart's v. St. Andrews, Burgess Hill. Monday, 5th August. Lost by 38 runs.

Following torrential rain throughout the night, the game started promptly on a very sticky, muddy wicket. St. Andrews batted first and were quickly in trouble against the accurate bowling of C. J. Smart. The tail-end batsmen, however, scored some quick runs and St. Andrews finally achieved a total of 132 runs.

The Hospital opening batsmen fell cheaply to accurate bowling on a now drying wicket. Thomas and Sidebottom once again batted sensibly and, aided by Harvey and Vartan, victory seemed in sight. A further collapse followed and

0-6:

the Hospital were all out 38 runs short of the required score.

St. Andrews 132. C. J. Smart, 7 wickets for

41 runs. St. Bart's 94. C. Vartan, 25. R. S. A. Thomas, 16.

St. Bart's v. Rottingdean C.C. Tuesday, 6th August, Lost by 2 wickets.

The Hospital batted first on a fine day at Rottingdean, and again the opening batsmen were lost cheaply. Harvey and Sidebottom then averted the collapse. Batting was difficult against the Rottingdean seam bowling, and the Hospital were all out for 134 runs.

Rottingdean lost quick wickets to Vartan, and later found runs difficult against the bowling of Smart and Harrison. The Hospital total was reached with 3 minutes to spare, and 2 wickets standing, to conclude a fine day's cricket.

St. Bart's 134. J. A. Harvey, 39. C. P. Vartan, 22.

Rottingdean 135 for 8 wickets. C. P. Vartan, 3-36. J. R. Harrison, 3-41.

St. Bart's v. Ditchling C.C. Wednesday, 7th August. Won by 68 runs.

W. Pagan batted well for Bart's, aided by R. Thomas, against the Ditchling bowlers, and with quick runs from D. J. Goldie and C. P. Vartan, the Hospital finally declared at 199 for 8 wickers.

Ditchling started well against the Bart's opening attack, but some accurate seam bowling by J. A. Harvey broke the back of their innings. At 118 for 8, Ditchling decided to play for a draw, and aided by R. Powles, they very nearly managed to do so! However, luck was at last on the Hospital side and the last batsman was out on the second from last ball of the day.

St. Bart's 199 for 8 wickets. R. S. A. Thomas, 53. D. J. Goldie, 37. P. Savege, 24 n.o. Ditchling 131. J. A. Harvey, 4 wickets for 36 runs.

St. Bart's v. Barcombe C.C. Thursday, 8th August. Won by 5 wickets.

Barcombe started uncertainly against the Bart's opening attack and were 31 for 5 after 40 minutes. As the pressure eased off, runs slowly accumulated and they were all out for 130 after lunch.

A disastrous start for the Hospital saw the first 4 wickets fall for only 7 runs. However, Harvey and Wild batted well for the Hospital, and together with a fine innings from Pagan, the score was reached for the loss of 5 wickets. Barcombe 130. Vartan, 4-25. Wild, 5 wickets for 21.

St. Bart's 133 for 5 wickets. Wild, 51 n.o. Harvey, 39. Pagan, 26 n.o.

St. Bart's v. Seaford Seagulls C.C. Friday, 9th August. Lost by 37 runs.

C. Vartan bowled well to dismiss the opening Scaford batsmen and, aided by a fine spell of bowling by E. Hoyd, the opposition were all out for 128 runs.

Pagan and Davies opened well for Bart's, adding 40 for the first wicket. The middle order batting collapsed against accurate bowling on a difficult wicket and the Hospital were all out for 91.

Scaford Seagulls 128. E. Hoyd, 4 wickets for 19. St. Bart's 91. J. Davies, 31.

# NORTH ESSEX TOUR

St. Bart's v. Clavering C.C. Saturday, 31st August. Won by 1 wicket.

Clavering batted first on the pleasant village green, and were soon in trouble against the bowling of Vartan and Harrison, and were all out for 80 runs.

Shorey and Phillips opened well for the Hospital, but the later batting collapsed against the Clavering bowlers. At 42 for 7, Waterworth and Harrison came together, and batted dourly to avert defeat and, aided by some big hitting from Bates and Richards, the Hospital managed to gain a victory by 1 wicket.

Clavering 80. C. Vartan, 5 wickets for 11 runs. J. Harrison, 4 wickets for 25 runs.

St. Bart's 82 for 9 wickets. M. Waterworth, 16. J. Harrison, 16.

St. Bart's v. Arkesden C.C. Sunday, 1st September. Won by 3 wickets.

Torrential rain delayed the start of this match, and eventually a 20-over game was decided on. Arkesden were all out for 105, due mainly to the bowling of Letchworth and Stephens, who moved the ball cunningly and with devastating skill.

The Hospital scored the necessary runs in 16 overs, due mainly to a fine innings of 49 not out by Vartan, who hit five sixes and lost three balls into nearby meadows.

Arkesden 105. St. Bart's 107 for 7. C. P. Vartan, 49 n.o.

# THE HOCKEY CLUB

The Hockey Club has its first fixture on Wednesday, 9th October. We have great hopes for this year's team, which seems to be a fairly young one. Admittedly the Club does not have an outstanding record from last year to improve on, but nevertheless we look forward to another enjoyable season.

Last year many part-time players returned to us from other clubs realising that we were once more back on our feet. In addition to the first eleven fixtures we look forward this year to quite a number of second eleven matches, for it would appear that this is where our main strength lies. In last year's United Hospitals' Cup the first eleven were eliminated early in the competition, but the second eleven gallantly battled on to the end, reaching the final only to be beaten in extra time by a slim margin.

For the sake of newcomers to the Hospital, anyone who would like to play hockey for Bart's this season will be most welcome. Finally, in looking forward to the coming season, may I take this opportunity of thanking Laurie White for the perfect way in which he tends our coveted

ground at Chislehurst.

P.I.K.

# TENNIS CLUB

# UNITED HOSPITALS' CUP—FINAL

St. Bartholomew's Hospital v. Guy's Hospital.

It was a sunny afternoon when the Bart's team reached Chislehurst to meet Guy's in the United Hospitals' Cup Final. There was only one change in the team that had previously triumphed over St. Thomas'—last year's Cup holders; A. Frank

took the place of P. Mitchenere.

When play began Bart's were in good form. The first, second and third pairs all took a 4-3 lead in their first sets-but in spite of this advantage, Guy's managed to pull back. At the end of the first round we were 3-0 down. Our hopes rose in the second round, when Edelstone and Fryer were set all against Guy's first pair, but unfortunately they lost the final set 6-4. Carden and Latham took the first set 6-1 against Guy's second pair, only to lose the next two. We were 6-0 down and the match was lost. In the final round Kohli and Frank led Guy's first pair 6-2; 3-6; 4-1 when rain stopped play. Edelstone and Fryer were 14-all in the first set against Guy's second pair and Carden and Latham were 3-5 down in the second set against the third pair.

The results show that all three pairs lost easily to the Guy's third pair—whilst all our pairs went to three sets against the first pair. The matches against their second pair were all closely fought. That we lost the first six matches may have been due to the fact that we tried to even out our available talent so that our regular first pair were playing with other partners. It was generally agreed, however, that the Bart's pairs all played well together, so that Guy's success was certainly deserved.

RESULT Round Round Round II Ш E. Carden 5-7: 6-1; 1-6; 4-6; 3-6; D. Latham 2-6: 2-6: 4-6; 4-6: S. Kohli 6-2; 1-6; A. Frank 3-6; 4-1; 3-6; A. Edelstone \ 0-6; 14-14; 4-6;

# Bari's 1st VI v. Roehampton. Saturday, 13th July.

7-5:

4-6;

This match usually proves to be one of the most enjoyable of the season, and indeed, this year was no exception. On one of the rare sunny afternoons this year, the team were beaten seven matches to two by Roehampton, in a match which was a little closer than the score suggests. Although Bart's were not quite at full strength, no excuses were offered by the team, both the strength of the opposition and the speed of the courts being considered a little too much.

However, mention must be made of the first pair of Carden and Edelstone, who played well all afternoon to win two of their three matches. The other two pairs, although beaten in all their matches, invariably managed to take the opposition to three sets.

Result-Lost 7-2.

M. Fryer

Team: E. Carden; A. Edelstone; M. Fryer; S. Kohli; D. Latham; E. Cantrell.

# Epsom College II v. St. Bart's Hospital II. 22nd July.

Played on hard courts and watched by a small number of spectators from amongst the Epsom schoolboys, Bart's lost more narrowly than the score 6-3 suggests.

Bart's first pair, Kingsley and Nightingale, had little resistance from the Epsom first and third pairs, but against their second pair a three set match ended in victory for Epsom.

Bart's second pair of Smith-Walker and Gibson lost to the Epsom third and second pairs, but played particularly well against the Epsom first pair and won comfortably. Our third pair, Clark and Farrow, never reached the standard required to win a set and lost rather easily in all three matches.

Result-Bart's II,3; Epsom II, 6.

# St. Bart's II v. St. Mary's II.

The first pair, A. Gordon and R. Farrow, had a close first set against St. Mary's first pair and the result might have gone either way. However, with Gordon gradually finding some of his best shots Bart's took the first set and went on to an easy victory in the second. St. Mary's

#### Cancer Report, 1948-1952.

The St. Bartholomew's Hospital Reports were published regularly from 1865 to 1939, but then lapsed owing to the intrusion of World War II. The Board of Governors also published Statistical Tables from 1860 to 1932 and from 1947 to 1960. Both these publications for one reason or another have died a natural death, but now arise from their graves in the new form of "occasional publications", not necessarily statistical, on a variety of subjects. The first of these, Cancer Report 1948-1952, has now been published for the Treasurer and Governors by Livingstone's of Edinburgh. The principle of "occasional publications" of volumes on subjects of special interest seems better than grinding out routine volumes, which tend to appear long after they are due. The reputation of the Hospital and the interests of medical practice will he better served in this way provided that the initiative survives the first enthusiasm of a new venture. It would be interesting to know what other publications the Board of Governors may have in view. Each one is bound to need prolonged gestation. The Cancer Report, the first major offspring resulting from the marriage of the Statistical with the Cancer Department, makes an excellent beginning. The material consists of 4,526 patients with malignant disease admitted to the Hospital in the years 1948-1952 and followed up for a minimum of five years, so that some idea of the five-year survival rates may be gained from their analysis. Innumerable individuals in the clinical, follow-up and statistical departments have contributed to this careful survey. The central figure is necessarily Mr. M. P. Curwen, the Medical Statistician. Dr. A. W. Franklin has shared with him the general editorship of the volume.

The main object of a statistical review such as this

is to provide information concerning the relative frequency of different forms of malignant disease, the various forms of treatment used in the Hospital and the relative efficacy of surgery, radiotherapy, or of the two combined. It would, perhaps, be too much to ask for figures of morbidity and mortality attributable to the treatment, and these are not usually given in the Report, though they are certainly important - particularly to the individual patients.

It is clear from the Statistician's Introduction that he has to contend with severe limitations, the greatest, perhaps, being the very variable adequacy of the records made as the patients pass through the departments. The junior ranks on the clinical side are continually changing, so that it is virtually impossible to achieve a uniformly high standard in recording the essential clinical details. Only a survey of far larger numbers on a national scale can hope to eliminate defects of this kind. It is plain that Mr. Curwen has faced his difficulties with courage and a determination not to claim too much for his results.

The Report as now presented gives a general survey of malignant neoplasms, with six chapters by various members of the staff giving special studies of particular regions, and three appendices with statistical tables. The regions chosen for special study are for the most part those that might have been expected, but there is one notable omission. The Statistician's preliminary graph of numbers of patients shows that three regions are by far the commonest-the breast, the bronchus and trachea, and the skin (excluding melanomas). Of these only the breast is studied in detail. It seems strange that bronchial carcinoma, so alarming in its incidence, so fatal in its consequences, and so much in the public eye, should not have been included. No less than 661 patients in this group were admitted in

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the period, but only a brief "provisional table" is provided. Perhaps it was felt that the results were too discouraging to be emphasized at this stage. Of the 661 patients 346 had to remain untreated, and of the 315 treated only 97 survived the first year; the fiveyear survivors numbered 41, or 13 per cent (six per cent. of the whole number). The subject, however, is so important and the skill of the surgeons and radiotherapists attracts so many of these patients to the Hospital that an "occasional publication" devoted to it seems to be desirable.

Clinicians, whether general practitioners or consultants, will naturally look in the special studies for guidance concerning the best form of treatment available. Here, the very interesting study of carcinoma of the stomach stresses the advisability of exploring surgically even those patients thought to have inoperable growths; some of these will be found to be not only operable, but also curable. It also deprecates the tendency of physicians to treat medically for too long gastric ulcers thought to be innocent. The diagnosis may be wrong and opportunities of surgical cure be lost. The full discussion of cancer of the large intestine is authoritative and helpful. In the chapter on cancer of the biliary system and pancreas numbers are small and the results of surgery no better than past experience has led us to expect. Neoplasms of the small intestine are uncommon, but six were treated in the period reviewed, with surprisingly good results. The long chapter on mammary cancer is of much interest, but it is clear that the great number of variables in diagnosis, selection, staging and methods of treatment makes guidance based on statistics extremely difficult, since the numbers in the various groups become too small to have significance. The chapter on uterine and cervical carcinoma concludes with the admission that St. Bartholomew's Hospital is deficient in the proper use of cytological methods of diagnosis. This has been to some extent remedied by the work done at the City of London Diagnostic Clinic, but clearly there is here a problem which calls for attention from the Board of Governors. Dr. Alfred Franklin's chapter on malignant disease in children under 15 surveys 121 patients, including 33 referred from other hospitals for radiotherapy. Of 15 patients with leu-kemia there were only two survivors at two years and one at five. On the other hand of 23 with Wilms' tumours there were 8 five-year survivors, all treated by surgery and radiotherapy-a striking tribute to the skill of both departments.

The "provisional tables" provided for all forms of malignant disease give a large amount of information and repay close study.

The whole book is admirably set out and has been printed in excellent style at Glasgow. If future "occasional publications" are as good as this, the reputation of the Hospital will be further enhanced.

GEOFFREY KEYNES.

Biochemical Values in Clinical Medicine. The results following Pathological or Physiological Change, by Robert Duncan Eastham, B.A.(Cantab.), M.D. (Cantab.), D.C.P., Dipl. Path., published by John Wright & Sons, Ltd., Bristol. Price 15s.

The second edition of this useful book, which is excellent value for 15s, luckily remains a handy pocket size. The general plan is of tests arranged in alphabetical order, and under each heading is given the normal range, physiological and pathological variations

The book is certainly a useful part of the equipment of younger clinicians, and their knowledge of even a part of its contents, should save the laboratory many unnecessary telephone calls.

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Diseases of Children

second and third pairs offered Bart's first pair no very serious opposition.

Our second pair, J. Pilling and J. Church, had an exciting first set against their opposite numbers, but lost it in the fourteenth game. They were out of touch in the second set and lost it more easily. They recovered well to resoundly beat St. Mary's third pair and playing even better they won 6-3; 6-2 against St. Mary's first pair

Bart's third pair, P. Challen and T. Clark, took some time to warm up against St. Mary's third pair and never really regained the lost ground to lose 6-2; 6-2. Against St. Mary's first pair they were again slow in starting, but managed to take the opposition to twelve games in the second set before finally losing. Beaten 6-2 in their first set against St. Mary's second pair, it was encouraging that Bart's third nearly took the second set, losing three set points before going down in the twelfth game.

Result—Bart's II, 5; St. Mary's II, 4.

Bart's 1st VI v. Charing Cross. 21st August.

Bad weather prevented play at Chislehurst, but the match was transferred to the Charing Cross ground at Cobham. This meant that Bart's had to play on hard courts, which involved an entirely different type of game to the usual fast pace of the Chislehurst grass. This adjustment to their game was made more difficult by the presence of a very strong cross court wind. However, after cautious openings by both the Bart's pairs they quickly settled down to win their first round matches easily. In the second round, the first pair won their match 6-0, 6-2; but although the second pair won their opening set very easily, they promptly lost the second set in a similar manner. By concentrating, and a general "tightening up" of all their strokes, however, they finally won the third set to give Bart's a deserved four-nil win.

Result—Won 4-0.

Team: P. Mitchenere; Mr. Fryer; R. Farrow; I. Pilling.

The Staff v. College Match. 31st August.

Sunshine (occasionally), good courts, relaxed tennis, and players more out to enjoy the afternoon than win a tense battle—these ingredients all went a long way towards making this a very pleasant match. The college team played sound tennis, they were a bastion that was never completely overcome by their opponents. The Staff were not so consistent and had to resort to other means of attack. Mr. Fraser played his usual well-planned, cunning game, with shots not often seen in the stereotyped speed game of the top

players of today. He and Mr. Dowie, in addition to clever tennis, displayed a running commentary that made Stephen Potter look really amateur! Brian Duff gave a demonstration of how a devastating net game really can be played.

The Staff were losing somewhat and so were forced back on their reserve players to stem the tide; and having fought to the last man, invited Ruth Smiley to play. However, all this could not prevail against the consistent play of the College team who won a well deserved victory. We can only wish them an even better season next year, and to our President that he will have many more opportunities to show us how to play.

Staff: Mr. D. B. Fraser; Mr. L. N. Dowie; Dr. B. Duff; Dr. E. Cantrell; Dr. M. Jennings; Dr. D. Cooke; Dr. P. Poore: Miss R. Smilev.

College: E. Carden; D. Latham; M. Fryer; S. Kohli; P. Kingsley; P. Mitchenere.

# NURSES' SWIMMING GALA

On Wednesday, 18th September, the Nurses held a very successful swimming gala in Gloucester House. Misses L. Tyler, J. Bowie and S. Tillman distinguished themselves with admirable performances. The occasion was enlivened by the Housemen v. Registrars race in which one houseman swam fully dressed and another attempted to leave the water with only a towel between him and disgrace. The results were as follows:—

Plunging:-1st. N. St. John. 2nd. B. Lori. Freestyle 2 Lengths:-1st. S. Tillman. 2nd. G. White. Breaststroke 2 Lengths:-1st. J. Bowie. 2nd. P. Millige. Backstroke 2 Lengths:-1st. L. Tyler. 2nd. J. Graham Style:-2nd. J. Bowie. 1st. L. Tyler. Diving:-1st. L. Tyler. 2nd. J. Bowie. Nurses Freestyle Relay 4 x 1 Length:-1st. 3rd Year:

A. Willis; G. Knudsen; P. Bevan Jones;
A. Mullaley.

Sisters v. Staff Nurses Relay 3 x 1 Length:—
1st. Staff Nurses.

Medical v. Surgical Relay 4 x 1 Length:—

Medical v. Surgical Relay 4 × 1 Length:—

1st. Medical:
G. White; J. Bowie; R. Courtenay-Evans; B. Lask.

G. White; J. Bowie; R. Courtenay-Evans; B. Lask. Students Race—3 Lengths Freestyle:—

1st. R. Groves. 2nd. B. Shorey.

Obstacle Race:—

1st. J. Bowie.

New-Nursing Staff 1 Length Freestyle:—

1st. K. Bignell. 2nd. F. Bignell.

Housemen v. Registrars 5 x 1 Relay:—

Result Unknown!

The Nancy Perrin Cup was awarded to Miss L.
Tyler.

B.J.B.

# BOOK REVIEWS NEW PENGUIN BOOKS

James Bond apart I have not bought a new hard-backed book for two years now. That does not mean that I do not read-I think I probably read more than I used to-especially with examinations in the offing (I must see Dr. Lynford Rees about that!). The two books devoured a week are in a very economical form-Penguins. I spend less on them than on cigarettes. Paperbacks have revolutionised the antiquated British publishing system as well as the reading habits of the public. The trouble is that the publishers' profit margin is very narrow and so many copies of an edition have to be sold to show a returnhence the preponderance of old favourites and proven successes amongst the paper-back titles. However, with a growing trade the publishers have summoned up their courage and are producing the odd original title, feeling, no doubt, that they can now afford to take the risk of losing a few quid in return for a philanthropic

Which brings me to the point—"The General Says No", by Nora Beloff—an intellectual journalist's reasoned review of Britain's rejection by the European Economic Community. She

deals well, if a trifle drily, with this sad episode in England's recent history. She had the advantage of having "a front seat" at the negotiations and, with her intimate knowledge of the chief actors in this farce, has succeeded in crushing misinformed opinion generated by the bad press that the Brussels bickering received. That is, of course, if her book is read—and it is worth reading; even if you are not vastly concerned about this business, you certainly should be — England's future depends upon the issues which this failure highlighted.

Richard Petty.

# OTHER REVIEWS

The Newly Born Infant by Andrew Bogdan. Publisher's agents Austick's Medical Bookshop, Leeds 1. Price 5s.

This is a revised edition of a book first published in 1959. Dr. Bogdan has not attempted to make a textbook of this little volume and those searching for such a work should look elsewhere. The function of this book is clear from the way it is printed—text on the left-hand page with the right hand page left blank. The text is designed to provide a skeleton to which the student can add with notes made in the wards, in lectures and from weightier volumes. In spite of one or two doubtful statements—surely breech presentation is not an indication for Ceaserian section as is implied—used intelligently I have no doubt that this book could make a valuable addition to any student's library.

T.P.D.

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# NEW BLACKWELL BOOKS

Hugh Jolly, M.A., M.D., D.C.H., M.R.C.P. January 1964. 544 pages, 57 illustrations.	About 50s
Diseases of the Digestive System S. C. Truelove, M.A., M.D., F.R.C.P., AND P. C. F.R.C.P. 1963. 704 pages, 205 illustrations.	REYNELL, M.A., D.M., 84s.
Ocular Pathology C. H. Greer, M.B., B.S., M.R.C.S., M.C.P.A. FO. NORMAN ASHTON. October 1963. 228 pages, 70 illustrations.	reword by Professor About 42s.
Immunology for Students of Medicine J. H. Humphrey, M.D., B.Chir., F.R.S., AND R. G B.CH. 1963. 460 pages, 91 illustrations.	G. WHITE M.A., D.M.,
Lecture Notes on Pathology A. D. THOMSON, M.A., M.D., M.R.C.P. AND R. E	. Cotton, M.D., B.S.

A Guide to Psychiatry for Students of Medicine JOHN GIBSON, M.D., D.P.M.

The Autonomic Nervous System

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Clinical Gastroenterology (Jones & Gummer—2nd) About 84s.

Clinical Tropical Diseases
(Adams & Maegraith—3rd) About 63s.

A Textbook of Human Embryology
(Harrison—2nd) About 50s.

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The Specificity of Serological Reactions by Karl Landsteiner. Pp. xviii, 330 with a bibliography of Dr. Landsteiner's works, 1962, New York, Dover Publications Inc. \$2.00.

Landsteiner is known and was made a Nobel Prize laureate because of his discovery of the blood groups. He himself thought that his more important and fundamental contribution to Science was the concept of "haptens" which he introduced into immunology. These are chemical radicals, some of which may be synthesised in the test-tube, which are attached to a protein and thereby change the immunological specificity of the carrier molecule. This book was written by Landsteiner three times. It appeared in German in 1933, in a second version in English in 1936, and again post-humously in 1945. It is very readable, and of particular value is a chapter by Linus Pauling which he contributed on Landsteiner's invitation. It describes molecular structure and intermolecular forces. The book has now been reprinted by Dover Publications as a superior paperback.

# WE MET AT BART'S

We Met at Bart's by Geoffrey Bourne. Publishers:

Frederick Muller Ltd. Price 25s. . . . I recalled with a shiver how near I had once come to destroying . . . my future at Bart's. Jimmy Calvert had asked me to hand him my torch. I had two, and after a moment's indecision handed him number one. . . . Had the imp of mischief won, from my second torch into the patient's mouth would have leaped, instead of a beam of light, a small mechanical

snake." Although written in the Victorian idiom and coloured by a humour of the same era Dr. Geoffrey Bourne's book is well worth reading.

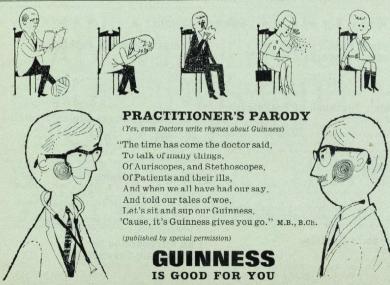
This book tells us very little about the author, except that he was hard working, diligent and moderately ambitious. It is not an autobiography, but a parochial case history of half a century of Bart's in which the author is at his most entertaining when reminiscing about the various characters of the period. Reference to interesting cases are recorded with more dignity but less excitement than those of that excellent medical raconteur, George Sava. But he was a surgeon!

Acerbity and perspicacity spice Dr. Bourne's occasional comments on the National Health Service. A complete chapter is devoted to the N.H.S. and the author's brief and undesired flirtation with medical politics. Supporters of our tottering System would do well to remark his judgements which are as true as they are reactionary. Dr. Bourne refuses to accept an attitude expressed in 1946 that medicine would in future be "on tap". "Medicine is a service, not a commodity, and it is the most personal service of all."

Chapter eighteen is meaty reading indeed—"State

control of law is fascism, and State control of doctors, if enforced is an equal threat to true democratic liberty." And again—". . . . the very nature of the bureaucratic structure of the Service constitutes the attraction it has for mediocre minds, who, as in the French Civil Service, see first the little prizes of a fixed salary, a petit bourgeois status and a small but safe pension.

Anyone connected with Bart's and at all proud of that connection must read "We Met at Bart's". It will be positively enjoyed by those over fifty and of interest to many others.



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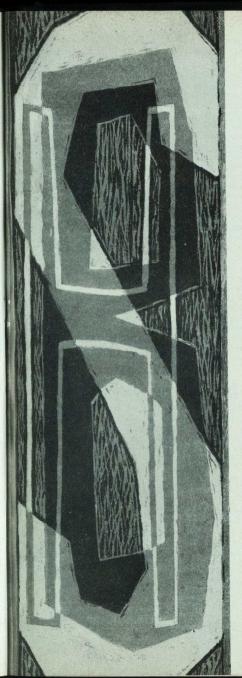
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# **EDITORIAL**

This Affluent Society

Security cannot be bought. And few men lacking it are happy. The extent of society's security is directly reflected in its social and moral standards. When society lacks security it often offends its own moral and criminal codes trying to find it. Thus, at the moment, English society is suffering a bellyful of abuse, indeed, it has become a glutton for punishment. Society, self-justifying, is indulging in an orgy of masochism when it chatters interminably about a New Morality. This is no more than a self-deceitful way of accepting what was totally unacceptable fifty years ago.

Man may find security in a god. The god he chooses matters little. (It can only be spiritual arrogance, in itself indicative of insecurity, that presumes some gods to be pagan.) Before history men often worshipped something larger than life, something beyond understanding. Once truly obtained this kind of security is as unassailable as it is inexplicable. The present decline in formal religion has its basis in the alternative "security" of this affluent society. The established churches, in spite of the widely publicised exhortations of the more progressive church leaders, have a limited practical allegiance.

Man may find security in a happy family, preferably a large one. To-day, when divorce is a formality, in an age of flats and the semi-detached, small, one-generation families in search of the trappings of affluence, empty their homes of any parental influence during the day and fill it with the vacuity of television at night. The Jews, a much persecuted race, know well the value of the loyalties of a true family life, and often live together or nearby, three or four generations at a time, helping each other out during hard times. Security assured, money may follow.

Man may even find security in money, risks apart. The more money he amasses the greater his security. This is not to say that he can buy happiness. There are many men of the middle and upper classes, some of them churchgoers too, who are secure enough, but patently miserable. Capital provides considerable security. (It is interesting that this is one of the Labour Party's pet hates, hence the wealth tax—all men must derive their security from the state.) An earned income and more especially consumer goods provide negligible security. Come a slump, and half-a-dozen washing machines will not buy a crust.

With less than six months to the next General Election, chameleons all, the three Parties talk identically of a modern, progressive, automated, scientific and planned Great Britain. (Mr. Harold Wilson waxes particularly eloquent on this point.) Identically, because they are all appealing to the same thing—affluence, to a Britain full of 30-hours-a-week, £100-a-month fathered, house and car owning planned families. Mr. Burlter's Blackpool wisecrack about battery hens, in reference to Mr. Wilson's Scarborough speech, was too true to be really funny.

From a material standpoint, apart from the increasing delinquency and the lowering of standards that seem to go with it, this appeal to affluence and the worship of it does not much matter until the economy collapses. When that happens the affluent men will suffer most, those

with no financial reserves, the flimsiest fabric of a family and a three-visits-in-a-life-time church. Then even the Welfare State will be unable to succour them. At present this great giver of security helps old age pensioners. We must hope that it will be able to extend its bounty to the next, larger generation of old men and women who will have saved little or nothing from £20-£40 a week, and will be surrounded in their dotage only by outdated and failing, because non-durable, gadgets of a consumer market.

The N.H.S., that pillar of our welfare society, provides security for many people. No man need worry about his wife's hospital fees or his sixteenvear-old daughter's next set of false teeth. So many wants are catered for that worries and responsibilities are reduced to a minimum. It is a truism, that like a baby with a rusk, man does best when struggling a little. As was well shown in the last war, a bit of suffering does him no harm, rather it does him good. For this reason belief in God is such a first-class security. Men who believe in struggling to lead good lives must suffer for their little sins. It is ironical that they must toil up a steep slope to find and benefit from security most, since at the summit there is only decadence of one sort or another. But for Christians the summit comes after death, and then, who knows?

Is the Journal Cheap?

The Journal costs 3s. 6d. a copy to print and post and even our youngest subscribers (those paying the full 25s. p.a.) are getting value for money. However, there are many loyal, older subscribers, paying by Banker's Order, who pay less, some 21s. and others only 15s. The Publications Committee, worried about increasing deficits over the years, hopes that those old Bart's men who think they are paying less than 25s. will fill in the Banker's Order form on page 343 and send it to us.

Christmas Card

We advertised the Journal Christmas Card in the last issue. It appears again in this issue on page 346. Bearing a wood engraving of considerable originality and merit and priced at a modest 5d., this card will probably be ordered by many old Bart's men. Consequently, the managerial staff, like the G.P.O., would be grateful if readers could post their order forms (on page 346) early.

Correction

In the editorial of the October issue, "Evidently Dr. Robb-Smith thinks the chief reasons are three: . . She feels, quite rightly, that . ." should have read, "Evidently Dr. Robb-Smith thinks the chief reasons are three. He feels, quite rightly, that . .". The editor regrets this error.

# Correspondence

CANCER REPORT, 1948-1952

Dear Sir.

We all welcome the return of the St. Bartholo mew's Hospital Reports in their new form after a break of twenty-four years. This is an important event within the Hospital and yet you hide a long and detailed review at the end of the October Journal. Surely this is an error of judgement. Even within the section of reviews James Bond and Nora Beloff take pride of place and are set in larger type.

Is there any way in which the Journal could assist this new publication? The Hospital Reports could be brought before your readers in many ways and it would be interesting to have some discussion of the tables and figures in the light of experience since 1952.

Yours, etc.,

HARVEY WHITE.
The Whittington Hospital,
N.19

21st October.

[We hope that a page-size advertisement insert in the June Journal by E. & S. Livingstone, Ltd., an excellent 1,000-word review by Sir Geoffrey Keynes in the October Journal and now your pertinent leading letter will indeed assist this new publication. The Journal is doing its best.—Editor.]

# SIR ANTHONY BOWLBY

Dear Sir,

Under the caption "Sir Anthony Bowlby" in your Journal of August, Dr. Lance W. Barlow writes that "I was a dresser on Sir Anthony's firm at a time when the late doctors Stanley and Just were his house-surgeons".

True enough as applied to 1910, but to be applied correctly to Aug., 1963, just two words should be deleted—namely "late doctor", as

witness my signature.
Would you be kind enough to do so in your

next issue?

Maybe Dr. Barlow would be glad to read this correction and possibly others of my old Bart's friends!

Yours faithfully,

E. G. STANLEY.
Wycollar, Salcombe,
South Devon.

16th August, 1963.

Sir,

The sudden death of Derrick Coltart when at the peak of his career leaves a gap in our ranks

which can never really be filled.

Those of his friends and colleagues who knew him well might care to subscribe to a memorial to him and, as in this hospital his great interest has always been the Athletic Club, it is felt that a cup bearing his name, to be awarded annually in the Inter-Year Competition, might be suitable.

Donations should be sent to Mr. J. N. Aston at the Orthopacdic Dept.

We are,

A. T. FOXTON, Captain, Athletics Club.
D. GOODALL, Hon. Sec., Athletics Club.
PETER LITTLEWOOD, Hon. Treasurer,
Athletics Club.
JOHN CAMBROOK, M.R.C.S., L.R.C.P.,
F.D.S., R.C.S.(Eng.)
JOHN H. HUNT, D.M., M.R.C.P.
JOHN HOWKINS, M.D., M.S.,

F.R.C.O.G., F.R.C.S. H. IACKSON BURROWS, M.D., F.R.C.S.

# Calendar

NOVEMBER

Sat. & Sun., 9th & 10th: Prof. E. F. Scowen Prof. G. W. Taylor

Mr. H. J. Burrows
Dr. T. B. Boulton
Mr. A. P. Fuller

11th November: Copy Date for December Journal. Sat. & Sun., 16th & 1/th: Dr. R. Bodley Scott Mr. A. H. Hunt

Mr. J. N. Aston Mr. F. T. Evans Mr. J. W. Cope

Sat. & Sun., 23rd & 24th: Dr. E. R. Cullinan Mr. C. Naunton Morgan

Mr. H. J. Burrows
Dr. R. A. Bowen
Mr. R. F. McNab Jones

25th November: Copy Date for January Journal. Sat., 30th November: Boat Club Ball. College Hall. Sat., Sun., 30th Nov., 1st Dec.; Dr. G. W. Hayward

Mr. A. W. Badenoch Mr. J. N. Aston Mr. G. Ellis Mr. J. C. Hogg

Physician Accoucheur on duty for the month of November is Mr. I. Howkins,

DECEMBER

Sat. & Sun., 7th & 8th. Dr. A. W. Spence

Mr. E. G. Tuckwell Mr. H. J. Burrows Dr. R. W. Ballantine

Mr. A. P. Fuller
The Physician Accoucheur on duty for the month
of December is Mr. G. Bourne.

# DEMONSTRATIONS Pathology (in the Museum):

NOVEMBER

6th-13th Rcticulo-endothelial system
13th-19th Liver

19th-26th Alimentary system and Gall bladder

26th-3rd Dec. Nervous system

DECEMBER 3rd-10th

-10th Ductless glands and Generative system

# ABERNETHIAN SOCIETY PROGRAMME Michaelmas, 1963.

All meetings are held in the Physiology Lecture Theatre, Charterhouse Square, unless advised to the contrary.

7th Nov.: R. L. Gregory, Some Perceptual Problems in Space Flight.

14th Nov.: Dr. I. G. P. Williams, Paramedical Problems of Sport.

28th Nov: Autoimmune Disease: a symposium.
5th Dec.: Prof. Keith Simpson, Foul Play.

# Engagements

ASIIBY—ALLSOPP.—The engagement is an nounced between Peter Maxted Ashby and Kathleen Mary Allsopp.

BACKHOUSE—McFARLANE.—The engagement is announced between Kenneth Morley Backhouse and Barbara Maud McFarlane.

BURNHAM-SLIPPER—LUCAS. — The engagement is announced between Charles John Burnham Slipper and Phyllis Mary Lucas.

NICOLSON—BOOTH. — The engagement is announced between Iain Colin Nicolson and Jennifer Anne Booth.

NIVEN—CALLWAY.—The engagement is announced between Peter Ashley Robertson Niven and Sarah Peta Callway.

# Marriage

KING—HUBER—On 28th September, David Edmund Lascelles King to Elisabeth Huber. LADD—PRIDDLE.—On 28th September, George Ladd to Susan Priddle.

REMERS—ROBERTS. — On 12th October, John Daniel Remers to Frances Philippa Roberts.

# Births

ABERCROMBIE.—On 21st September, to Jennifer (née Kirby) and Dr. Forbes Aber crombie, a second son (Colin Francis).

DICK.—On 15th September, to Caroline (née Baillon) and Dr. Donald Dick, a son.

VISICK.—On 29th September, to Angela (née Pattinson) and Dr. James Hedley Visick, a son (Mark Hedley).

# Deaths

CRAGGS.—On 2nd October, Charles Philip Craggs. Qualified 1925.

DAVIES On 27th September, John Llewellyn Davies, F.R.C.S. Qualified 1914.

JONES.—On 14th September, Dr. P. A. Knill Jones, aged 49. Qualified 1938.

MARTIN.—On 28th September, Douglas G. Martin, F.R.C.S. (Ed.). Qualified 1924.

SCOTT.—On 28th September, Rupert Strathmore Scott, aged 76. Qualified 1913.

SMITH.—On 12th September, A. J. Durden Smith, M.B., B.S., F.R.C.S., aged 63. Qualified 1923.

# **Changes of Address**

Dr. and Mrs. Colin Juniper, 12 St. Martin's Road, Knebworth, Herts.

Mr. J. E. A. O'Connell, 149 Harley Street, W.1. Dr. D. S. Poole, 1 Holmesdale Road, Teddington. Dr. Jill M. Thwaites, 40, Belsize Grove, N.W.3.

# LAST MONTH

Travelling, for the sake of travelling has, for me, no appeal whatsoever. I have just returned from a three-month vacation in the United States and there was one thing that made the trip really worthwhile; that was the excitement of coming home to dear old England.

Was it possible, when in California, with the sun, the surf, and the palm trees, to look forward to the English winter in London?

Was it possible, when lying on a Californian beach with the pacific ocean at your feet, to actually long for those inspiring Anatomy lectures or those stimulating Biochemistry practicals?

When working with doctors, who earned \$100,000 a year in magnificently equipped hospitals, and had the freedom and facilities for medical practice unknown in this country, could one look forward to the prospect of practice under the National Health Scheme?

I am proud to be able to answer "yes" to all these questions. Whether or not I still long for those inspiring anatomy lectures and biochemistry practicals is a trifle doubtful at the moment! Nevertheless, it is good to be back in Charterhouse Square. The Anatomy rooms are certainly much the better for a new coat of paint, which was long overdue. Now that the builders have left us in peace the library is a different place, concentration being somewhat easier—if concentrating on pharmacology could ever be easier.

It was only when I had to give a lecture on "Socialised Medicine in England" to students of San Diego State College that I appreciated what a great Health Service we have in this country. It amazed me how disillusioned the average American was about our Health Service. I soon discovered that this was due entirely to the American Medical Association, who had rather obvious reasons for painting a grim picture.

# OBITUARY

# MR. RUPERT STRATHMORE SCOTT



Rupert will be remembered by his many friends for his good fellowship, his quiet manner, his pleasing dignity, his constant consideration of others, his perfection in dress and his cultured way of life.

He was in the fullest sense a gentleman; and moreover was one of those rare men who have held positions of considerable responsibility and made no enemy.

He was born in Australia. In 1906 he entered Caius College, Cambridge, for which he always

had a deep affection. In 1913 he qualified at Bart's and after serving in the 1914-18 war he returned as eye house-surgeon. Later, he became Chief Assistant and was appointed Assistant Eye Surgeon to the hospital in 1924, and on the retirement of Foster Moore in 1937 he became surgeon in charge of the department. He was curator and pathologist at Moorfields Eye Hospital, became Assistant Surgeon in 1928, and full surgeon in 1933.

His old house-surgeons and students were enriched by the example of his constant kindness, the immense care and human interest he took in every patient under his charge. He was a careful and sound operator who kept to the techniques which his generation had found good. He had a lively sense of humour and a capacity to enjoy the gayer side of life. Genuine modesty was so characteristic of him.

His courage in a Field Ambulance in the first World War and whilst living in Bart's throughout the bombing of London in the second World War was admirable

Rupert accepted with characteristic patience, cheerfulness and stoicism the physical adversities which affected him in the later years of his life.

He was a man of absolute integrity with a strong simple faith in Christianity and the Church. All who knew Rupert had for him a deep affection which endured. Our sympathy is extended to his widow, to whom he was devoted throughout their long and happy married life.

H.B.S

# **FIFTY YEARS AGO**

"Union is best for men, either with their own tribe or with strangers; for even a grain of rice groweth not when divided from its husk." Hitopadesa originated this statement a good many years ago. It has since become the foundation of civilised life.

This fact has of late been often in our mind; and to fight a lone hand, though heroic, is not always the best statesmanship. We conceived the idea that the united journals of the various hospitals, acting in common cause, might prove a valuable weapon for students when their interests were threatened by outside forces. As the result a meeting of editors of the various London Hospital Journals was held at Bart's on the 10th inst., when various resolutions embodying these ideas were unanimously adopted. The following hospitals were represented: London, Guy's, St.

George's, St. Thomas's, Royal Free, St. Mary's, Middlesex, University College, St. Bartholomew's.

In these days of legislative revolution, of Royal Commissions on Universities, and of B.N.A. Terminologies, unity of purpose becomes a very important matter, and we believe that a step in the right direction has been taken in forming this "Concert of Editors." Our field of operations has been considerably widened by the decision to include all the provincial teaching schools of Great Britain and Ireland, and to notify these of resolutions adopted and lines of policy which are being taken.

We hope that in the course of time this organisation may result in something very much stronger—but of that it is unwise to say too much, for developments will depend upon the students themselves.

# MR. CAPPS—ON HIS RETIREMENT

FREDERICK CECIL WRAY CAPPS retired from the active consultant staff in May, 1963, thus bringing to a close an exceptionally long and distinguished career in the service of the Hospital and the Medical College.

Born in the Naval Hospital, Gibraltar, the only son of Fleet Surgeon F. A. Capps, he was from an early age destined for the Royal Navy, and duly entered the Royal Naval College, Osborne, as a cadet in 1911. However, when the time came for him to go on to Dartmouth it was found that his eyesight was not up to naval standards, so in 1913 he entered Epsom College, where he rapidly

made his mark both in work and in games. He won prizes for Science and English Essay, and before leaving, passed the 1st London M.B. examination with distinction in Physics. He played for the school at Rugby football, and was secretary of the 1st XV in his last year.

He arrived at Bart's with the Epsom College Scholarship in 1916, and by dint of extreme diligence he passed the 2nd Conjoint examination within nine months of his arrival. Thus equipped he joined, in 1917, the Royal Naval Volunteer Reserve as a Surgeon Probationer, and after six weeks' clinical training at Haslar he was posted to serve at sea in minesweepers and destroyers until he was released to resume his medical studies at the end of the war. With his return to normal student life, Freddie-as he was widely known-soon established an outstanding place among his contemporaries by gaining the Treasurer's and the Foster Prize in Anatomy, and later the Brackenbury Scholarship in Surgery. As was customary in those days he took, and passed, his Primary before qualifying in 1921.

Next followed a year as house surgeon to Holbert Waring and Harold Wilson, a discipline of the highest order which did much to mould his future surgical outlook. In 1923 he joined the Throat and Nose, and the Ear Departments, which were then still separate, although sister departments, as house surgeon to Douglas Harmer and Sydney Scott, and thus began an active connection with these departments which was to



Mr. Capps on his last ward round.

persist for the next forty years. Having passed his Final F.R.C.S. in 1924, the next years were busy ones for him at Bart's, for as well as being a part-time clinical assistant in the Throat and Nose, and Ear Departments, he also served in succession as Junior Demonstrator of Anatomy, and Junior Demonstrator of Pathology, until in 1927 he was made Chief Assistant to the Ear Department. By this time he had also obtained important outside appointments as E.N.T. Surgeon to the Metropolitan Hospital, the Willesden General Hospital, the Victoria Hospital, Barnet, and also to the West Suffolk General Hospital, Bury St. Edmunds, which he visited regularly every month until his recent retirement. This has made him a very well known and respected figure in East Anglian medical circles.

In 1930 he was elected Asistant Surgeon to the Throat and Nose Department at the unusually early age of thirty-two. The following year was likewise a momentous one, for he met and married a charming Swedish lady, Miss Gertrude Torell, then living in London.

Many other positions of responsibility at Bart's were entrusted to him. On the outbreak of the last war he was made Deputy Sector Medical Officer in the Emergency Medical Service, and was later promoted to be Sector Medical Officer on the death of Sir Girling Ball. In 1946 he became Surgeon-in-Charge of the E.N.T. Department, a position he was to hold for the next seventeen years. He has served in his time both as

Secretary and as Chairman of the Medical Council, has been a member of the Board of Governors of the Hospital, and of the Hospital Planning Committee, and has been Treasurer and later Vice-President of the Medical College.

There are few aspects of Bart's life with which he has not been directly concerned at some time or other. He has always taken the deepest interest in student activities, and has in turn been elected President of the Students' Union, the Paget Club, the Rugger Club and the Drama Society, as well as Master of the Fountain Club on two occasions, and secretary of the 11th Decennial Club, a post he shared with the late Wilfred Shaw. Having been a member of the Bart's Rugger side which played against Guy's in the Final of the Cup in the 1919-20 season, a match watched by King George V, it seems likely that so far he is the only President of the Rugger Club ever to have played in a Cup Final. It is not surprising that he has remained a most loval supporter of Bart's rugger throughout the years, lending much-needed vocal support from the touch lines in fair weather and in foul.

Inevitably, many honours have been conferred upon him in the world outside the hospital. In 1957 he was Semon Lecturer and recipient of the Semon Medal of the University of London. which is the highest distinction which a laryngologist can receive in this country. In this he was following in the footsteps of his predecessor and teacher, Douglas Harmer. In 1949 he was General Secretary of the 4th International Congress of Otolaryngology, which was held in London. He has been President of the Section of Laryngology at the Royal Society of Medicine, and has delivered the Annual Address at the Institute of Laryngology and Otology. He was one of the founders of the Association of Throat and Ear Surgeons of Great Britain, of which he was to be Secretary and later Vice-President. He has also been made Consultant in Otolaryngology to the Royal Navy, and Referee in Otolaryngology to the Treasury Medical Service.

He has contributed many papers to the literature, as well as writing chapters for several standard textbooks, but above all he has enjoyed and excelled at teaching the many generations of students and housemen who have passed through his hands. These quickly learnt to enjoy his great sense of fun and good humour, and not to mind too much the occasional but usually well-merited gruff rebuke and fierce look provoked by slackness or extreme stupidity. His popularity with his ex-house surgeons can be measured by the dinner given in his honour in June, immediately after his retirement, when no less than fifty-four old house surgeons and registrars gathered together to pay their respects to him on his leaving the active staff.

Freddie has been a man of wide interests. He has a beautiful home in Regent's Park filled with antique furniture, much of which he has collected himself, and graciously presided over by his charming wife, where they have brought up their family of four children, two sons and two daughters, and where they have delighted to entertain their many friends. One daughter has recently finished her nursing training at Bart's. He is fond of the theatre and the cinema, and when abroad is an assiduous visitor to picture galleries and museums. A man of boundless energy, he has much enjoyed active sports such as tennis, squash and ski-ing, although these have now been superseded by the more leisurely pastime of fishing.

Although leaving Bart's must mean a big adjustment in his very active life, the demands of his large practice and his many other interests, family, social and cultural, will undoubtedly help in some measure to fill the gap. At the same time it is our earnest hope that he will continue to be a familiar and welcome figure at our Bart's gatherings, so that his numerous friends and pupils will still have the opportunity to meet him and to pay him their respects.

I.C.H.

IF YOU HAVE TAKEN THE TROUBLE TO READ THIS PERHAPS YOU WOULD BE SO KIND AS TO RECOMMEND THE ST. BARTHOLOMEW'S HOSPITAL JOURNAL TO OTHER OLD BART'S MEN

	I would like to subscrib	e to the St.	Bartholomew	's Hospital	Journal	and	enclos
25s.,	the annual subscription.	Please send	the Journal	to:			

Name	Send this to: The Manager,
Address	St. Bartholomew's Hospital Journal,
	St. Bartholomew's Hospital,
	London, E.C.1.

# **FIVE MINUTES FROM BART'S**

by our drinking correspondent Photographs by B. C. P. Lee



Above: Cock Tavern—entrance between the two parts of the Market.

Below: The Doctor himself.



The old Poultry Market was destroyed by fire five years ago and this resulted in the loss of one of the most popular pubs in the area—the Cock Tavern. During the rebuilding of the new Market a temporary site was found for the pub on the south side of Smithfield. Now that things are back to normal the Cock has returned to the new building, and is proof that modern pubs do not have to be like coffee bars.

Go at lunchtime, since it is one of these places which keeps special hours for the market workers (6 a.m.-9 a.m., 12 noon-3 p.m.). You will find it in the basement of the new building with its entrance in the street between the two parts of the Market.

The interior has the usual soft indirect lighting and modern furniture that is associated with the contemporary idiom, but by using dark wood panelling on the walls the architects have produced something which is unmistakably a pub.

There are two bars, with lots of tables and chairs so you can sit down in comfort and enjoy good, inexpensive snacks, or a hot meal for about five shillings. The beer is Whitbreads—very good as always, and the clientèle mainly market types; management in the saloon, porters in the public. The whole atmosphere is cheerful and pleasing. It is well worth a visit.

Another Whitbread house worth trying is the **King's Head** in Chiswell Street, which is owned by and attached to the brewery. Naturally the beer is very good, and the entire range of Whitbread brews is stocked.

Incidentally, it is worth noting here that Whitbreads have recently taken over Flowers, so that you can now get Keg bitter in their houses. Stella and Heineken are also available for lager drinkers.

The pub itself is not particularly exciting, but good cold snacks are served, and there is also a proper restaurant upstairs.

In Clerkenwell Green you find the Crown, which is one of the six pubs in the country where the land lord is medically qualified, hence its popular name—"The Doctor's". The doctor does part-time general practice in Barking during the day and manages the pub in the evenings as a hobby. That he works for love as well as for profit explains why the beer (Ind Coope) is as cheap as really good beer can be at 1s. 7d. a pint.

The Doctor's is a really splendid place, beautifully furnished, well kept, cheerful, friendly and inexpensive. The Doctor himself is a vivid and charming personality. He also owns a vintage Rolls Royce and a fine moustache.

The Rugby Club and other serious drinkers have been going to the Crown for years, which indicates that this is a fine place for single-minded boozing.

# THE SMOKING CONCERT, 1963

by a Social Correspondent

In the Bart's Smoker someone likens a wine to "grey limestone before the dawn". This is more the feeling one gets on attempting to write about the revue. Behind a very real early morning veil lurks a mass of rapidly formed impressions, whose overall shape is very difficult to define. The Smoker was produced with Bart's men providing a large part of it, for the first time since the last war. An extremely zestful performance, it was enjoyed greatly by everyone and some very excellent punch kept the high spirits simmering throughout the evening.

The first two parts containing some twenty-five pieces varied considerably in style and content, with an increase in polish as the cast reassured themselves about an unusually reactive audience. It must be disconcerting to have an audience cheer the unintentional and miss the obvious. Perhaps this is the secret of good revue, in being sufficiently relaxed to turn the unexpected to advantage.

Out of such a variety of material it is difficult to select or comment. On the whole, those sketches with only one or two people made the greatest impact; perhaps a reflection on the rehearsal possible. Kasteliz and Smart, "it was all over in a quarter of an hour", reporting on their bush holiday, were a feature of the first half, which finished so well with the Fan Tums. As a picture of agonised embarrassment, Garson was superb and the whole timing was excellent. Garson's features were a strong point in several of the sketches, and as the German officer his gesture to the audience was upon officer in the sketches.

The second half contained a greater proportion of solo items, with some very good sniping at the Archers and TWTWTW. Matheson's rustic revelry was much appreciated as also a characteristically direct contribution from Gilmour. The sketch on a workman's retirement presentation had a mixed reception, and it was apparent that some of the audience were a little ill at ease.

The transition of McElwain from a hooded Bergman executioner to a falsetto Millicent Martin was via the traditionally mad Carew, ably supported in all directions by Smart. With relaxed ease—perhaps too much in one place—Chapman took us through his prophesying experiences and geared the Bart's section towards the more professional tempo of the Footlights. The final scene, a retrospect of the year, employed everyone to effect, and gave way to a further genial spell of drinking.

As everyone expected, the Footlights and the Cambridge Circus cast produced a very fast-moving and clever hour's entertainment. The sketches were of a uniform standard and some were taken directly from the present show at the Lyric. "Loving Free", the lady in love with a lion was a great success, and the animal interest was maintained on a slightly sicker note with the crows with a weakness for Sheeps' eyes. Topically, the Robbins Report featured as Graduation Day at Scunthorpe, awarding degrees in woodwork and spelling. Two very good songs showed the amount of work that must have been put into them. It was a pity, really, that this took place so late as many wits were feeling a little less keen for one reason or another.

Comparisons have no value and are unnecessary. The Smoker cast from Bart's are to be congratulated on a most entertaining evening to which the Footlights cast a final professional touch. As a new venture, it has surely been a great success.

# UP TO THE MINUTE IN A MOMENT

[Because this columnist is in no way anti-royalist it is difficult to apologise to the one or two readers whose royalist feelings were angered by the alleged tastelessness of a reference to Her Majesty the Oueen in the October Journal. Ironically it was in an attempt to shun the tasteless—the sickening syco phancy of the popular press, that an ordinary royal event was noted in another way. (Incidentally, criticisms should be set down in a letter to the Editor. He is quite prepared to publish letters of blame as well as those of praise—indeed, any reasonable letter:

October was an exciting month. Ladbrokes were taking almost as much money on the outcome of the next General Election as they were on the result of the flat racing jockeys' championship. As the odds being laid about Messrs. Scobie Breasley and Lester Piggott see-sawed, a mint of money was placed on the Conservative Party at 13-8 in spite of the Labour Party remaining the firm odds-on favourite. But most interest, political and pecuniary, was aroused by the Big Race, the Tory Leadership Stakes, which was won in a tight finish by an outsider, Lord Home. The result was announced on 18th October after nine days of thrilling political infighting, precisely a third of the time it took the Socialist Party to sort out their leadership problem last February.

On 6th October hurricane Flora, the sixth this year, caused havoc in the Caribbean. On the 7th Dr. Beeching announced further railway closures and the Press Council deplored the printing of the Keeler story by the News of the World. On 9th October Mrs. Shepherd opened the Conservative Party Conference at Blackpool and Mr. Alec Badenoch took out Mr. Harold Macmillan's prostate gland in the King Edward VII Hospital for Officers. The Big Race was on.

On 14th October Dr. Adenauer retired after leading West Germany for 14 years, London busmen asked for a further 30s. a week and a new fashion of black tights and shortie capes was announced for night nurses. At last, on 23rd October, we stopped waiting for Lord Robbins who published a report recommending an increase of 28 universities by 1980 and a doubling of Government expenditure on education over the next 10 years. Our ex-Prime Minister came out of hospital on the same day that Mr. Khrushchev said the Russians were coming out of the space race-27th October.

On the domestic front the new Abernethian Room neared completion, Dr. Peter Borrie was quoted as saying there is no way whatsoever of making hair grow and on 29th October, the Wine Committee, or more accurately, Mr. Graham

Chapman, produced a first-class Smoker which is reported by a social correspondent on page 333.

The Students' Union year neared its end as Conjoint finalists celebrated their various suc cesses. Mr. Trevor Powles, the chairman, reviews the year on page 336. His report is long because much was achieved in 1963. One can gather from the report that the Medical College authorities are now interested in co-operating with the Students' Union in the running of the College. We must hope that the enthusiastic Union Council will continue to encourage such a healthy spirit without demanding any actual control in the administration of our Medical College and without allowing too much familiarity to sour the present good relations.

The season of tours has begun, writes our sporting correspondent, and as we go to press the Rugby XV are on their annual Cornish jamboree. Unfortunately, on 2nd November, they lost 8-19 to Penzance whom they beat last year. However, apart from this the side has had an encouraging start to the season, winning four of its seven other matches; especially notable was a very close game on 16th October against Cambridge University LX Club which was lost by 6 points to 8. On 12th October the team had beaten the Old Blues 20-6. Mr. Simon Harris is now making a habit of successful conversions from the 50-yard line.

On 29th October the Soccer XI, playing five freshers including an able goalkeeper, beat U.C.H. 4-2 in an away match. At present the team are at the top of both the United Hospitals and the University (Div. 2) leagues and Mr. Philip Herbert, an inside forward, has lost a stone in weight and scored a goal a match. On 2nd November at a successful Soccer Club Ball the Alpha Beats put a 3s. 6d. premium on College Hall Bar drinking.

The Hockey Club started off the season with a 13-0 win against the R.N.C. Greenwich. After this they did well to hold a 2nd Beckenham side to 0-1; not so well to be beaten 8-2 by Kingston Grammar School. On tour in Cambridge from 23rd October to 26th the 1st XI drew with Kings 2-2 and defeated Pembroke 2-1. Queens' and Jesus, both weighted with University players as well as Wanderers, beat Bart's on the first two days 6-1 and 4-0. The Club misses Mr. Steve Thomas who plays for Dulwich. On 19th October he played for Wales for the first time, on the same day that Miss Ruth Smiley represented England-lacrosse not hockey.

On 31st October Bart's were 2nd in a motor car rally arranged by the M.S.S. between four leading London teaching hospitals. There were some 30 entrants; Messrs. Malcolm Smith-Walker and James Underwood (navigating) came 3rd driving an M.G.

(4th November.)



Mr. A. W. Badenoch

# ST. BARTHOLOMEW'S HOSPITAL STUDENTS' UNION

# CHAIRMAN'S REPORT 1962/3

#### Introduction

As we approach mid-November, the Students' Union year draws to a close and it is my task as Chairman to review the year's events.

I came into office on 13th November, 1962, with an excellent and keen Council behind me, but, in the light of experience, with poor prospect of achieving anything of use to the students that would not happen anyway without the intervention of the Council. It seemed to me that noone had been willing to stick his neck out and ask for anything for fear of offending someone. Because of this there was almost complete apathy both from the students and the staff towards the Students' Union.

# New Abernethian Room

We therefore took over with the fine prospect of the immediate loss of our Rifle Range in the Hospital to the Records Department and our removal from the Abernethian Room to part of a shack on the car park. It seemed that the last stronghold of the students in the Hospital was to be the gentlemen's lavatories. With the excellent and unfailing help of the Dean and the Medical College Secretary we determined to keep Bart's a teaching hospital.

We saw Mr. Gooddy about our new accommodation and he kindly arranged for us to meet the architects. After long consultations we decided to ask for extra space in the new building and were surprised to be given another large lounge. For this we are very grateful to the Board of Governors. Although the Union will have to spend many hundreds of pounds on the furniture, we should be grateful because the new accommodation will, in all probability, be quite comfortable. It is of course a pity that it is not so well placed as the old Abernethian Room. We must thank Mr. Gooddy for his help and understanding in this problem.

The Rifle Range presented a much more difficult problem. It seemed that it had become absolutely necessary for us to lose the only sports facility we had within the Hospital. We decided that a last stand should be made. We saw the Dean and Mr. Morris who gave us their full support. We then arranged an interview with Mr. Gooddy and explained to him how important the facility was to us. We were advised to write to the Board of Governors and this we did, claiming the moral right of access for all time to the Range and asking for £10,000 to complete a new rifle range if we were to be moved. Fortunately Mr. Gooddy granted us a month to month exten-

sion and now it seems that the Records Dement has solved its problem another way. We all sincerely thank Mr. Gooddy and the Board of Governors for their sympathy over this matter. We also apologise to the Records Department for the difficulties we must have caused them.

Matron was approached about the swimming. She very kindly granted me an interview and offered to double the time available for mixed swimming. I should like to say how grareful we are to her for the very great privilege of using the pool. It is a great asset to the sporting life of Bart's and I sincerely hope that we will never abuse this privilege.

#### Food

Our relations with the Hospital have been very good this year. Senior members of the staff have made themselves available for consultations, which for the most part were of a begging nature. Usually the results exceeded our hopes.

Our continued campaigning for improvements in the standard of the food have at last succeeded. Mr. Morris has completely transformed the running of the Hospital refectory and now the food is generally considered to be more palatable. Congratulations Mr. Morris! Mr. Morris employed a Miss Gibbins as domestic supervisor in the Hall of Residence, a dynamic awe-inspiring woman who knew what she was doing and made quite sure it was done. For the first time in vears some of the maids broke into a fast walk and did a bit of work. The serving system was re-organised and investments made in laboursaving innovations, and Miss Gibbins went out of her way to help the students. She gave them what they wanted and not what was easiest to do. Alas, as predicted in Broadsheet, a clash of personalities was inevitable and although we tried everything, the situation became impossible for her and she resigned. We thank her for all she did for us in the short time she was here and wish her all the best in the future.

#### Smoking

Two years ago smoking was stopped in the Hospital Library. Since we felt that this was unjust the Council discussed it and the Dean was approached. After we had called a General Meeting of the S.U. our request was granted by the Library and College Council Committees, and smoking is now permitted in the gallery.

# Car Parking

Over the years more and more car parking restrictions have been imposed on students. This has caused great hardship and expense to the commuting students with cars. We therefore approached the Medical College and asked them for more parking space. A new car park has now been built to hold 60 cars. Our thanks are due to the Medical College and to the Car Parking Committee for this concession.

#### Student Selection

Earlier in the year senior members of the S.U. and constituent clubs were asked to sit on the interviewing board for new students. Although we played no part in the actual selection we were given the opportunity of chatting to the interviewees as student to student, helping to ascertain their extra-curricular activities. We sincerely hope that we were of some help; we certainly felt that this quite revolutionary step was very successful.

#### Administration

This year the Athletic and General committees produced a brochure for the Freshers. This was a stereotyped twenty-page booklet edited by Peter North. The Dean made arrangements for the Students' Union to show Freshers around and gave an excellent opportunity for the secretaries of the sports clubs to canvass for members.

Over the year it has been necessary to improve the running of the Union. This has been well symbolised by the complete renovation of Percy, the Hospital mascot, who now stands outside the Clinical Lecture Theatre.

The minutes of all Council Meetings are now posted on various notice boards in the Medical College. This should allow all students to take an interest in the running of their College life and perhaps stimulate them to offer suggestions occasionally.

It has been found necessary to make changes in the structure of the Union to decentralise the administration. This has been done by the formation of several sub-committees. The Wine Committee had its first year under the Presidency of Mr. G. H. Ellis who has shown very keen interest in the Committee's activities. The Chairman, R. L. Powlcs, has worked very hard to make the Wine Committee one of the most useful, profitable and influential bodies in the S.U.

# Teaching Committee

In August the Teaching Committee, composed entirely of students, was formed. It meets regularly to discuss the teaching at Bart's, department by department. Before each meeting representatives of the Committee go to the heads of the relevant departments to discuss the teaching. Then the opinion of the students is ascertained and the Dean is consulted. The members of the committee discuss the department and a report of the meeting is sent to the Dean, who at a later

date discusses it with the Committee.

#### Sports Day

This year a Committee was set up to organise Sports Day and although the weather was bitterly cold the event was a great success. The small profit made from some of the side-shows is to be donated towards the cost of furniture for the A.R.

# Constitutional Changes

The Athletics and General Committees have been amalgamated into the Clubs Union Committee (C.U.C.). This is under the control of a chairman, elected by its members, who reports the activities to the Council. The C.U.C. has representatives of all the Union Clubs and Societies, and functions to administrate the needs of those clubs. The previous arrangement of having two committees, one to control the Athletic Clubs and one to control the other Clubs, was quite unworkable. As a result of this amalgamation the problem of the award of Honours Colours arises, not only because it would be quite improper for the C.U.C. to do this, but also because there has always been a need for the standardisation of the awards over the years and between the various sporting clubs. So an Honours Colours Committee should be formed. This Committee should consist of three members of the staff, prepared to sit for several years, the past and present Chairmen of the C.U.C., and representatives from the clubs concerned. The awards will be ratified by the S.U. Council. The formation of this Committee necessitates a change in the Constitution and we hope this will be done at this year's A.G.M. At the same time other changes in the Constitution should be made to make the Council more efficient. The post of Publicity Officer is no longer necessary and should be changed to Assistant Hon. Secretary, whose job will be to help the now seriously over-worked Hon. Secretary. This post should also be very good training in Union Council work. There also seems to be no need for a lady Vice-President because the ladies are well provided for with their pre-clinical and clinical representatives.

Generally speaking this year has been very successful. Our relations with the Dean, sub-Dean, Medical College Secretary and other members of the Medical College Staff have never been better. I must thank the Council for making the success of this year possible, but above all I must thank the President, Professor Taylor, for his excellent control of the meetings and for his invaluable help and advice and the Hon. Sec., T. J. Mc-Elwain, for his hard work and unfailing enthusiasm throughout the year.

T.J.P.

# WINE COMMITTEE ANNUAL REPORT

Early in 1962 T. J. Powles proposed to the Students' Union that a Wine Committee should be set up as a sub-committee of the Students' Union to run a bar at College Hall. The first meeting of this Wine Committee was held on Thursday, 30th August, 1962, with Mr. G. Ellis as President. He had been cleverly talked into this at a Students' Union Cocktail Party. T. J. Powles was Chairman and the members present were R. Wilson, T. R. G. Carter, T. J. Mc-Elwain and R. Hillier.

The Bar was opened on 3rd September, 1962, for a trial period of one year. The opening hours in the evening were extended and for the first time for several years the Bar was opened at lunch-time.

At the onset it was apparent that there would be difficulties with barmen. These were recruited from the student body on an unpaid basis and over the year it has worked out fairly well. In November of that year a new Committee was elected in accordance with the Students' Union Constitution and seven members and two copted members were voted in. The policy was to reduce prices and to use the Bar's profits to finance social events at Bart's.

Our first social occasion was a Smoker held on 4th December in the Recreation Room at College Hall, with Graham Chapman, the Social Secretary, providing the entertainment with his friends from the Cambridge Footlights. In spite of thick fog, a full house was present to enjoy the excellent entertainment provided and the superb free punch concocted by the President.

The President summed up the evening in his vote of thanks by saying that it was perhaps one of the better evenings that he had ever attended. This was all the encouragement the Wine Committee needed to go ahead with the idea of a summer ball.

By way of a celebration for the success of the Smoker the Wine Committee held its Annual Dinner at Rules in Maiden Lane. Our guests for the evening were Mr. Morris, Secretary to the College, Mr. Birnstingl, the Warden, the Sub-Warden, and representatives of Whitbreads Brewery. Later, at the President's flat, we waxed happy on his excellent brandy. The evening luckily spared us some embarrassment of the profits we were making.

This Summer we organised a Barbecue Ball in the hope of re-distributing some more of the year's profits. The Ball was held at College Hall with dancing on the lawn and in the lounges. Luck being on our side, the weather was fair and almost everyone had a thoroughly enjoyable evening. Two bands, a steel band, a piper, excellent food, two bars, a roasted pig and extensive floodlighting still failed to let us make a loss and so in this respect we failed in our aim to subsidise social life at Bart's. We owe a great debt for the success of that evening to the excellent food provided by Miss Gibbins and the kitchen staff, and to Graham Chapman for the general organisation. We are sorry that more members of the Medical Staff did not attend since it was generally agreed that the ball was better value—at 30s.—than most View Day Balls.

The Wine Committee had planned to go on a wine tasting tour of Europe this year. However, because the weather this summer was poor and rumour held that the grape was not good, we decided to go on a mystery tour to Southend for the evening of 21st July.

Our next social event will be another Smoker to be held on 29th October. This will be run on exactly the same lines as the last one, with Bart's men providing most of the entertainment this time.

In the future we have also organised a visit to Whitbread's Brewery for twenty people for luncheon and the opportunity to look at Lister's original microscope. The Wine Committee will provide wheelbarrows for the journey home.

When the Wine Committee was handed over to the Students' Union it was at that time making a loss. Having eliminated many of the overheads, we have shown that quite a reasonable profit can be made by the Bar even though the prices have been reduced. Of the £4,600 taken this year, £350 is profit. Future Wine Committees must use the profits to lead the social life at the Medical College. They will have the money to think big and to take financial chances with worthwhile social ventures. This opportunity is unique. An example would be the revival of the Champagne Party to the Derby which was an annual event in this Hospital at the beginning of the century. Ideas will always be considered by the Wine Committee.

For the success of this year credit must go to the members of the Wine Committee consisting of T. J. McElwain, T. J. Powles, T. R. G. Carter, M. Whitaker, B. Shorey, E. Abel, G. Chapman and R. Hillier, the assistance of pre clinical representatives, and the enormous support given by the President. Mr. G. Ellis.

R.L.P. (Chairman)

# APPLIED RESEARCH IN THE ROYAL NAVAL MEDICAL SERVICE

by SURGEON COMMANDER J. S. P. RAWLINS, O.B.E., Royal Navy

# INTRODUCTION

NAVAL Medical research covers a very wide range of activities, for Naval operations are conducted in the air, on the land, on the surface of the sea and under water. There is an immense requirement for applied physical and biological research in all these media and, since the Naval medical research worker is likely to want to pursue his studies in more than one physical situation, it follows that he will develop techniques which will place him in a relatively unique position vis-à-vis his scientific colleagues. For this reason he can expect to be consulted on a variety of problems-physiological, psychological and anatomical, and he may receive requests to employ his techniques and special equipment in many different fields of research. He may expect to be in demand as a speaker at International Symposia and not infrequently will have the opportunity of applying the results of his specialised work to problems which affect the public at

In my own case it has been necessary to become familiar with a wide range of instrumentation techniques, both physical and physiological, to understand the principles and potentialities of scientific photography, and to acquire a good working knowledge of manufacturing methods employed in the light engineering, textile, plastic and rubber industries. In addition, although I am not personally qualified as aircrew, it has been necessary to gain some experience of piloting and navigating military aircraft and to qualify as a diver; amongst my colleagues there are fully-qualified jet and helicopter pilots and observers, some of whom have a diving qualification as well. In contrast there are others who are engaged full-time in basic physiological research.

A large proportion of applied military research is concerned with survival, with extending the limits of human tolerance to adverse physical conditions, and with making the most of human capability. It follows that the items of equipment and the techniques developed in the laboratory must ultimately be employed in the field by Service personnel, and it is highly desirable therefore that subjective assessment of the final product under as nearly realistic conditions as possible should be carried out by the research group responsible for its development. Only then can a research worker feel fully confident in recommending it.

Very often there is no alternative to subjective assessment as a form of investigation in the early stages of a programme. Instrumentation can define a situation in physical terms, but there may be no yard-stick for interpreting these in terms of human tolerance. Animal experiments may help, but unless a quantitative relation between the selected animal and the human subject has been established, a human

subjective assessment, or a series of them, will be required to bridge the gap. In the event, it may be quicker and simpler for the research worker to make a personal subjective assessment of each situation, if necessary approached by a series of graded steps of definite increment (defined by physical measurements) and then to use this experience to interpret subsequent physical measurements in biological terms. This is in fact the well-proven medical method of assessing a situation on the basis of the experience of a trained observer. When the initial assessment has been made, its validity can be checked by the exposure of additional subjects.

In the course of ten years' experience in the field of applied research I have had to deal with a wide variety of projects, have carried out experiments in the air and under the water both at home and abroad, and have presented papers at Symposia in France, Holland, Norway, Denmark and the U.S.A. Whilst this is in no way remarkable in the light of the experience of my R.N. and R.A.F. colleagues in the same field, it is perhaps sufficiently removed from the usual practice on medicine and medical research to the usual practice of medicine and medical research to and a brief description of some of the problems with which I have personally been concerned may serve to illustrate the possibilities of a career in the Royal Naval Medical Service.

#### 1952 DEVELOPMENT OF AN ANTI-G SUIT

Pioneer work on protection against the effects of "g", the acceleration imposed upon an aircraft when it changes its direction or velocity in flight, was carried out in most of the combatant countries during World War II. British pilots used the Franks Suit, developed in Canada, which was a double-walled garment containing waterfilled bladders covering the legs and lower half of the trunk, with a non-stretch outer layer closely adjusted to the wearer by means of tapes. Later this was superseded by a similar type of garment with air-filled bladders, the air pressure being automatically regulated by the "g" loading on the aircraft.

Wearing an anti-g suit, aircrew were able to turn more steeply and at greater speeds without "blacking-out"; furthermore the support given to the circulation diminished the cumulative effects of repeated cerebral hypoxia resulting from the decreased blood-flow to the brain during successive manoeuvres, and greatly reduced the fatigue produced by aerobatics and combat. At the outbreak of the Korean War only the U.S. Air Force pilots flying F.86 Sabres, were equipped with anti-g suits and there was an urgent requirement for "g" protection for R.A.F.

and R.N. pilots.

Newly arrived at the R.A.F. Institute of Aviation Medicine, Farnborough, I was given the task of developing a suitable anti-g garment. An experimental model already existed, but it was very uncomfortable in use and, being worn like a pair of very tight trousers under the flying overall, restricted movement on the ground and was impossible to discard in a hurry. This was of the greatest concern to aircrew liable to be shot down

in enemy territory.

My first task was to assess the protection afforded by the existing garment. This was done by a series of flights in a dual control Meteor 7 aircraft fitted with the necessary air supply and valves. Repeated turns and pull-outs at up to 7 "g" (the maximum permissible for the airframe) were carried out. It was found that at about 4 "g" the pressure in the abdominal bladder was such that breathing became impossible and the descending spiral that we found most suitable for applying prolonged "g" had to be abandoned so that one could breathe again. Modification to the shape and size of the abdominal bladder was made and eventually a satisfactory compromise was reached.

I now took the modified suit to the manufacturers, Dunlop's, in order to develop a production version which could be donned in less than thirty seconds and doffed in less than ten. Initially this appeared impossible but after five days spent in the cutting rooms of the factory I was able to return with the garment, which subsequently became the standard issue to R.A.F. and R.N.

aircrew.

# 1952 DEVELOPMENT OF A CRASH HELMET

Another urgent requirement which arose during the Korean War was for a crash helmet for Naval aircrew operating from aircraft carriers whose aircraft, particularly if damaged, were liable to engage the steel wire crash barrier on the flightdeck. This had been known to cause fatal head injury when the top wire carried away the pilot's canopy. There was also the danger of a crash on deck.

A search of the literature revealed that the question of a crash helmet for aircrew had been considered during the war, but an eminent surgeon had given his opinion that in order to have a significant effect on the head injury rate a crash helmet would have to be so heavy that it would be impractical to wear it while flying.

An examination of a variety of protective helmets, from medieval armour in the Tower of London to current racing motorists' helmets,



1953 Aircrew Protective Helmet Mk. 1.

showed these to be designed on a basis of bad physics and worse anatomy, and it was therefore decided to survey the mechanics of head-injury and to base the design of the aircrew crash helmet on this.

In the event it proved a good deal more difficult than had been anticipated. The helmet had to be strong, but light and comfortable, and was required to fit a wide range of sizes and shapes of head. It had to be cool, it had to carry the wearer's communication equipment and oxygen mask, it had to be virtually fireproof and had to provide effective noise attenuation.

Once the design basis had been decided a plasticine model was made, followed by a linen and shellac mock-up. After fitting this with an inner helmet carrying the communication equipment, it was flown by a selection of pilots in a variety of aircraft and the shape modified as experience dictated. Next, a prototype in the final material, laminated nylon, was constructed and fitted to a wooden head form. This was suspended on wires and a succession of blows were imparted to it by a steel pendulum, the impact accelerations in the pendulum and the head-form being recorded by accelerometers and the effectiveness of the helmet defined in terms of reduction of the acceleration transmitted to the head-form.

Although there was no R.A.F. requirement for such a helmet, no sooner did the Navy order its initial quantity of 350 than the R.A.F. ordered

30,000 without further test. It has been a standard item in both Services and in many of the NATO air forces ever since.

The work was subsequently reported in the Lancet (1956) and as a result of criticisms in the article of the British Standard for motor-cyclists' crash helmets. I was invited to join the B.S.I. Sub-Committee which was engaged in drawing up new standards for protective helmets. After months of discussion with the manufacturers and a long test programme, new standards for helmets for motor cyclists, racing motor cyclists, and racing motorists were eventually drawn up, and it is now an offence to offer for sale any helmet which does not meet the exacting requirements of the Standard.

This is an example of the manner in which military medical research may be of benefit to the community at large.

#### 1955 LINEAR ACCELERATION

Many people will be familiar with the celebrated experiments of Colonel Paul Stapp who investigated the limits of human tolerance to linear acceleration and who, on 1st June, 1961, subjected himself to a linear deceleration of 46.6 "g", decelerating from 155 m.p.h. to 35 m.p.h. in 30 feet, as a result of which he sustained a large left retinal haemorrhage, producing a visual defect which lasted for ten weeks.

There has been no requirement for similar work in this country, but in 1955 the Admiralty requested information on the maximum linear accelerations and decelerations at which a man might be expected to control an aircraft. This being relevant to the design of aircraft carrier

catapults and arresting gear.

Accordingly an experiment was set up using a small rocket track at Farnborough. On this a rocket driven sled could be accelerated from a standstill to 110 m.p.h. in less than 35 feet, giving a maximum acceleration of 10.4 "g". A simple tracking task was provided for each subject to follow during the acceleration phase. This consisted of a white circle moving in a rotary manner on a black background at 15 r.p.m. The subject was required to maintain a white cross on this circle by manoeuvring a standard aircraft column in a combination of fore-and-aft and side to-side movements.

The initial impression of riding this trolley was unforgettable. Since there was a delay of a variable number of seconds between the subject signalling that he was ready and the test crew igniting the rockets, one never seemed fully prepared for the sudden violent and sustained thrust. However, only minor symptoms of discomfort

were experienced and with practice it was found possible to complete the tracking task quite successfully at up to 7 "g". Above this the acceleration was too great for the muscular strength of the subjects.

For the deceleration experiments, the sled was accelerated to 90 m.p.h. and it then engaged arresting gear, identical with that used on aircraft carrier flight decks. The tensioning of the arrestor wire could be varied to produce a maximum deceleration of 7 "g". This gave quite an impressive jolt, the subject's head being thrown forward at the moment of impact. It was felt that this represented the absolute maximum that could be tolerated by pilots who had to carry out a number of sorties in a single day and a recommendation to maintain arresting decelerations at a lower level was made.

## 1956 ESCAPE FROM SUBMERGED AIRCRAFT

During World War II, "ditching" an aircraft, that is, landing it on the sea, was a recognised emergency procedure, preferred by many pilots to making an escape by parachute. The introduction of the jet aircraft and the ejection seat virtually eliminated deliberate ditching, partly because the ejection seat greatly simplified the procedure for making an escape in flight, and partly because the large engine intakes of the new generation aircraft resulted in very poor ditching characteristics

However, in carrier operations, due to engine or catapult failure on take-off, pilot error on landing, or brake failure during taxi-ing, inadvertent ditchings continue to take place, frequently with fatal consequences. Often the aircraft sank before the pilot could jettison his perspex hood.

In 1956, the Admiralty requested that the functioning of the hood jettisoning mechanism in the prototype Sea Vixen should be tested underwater, and it was decided to take the opportunity of experiencing the effect of the inrush of water

on the crew.

For this it was first necessary to qualify as a diver. Then a series of test jettisons at depths down to 50 feet were made with the cockpit section of an actual fuselage, the mechanism being operated by remote control. When the behaviour of the jettison system had been adequately established, a further series of tests were made, operating the system from within the cockpit and subsequently effecting an escape. For the initial tests, closed-circuit oxygen breathing apparatus was worn, later escapes were made using the aircraft oxygen system.

As usual when experiencing a new situation, the



1962 Aircraft Underwater Escape Trials. Ejecting at 20 ft. beneath the surface from the observer's compartment in a Sea Vixen, using the prototype automatic underwater escape system.

first impression was memorable. The explosive jettison system operated with a loud bang and icy water poured in, buffeting the subject's head and partially dislodging his diving mask. Then quite suddenly the turbulence subsided, it was possible to see, and to release the seat harness and climb out.

It was concluded that there was a reasonable chance of escape when the aircraft was sinking in the horizontal attitude, or when the rate of sink was low, but in the inverted attitude or when the rate of sink was rapid, the chances of escape were small, and it was recommended that a study be made of methods of ejecting the seat and its occupants from the aircraft similar to the system that is employed in all jet aircraft in flight.

It was not envisaged at that time that it would be possible to eject the seat with the same explosive charges as were used for airborne ejection; however, an actual incident in which a pilot operated his ejection seat underwater and reached the surface without injury prompted an investigation into the effects of the underwater ejection using standard ejection guns and standard charges. Measurements were first made of the acceleration, velocity and distance of travel of seats ejected underwater, and of the peak pressures induced at various points about the seat by the explosion of the charges.

When the parameters of underwater ejection were established, techniques were developed for exposing human subjects to the various stresses which would be encountered. Tolerance to underwater velocity was established by towing the sub-

jects underwater across a lake by means of a metal trapeze attached by a rope to a 3.4 litre Jaguar car. We were able to show that one could be towed head-first at velocities up to 40 ft./sec. for the priods with no further residual discomfort than would be expected after a stiff game of rugger.

The possibility of lung-rupture due to the rapid rise towards the surface when ejecting from an aircraft in the horizontal attitude was obviated by breathing out completely prior to firing the seat. The effect of the blast wave from the underwater explosion of the ejection cartridges was assessed subjectively by moving progressively closer to the ejection gun during underwater tests with dummy subjects.

Subsequent underwater ejections with human subjects and reduced charges were carried out, and finally three subjects were ejected underwater with the full charges, and it was concluded that use of the standard seat and charges was feasible as an underwater escape procedure.

However, this did not entirely solve the problem of underwater escape from aircraft for there was still the difficulty of jettisoning the cockpit canopy. In some aircraft it might be possible to eject through a perspex canopy, but in others reinforcement of the canopy precluded this and some method of flooding the cockpit was required in order to equalise the pressures across the canopy so that it would be jettisoned. It was apparent that the underwater escape potential of each Naval aircraft would have to be assessed separately, and this involved a further series of trials.

At this stage an improvement in the performance of the latest types of aircraft required to be matched by an improvement in the performance in the cicction scat in order to permit ejection at higher indicated air speeds; this involved alterations in the design of the ejection gun and employment of more powerful explosive charges. Calculations based on the experience gained in the underwater ejection trials indicated that the blast wave generated by this combination when fired underwater might cause incapacitating injury to the occupant of the seat. Accordingly, measurements were made of the peak pressure, impulse and energy of the blast wave, anaesthetised sheep being exposed at various distances with a variety of shielding. The pathological effects of the blast wave were assessed by sacrifice and autopsy. A single human exposure was also made and it was concluded that underwater ejection using the latest type of gun and charges was potentially lethal, and an alternative method of underwater ejection was required.

From time to time experiments had been car-

ried out using compressed air to eject the seat, with promising results. This project was now re-opened and tests were made with a compressed-air-operated seat in a Sea Vixen fuselage which had been fitted with a rapid flooding device. A series of successful escapes were made by eight subjects, but it became apparent that there was a requirement for some automatic method of separating the man from his seat subsequent to ejection, and also for an appreciation of the mode and rate of sink of the submerged aircraft.

In April, 1962, a prototype separation system was successfully tested and preparations were made for a large scale experiment to determine the rates of sink of two representative Naval aircraft, a British Scimitar and a French Etendard, in co-operation with the French Ministry of Marine. These aircraft were dropped into 100 feet of water off Toulon during the summer of 1962, their underwater behaviour being recorded by self-contained instrumentation and ciné photography. Naval medical officers from Farnborough and from the French Navy were responsible for scientific control of the trial and carried out most of the underwater photography; it was also their task to examine the aircraft for damage where it lay on the sea-bed and to prepare it for recovery. During this trial two tests were also made with an automatic escape system and dummy pilot. In the second the aircraft was catapulted into the sea from an aircraft carrier. From the information derived from this trial it was possible to draw up a specification for an ideal underwater escape system, and during this winter it is hoped to carry out final tests of an automatic system manufactured to production standards for the Sea Vixen and the Buccaneer.

This long series of experiments has been not without its difficulties nor without its hazards. We have had one or two alarming moments, but thanks to a well-trained and quick-thinking team, we have had no serious accidents. In the course of the work we have uncovered fundamental problems of the psychology and physiology of diving, some of which have merited investigation on their own account and have formed the basis of presentations at international symposia.

The foregoing gives some idea of the variety of work which a Royal Naval Medical Officer may be required to undertake. However, the examples given represent only a tiny fraction of the total research effort carried out by Service medical officers throughout the world, which covers human capability and behaviour throughout the range of environments from the very depths of the sea to the fringes of outer space.

# **ACKNOWLEDGEMENTS**

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# A BUSMAN'S HOLIDAY IN DUBLIN

by PATRICK SMITH

The city of Molly Malone is still much as the song has it—one "of streets broad and narrow". It is a place of stately Georgian squares and slum tenements, of turf accountants and high class lounges, of the cloth and the rabble. The charm is difficult to define, but to a stranger the first impression is one of an older, more tranquil, London of forty years ago. Dublin is still small enough to have retained its heart, and with it an almost parochial spirit, which together have, despite the inroads of business into the city, supported the individuality of the Dubliners against the depredations of a common culture and the unifying influence of progress. Perhaps for the persecuted motorist there is the greatest liberty, not to be pursued by traffic wardens patrolling like predatory wasps, to park where and when he pleases, to be stopped only occasionally by lights which observe the Sabbath, and to laugh cheerfully with the rest of Dublin at the newly-instituted speed limits. No less on foot than in a car is there a sense of space and freedom, light and air, which are all part of an eighteenth-century legacy in town planning. Such foresight is only matched in Paris by the Champs Elysées, and indeed, the comparison is not inapt, for there is a certain foreign atmosphere in Dublin (allowing for the determined Anglicism of the average traveller). This effect is in part attributable to the activities of the Gaelic League, who secured the erection of street signs in both Gaelic and English. There is consolation in the fact that the Gaelic Heros remain as unpronouncable to the majority of the Irish themselves as to the uncomprehending visitor. In fact the Gaeltacht in the West of Ireland remains the only area where the Gaelic tongue is used equivocally with the English. English coloured, however, with a surprising and pleasing measure of novelty and nuance, even Americanism. The decline and revival of the Irish tongue might pass for a tragi-comedy, but it is nonetheless a healthy tendency to retain as much as is possible in the modern world of a cultural identity.

Dublin has its wide streets and to match them its splendid Georgian squares. Nowhere in England will one see such handsome façades as there are here. Exquisitely moulded door frames, lintels supporting fanlights of infinite variety, doors of every brilliant colour, simple impressive ironwork railings and balconies, all give a spontaneous period charm. These, however, are the well to do and prosperous quarters of the city. There are inevitable slums, and here it is all too obvious that the majority still live in hopeless and helpless penury. There is something unnaturally sad about these areas, for they too, were perfect Georgian, but now alas, delapidated and "démodé". Something of that elegant age remains though the doors hang agape on rotten hinges, beneath smashed fanlights and cracked mouldings. Within live one family to each of the ground floor rooms; in indescribable squalor they exist beneath the mocking grace of past glories. It is not unusual to find anything from seven or more children, three or four of them evidence to the insensible idiocy of a priestridden society. Too often the family situation is evocative of Gin Lane; father, to get

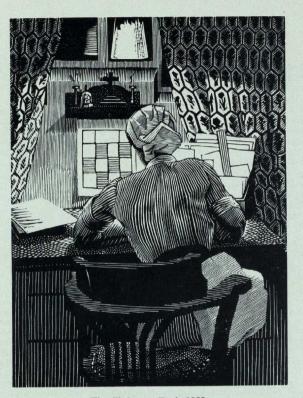
away from it all, spends his evenings drinking, and then, not unusually, the situation becomes one worse. However, though this is depressing, these families retain a spirit and a rather grim humour which demands one's admiration.

The Irish have a propensity to dream, and if it is not "by lukin a heven through a glas" it is at the cinema. Dublin has the highest film going population in the world, and the vicarious drama is not surprisingly of deep affect on the simple and uneducated. This enormous film-going society is one of a number of curious and exclusive features. For instance, there is a numerical majority of 55,000 in the female population, and while this is the only place in Europe where the lions will breed (a source of income to the zoo and compliments to Catholicism), it is also the birthplace of Guinness.

If one can for a while forget the underlying poverty and the social problems, the back streets become a sociologist's paradise. Every street corner boasts its turf accountant, inviolate behind green and frosted glass, and a high-class saloon georgously arrayed in Betjemanesque Victorian. The streets themselves, usually cobbled, are the almost exclusive kingdom of the children who terrorise with wild delight this Chicago of their fantasy. Occasionally hawkers pass, selling anything—coal, second-hand spectacle frames, old paperbacks and even reconditioned dentures. Sometimes they transport their wares with pony and cart, but usually in an old pram. Prams somehow never die in Dublin. Though simple and restricted by adversity, these people of the back streets still retain a determined conviction in their faith, which to the outsider seems an almost maudlin religosity.

Of the well-known institutions in Dublin, Trinity is famed not only for past glories but also for being one of the few Universities completely within its own walls. It occupies a choice site in the middle of the City. In size and classic design it must have few rivals. The Rotunda is another renowned institution—being the first in the world of its kind; it remains today a byword in obstetrics. All told there are nearly 7,000 deliveries a year, over 5,000 of these actually in the hospital. These institutions, together with many others, reflect the foresight of previous generations. Generations which also produced the literary genius of the Irish; Congreve, Sheridan, Burke and Steele, to say nothing of the later revival of Irish writing embodied in such men as Yeats, Synge, O'Casey, George Russel, James Stephens and, of course, Frank O'Connor. Among the spiritual progeny of the land there were Shaw, Wilde, O'Neill and Joyce, who drew such immortal descriptions of his youth in the "Dubliners". Perhaps of all these, George Moore, writing in what he believed a dead language, and Maurice O'Sullivan, the "Irish Homer", did more between them to realise some of the dreams of a literary revival.

It is in the works of these men that one may learn something of the nature and spirit of the Irish. They are essentially carefree and expansive, having at the same time deep emotional capacities which occasionally give a spurious impression of the irrational. Above all there is a talent for native wit and innumerable stories are told giving testimony to this. Their Blarney is proverbial—and if it is intended to deceive without offending, what matter? One of their most engaging habits is that of pulling people to pieces, their friends not excluded, and then, out of charity, putting them together again. A special form of charity? Not really, but one that is worth the acquaintance.



The Christmas Card, 1963.

Christmas Card Order Form.	Please use BLOCK CAPITALS			
NAME:	No. of cards required			
ADDRESS:	Cost at 5s. per doz£ s. d.			
	Plus postage, 1st doz. 9d			
	additional doz. 4½d. (Orders over 5 doz., post free)			
Size 6" × 4\frac{3}{4}" fly.	Total £ s. d.			
Please enclose remittance with order, addressed to The Mar E.C.1. Cheques and P.O.'s payable to St. Bartholomew's	nager, The Journal, St. Bartholomew's Hospital, London, Hospital Journal.			
Date	igned			

# FIGHTING ON TWO FRONTS

by A SPECIAL CORRESPONDENT

The first of two articles about Oxfam.

Sudden disaster and long-term suffering—these are the two enemy fronts on which the Oxford Committee for Famine Relief is waging war.

This war began exactly twenty-one years ago, on 5th October, 1942, when a group of Oxford citizens organised an appeal to help starving children in German-occupied Greece. As a result, money and clothing were sent through the Red Cross and the Friends Relief Service. During the war there were several organisations like the Oxford Committee and in 1946 many of them disbanded because austerlty at home made appeals difficult. However, Oxfam continued to help, not only in Greece but also amongst displaced persons in Germany, not an overwhelmingly popular thing to do. Nevertheless there was established a principle which has become the foundation of Oxfam's policy—namely that help should go wherever there is suffering, regardless of politics, religion or race.

In 1947-48 £7,000 in cash and £33,000 worth of clothing was raised. For the first period of Oxfam's history most of the money and clothing went to European refugees, but in 1951, there was a famine in Bihar in India and an appeal was launched for help. £3,000 was sent, and Oxfam had taken a definite step forward. All the same, it did not then seem likely that by 1963 Oxfam would be administering funds in 70 countries.

The Korean War was another event which broadened Oxfam's horizons. By the end of 1953 over £8,000 had been sent to help the three million Korean refugees and the 100,000 war orphans. In 1954 a further £19,000 meant that Korea had had the highest allocation so far of all the countries to which Oxfam had sent help.

A further step in 1954 was the sending of help to refugees in Hong Kong and Macao, and by the mid-fifties funds were being channelled to sixteen different countries, including four in the Near East

New refugee problems were created by the Hungarian crisis and the war in Algeria. At the same time the attention of the world was being focussed on European refugees. The culmination of all this was the World Refugee Year in 1959 when all the voluntary agencies proled their resources in a massive attack on the problem. The publicity which this campaign attracted produced a further development: for the first time cash income exceeded income in kind (such as clothing). Oxfam was in business and was responsible for distributing £250,000 of the public's money.

This is a great responsibility and a constant concern of Oxfam leaders is that the money is not misused. Every application for money is carefully examined—an average of twelve applications come in each week from all over the world. Moreover, it is a rigid policy that administrative costs are kept to a minimum. The percentage of money received spent on staff salaries, administrative expenses and advertising is 11.5, the staff of Oxfam being paid only 70 per cent, of what they could receive in commerce or industry.

By 1955 it was obvious that Oxfam was becoming increasingly important in the programme of long-term development of the poorer two-thirds of the world and that it was accepting long-term responsibilities. It came increasingly into contact with the agencies of the United Nations, especially the Food and Agriculture Organisation. A few grants had been made in Kenya and Tanganyika for feeding schemes and these paved the way for the establishment of heavy responsibilities in the High Commission Territories, where £500,000 has been committed for a long-term programme of development.

Another factor in this widening of scope has been the launching of the Freedom from Hunger Campaign in 1960. This gave a new emphasis to the responsibility of the richer nations for the development of the poorer ones and brought home the problem of the desperate gulf between insufficient food supplies and rapidly increasing birth rates.

World Refugee Year did not solve the problems of world refugees, it merely brought it into the public eye. The refugees of Hong Kong and the Near East respectively, accounted for 9 per cent. and 11 per cent. of Oxfam's expenditure last year. In any disaster—such as the Congo, where Oxfam sent £75,000 last year, or Skopje, where £18,000 was sent, aid is available immediately. Often Oxfam aid had been the first to arrive. A telegram will come, as for instance from Chittagong, where cyclones caused tremendous damage this June, and on the same day a cheque is sent off for immediate relief work.

So Oxfam is fighting a war on two fronts and its ammunition is the £1½ million which is its present annual income from the people of this country. It is fighting the sudden enemies, dramatic human needs that arise from floods, earthquakes, droughts or typhoons, and it is fighting the ancient enemies: hunger, disease, ignorance and strife.

The money comes in every day—about £6,000, in various forms. The result is the biggest permanent charity of its sort in the country, with half a million regular supporters and commitments in all parts of the world. Oxfam has a heavy responsibility to both those giving and those receiving, to see that the money reaches its destination in the shortest possible time, with the least possible deduction. This final responsibility is not one that is taken lightly, for

# OTHER HOSPITALS: 3 THE LONDON HOSPITAL

by J. P. ENTRACT, College Librarian

Arms: Quarterly argent and gules a cross couped countercharged on a chief azure three feathers of the first quilled or.

Motto: Homo sum: humani nihil a me alienum puto.

IF the circumstances of this hospital's foundation were unusual—it was "born" in a tavern—its survival was a miracle. Two weeks before the day of opening the treasurer reported, "there be only one shilling in the Bank". A few years later, when finances had improved, the secretary embezzled \$\frac{4400}{2400}\$

Two things combined to necessitate
The London Infirmary, as it was first called. While the City,
Southwark, Westminster and rural Knights-bridge were all pro-

vided by this time with a general hospital, there was no institution to serve the north-eastern purlieus of a metropolis rapidly increasing in population. Moreover, the winter of 1739-40 had been one of particular severity when the freezing-over of the Thames had prevented colliers from reaching London, and a ruined harvest had made bread prices leap, hitting the poor the hardest of all. There had even been a war with Spain—that of Jenkins' Ear.

To satisfy this want seven men banded themselves together, collected 100 guineas, and met in the bar-parlour of the Feathers Tavern in



Cheapside on the night of 23rd September, 1740. Their names were John Harrison, surgeon, of Deptford; John Snee, senior; R. Sclater (chairman); Fotherley Baker, lawyer; G. Potter; Josiah Cole, apothecary, and Shute Adams, druggist. Aged only twenty-two, Harrison was the prime mover in the scheme and has always been regarded as the virtual founder of the hospital. He leased a house in Featherstone Street, Moorfields, for the purpose of the charity, and with the spectre of the Shilling before him, prevailed on Charles Lennox, 2nd Duke of Richmond, Lennox and Aubigny—grandson of Charles II—to interest

himself in the project. Subscriptions then flowed in and the infirmary was enabled to open as planned on Monday, 3rd November, 1740. Many persons "of Quality and Distinction" became governors, with the Duke of Richmond as president, the first of a long line of royal and noble holders of that office. It was he, who in 1748, suggested that the title should be changed to The London Hospital

In 1741 the charity had outgrown its accommodation so Harrison acquired premises in Prescott Street, Aldgate, a locality more in keeping with the intention of the founders, which was to provide medical relief for "sick and diseased Manufacturers. Seamen in the Merchant Service. and their Wives and Children". After a few years these premises were also abandoned and, to the designs of Boulton Mainwaring, the nucleus of the present hospital was built on land leased from the City of London in Whitechapel Road. Admiral Sir Peter Warren, K.C.B., had in 1752 laid the foundation stone. In 1759 the work was finished and, with a charter of incorporation granted by King George II, "Harrison's Hospital" was firmly set for the next two centuries.

In 1785, due to the exertions of Mr. (later Sir) William Blizard, surgeon, Dr. James Maddocks, Dr. (later Sir) Busick Harwood, and Mr. Liptrap, chairman of the House Committee, "the first organized medical school at a hospital" was opened on the east side of the building. In 1854 this was transferred to its present position in Turner Street. Blizard also adopted from Terence the hospital motto, the spirit of which is rendered by "I am a man (hence) nothing affecting mankind fails to concern me". Sir Ernest Morris, a former House Governor, was once provided with a young houseman's translation which, in all seriousness, ran, "As I'm a man, I don't believe an alien's a human being"!

There have been many famous names connected with the London. James Parkinson (Essay on the Shaking Palsy) was a pupil in 1776; John Scott invented the dressing known by his name;

Sir Ionathan Hutchinson, F.R.S., "the most famous general practitioner in the world" and founder of the Haslemere Educational Museum, was on the active staff for twenty-three years; John Hughlings-Jackson, F.R.S., father of British ncurology, was there, Barnardo of the Homes, and Sir Morell Mackenzie, founder of the Golden Sq. Hospital for Diseases of the Throat (1862) and jointly of the Fournal of Laryngology and Otology. William John Little, founder of the (Royal) Orthopaedic Hospital, 1838, and Sir Frederick Treves, Bt., were other great surgeons. The latter rescued the grossly deformed John Merrick-The Elephant Man-from a travelling showman and gave him a room in the hospital (1884). Lord Dawson of Penn, Sir Henry Head, Sir Wilfred Grenfell of Labrador, Lords Brain, Evans and Hill have, amongst many other "Londoners", made distinguished contributions in their several spheres, while on the lay side the names are almost as numerous. John Ellicott, F.R.S., a Governor and clockmaker to King George III, designed the great seal and the original hospital clock. William Hogarth illustrated the Patients' Admission Ticket, and the Pupils' Certificate. Jonas Hanway (another Governor) launched not only William Blizard on the path to fame but also the now commonplace Umbrella. Florence Nightingale of St. Thomas's was made a life Governor, while Sydney Holland, Viscount Knutsford, earned for himself in the "voluntary" days the appellation "Prince of Beggars".

The London can claim one recipient of the Victoria Cross — Captain Neville Howse, F.R.C.S., who won it in 1900 during the South African War. IIe later became Australian Minister for Defence and Health.

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# Case Report—MYOCARDITIS

by CAROL R. MARTIN

History. Mr. R., aged twenty-two, a physics student from Sussex, was admitted to Dr. Hayward's ward late in February, 1963, complaining of pyrexia and tachycardia.

He first became unwell in October, 1962. An attack of "flu" characterised by sore throat, rhinorrhoea and pyrexia apparantly precipitated a tachycardia of a 100-120 lasting for seven to ten days. From this time on he complained of general malaise and lassitude. In December, 1962, and January of this year two further bouts of "flu" were again accompanied by tachycardia and, in addition, mild lower left chest pain and fleeting discomfort in the distal and proximal interphalangeal joints and the left shoulder. All symptoms had gone in two weeks.

In the month preceding admission the patient suffered intermittent attacks of pyrexia and tachycardia with dyspnoea on mild exertion. There was no history of rheumatic heart disease, or of cough, excessive sputum, ankle oedema or chest pain.

On Examination. The boy was pale and sweating profusely. His temperature was 100°F, his pulse rate 130 and his respiration rate 25. The fundi were normal. There was no cervical lymphadenopathy and no signs of thyrotoxicosis. The lungs were clear. The heart was hyperdynamic with a slight lateral displacement of the apex beat. There was a loud summation gallop with a soft apical systolic murmur. The radial pulse was regular with a normal wave. The B.P. was 130/70. The other systems were healthy. The limbs showed no signs of acute rheumatism.

The preliminary diagnosis was myocarditis of uncertain origin, the possible causes were legion—the most likely being rheumatism, virus infection, tuber culosis, sarcoidosis, brucellosis or a collagen disease. Subacute bacterial endocarditis and Fiedlers myocarditis were also considered.

Investigations. The initial investigations were aimed at excluding some of the many possible diagnoses. The hacmaglobin was 88 per cent., the W.D.C. normal; no L.E. cells could be seen, latex fixation tests were negative; the W.R. was negative and the E.S.R. was 5 mms. This data was felt to be sufficient to exclude the collagen diseases.

The following investigations gave negative results: blood culture, antistreptolysin titre, faecal culture for viruses, Paul Bunnell, agglutination tests for salmonella and brucella antibodies, intradermal brucellin tests and intradermal congo red tests for amyloid disease. Normal results were obtained from M.S.S.U., P.B.I., blood urea, serum proteins, liver function tests and sternal marrow puncture. A chest X-ray showed a normal heart shadow (diameter 15 cms.) with poor movement on the right side. The lung fields were clear. The E.C.G. showed a sinus tachycardia with T wave inversion of the anterior praccordial leads, suggestive of a heart muscle disorder.

Subsequent History. The patient was treated with salicylates pending further investigations. Lack of positive evidence to support the diagnosis of either acute rheumatism, subacute bacterial endocarditis or brucellosis suggested that the patient was probably suffering from a viral myocarditis, despite the negative viral cultures and consequently he was treated with bed rest. The fever continued.

During the first week of April the patient developed heart failure. The jugular venous pressure was raised 1 inch and the liver was palpable two fingerbreadths

below the costal margin. The heart improved rapidly after digitalisation. On 22nd April, he developed a right-sided pleural effusion and about this time the spleen became enlarged. Aspiration of the effusion showed histocytes, lymphocytes and some multinucleate giant cells. No malignant cells were seen. Z-N and culture for tubercle were negative, as was viral culture. It was felt that a tuberculous pleural effusion was a possibility and for a month he was treated with streptomycin and P.A.S. His temperature was uninfluenced.

Reassessment of the situation at this time made brucellosis the most likely diagnosis in spite of repeatedly negative brucellin tests. The patient was discharged in early July on intermittent 5-day courses of oxytetracycline with a view to readmission after

When the patient was next seen there was no clinical change in his condition except for a small right-sided pleural effusion. The results from simple investigations were unaltered. The ECG showed decreased T wave inversion suggesting improvement in the myocardial disorder. During his second stay in hospital he still had a fever, with a swinging temperature rising to 99°F, in the evening. His tachycardia remained the same. He was discharged at the beginning of August on oxytetracycline. His pyrexia gradually settled in the next two months.

#### Discussion

As yet there is no confirmed diagnosis for this patient. The facts will be reviewed here, remembering that the only positive findings were two plcural effusions and a suggestion of a cardiomyopathy shown in the electrocardiagram tracings.

The patient was suffering from unexplained pyrexia and tachycardia with an indication of myocardial disease. Brucellosis is the first disease to come to mind which causes a persistent pyrexia. Marston, when first recognising the disease, said "it affects, par excellence, young men, under 35, particularly those of rheumatic diathesis". Attempts to show agglutination by the patient's serum of a suspension of Br. abortus were negative on five occasions between February and August. The intradermal Brucellin test was repeated three times; blood, urine and throat swab cultures were attempted, all without success. According to Dalrymple-Champneys, "the only certain proof of Brucella infection is culture of the organism from the body or its secretions. Failing this, an agglutinating power of 1/80 can be regarded as acceptable evidence. A positive intradermal test indicates Brucella infection past or present, while a negative test is strong indication, though not an infallible one, of the absence of such infection in the near past or present".

The cardiac effects of Brucella infection are variable. Tachycardia is the rule in serious cases, especially where there is lung involvement. Spink considers that the myocardium is not adversely



One week of the temperature chart showing temperature (above) and pulse rate (below).

affected, at any rate in any specific manner, and Hughes found that all his post mortems showed normal heart muscle, except one which was "flabby". However, several sources have stated that myocarditis can occur. There is no previously recorded evidence of pleural effusion.

Tuberculous myocarditis is unlikely in the light of the results of anti-tuberculous therapy. Cold pleural effusion is unusual in any other conditions unless accompanied by further physical signs. Sarcoidosis as a closely related disease was considered feasible, but the Kveim skin test for sarcoidosis was negative after six weeks.

A myocarditis of infective origin has a course of weeks not months. It is a well recognised result of influenzal illnesses, diphtheria, scarlet fever, infectious mononucleosis, typhoid and paratyphoid fevers, acute and subacute endocarditis and tuberculosis of the miliary type. Post-influenzal myocarditis is reported by Woodward, McCrumb, Carey and Togo. Their cases showed the ECG changes of myocarditis appearing after one week of the influenzal illness, recovery taking a very stormy course. ECG abnormalities were normal within two months. One of their cases developed dyspnoea, fever and extreme weakness on the third day of the disease and died the same day. Post mortem examination showed mononuclear infiltration of the myocardium. Mackenzie reports myocardial damage in autopsy material and assumed that "influenza may be the beginning of a myocarditis which leads ultimately to heart failure"

Isolated myocarditis was the subject of a paper by Saphir, published in 1942. He described a disease of unknown aetiology not accompanied by endo- or peri-carditis. It occurs in patients who have no other related disease. Apparently healthy people progressively develop myocardial weakness, succumbing rapidly. Clinically the outstanding features are a weak, rapid pulse, low arterial pressure and cardiomegaly.

In Fiedler's original paper, he states that the disease "runs its course with little or no fever. . . . The pulse rate is almost always very much accelerated, and very rarely reduced. The heart is dilated with an irregular action".

Bridgen, in 1957, reported a review of 50 cases of isolated myocarditis at the London Hospital. Of his cases, 7 were considered congenital, 8 presented as infective myocarditis, 3 were cases of puerperal myocarditis, 3 showed features of hypersensitivity and were classified as localised collagen disease, 1 was associated with acromegaly, 7 showed primary cardiac amyloid disease and 13 had alcoholic cardiomyopathy.

The onset of symptoms was usually due to heart failure, but in some the first complaint was of paroxysmal tachycardia or praecordial discomfort. The majority of cases developed dyspnoea on exertion, lassitude and fatigue. Oedema was usually marked, with a high jugular venous pressure; pleural effusions were common, especially on the right side. Pulmonary congestion was not conspicuous. The first heart sound was never loud, triple rhythms were common and apical systolic murmurs were found in 50 per cent. of cases. ECG changes were variable, involving any part of the wave pattern, T wave changes being a universal finding.

#### SUMMARY

A case is presented of a patient with pyrexia and tachycardia with a suggestion of cardiac involvement. All the investigations were negative. The course of the illness remained apparently unaltered by treatment, gradually setting after twelve months. No confirmed diagnosis was obtained but brucellosis was felt to be the probable explanation.

# ACKNOWLEDGEMENT

I wish to thank Dr. G. W. Hayward for permission to report this case, the Library Staff for their help with the references, and Mr. Johan Kuur for the illustration.

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# SPECIAL DEPARTMENTS. V. VIROLOGY AT BARTS by R. B. HEATH

Late in 1960 the Department of Bacteriology established a Virus Laboratory on the fourth floor of the Pathology building. The purpose of this laboratory was to engage in research on acute respiratory disease, to provide a diagnostic service for the hospital and to provide staff for the undergraduate teaching of virology.

The establishment of a new department in a medical school is usually demanded by a sudden upsurge in knowledge in a particular speciality and this has certainly been true of virology. It is of interest that before the war only about half a dozen British Medical Schools had virus laboratories compared with over 50 per cent. to-day.

The majority of virus diseases have been recognised and well documented for centuries and the essential nature of their aetiology has been recognised since the earliest days of bacteriology. However, in the years that followed, bacteriological science was to surge ahead of virology partly because the viruses were so small that they could not be seen with ordinary microscopes, but mainly because they could not be grown on inanimate media. Before a serious study of viruses and virus diseases could be undertaken, it was essential to obtain living cells in a form which could easily be handled in the laboratory. This has only been achieved in recent years with the introduction of embryonated eggs and tissue culture techniques. Laboratory animals have played an important part in the history of the science, but in general they are too crude and too insensitive for present-day requirements.

These new techniques have now been established in the virus laboratory at Bart's, which can provide a reasonably comprehensive diagnostic service for the clinician. The usefulness of this service is still being explored. Many of the virus diseases are clinically so obvious that there is no need for laboratory confirmation and very few of these diseases are knowingly admitted to a general hospital. The aims of laboratory diagnosis of virus and bacterial diseases are not the same, because so far only bacterial diseases can be effectively treated with chemotherapeutic drugs. Viruses are, however, excellent antigens and vaccine prophylaxis has proved to be a most effective way of eliminating the diseases they produce. Laboratory diagnosis of virus disease is therefore of very little value from the patient's point of view, although such tests are often of considerable academic interest and can be of use in excluding other aetiological factors. The most profitable use of virus diagnostic procedures is to direct them towards epidemiological type studies because vaccine prophylactic measures can only be seriously contemplated when we have more knowledge of the frequency of specific virus infections and more knowledge of the range of illnesses produced by these infections. To date the virus laboratory has undertaken several interesting diagnostic studies, some of which are still in progress. These include the investigation of aseptic meningitis, acute myocarditis, atypical lesions of herpes simplex, exacerbations of chronic bronchitis and severe respiratory disease of young children. In another study we have confirmed the findings of other workers that adenovirus infections can be the precipitating cause of acute intussusception in infants—this is of particular interest since the association of this disease with a virus infection was previously unsuspected.

The research of the laboratory is mainly concentrated on the problems of acute respiratory disease. These are the commonest virus infections we have in this country and although usually mild they are nevertheless responsible for more morbidity than any other group of diseases. Before the war only the influenza viruses had been isolated from such cases, but to-day we know that at least six major groups of viruses are involved and some of these groups contain many different antigenic strains. We have been trying to determine the importance of some of these viruses as causative agents of common upper respiratory tract infections. We have in particular been studying the problem of whether the high incidence of acute respiratory disease is mainly due to the large number of viruses involved or whether it is also due to the fact that these infections produce poor immunity. Most of our work has been concerned with the development of immunity to respiratory viruses in man, but we have recently been developing model systems of respiratory disease in monkeys, which are providing most useful information.

At the moment there is a shortage of trained virologists, not only in this country but in the Commonwealth and the U.S.A. and consequently there are excellent opportunities for anyone wishing to take up the speciality. It is a career suitable for those whose interests and inclinations are more scientific than clinical and who are prepared to take time in learning difficult and exacting bench techniques. Leading virologists to-day have been recruited equally from the fields of general medicine, clinical pathology and the basic sciences and it is difficult to say if experience in any one of these fields offers any particular advantage.

# THE NEW RADIOTHERAPY DEPARTMENT

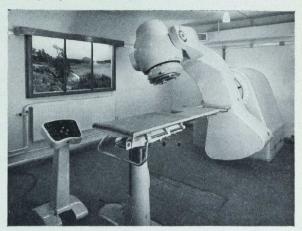
by R. J. M. WHITTLE

It is the custom for radiotherapy departments to be born in a dark corner of the diagnostic X-ray department. Their rate of growth in the twenties was inevitably slow and laboured from lack of financial support. Further, the therapy sets often presented a greater hazard to the intrepid operator than to the troubled patients. The emphasis was upon the treatment of skin diseases and, of course, the use of radium. The pioneer at Bart's, and indeed, in this country, was Dr. N. Finzi who installed the first therapy machine-a 110 kV set on the third floor in the Diagnostic Department. The departments were separated spatially in 1924 when the radiotherapy apparatus was moved up to the fourth floor. The banner with the strange device was then shouldered by Dr. W. Levitt who was appointed Physician-in-Charge of the Radiotherapy Department. His equipment at that time consisted of two 180 kV sets which had no protection and were not shock proof. A further unit was

maintained in the Skin Department under the aegis of Dr. H. Adamson, Nonetheless the foot was poised on the first rung of the kilovoltage ladder. In this field the hospital was to display a bold policy. At the time Mussolini was grouping his forces for the rape of Abyssinia the order was placed with Metropolitan Vickers to construct the first supervoltage X-ray unit. This was later housed in the Sassoon Department and was used to treat 5,000 patients from 1937 to 1962.

After the second world war it was evident that this country had slipped behind the United States of America and Canada in the development of megavoltage units. Nuclear reactors in these countries had nade available large amounts of radioactive cobalt. The hospital, under the stimulus of Professor F. Hopwood, decided to back the linear accelerator in preference to the betatron or Van de Graaff high energy generator. An order was subsequently placed for a machine of great potential—the 15 MeV. linear accelerator. Unfortunately, when Mullards supplied the machine in 1955 a suitable site was not available, and it was placed in the Medical School. Five valuable years of clinical experience were lost.

It now became imperative that the department's equipment, scattered over half a mile, should be united in one building. The St. Bartholomew's Dispensary stood in the Close off Little Britain until one night in 1940 when it was blitzed. On this derelict site there now stands the New Radiotherapy Department. Like an iceberg, there is more below the surface than above. In the basement—thirty feet below street level, there are the three major units. The 15 MeV



The Treatment Room of the Cobalt Unit.

linear accelerator, now 13 years from the drawing board, is still a Colossus. Its electrons are potent up to 4 cms. and its X-ray beam is capable of treating the largest bummaree from Smithfield Marker

It is now partnered by the 6 MeV linear accelerator which was built by Vickers Research Limited. This is a compact unit because the sealed off accelerator tube is contained within the rotating gantry. This conservation of space is an important factor because accelerators tend to spill over into adjoining rooms which are packed with their apparatus. The high output of 200 rads per minute at one metre from the target makes possible a heavy patient load—in the region of 50 cases a day. This will allow two 250 kV sets to be scrapped leaving only one orthovoltage unit.

The cobalt unit completes the triad. This machine, capable of fixed or rotation therapy, has accomplished 3 years' sterling work and is due for a "face lift". Next January its tiring source will be replenished by 3,000 curies of <sup>60</sup>Co of high specific activity.

There will still be a place for radium. Consequently a room has been set aside, on the first floor, for the preparation of moulds and storage of radium needles. There is a protected room on the ground floor where an outpatient may be treated each day with an applicator, thus avoiding

St. B.H.J., November, 1963

inpatient treatment and sparing a hospital bed. The two skin units—a K.X.10 and a Dermopan have been brought over and installed on the ground floor. This completes the picture, so that finally the equipment ranges from 10kV to 15 MeV.

The use and maintenance of all this equipment demands a background of supporting departments. Hospital Physics, under Mr. George Innes, will in the near future be moved out of the Department. Although vital to the radiotherapy department their work takes them into every department in the hospital. Another rapidly

expanding branch is the Electronic Division at present found on the mezzanine floor. The vast array of research equipment, the Isotope Department and the "bleep service" make heavy demands upon their services.

Inevitably some facets of this new department will not have received the polish they merit, but enough has been written to convey the impression of bewildering complexity of the organisation which is but only forty years distant from its origin in the masterly hands of Dr. N. Finzi and Dr. W. Levitt.

# SAINT BARTHOLOMEW

by M. D. ANDERSON

Why St. Bartholomew?

How came this most obscure of the twelve Apostles to be the patron saint of our hospital?

The story of the founder, Rahere, tells that he made a pilgrimage to Rome, and visited the places where St. Peter and St. Paul were martyred. He then fell ill, and thought he was going to die. He vowed that if he was able to return to his own country he would build a hospital "for the recovering of the poor, and would serve the poor gathered there, as far as he could, in all their needs". Being restored to health, he was on his way home, when one night he had a vision, in which he was carried by a four-footed winged beast to a high place above a frightful pit, into which he feared to be cast. But a holy figure appeared to him, and consoled him. "I am Bartholomew, Apostle of Jesus Christ. . . . Know that by will and command of the Trinity on High I have chosen a place in the suburbs of London, at Smithfield, where in my name thou shalt found a church." And so, in St. Bartholomew's name, Rahere did as his vow and his vision directed him. But why was it St. Bartholomew whose name was so associated with hospital history?

The first three Gospels mention St. Bartholomew only in the list of the twelve Apostles. In St. John's Gospel, there is no Apostle Bartholomew, the name of Narhanael appearing instead, and being assumed to refer to the same man. The legends about St. Bartholomew are confused and contradictory, but usually concur in saying that he preached to the Armenians, and was martyred on the shores of the Caspian Sea. According to the legends he was flayed, and a knife is the

emblem by which he is characterised in Christian art. His body, enclosed in a leaden coffin, was said to have made its way by miraculous means to the Lipari Islands, off Sicily, and reputed relics of the body are venerated in churches throughout Europe. Croyland Abbey, at first dedicated to its founder, St. Guthlac, was later re-dedicated to St. Mary, St. Guthlac, and St. Bartholomew, and little "Bartholomew" knives were given to pilgrims there.

In this country, there are about 150 churches dedicated to St. Bartholomew, spread over 35 of the 40 counties—more than to any of the other Apostles except St. Peter, St. Andrew, and St. James. "It is difficult to account for the special popularity in old times of St. Bartholomew," says the specialist in church dedications.

Several other churches dedicated to St. Bartholomew had hospitals connected with them, besides Rahere's foundation of 1123. There were St. Bartholomew's leper hospital at Rochester, founded by Bishop Gundulf at the end of the 11th century, and St. Bartholomew's hospital at Sandwich, Kent, founded in 1190 by Sir Henry de Sandwich for "maimed mariners and decayed townsmen". St. Bartholomew's hospital, Oxford, was another leper hospital, founded in the 13th century by Henry I. There used also to be a lazar house in association with the church of St. Bartholomew (now disappeared), near Castle Acre, Norfolk.

Another association between St. Bartholomew and healing appears in a custom once prevalent in Brittany and Belgium: patients subject to fits spent the night before St. Bartholomew's day dancing in the parish church, "and found it an

infallible cure"

How did it come about that St. Bartholomew, whose story is so obscure, was so widely honoured in mediaeval times? How is it that although no medical miracles are attributed to him, although he is not an official patron saint of doctors or nurses or patients, or an official protector against any particular disease, yet he has some mysterious association with hospitals and healing?

The very fact that there is no official connection apparent suggests that some unofficial contact with the pre-Christian world is involved, permitted but not acknowledged by the Church. And there is one clue that points the way to a possible explanation. The church of San Bartolomeo in Rome was founded in the 10th century in honour of St. Adalbert of Prague. It is situated on an island in the river Tiber—the Isola Tiberica, on which there had been a temple of Aesculapius. About 400 B.C., the Romans were sorely stricken with plague, and they appealed to the shrine of Aescuplapius at Epidauros in Greece for succour. In response, an Aesculapian snake came aboard the Roman ship, along with priestly attendants, and on the return of the ship to Rome, the snake swam to the Isola Tiberica,

and coiled up there to indicate the place on which a temple to Aesculapius should be built. The temple was accordingly erected, and here for centuries the sick were treated in the name of Aesculapius. The temple gave help particularly to slaves, and the emperor Claudius decreed that slaves who recovered their health there should be set free. The Aesculapian and other pagan temples were closed by order of Constantine in A.D. 335 (when the temple on the Isola Tiberica was nearly as old as St. Bartholomew's in Smithfield is now).

What happened on the Isola Tiberica in the six centuries after Aesculapius was banished, and before the church of San Bartolomeo was built? Did the healing art continue to be practised there in some form? Can we conclude that the church of San Bartolomeo inherited some of the aura once belonging to the temple of Aesculapius? Did the cult of St. Bartholomew as a healer spread from Rome? Did Rahere visit this church on his pilgrimage? Was he perhaps cared for there during his fever? Could this have been the source of his vision and the dedication of his hospital?

# **NORFOLK IDYLL?**

Natural History Society weekend in North Norfolk. 27th-29th September.

Shivering in a gust of wind I desperately tried to focus my telescope on a few specks wheeling and dipping over the distant saltings. A hazy image appeared for a moment or two in my field of vision and then disappeared—I gave up in despair. "Why," I reflected grimly, "should anyone in his right mind want to take up bird watching?" It could, I know, be an art, a science, a superstition, a tradition, a pleasure, or a bore, depending on the sort of person you were. Were my companions' motives purely aesthetic? Was it the shape, the colour, the song of birds that attracted them, or were they determinedly scientific, spending their spare time classifying chaffinches or investigating the theory of territories? One member of our group had strange motives for a naturalist, for no sooner had we set up camp the first night then he disappeared, totally unrecognisable, into the darkness withdare I mention it-a shotgun, only to reappear some time later empty-handed. No, I could not say what it was that attracted me to bird watching unless it was that strange fascination that the countryside has for the townsman.

Nevertheless, I was glad that the Natural History Society had chosen to spend this weekend in Norfolk. It was a part of the country which I had never visited before and I was immediately struck with its unspoilt beauty. Cley-on-Sea, where it had been decided to camp the first night, is a quiet rambling village of old flintstone houses. Tents set up, the party settled down for the hight and once again I was reminded of the "joys" of camping. The unyielding hardness of the ground, a cold west wind and the incessant roaring of the breakers made getting up at 6 a.m. sweet relief.

The spit of land between Cley and Blakeney Point is National Trust property and we set out to walk the four miles to the point along the descrted shingle. Flying low over the breakers Arctic skua were much in evidence. These aggressive birds obtain their food by levying contributions on the white gulls. When a gull has picked up a fish, the skua, seeming to sense it instinctively, swoop down on the unfortunate bird and, in spite of screams and attempts to escape, beat it until it disgorges the fish, when they dart down and catch the booty before it reaches the water. A solitary guillemot was disturbed and

driven flapping into the water. These birds were, at one time, killed and salted in great numbers to provide the staple winter diet of the inhabitants of the lonely island of St. Kilda off the west coast of Scotland. A flock (skein, for the purists) of pink-footed geese was seen later in the morning flying low over the saltings with their characteristic cry.

By early afternoon Cley seemed too full of other bird watchers so we set off for the Wash. It was at Wolferton, near Sandringham, that we decided to pitch our camp for the night. Who knows what we might have seen there had it not been for the sudden appearance of a rustic gentleman who viewed our proceedings with justifiable suspicion. As he was a gamekeeper, and an employee of H.M. The Queen to boot, we retreated rapidly in the direction of King's Lynn, stopping on the way only to purchase a bottle of red wine which was later consumed with great gusto at a new camping site on the sea wall a few miles outside the town. After breakfast the following morning the surrounding area was thoroughly explored but was found ornithologically disappointing. Most of the true saltings had been overgrown with spartina Townsendi, a grass which, although introduced comparatively recently into this country, has spread over estuaries and mud flats with remarkable rapidity. A few grey plover, knots, greenshanks and redshanks were seen. Redshanks, like skua, are distinguished by their curious manner of feeding. Although shy birds, if approached close enough they can be seen searching in the mud for worms, darting the length of their bills into the ground, doing this by giving a peculiar little jump so as to bring the whole weight of their bodies to bear on the task.

The marshland around Lutton, Gedney Drove End, and Long Sutton is the haunt of geese, especially in winter, and the loneliness of the place was emphasised by the cerie note of the curlew as it was borne on the wind. Nothing was to be seen but mud, forlorn looking cattle and an even more forlorn looking bunch of wildflowers. As there was nothing further to be gained by staying in the area we made our way home.

I had enjoyed the weekend as had my companions, and yet, I reflected on the journey back, I was still no nearer understanding why I watched

# Christian Viewpoint— NERVOUS DISORDERS

by Dr. Gerald Tewfik, M.D., D.P.M.

Modern medicine owes much of its strength to the scientific revolution of the past two centuries. It has been shown that if natural phenonema are closely observed and recorded in a variety of situations, a theory of causation can be postulated which, in the same field of study, gives the observer the ability to predict further natural events. The education of the doctor is dominated by this basic scientific attitude. He learns from the study of simpler organisms certain principles which remain true in his study of man.

I would think that medical students cannot also fail to be impressed by the perfection of man in health. They then learn the result of various disease processes on man and how these variously affect his function. However, the human body has considerable powers to mask the effects of disease by using other healthy parts to take over the function of the diseased portion. The determination of the sick person to maintain his previous level of function is another big factor in the recovery of many diseases.

Unfortunately the opposite occurs only too frequently. The disease response of the patient is in excess of that expected by the lesion or even that functional loss occurs without any demonstrable illness. Here the scientific training of the doctor can be a weakness in the understanding of the difficulty. In this situation many doctors feel baffled and infuriated, they may think that the patient has cheated with the result that the patient feels rejected and humiliated.

Medical students spend some six years trainings in organic medicine which usually includes only as many weeks in the study of human personality and functional

The psychiatrist may tend to adopt the same basic scientific attitude to patients as the general physician and assume that when the morbid influences on the personality are removed, health will be recovered. Certainly mental health is considerably improved by coming to terms with inhibitions and difficulties in the personality and environment, but this is not in itself sufficient.

In the war years, for example, despite great hardship from bombing, severe food rationing, separation of children from parents, and the death of so many sons, the neurosis rate in London was at a minimum. A strong community spirit and a sense of purpose were able to preserve morale despite daily tragedy and severe hardship.

It would have been expected that with the welfare state, high employment, material prosperity, lowered class barriers, and a measure of sexual and intellectual freedom, that nervous disorders would diminish, but in fact the opposite has occurred. In the last 10 years the admissions to prisons and referrals to psychiatric hospitals have risen sharply. Throughout Europe a high standard of living is positively correlated with high rates of suicide and alcoholism.

For a variety of reasons our present way of life has brought to many, social isolation, material dissatisfaction and a loss of sense of purpose. Man needs some thing more than just prosperity.

I am sure that most doctors have no wish to involve themselves in problems of personal and moral values. Many feel it is an unnecessary intrusion into private life. But they are part of man's situation which he brings with him into every illness presented to the

In order to practise medicine at all a doctor must believe that each human being, regardless of his plight, has a unique intrinsic value. For an individual to be healthy, he must feel that regardless of his health and his ability to contribute to others he has a unique value as a member of the human race. Many find it impossible to comprehend this sense of "being valued' just as a humanitarian ideal.

As well as a sense of belonging, man also needs a sense of correct and incorrect conduct. However, correct conduct rarely comes from obedience to an impersonal set of moral rules. In the presence of our juniors and our family our behaviour is frequently at its worst. In the presence of a person whom we deeply respect and who cares for us correct conduct becomes almost the normal form of behaviour.

For man to attain peace he also needs a way in which past errors can be put aside, and a sense of direction and purpose for his life. Finally he needs a way in which death is not to be feared, but rather, to be considered as a gateway at life's end. The understanding of this goes beyond the scope of man's intellect. But it has been revealed to us. God has shown himself through the scriptures and the life of His Son, Jesus. Our way has been walked through His Life, Death and Resurrection.

Many of our patients have a personal experience of living in the presence of God and in this find their peace, direction and assured confidence in the present and the future.

Science and prosperity has failed to bring peace to man, can the doctor afford to neglect the spiritual needs of his patients?

# ORGAN RECITAL ANDREW PEARMAIN

Thursday, 3rd October, 1963, in St. Bartholomew's the Less.

Jean Titelouze ..... Verset on "Pange Lingua" J. S. Bach ..... Fantasia and Fugue in G Minor John Stanley ...... Voluntary in E Minor Percy Whitlock ... Reflections, Three Quiet Pieces Henri Mulet ...... Carillon Sortie

It was most enjoyable to go along and listen to this organ recital at lunch-time. This is a venture which should be repeated and the organizers must not be discouraged by the rather sparse attendance at this recital. I hope that it will be the first of many in Barts-the-Less.

The programme gave us a very reasonable cross-section of the organ repertoire starting with a verset by Titelouze. I thought that the pro blems of registration of the various pieces on an organ such as the one in Barts-the-Less and in a church of this size might prove too much for Mr. Pearmain, but he showed himself well aware of the problems. The Titelouze was slightly on the loud side and I would have preferred a more brilliant and varied tone in the Great G Minor, but these are minor points compared with the rhythm and phrasing in the performance.

The charming Stanley voluntary was played with a delightful elegance and the three Whitlock pieces were also shown to be the beautiful miniatures they are. Henri Mulet's "Carillon Sortie" requires more reeds of a French timbre than this organ possesses. A splendid recital and I look forward to Mr. Pearmain's return.

# **NEW PENGUIN BOOKS**

The Family Life of Old People by Peter Townsend. Published by Penguin Books. Price

Peter Townsend chooses a random selection of old people in the borough of Bethnal Green to conduct an intensive survey into the mode of life of old people, particularly with regards to their relationships within the family. He finds that the role of the family in caring for these people is very great and that family ties are very strong. While most are comparatively well off, a substantial minority suffers from poverty, loneliness and a sense of uselessness. Social improvements would follow if old people could obtain houses near their offspring, if the pension and national assistance systems were altered, and if subsidised part-time employment was available

This book will appeal to a small section of the community, but those entering the social service, politics, or general practice would benefit by reading it. It provides a competent, scientific survey coupled with human insight into the age-old problem of the care of the old, and answers many questions frequently asked about the way of life of old people.

Cooking in a Bedsitter by Katherine Whitehorn. A Penguin Handbook. Proje 3s. 6d.

At last a cookery book which realises that not everyone has a set of fluted biscuit cutters immediately to hand! Miss Whitehorn has an enterprising, amusing but above all practical approach to the difficulties of gas-ring cuisine. Acknowledging the existence of sliced bread and tins, she gives over 300 recipes all to the right scale, price and timing, together with information on every conceivable possibility or limitation which could arise.

The invaluable section on "Cooking to Impress" covers all occasions from dealing with your parent's spies, through the troglodyte next door to parties deux. But with Ratatouille, Paupiettes de Boeuf, or Shrimp Wiggle how can your supper parties fail to be the hit of the season

A final chapter on Drink and Parties is contributed by Gavin Lyall and will win instant approval from beer drinkers.

This book is a must for all who do not so much cook in the bedroom as sleep in the kitchen.

Change of Life-Facts and Fallacies of Middle Age by Joan Malleson. A Penguin Handbook. Price

Under this self-explanatory title, the late Dr. Joan Malleson gave a lucid and useful account of the various aspects of the menopause.

The physiology of the condition is simplified for the general reader. Believing that the difficulties of many middle-aged women are due in great part to ignorance, she aims to reassure her readers that their physical and mental difficulties are mainly transient. If further help is needed therapeutic measures under medical supervision are advised. There is always the probability that those most in need of sound advice on the climacteric do not acquire knowledge sufficiently early. However, the necessary advice incorporated in a Penguin handbook and published at half-a-crown is

a most worthy attempt to bridge this gap. Would not

such a book be a useful addition to the literature

available in any doctor's waiting room? Judy Bell

# OTHER REVIEWS

Cancer Report, 1948-1952, is published by E. & S. Livingstone, Ltd., Jeviot Place, Edinburgh, at 30s. (Post 1s. 3d.) and is available from the Hospital Library and from all medical booksellers.

We regret the omission of the above details from the review (published last month) of the Cancer Reports .-Editor.

The Cytologic Diagnosis of Cancer (2nd Edition) by Ruth M. Graham. Published by W. B. Saunders Co. Price 98s.

When this book was first published in 1950, cytology was still struggling for recognition; at that time barely a handful of individuals in this country had had any experience of the method. Dr. Graham's book together with Professor Papanicolaou's Atlas did much to stimulate interest in the subject. This 2nd Edition comes at a time when clinical cytology has become generally accepted and will be welcomed by all the established and embryo cytological laboratories in this

Since the death of Professor Papanicolaou, Dr. Ruth Graham is the acknowledged authority on gynaecological cytology; it is therefore right that over one half of the book should be devoted to the cytology of the female genital tract. Owing to the great variety of cells encountered and the importance of minute nuclear detail, a book on cytology can be no substitute for the prolonged experience necessary with the microscope; though invaluable as a basis for training it is bound to be limited by the number of illustrations, the quality of reproduction of the micro-photographs, and the problem of displaying a three dimensional object in one plane. In this book every cell is shown in low and high power and the reproduction is as good as printing will allow; additional nuclear detail is provided in each case by a drawing—a device which partly solves the problem, but is not always con-

The cytology of sputum, urine, stomach washings and serous fluids are dealt with more briefly; additional chapters on the cytology of dysplasias of the cervix, oesophageal washings, aspiration of solid masses and pernicious anaemia have been added since the 1st Edition. A very useful Bibliography, though admittedly incomplete, has grown from 200 to 1,000 publications, which gives some idea of the enormous amount of new material available since 1950.

G.C.

Current Medical Research. Pp. 69 plus 3 plates. Published by H.M.S.O. Price 5s. 6d.

This publication consists of articles formerly published in the Annual Report of the Medical Research Council as "Some Aspects of Medical Research".

The booklet contains eleven annotations on research including work on The Genetic Code, Cancer in the Tropics, The Demyelinating Diseases and Metabolism of Plasma Proteins. Several articles are of particular concern to biologists and biochemists, but many others would find much of interest. Any purchaser of this booklet would feel his 5s. 6d. to have been well spent. T.P.D.

Three Hundred Years of Psychiatry, 1535-1860. A Richard Hunter and Ida Macalpine. Published by Oxford University Press, London. Pp. 1107, xxvi. Price 84s.

Too few modern historians of medicine conduct thorough investigations before putting pen to paper, preferring to paraphrase the writings of others, presenting a re-hash that adds nothing to our knowledge and merely adds to the oppressive weight of medical outpourings that are suffocating research workers. This work is original in concept and execution. It is the result of thorough investigation, sifting and selection, and must be valued as a reference book that will never become obsolete. Not only psychiatrists, but neurologists, sociologists, general and medical historians in any field will find material that will stimulate, entertain and educate. Beautifully produced, Three Hundred Years of Psychiatry is an ideal gift book for a friend or for one's own collection, and will certainly prove a valued accession in any medical library.

I.I.T.

(This was the last part of a review which appeared last month, The editor regrets its omission.)

A General Textbook of Nursing by Evelyn Pearce. Published by Faber and Faber, Ltd. Price 32s. 6d.

Evelvn Pearce has been known to student nurses for a quarter of a century through her Textbook of Nursing, and it is a pleasure to see that she has been personally responsible for the sixteenth edition that has just been published.

This book retains its encyclopaedic character that has made it so popular down the years, but has been very extensively revised. Miss Pearce is at her best in describing the procedures and treatments that she herself performed so expertly during her clinical days, but extends her range up to open heart surgery. This is understandably a brief section, with no mention of profound hypothermia. However, many students who will read Miss Pearce with profit will never need to know about this subject. W.E.H.

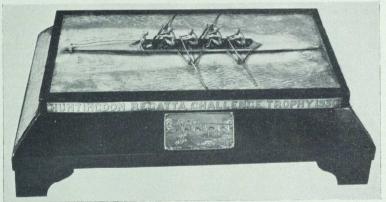
Wake up, Nurse! by Roger Brook. Illustrated by Timothy Birdsall. Published by Souvenir Press. Price 7s. 6d.

This is a small book, described as "more hilarious nursing howlers from actual examination papers of many great hospitals". It contains sixty-two pages of howlers loosely grouped together into chapters ranging from "Gutter Atropine was applied to the eye" and "The patient's lover was enlarged and causing him some embarrassment" to "The houseman said he had taken the bloody pressure twice that day" I must confess that this form of humour leaves me cold although I am sure that there will be some for whom this book will prove a source of entertainment. The book is a sequel to a similar volume entitled "Really, Nurse!" which is apparently a best seller and which I have not read. The book is well laid out and the illustrations by Timothy Birdsall are charming and witty.

T.R.S.

# SPORTS NEWS

SPORTS	CALENDAR	23 Nov.	1st XV v. U.S. Chatham. Away.
Rugby 2 Nov.	1st XV v. Penzance. Away. "A" XV v. Rosslyn Park. Home.	27 Nov.	"A" XV v. U.S. Chatham. Home. Ex. "A" XV v. U.S. Chatham. Away. "B" XV v. Ilford Wanderers. Away. 1st XV v. No. 5 District Police. Home.
	Ex. "A" XV v. Rosslyn Park. Away. "B" XV v. Old Merchant Taylors. Home.		1st XV v. Woodford. Home. "A" XV v. Woodford. Away.
4 Nov.	1st XV v. Falmouth (7.30 p.m.). Away.		Ex. "A" XV v. Woodford. Home.
6 Nov.	1st XV v. Brit. Roy. Nav. Coll. Away.		"B" XV v. Woodford, Away.
9 Nov.	1st XV v. Old Alleynians. Away. "A" XV v. Blackheath. Away. Ex. "A" XV v. St. Thomas's Hosp. Home. "B" XV v. St. Thomas's Hosp. Away.		Institute of Education (UL). Home. Cambridge Tour: 7 Nov. Trinity Hall.
3 Nov.	"A" XV v. R.D.H. Home.		8 Peterhouse. 9 St. John's College.
l6 Nov.	1st XV v. Cambridge. Away. "A" XV v. Old Alleynians. Away. Ex. "A" XV v. Old Alleynians. Home. "B" XV v. Old Alleynians. Away.	20 Nov.	Roy. Vet. College (UL). Home. Queen Elizabeth Coll. (UL). Home. King's Coll. Hosp. (UHL). Home. King's Coll. Hosp. (UH Cup). Home.
20 Nov.	Ex. "A" XV v. Coll. St. Mark & John. Home.	30 Nov.	School of Oriental and African Studies (UL). Home.



The Huntingdon Rowing Trophy. (See Boat Club Report.)

#### THE SOCCER CLUB

The Bart's Soccer Club has been in existence since the latter part of the 19th Century and around 1900 boasted one of the finest sides in London. Now, however, the activities of the Club are confined to competitions run under the auspices of the University of London. They include two League competitions, namely, the University of London League and the United Hospitals League, the main competition of the season being the latter.

The Club runs two teams, the first XI playing both on Wednesdays and Saturdays in order to get through their extensive fixture list. Training sessions are held every Monday and Thursday at Charterhouse Square. This season the new intake has provided us with several very good players, with the result that the First XI now contains four freshmen. Indeed, the playing strength of the Club now looks better than it has for several seasons, especially as the majority of the First XI are preclinical students.

The present Captain of the Club is H. Phillips, now in his second year of office. Also still playing we have P. Savege, a past Captain who has earned honours colours for his services to the Club. Both are talented and experienced players who have held the team together on many occasions in the past.

Finally, let it be said that hopes and expecta-

tions are higher this year than for a long time, owing to the quality and youth of the First XI.

# RUGBY CLUB REPORT Saturday, 28th September. 1st XV v. Trojans. Away. Result: Won 8-0.

On a pleasant autumn afternoon Bart's enjoyed a fine start to the season. After a long and arduous period of training the team was very fit and fiery in spirit. For the first ten minutes the opposition was denied possession of the ball and the pack did some very fine short passing in the loose play. Unfortunately several scoring opportunities came to nothing due to the very noticeable lack of practice in handling the ball. Eventually, just before half time, Gibson landed a very fine penalty to give Bart's a slender lead. The second half followed the same pattern, with the pack playing very well in the tight scrum and lineouts, to give the backs plenty of the ball. The threequarters, though playing well individually, lacked cohesion and no dangerous attacking moves were seen. And, typical of the play, the final score came after a break by the centres had been stopped. A quick heel found Smart backing up to take the ball and run through the disorganised defence to score under the posts. Gibson converted.

Team: M. E. Fryer; D. Goodall; P. E. Savage; E. Sidebottom; S. G. Harris; A. T. Letchworth; D. Chesney; O. J. A. Gilmore; M. Revill; A. J. S. Knox; T. Bates; D. Delaney; J. A. Gibson; C. J. Smart (capt.); M. F. Hudson

# Wednesday, 2nd October. 1st XV v. Reading. Away. Result: Won 21-0.

Arriving five minutes before the kick-off, the Bart's team ran off the coach fully changed and proceeded to have a serious warm-up on the field, while the home team quickly changed. The psychological advantage of this one-upmanship was followed up immediately after the kick-off when Gibson kicked a penalty goal. However, the pack lost some of its zest and allowed the slower Reading forwards to dictate the play. The opposition had been pinning the Hospital side into their own "25" for some ten minutes when Savage suddenly snatched on a loose ball and ran the length of the field. He was well supported by Sidebottom who took the well-timed final pass to score under the posts. J. A. Gibson converted. This opportunist try injected some spirit into the team and soon another good try was scored. The conversion was missed.

After the interval the pack continued to provide the backs with plenty of the ball, especially from the lineouts and set scrums where Gurry

was back in fine form as hooker. The heel from loose scrums was still rather slow. This superiority in possession was rewarded when Griffiths broke in the centre and ran well for 50 yards before sending Harris over for a try. A further try followed soon afterwards when Dorrell made two nice breaks to link up with Griffiths, who again ran well, and gave Harris his second try. Gibson converted both these trys.

Team: A. P. Ross; E. Sidebottom; P. E. Savage; N. J. Griffiths; S. G. Harris; E. D. Dorrell; D. Chesney; D. A. MacPherson; B. H. Gurry; O. Gilmore; T. Bates; M. M. Orr; J. A. Gibson; C. J. Smart (capt.); D. Goodall

# Saturday, 5th October. 1st XV v. Sandhurst. Home. Result: Lost 0-6.

For the first home game of the season both the wet weather and the result were disappointing. The play, too, was exciting only in the last fifteen minutes, when Bart's eventually got unlimited possession of the ball and launched many attacks on the visitor's line. Two of these, at least, should have resulted in scores, but the wet ball and slippery fingers prevented this. A pushover try was very nearly successful. The rest of the game, in contrast, was rather drab. The cause of the trouble was that players were playing out of position both in the front row and the second. The bigger Sandhurst pack had little difficulty in pushing the Bart's pack backwards. This naturally made things very difficult for the front row when it came to hooking. Sandhurst's dominance was also evident in the lineout although good spoiling play by the Bart's pack denied them the advantage of possession. The encouraging factor in the game was the play of the Bart's back row which showed that Smart, Gibson and Goodall are developing into an effective unit. The keystone of this is the fine form of Smart, who is deservedly holding his place in the United Hospitals side. The Sandhurst backs were allowed no room and never looked dangerous. The scores came from their left winger; the first after a blind side movement initiated by the scrum-half, the second following a lucky cross kick from the fly-half which landed in the winger's arms for him to crash over in the corner. Team: A. P. Ross; S. G. Harris; P. E. Savage;

A. T. Letchworth; E. Sidebottom; E. D. Dorrell; D. Chesney; D. A. MacPherson; B. Gurry; A. Knox; T. Bates; O. Gilmore; J. A. Gibson; C. J. Smart (capt.); D. Goodall.

# Other Teams:

The "A" XV started the season well by defeating a strong London Welsh "A" XV by

12-6 after being 0-6 down. Freshmen Grafton and Johnson added strength to the three-quarter line which provided three tries (Stevens, Bradley-Watson, Johnson). Revill backed up a break by Grafton to score the fourth uy.

# BOAT CLUB REPORT The Senior Four

In the last report we explained why it was decided to train a Coxless Four for Henley instead of the First Eight. The crew of the Four were:

 Bow
 D.
 A.
 Lloyd
 11 st
 5 lbs

 2
 W. P.
 Garson
 11 st
 12 lbs

 3
 H.
 C.
 Coleridge
 10 st
 9 lbs

 Stroke
 M.
 F.
 MacKenzie
 13 st
 2 lbs

Starting on 21st May we rowed six nights every week until the middle of July. In addition, we had lunch-time outings in a tub pair on the City Canal under the hypercritical eye of Douglas Chamberlain, whose advice was invaluable.

At first the rowing was rather tentative, while Garson adjusted himself to stroke side and Bow tried to master the steering, but it was better than we anticipated. During the second week we lost confidence and started worrying because we were not improving as quickly as we would have liked, and we reacted to this by rowing very badly and by being most objectionable to our coaches, David Dunn and Andy Robertson. As a result they were unable to help us much! In the hope that a race would shake us together we went to a regatta after only ten days' training. Because of Mackenzie's Senior Status we had to row in Wyfold Class events from the beginning, so we were always up against experienced crews.

Twickenham Regatta, 1st June. The first heat of the Wyfold Fours was a row-over for us as our opponents had withdrawn, and in the second heat we raced against Bedford R.C. Conditions were very rough, and our lack of boat control enabled Bedford to forge ahead and win easily, in spite of our efforts to get on equal terms.

At this time our morale was at its lowest, but we put our heads together and determined to make a real effort to redeem the situation during the coming week. Unfortunately we were frustrated by coaches who were unable to turn up, and we could not really make much headway on our own before the next regatta.

Walton Regatta, 8th June. In fairly pleasant conditions we got off to a good start against Vesta R.C. at the second attempt (the first start ended in a midstream collision) and led by half a length for the first two minutes. They pressed back hard, under which stress our rowing became

very rushed, and, together with some rather erratic steering, this gave Vesta their chance to break through and win by  $1\frac{1}{2}$  lengths. Our performance was better than that of a week ago, but we were nevertheless very disappointed.

The following week we were coached every day and seemd to improve overnight. After one outing with Colin Dale, and the next with John Curry (who took us back to square one and got our rowing more uniform and co-ordinated) we started moving the boat further, and we continued to do so under Peter Brass, who proved to be a most inspiring coach. Instead of going to Reading Regatta on 15th June, we stayed in London and had a marathon outing with Chris Hudson, who took us from Chiswick to Putney, back up to Zion House and then home to Chiswick (about 16 miles in all). By the end we were beginning to look like a crew—though at the time we were past caring! Chris continued to coach us the following week and we regained our confidence as our rowing further improved.

Marlow Regatta, 22nd June. We moved to our Henley residence the day before Marlow Regatta, in time for an outing on the course. On the day our first race was against Kingston R.C., a good but not oustanding crew. We started well, but settled to a low rating of 32, and Kingston established a lead of just under a length. However, by half-way we were going up so strongly that it seemed as if Bart's had the race in the bag. We then tried out a new way of calling for a spurt, but this failed dismally and after several abortive attempts to pass Kingston we had become so frustrated that the rating stayed at 32 and Kingston held their lead. Our final effort was too late to save us, and we lost by a length.

We were justly annoyed with ourselves after this performance, because a single good spurt at half-way could have broken the Kingston crew and won us the race. It is only a good crew which can win a race from behind—a fact which was brought home to us later at Kingston.

After this race we rowed "Sir George" from Marlow to Henley in pleasant though windy conditions, and enjoyed it very much—a sure sign of improvement. On arrival we still had strength enough to paddle over the course at 29 into a stiff headwind, which pleased Chris Hudson, who was there to meet us.

Henley Royal Regatta—Visitor's Cup. For two weeks we once again enjoyed the generous hospitality of the "Greyhound" at Wargrave, our daily routine consisted of an outing in the morning, followed by lunch and a very necessary rest, with another outing in the evening after tea.

Since we had not won any races we were not surprised to be asked to row in the Eliminating Heats for the Visitor's Cup on Saturday, 24th June, which gave us five days' training at Henley. We were most fortunate in having Tom Langton to coach us again, and whenever possible we preceded our outings in the Four with extremely valuable sessions in a tub pair with Tom.

There was no time for Tom to try and improve our styles of rowing (for no two of us rowed alike), so he concentrated on getting us to row more athletically. We had some difficulty with our steering on the dead straight Henley course, which was partly due to the difference in weight between Bow side and Stroke side. By the end of the week Tom had succeeded in instilling a good deal of confidence in us, and our rowing was far more relaxed and controlled, as a result, the steering improved as well.

We were very pleased that Joe Bailley was able to coach us for a few outings (his anecdotes are as good as ever) and Chris Hudson, who was officially coaching Queen's Wyfold Four, also took us several times. During the week we beat far more crews in practice rows than we lost to, and by the Saturday were ready to do

The eliminating Heat was against St. Catherine's, Cambridge, in good conditions apart from a head wind. Both crews started well and Bart's, striking 40, were 3-length ahead when we hit two vellow buoys marking the course. We kept going well and were 4-length up at the 4-mile signal, with Catherine's fighting back hard. At the Barrier Catherine's had their bows in front, but Bart's went ahead again and were leading at a lower rating at the half-mile signal. Catherine's gave a terrific spurt at Fawley and took a lead of 1/4length which they held as far as the mile, where the race was still anybody's. By now our individual styles were very much in evidence, and because of this we could not keep up enough pressure to stop Catherine's slipping away. In spite of a last desperate effort to catch them, we lost by 1½ lengths.

There is no point in discoursing on our disappointment, or in a long post-mortem, but at the peak of our despondency we phoned up Huntingdon and entered in their regatta on the following Saturday. The only Senior event at Huntingdon was for Coxed Fours, so we borrowed a boat from Henley R.C., and a cox from Jesus College, and during our second week at Henley we continued to row every day. Chris Hudson coached us, and throwing aside all niceties he hammered us until we were able to row flat out for four minutes—which was quite an

effort in a boat which was twice as heavy as the one we were used to. In order to balance the work more, Coleridge and Lloyd changed places, and this did appear to make a difference.

Meanwhile our spare men, C. R. S. Anderson and D. C. Parr, had been training hard for the Henley Spare Men's Pairs races on Tuesday, 2nd July. Competition in this event is not to be taken lightly, and our pair rowed very well, but were beaten in the third round after an exciting race against Burton, Leander and Argosies.

Huntingdon Regatta, 6th July. We left the rain and mud of the Final Day at Henley in order to travel to the mud and rain at Huntingdon, where our first race was against Leeds University. After pounding off the start at about 40 we took half-a-length off Leeds in the first ten strokes, and were leading by two lengths at half-way. We continued to go ahead and led by three lengths at the finish, where we were only one second outside the course record. Our relief at having won a race at last was enormous, and when we later got back to the start for the final race against Norwich Union, we were determined that nothing was going to stop us winning. Once again we leapt off the start and were soon a length ahead. Norwich fought back, but we held them off and led by a good two lengths at halfway. Even then we kept the pressure on, for there was a record to be broken, and we romped home strongly to win easily in 3 minutes 8 secs., two seconds inside the record. Credit must also go to our cox, G. Stowell, of Radcliffe School, who had been coxing his school crew earlier, and who proved to be a great asset. (Unfortunately, he does not want to read Medicine.) The competition at Huntingdon was admittedly not particularly high, but we did break the record, and it's many years since Bart's has won a Senior

Barnes and Mortlake Regatta. 11th July. Back in London again we entered in the Senior Coxed Fours event at Barnes, with I. E. Cole at the helm. We drew National Provincial Bank in the first heat, a crew of no small repute, and to our surprise we led by \$\frac{3}{4}\$-length off the start, although we were under-rating them. Our rowing was very scrappy and rushed, and N.P.B., whose rowing was far more controlled, gradually drew past us about half way over. Try as we could, we were unable to catch them, and they won by over a length.

Kingston Regatta, 13th July. The day after Barnes we went back to Coxless four rowing, and had a pleasant outing in "Sir George" up at Kingston. The course at Kingston is on an increasingly sharp bend, and because Coleridge had not steered since last December we reverted to our original order, with Lloyd at Bow, but in view of what happened the wisdom of this change is certainly questionable.

On the day of the regatta our first race was against Midland Bank in the second round of the Wyfold Fours event, as we had a bye in the first round. We had a smooth start, and with the stagger in our favour were leading by a length when we found ourselves outside the course. Midland Bank had come over on our station, and by the time we had sorted ourselves out they were a length ahead. Two minutes from the finish we started sprinting hard, and gradually drew level with them for a very exciting finish—so exciting that we nearly had a shipwreck. It was not until the Judge's announcement that we found we had won by 4-length.

The next race was the semi-finals, in which we were up against Marlow R.C. This time they had the advantage at the start, and in our panic to catch up with them we shot off at far too high a rate of striking. Before we realised what had happened we were off the course, and Marlow established a two-length lead which they held to the finish. They went on to win the Final.

This was our last race of the Summer, and although we had been rowing for a long time we were rather sorry to stop. We had not been very successful at Regattas, but we had all enjoyed ourselves and felt that our efforts had not been in vain, which is the main object of the exercise. Our thanks are due to the men who gave up so much time to help us, and to all our supporters who gave us encouragement.

Roger Nicholson continued rowing for the University of London after winning the Grand at Henley, and the U.L. crew recently represented Great Britain in the European Games at Copenhagen, where they finished 5th out of 14 entries.

Colours have been awarded to W. P. Garson (the new Captain), C. R. Anderson, M. F. Mac-Kenzie, R. G. Nicholson and D. C. Parr.
D.A.L.

# HOCKEY CLUB REPORT Wednesday, 9th October, 1963.

1st XI v. R.N.C. Greenwich. Won 13-0.

This first match was most encouraging for the Club. From the start the forwards got going well, and the score at half-time was 5-0. This was mostly due to some good runs from rightwinger

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A. Edelstone, and inside-right W. Castleden, although most of the final touches were provided by P. Kingsley. As Steve Thomas is playing for Wales this season he will be playing most of the time for Dulwich; for this reason we are very glad to welcome Graham Benke to the side, who will make an admirable substitute at centre half. We also have another very useful player in Andy Barclay, who has already had a U.H. Trial.

The second half went better than ever, with the forwards making full use of their abilities, the score mounting up every second. Regardless of our lack of training we found ourselves fitter than the opposition, and were soon running them off their feet. Let us hope we can keep up this most encouraging start right through the season.

# Saturday, 12th October, 1963

1st XI v. Beckenham 2nd XI. Lost 1-0.

This team is one of the best we have to play throughout the season. Last year they beat us 19-1. The first half was a bit ragged, but just before half-time we found our feet. Our regular goal-keeper was not able to join us, so Hubert da Silva gallantly volunteered, where he played magnificently throughout the match. The one goal scored against him he could not possible have seen

In the second half we started off well, and the ball was skimming inches past the goal-post within the first few seconds. Unfortunately their keeper was virtually invincible, although we put many a well-aimed shot at him. With only a few minutes left, and Bart's having most of the play, a final vast offensive was launched, the defence coming right up to the attack. With the ball just inside the circle, it was hit hard to within inches of the right upright, passing through three defenders, only to be stopped very calmly by a well-positioned goal-keeper who couldn't possibly have seen it coming. Again the defence played well, particular credit must go to M. Smith-Walker.

# CRICKET CLUB REPORT, 1963

The Cricket Club has had a successful season, having played 31 games, winning 13 and losing 12, 6 matches resulting in a draw. The Club continues to play strong club sides in London and the Home Counties, with varying success, but all the games have been enjoyable and hard fought. Only once were the team humiliated, and then by a very strong Hampstead side early in the season.

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At the end of the five years you may enter civilian practice with a tax free gratuity of between £1,400 and £2,600, or you may be selected for a permanent commission which guarantees employment to the age of 65 and which may take you to the most senior ranks in the Service.

#### 'Pre-registration year' scheme

If you are a medical graduate you may be commissioned in the Royal Air Force immediately in the rank of Flying Officer You may then spend your pre-registration year seconded to a civilian hospital. On registration, you will become a Flight Lieutenant with possible earnings of  $\mathcal{L}_2$ ,000 a year. To quality for this scheme you must undertake to serve for at least three years after full registration. Your pre-registration vear counts towards your gratuity following short service commission and towards retired pay on permanent commission. The gratuity on completion of a three year commission is  $\mathcal{L}_{1,500}$  plus  $\mathcal{L}_{300}$  for the full pre-registration year; on completing a five year commission the gratuity is  $\mathcal{L}_{3,000}$  plus  $\mathcal{L}_{200}$  for the full pre-registration year. These gratuities are tas free.

For full information on the latest conditions for doctors, specialists, graduates and cadets in the Royal Air Force, write to The Director-General of Medical Services, Air Ministry ([Q-81B) 1 Tavistock Square, London WC1

The Royal Air Force

The team this year was captained by R. S. A. Thomas, who scored three times more runs than any other member of the side. This fact underlines the fundamental weakness of the Hospital side at present. We lack batsmen of both skill and experience, and if we are to maintain the strong fixture list which we have at present, then we must have more determined batting throughout the team.

The bowling strength of the team has been adequate and on the whole economical, with C. Vartan, C. Smart and J. Harrison bowling most of the overs. P. Savege, a newcomer to the side, bowled admirably on many occasions and will in future years be a great hazard to the opposition. The weakness on the bowling side is a lack of a good slow spinner, to take advantage of the English Summer conditions.

Returning to batting, D. Delany, last year's captain, played well and scored freely, but alas, qualified in mid-season and was unable to play regularly. C. Vartan played many invaluable innings throughout the season and was always capable of scoring rapidly when required to do so.

Our record in the U.H. Cup Competition was shattered by a surprise defeat by the London Hospital. Having dismissed the London for 180 runs, thanks to a fine spell of bowling by P.

Savege, an easy victory was in sight. However, a batting collapse resulted in a defeat by 70 runs.

The first tour of the season was in Oxford, when we played University College and B.N.C., and although both games were drawn, the weather was kind and it was a most enjoyable tour.

The August Tour to Sussex was once again a great success on and off the field. Three games were won and three lost. A great deal of the success was due to some admirable bowling by C. J. Smart, particularly in the first three matches. The batting was strengthened by J. A. Harvey who, together with R. S. A. Thomas, scored most of the runs.

The final tour to North Essex against Arkesden and Clavering, was the most successful. Both matches were won for the first time since the tour started 5 years ago.

The team is fortunate to have Mr. "Bert" Blundell as the regular umpire, whose decisions are always fair and unbiased.

On numerous occasions we have been able to raise a 2nd XI, who have had an enjoyable and successful season. In the 2nd XI Cup, H. Phillips captained the side to two fine draws against the London.

The Square at Chislehurst has once again been maintained in first class condition by Laurie

# WHEN YOUR PATIENTS/PATIENCE ARE/IS EXHAUSTED PRESCRIBE A GUINNESS

White, and the lunches and teas prepared by Mrs. White have been of a high standard. The Cricket Club thank them both for their continued interest in the Club.

I.R.H.

# TENNIS REPORT

Singles Tournament

Bad weather during the latter part of the season prevented this year's Singles Tournament from being held at Chislehurst. It was therefore decided to hold the Tournament on the hard courts at Charterhouse on 28th September. With a fairly strong wind and slow courts, conditions were not ideal, particularly for the more powerful but less steady players. Once again steadiness proved to be the decisive factor at this standard of tennis. The eventual finalists were A. Edelstone and D. Latham, and congratulations must go to the former for winning the Tournament for the second year running, with a score of 6-2, 6-4.

COPY DATES for December and January are 11th November and 25th November respectively. The Sports Editor will accept only type-written reports.

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# **EDITORIAL**

Public Image

"If anyone questions the motives behind seemingly critical contributions, I don't think they will have to look much further than pride—pride in the great tradition of this Hospital. Anyone who is not proud of his pivileged association with Bart's is not only foolish but unworthy of his place here." (Broadsheet editorial, 12th December, 1962.)

In an age when patriotism and even nationalism are dirty words, too many of the present generation of students here show a minimum of loyalty to the Royal Hospital of St. Bartholomew. The alumni of a generation or more ago, some of whom now assist in the administration of the Hospital and are at the top of our profession, lack nothing of a proper pride in our foundation; but in a fast and competitive world they seem to lack the will to project this pride any further than the limits of this island-site. Their pride is passive.

There are many signs of this reluctance to project a favourable public image any distance at all. In the last fifteen years the City Police have not been welcomed with the courtesy and friendliness that they expect and deserve when dealing with the casualty department. St. Bartholomew's is one of the few teaching hospitals in London which does not circulate the local general practitioners with information about its clinic times. Over the past few years it has been no coincidence that the quantity and even perhaps the quality of the Cambridge entry has dropped—no longer can we expect to see its ablest men. (Years ago a consultant of this hospital suggested an annual open day for varsity medical undergraduates, with transport provided, luncheon in the Great Hall and tea on the wards. This idea was not adopted.) On 23rd October, the Lord Mayor of London came in state to the St. Luke's Day service in St. Bartholomew's-the-Great. Sadly, there was only a handful of consultants other than those who are governors, the bulk of the congregation being senior members of the nursing staff and, most noticeably, many para-medical and office per-

It is possible that this occasion may be added to the Lord Mayor's calendar of official functions. We hope it is. Then in future, morning dress de rigueur, the Hospital must spare nothing to receive the City Authorities royally. Over the next twenty-five years large scale rebuilding schemes are planned and although Bart's is possessed of some millions of pounds it cannot afford to be casual towards so rich a patron as the City; indeed, if it is to match the prestige of other London teaching hospitals it would do well to include a private wing in its building plans, sooner or later. Such a venture would probably require considerable financial backing. At a time when the increase in the popularity of private treatment is proof of the inadequacies of the National Health Service, the City Authorities, always generously disposed towards competitive as opposed to nationalised ventures, might be in a position to see that such support was forthcoming.

Doubtless, radicals of this hospital and our profession would deplore a private wing, regarding it as a defeat for socialised medicine which would interfere with teaching and do nothing to improve the standard of medical and nursing care. In fact we believe that it would assist the teaching in at least three ways. Firstly, consultants here would be able to spend more time in the hospital instead of rushing backwards and forwards between Bart's and various private institutions; secondly, the care and treatment of private patients would be a useful adjunct to the education of housemen and registrars; and thirdly, G.Ps. with mixed practices on finding their private patients well treated here would

naturally be encouraged to send their N.H. patients as well.

In these days there must be no fear of cultivating a popular image and of courting the rewards of prestige which can only do Bart's and Bart's men good. "... Knighthoods, baronetcies and peerages are conferred upon doctors more because of the social importance of their patients or the political value of the committees they preside over than because of their own distinction in their own fields. . . . "\* This is a fact of life and does not matter so very much: there are distinguished men at this hospital, loval against odds, who would be so rewarded soon enough if St. Bartholomew's acted as if it were London's top hospital.

There is a man of vision in the administration who is striving to lead this hospital to the front and we must hope that in the next five years, not twenty-five or even ten, Bart's will so improve its prestige, private patronage and public popularity that student selection either to the hospital or to its college will be no problemonly the sporting, social and academic cream of varsity and the schools attempting entrance to this Royal and Ancient Hospital of St. Bartho-

\* Reflections of a retiring Sub-dean, by H. Wykeham Balme, page 389.

# Christmas Card

We advertised the Journal Christmas card in the October and November issues. Because the response from old Bart's men has not been as good as we had hoped we still have some left. It is by no means too late for readers to order this card; if you fill in the form on page 393 and send it to us we will post your order at once. Up to the Minute in a Moment

This month this column has been relegated to a back page, page 392.

# COULD YOU HAVE BEEN. . . .

Like, I feel sure, many others, I read with great pleasure the article "Could you have been a Solicitor?" emphasizing resemblances between the professions of law and medicine.

Recently I was talking to a patient on whom I had operated and who was, as all patients should be, a good friend. He came out with the remark that doctors are very like lawyers, and then, after a pause, "they both get you into a hell of a mess ".

Yours faithfully, H. JACKSON BURROWS. 25 Upper Wimpole St., W.1. 13th November, 1963

# NEW RADIOTHERAPY DEPARTMENT

I read with interest the article about the Radiotherapy Department, and it may amuse your readers to know how the money for the Xray machine taken over by Dr. Levitt on the first floor of the Outpatient block was obtained. In those days there was an annual "Fleet Street Collection Week". The writer contacted the organizer and over a cup of coffee in a Lyons tea-shop persuaded him to earmark £2,000 for Radiotherapy when handing over the cheque to the Governors. The Clerk to the Governors. Dr. Havs, suspecting the writer to be the culprit, had him on the mat, and said the Governors did not like to have part of the cheque earmarked beforehand. The surgeons also were not amused as they wanted every penny possible for the new Surgical Theatres.

Yours faithfully,

M.D. 17th November. (address supplied.)

# Calendar DECEMBER

Sat. & Sun., 7th & 8th: Dr. A. W. Spence
Mr. E. G. Tuckwell
Mr. H. J. Burrows
Mr. R. W. Ballantine
Mr. A. P. Fuller

Tues., 10th: Dr. J. M. Roberts will lecture on "The Surprise of General Practice" at

Sat. & Sun., 14th & 15th: Prof. E. F. Scowen Prof. G. W. Taylor Mr. J. N. Aston Dr. I. Jackson

Mr. J. W. Cope Sat. & Sun., 21st & 22nd: Dr. R. Bodley Scott Mr. A. H. Hunt Mr. H. J. Burrows

Dr. T. B. Boulton Mr. R. F. McNab Jones

23rd December: Copy Date for the February Journal. Wed., 25th: Christmas Day. Thurs., 26th: Boxing Day. Pot-Pourri first night

Sat., 28th: Pot-Pourri last night. Sat. & Sun., 28th & 29th: Dr. E. R. Cullinan

Mr. C. Naunton Morgan Mr. J. N. Aston Mr. F. T. Evans Mr. J. C. Hogg

Tues., 31st: New Year's Eve. Physician Accoucheur on duty for the month of December is Mr. G. Bourne.

# Births

CHURCH.—On October 28th, to Joan and Robin Church, of the Ruanda Mission, Kampala, a son (Christopher Mark).

HARPER.—On October 13th, to Sylvia (née Mainprice) and Dr. Kenneth H. Harper, a daughter (Caroline Amanda).

Engagements

ALMEYDA-MURPHY.-The engagement is announced between John Ryan Almeyda and Shei'a Mary Murphy.

HARDY-ALEXANDER.-The engagement is announced between Frederick John Hardy and Caroline Greer Alexander.

TRVINE-UROUHART.-The engagement is announced between Robert John Macferson Irvine and Lesley Marian Urquhart.

McKERROW - SIMMONS.-The engagement is announced between Colin Bonnet McKerrow and Antonia Mary Simmons.

MARTIN.-On October 2nd, Mr. D. G. Martin, M.B., F.R.C.S.(Ed.), aged 63. Qualified

Changes of Address

Mr. J. Burfield, F.R.C.S., to Glebe Farm, Swainsthorpe, Norwich, Norfolk.

Miss P. M. Cholmeley, to 27, Upper Richmond Road,

Putney, S.W.15.

Dr. H. M. Collymore, to General Hospital, Port-of-Spain, Trinidad, West Indies.

Dr. C. W. Coole, to "Ridehanger", Park Hill Rise,

Croydon, Surrey.

Dr. B. H. Goodrich, to The Tile House, Shenfield Road, Brentwood, Essex. Tel. Brentwood 4755. Dr. A. E. Lorenzen, from c/o Public Health Dept. to

Home Farm House, Sloley, Norwich, Norfolk. Dr. D. J. H. Rogers, to 128, Parkway, Welwyn Garden

City, Herts.
Dr. A. T. Pogan, to Orchard House, Baker's Lane,

Westleton, Saxmundham, Suffolk.
Dr. Ranyard West, to Balliol College, Oxford.
Dr. T. H. N. Whitehurst, to 49, Rutland Gate, Knightsbridge, S.W.7.

Appointments

Dr. F. H. Young, O.B.E., F.R.C.P., has been awarded the Weber-Parkes prize for outstanding work in the prevention and treatment of tuberculosis.

Mr. N. L. Capener has been appointed Emeritus Consultant by the South Western Regional Hospital Board in recognition of his services in orthopaedics in the Devon and Exeter clinical area

Mr. S. D. Sturton has been elected F.F.R. (R.C.S.I.).

#### GENERAL PRACTICE TEACHING PROGRAMME, 1963-64

Although General Practice is not yet a subject on the syllabus of Final examinations it is the ultimate destination of many of us. In order that Final Year students may, if they wish, gain insight into some of its workings the following programme is being arranged:

1. A formal lecture on the Programme and on General Practice to-day. (Spring 1964.)

 An evening meeting in early March, 1964, on the subject "General Practice in the Teaching of Medicine" at which it is hoped both students and G.P.s will be present

3. Visits in the Summer of 1964 to rural and town

4. Facilities for attachment to selected general practitioners for a period of one or two weeks.

All these events will be publicised on the Notice

Board well in advance. It is my hope that students will pass on their comments and suggestions to me so that the previous high

level of interest may be maintained.

Each year the College of General Practitioners offers an undergraduate prize for the best essay on the clinical history of a case from the general practice viewpoint. Application forms and information about this Public Welfare Foundation Prize are available from me at the Sub-Dean's Office and the closing date for entries is 30th April.

Many Old Bart's men, now in general practice, prefer to choose their prospective new partners from those trained in the same discipline and a list is kept of both jobs available and graduates requiring them.

# BRITISH MEDICAL STUDENTS' ASSOCIATION—ANNUAL GENERAL MEETING, 1963

The Annual General Meeting of the BMSA was held in Edinburgh on 8-10th November, and was attended by the four Bart's representatives. There were also two Bart's students on the Executive Committee of B.M.S.A. this year.

Sir George Pickering, who has been the Honorary President for 1963 invested Professor J. H. F. Brotherston as the Honorary President for 1964 at the Annual Dinner on 9th November. Professor Sir Derrick Dunlop also attended the dinner and replied to the toast to the guests.

The new student President for 1964 is Mr. Jeremy Cobb from Cardiff Medical School. We were very pleased that Mr. Alan Bailey was elected as Chairman of the London Region Branch.

[A more complete report of this meeting will be published next month.]

# **50 YEARS AGO**

On November 13th a largely attended meeting of the Abernethian Society listened to an account by Mr. J. E. R. McDonagh, F.R.C.S., of his researches into the life-history and chemistry of the organism of syphilis. According to Mr. Mc-Donagh the Spirochæta pallida is merely the male gamete in the life-cycle of an intracellular organism, the Leucocytozoon syphilis, all the stages of which he has demonstrated, and, with a few exceptions, photographed. Mr. McDonagh has a convincing, though dogmatic manner, and it was evident that the greater part of his audience believed in the truth of his discoveries in spite of their subversive nature. In some scientific circles these facts are still accepted with some incredulity, but Mr. McDonagh may be trusted to carry the truth home in the course of time. Meanwhile, St. Bartholomew's may be proud to have produced a researcher of so much originality and resource. It is only a matter of time before the value of Mr. McDonagh's work will be generally recognised.

# **FIVE MINUTES FROM BART'S: 5**

by our Drinking Correspondent. (Photograph by B. C. P. Lee)



The College Hall Bar.

This is the last article in the series and is a postscript since, apart from this week's choice, I have exhausted the list of interesting pubs in the area.

I have chosen College Hall Bar as the last "pub" since it deserves a very special mention and should most definitely be visited by all Bart's men, new and old, as frequently as possible. It has only been run by the students for one year, yet has proved to be one of the most successful ventures ever undertaken by the Students' Union. You can get a drink at lunchtime or in the evening and the Bar has provided a much needed focus for social life in College Hall. How the residents ever got along without it in the past I can hardly imagine.

Apart from selling liquor, the Wine Committee who run the bar try to provide a social service for the students in the shape of dances, smokers and tours of a frankly alcoholic nature. This Christmas there will be a special 5 per cent reduction for any Bart's man buying his Christmas liquor from the Bar.

In winding up this series I should like to thank all those people who said they enjoyed it and leave them with an interesting little fact that I discovered recently. In 1535 there was a City statute saying that only 15 pubs could exist within the City boundaries, there are now 410!

I wish all serious-minded drinkers a Merry Christmas and a Happy New Year.

# CHINA GODS AND ANGELS

by Patrick Smith

Christmas has an impure pedigree, being born of the many vicissitudes which have occurred since the three sages went journeying—suffering first the influence of the Roman Saturnalia, next corruption by the mongrel cosmopolitans of the Levant, then mixture with Celtic Paganism and Gothic superstition, finally it becomes in our own day the biggest parturition orgy of all time. The lights go up, the days are numbered and all are coming to spend in remembrance. Our Father which art in Harrods, is rubbing his hands at the prospects of bigger and better sales, for never has there been such a boom in the mush and gush of Happy Xmas.

Not least among the prospering shopkeepers are those who, usually in some dark side street, offer the more authentic trappings of Christmas. Only by accident does one find one-self among the sellers of China Gods and angels, but what a paradise of exotic deviations in the Christian spirit is this view of votive statuary. China Gods, graded in size and magnificence, angels of celestial asexuality supported inade-

quately with semi-fledged wings, and a variety of virgins that do credit to every pure sentiment of the creative instinct. Virgins large and small, virgins with self-fillings fonts at their feet, attachable, detachable and unbreakable virgins, washable and magnetic virgins, and finally the prizewinning luminous virgin, all these selling at bargain Christmas prices. The effect was unearthly -perhaps not divine. This selection was but a fraction of the whole which included cards for every festival, chronologically and alphabetically, from the Annunciation to the visitation of the B.V.M., beads for each sacrament, black Christs by special dispensation, non-staining chalices, missals of imponderable grandeur in unparalleled confusion, uncreasable terylene copes—and still the list is incomplete. The prize piece, a "Happy death set", comprising two pseudo Georgian candlesticks and vet another mawkish virgin, had about it the mark of genius. Perhaps the brazen image helps to bring the divinity a little nearer, but undoubtedly Aaron has been at work again while Moses has been away, this Christmas

is for Auntie asleep in her chair, B is for bibulous—that's why she's there, C is for cards on sale from September, C D for the dear ones we never remember. E for embarrassment at childhood recited, F is the family so fondly united, II A G is for gout or addiction to drink, H for the Hellebore-not what you think. I is for ivy which trails down the walls, R J for the jungle produced when it falls, K is for kitchen where the menu's perfected, L for the Lord who is rather neglected. M for the message at three on the air, N for nystagmus where one makes a pair. O for the once that it comes in the year, P for the penury that greets the New Year, O for the quaint little customs we keep, R is the ramble through slush ankle-deep. S for the stocking which hangs from the bed, T for the long weeks of turkey ahead, U is for ulcer—it brings deprivation, V for the vine which increases temptation. W for what will they ever send next? X for expressions like Xmas and sex, Y is the question one's tempted to pose, Z is for Zounds! for nobody knows.

#### THREE CASES OF NEW GROWTH INVOLVING BONE

by P. Stanley

The three cases described below were admitted to the hospital under the care of Mr. H. Jackson Burrows during the past year.

#### Osteosarcoma of the femur

The first case is that of a boy aged fourteen, who presented with an eight week history of a painless swelling in the left thigh which he first noticed when he was wearing shorts. He had been kicked there about a month before, but enjoyed good general health.

On examination he had a large fusiform swelling in the left thigh seemingly arising from the femur. The tumour was smooth and hard with a well defined surface. There was a two-inch increase in girth of the thigh. He had enlarged lymph glands in both groins. He had lost a few degrees of flexion at the knee.

The X-ray of the femur revealed a fusiform swelling with a sunray appearance occupying the middle third of the shaft of the left femur. There was evidence of reactive new bone formation mostly in spicules at right angles to the axis of the femur and also evidence of bone erosion in the lower half of the tumour. The plain X-ray of his chest and subsequent tomograms failed to reveal any secondary deposits. His Wasserman reaction was negative. The tumour, which was biopsied on the 10th July, 1963, appeared to be very fleshy upon incising the periosteum. The histology confirmed that this was a malignant spindle celled tumour showing abundant formation of intercellular bone matrix with numerous mitoses present. The size of the tumour, without pain, suggests that it was of long standing and yet there were no metastases evident. It was therefore considered best to treat this surgically and on the 31st July, 1963, he had a disarticulation of the lower limb at the hip. After operation he made good recovery and was discharged five weeks later.

#### An obscure tumour involving the ulna

The second case has aroused much discussion between leading histopathologists as to the diagnosis and hence the treatment. The patient is a naval rating of twenty-five, who struck his wrist on the crank case of an engine in a submarine last December. The wrist was painful at the time, but he was able to return to work after five to ten minutes. His wrist gave him some discomfort in January and became swollen in February. An X-ray taken at the time revealed an old fracture at the lower end of the right ulna. By April, the diffuse swelling had developed into a hard nobbly



X-ray of left femur revealing a tumour arising from the middle of the shaft. The upper half of the tumour shows periosteal electation with new bone formation. In the lower half of the specimen there is distruction of the bone cortex.

mass 4 cm. by 6 cm. which appeared to be arising from the lower end of the ulna. He was seen by the late W. D. Coltart, who thought that the patient had a fracture through an area of osteitis with a chronic bone abscess, but, appreciating that this might be more sinister, excised the lower three inches of the right ulna. The specimen fell apart through the old fracture site. The biopsy

specimen was sent to St. Bartholomew's Hospital and several centres in the U.S.A. Various opinions were expressed, but the consensus of opinion, including Dr. Cureton's, thought that this was a locally malignant tumour of either fibrous or synovial origin.

The problem of diagnosis was partly solved by the patient presenting himself in July with a fixed indurated swelling having a firm nodular surface at the site of the original biopsy. The swelling was not attached to skin and there was no axillary or cubital lymph adenopathy. An X-ray taken at the time was really not very helpful.

It was thought that this must be a recurrence and after consulting with the radiotherapists it was decided to treat this surgically. On the 17th July, 1963, a below-elbow amputation was performed, the amputation site appearing to be well clear of the growth. Histology confirmed that this was a recurrence of the original tumour and showed none at the site of amputation.

#### Squamous-celled carcinoma complicating chronic ostcitis

The third case is that of a patient with chronic osteritis with a well recognised complication: malignant change in the chronic discharging sinus. He is a man of sixty-seven, who developed



X-ray of the lower end of the ulna and radius of the right arm showing an area of translucency with a pseudo fracture through it. The medulla shows a find granular calcification and there is irregular erosion of both cortices.



Lateral X-ray of the lower end of the femur showing a chronic osteiis cavity with a fracture through it. The walls of the cavity are irregular and indefinite suggestive of malignant change.

osteitis of the lower end of his femur when he was five. He was left with a discharging sinus which had never healed and which he dressed daily. In 1942 a sequestrum was removed from the lower end of the femur and he was given a course of penicillin.

He was admitted to hospital on 11th October, 1963. The day before, he had fallen, twisting his leg. Bright red blood had discharged through the sinus. He had an obvious supracondylar deformity of his left femur with a sinus leading to the base arising from the lateral side of the lower thigh. An X-ray revealed a fracture through his chronic osteitis.

The only acceptable method of managing the fracture was to put the patient in a hip spica with a window cut in it so that his sinus could be dressed daily. Since the X-rays revealed that the cavity had indefinite and irregular walls, the cavity was biopsied.

Histology showed a well differentiated squamous-cell carcinoma of the skin apparently not involving bone. The only way to treat this was by surgery and so on 23rd October, 1963, he had a disarticulation at the hip. So far he has made satisfactory progress since the operation.

#### Discussion

All these cases just described were treated with surgery without prior irradiation. There was no choice in the last case since his sinus was already inflamed and necrotic. The osteosarcoma was treated by surgery because, although the history was not long, it had from the X-ray appearances been present for a long time and the absence of pain suggested it was slow growing. The neo plasm of the ulna was treated by amputation because it was an unusual tumour apparently with-

out metastases and the response to radiotherapy could not be foreseen.

Both the sarcomas had a history of trauma, although this is probably co-incidental it may be accepted in a court of law. Lastly the third can demonstrate another complication of chronic osteitis—fracture.

ACKNOWLEDGEMENTS

I would like to thank Mr. H. Jackson Burrows for his advice and encouragement in the preparation of this paper, and the departments of Pathology and Photography for the preparation of the photographs.

# THE BEDSIDE DIAGNOSIS OF THE COMMONER ENDOCRINE DISORDERS

by A. W. Spence

Introduction

THE diagnosis of disease has been considerably advanced by the radiologists, pathologists, chemists and physicists. This especially applies to endocrine disorders. There is, however, a growing tendency to overlook the importance of "bedside diagnosis"; that is, the careful taking of the history, the physical findings on examination of the patient and the conclusions derived therefrom. A welter of investigations are performed, many of them being quite unnecessary (this is particularly true of American medicine) with the result that the laboratories are swamped and there is delay in performing those tests which are really essential—a good example of "cluttering up the works".

In my view, investigations should be performed for one of two purposes—either to assist in the diagnosis of disease and sometimes to ascertain response to treatment or when research is being carried out. The greater the clinical acumen of the physician, the fewer the investigations he will request (unless he is engaged in clinical research), for he will be able to pin-point those tests essential for diagnosis, which after all is the object of the exercise. In my experience it is when the bedside diagnosis has been missed that the number of investigations increases.

Furthermore, do not always put your trust in the figures and do not allow the figures to sway your clinical judgment. I shall mention some of the discrepancies that come to mind. The urinary steroid results may be inaccurate because of failure to collect a proper 24-hour specimen of urine. The basal metabolic rate may be raised because of fright on the part of the patient. On one occasion the correct bedside diagnosis of hyperinsulinism was abandoned because of normal

blood sugar values: something had gone wrong with the standard solutions. The serum cholesterol is raised in conditions other than myx oedema. I have known of patients being treated for a non-existent hypothyroidism because the serum cholesterol figure was above normal. The bedside diagnosis of myxoedema has been correctly made when the serum cholesterol and serum protein-bound iodine were normal. There have been cases of hyperthyroidism in which the serum protein-bound iodine has been normal. An isolated serum calcium may be normal in hyperparathyroidism. The urinary 17-ketosteroids are of little or no value in the diagnosis of testicular insufficiency firstly because the normal range is from 8 mg. to 22 mg. per 24 hours and secondly because the adrenal androgens contribute twothirds of the amount excreted.

The curtailment of investigations is not only necessary in hospital practice to spare the already overworked laboratory staff and to play a part in trying to check the steadily rising cost of the National Health Service, but perhaps even more so in private practice where the patient has to foot the bill. I shall therefore endeavour to demonstrate the value of bedside diagnosis in the commoner endocrine disorders, although it will be appreciated that in a short article it is impossible to treat the subject fully.

Obesity

Although in most patients with obesity there is no evidence of an endocrine disorder (simple obesity), it is about the commonest condition seen in an endocrine clinic. Simple obesity, often due to overeating, may have started in childhood, the increase having been gradual throughout the years, or it may begin at any time in later life or

it may arise after pregnancy (postpregnancy obesity). It may be familial. Sometimes the obesity is gross, the patient attaining the weight of 20 stone or more. It is pointless investigating such cases since none of the tests has ever revealed an endocrine cause. The following are some of the fruitless investigations that are sometimes carried out—urinary 17-ketosteroids, urinary 17-hydroxycorticosteroids, serum sodium and potassium, glucose tolerance test, basal metabolic rate, serum cholesterol, serum protein-bound iodine and X-ray of the pituitary fossa.

On the other hand, if the obesity is fairly rapid in onset and is associated with impotence in the male or amenorrhoea in the female, then a pituitary tumour should be considered and the pituitary fossa X-rayed. The tumour which most commonly causes obesity is the craniopharyngioma which does so by damaging the hypothalamus: hypopituitarism does not cause obesity.

Gross obesity is not caused by hypothyroidism and where the two conditions are associated the obesity has usually been present long before the symptoms of hypothyroidism. A patient recently seen developed gross obesity while taking full doses of thyroxine for post-thyroidectomy hypothyroidism, so that her obesity could not possibly be due to hypothyroidism. Thirty-seven per cent of patients with hypothyroidism are of or below normal weight; much of the increase in weight in hypothyroidism is due to water-retention. When hypothyroidism is suspected as a possible cause of obesity, which is never more than moderate, inquiry should be made concerning other features of this disease, especially sensitivity to cold. It should be noted in passing that very occasionally weight gain and moderate obesity occur in hyperthyroidism due to excessive intake of food over the metabolic requirements.

The obese woman with a red face and slight hirsutism—you can see a number of them in Whitechapel Road—is not suffering from Cushing's syndrome, for in this disease the obesity is confined mainly to the face and trunk, the limbs being relatively slender. The face is round with a reddish-cyanotic colour and purple striae are present on the abdomen and/or hips, unlike the pink striae which are sometimes seen in simple obesity.

The obesity of children is usually puppy-fat which disappears when they grow older. If the boys have knock-knees and genitalia which appear to be small because they are buried in the pubic fat, do not consider that they have Fröhlich's syndrome, although it is wise to have the pituitary fossa X-rayed to exclude this disease. Fröhlich's syndrome is a very rare condition and is defined as obesity, permanent genital hypoplasia and (in males) a feminine configuration of the body, sometimes associated with dwarfism and diabetes

insipidus and caused by a definite pathological lesion, usually a craniopharyngioma, damaging the hypothalamus.

Hypopituitarism

A young woman with wasting, amenorrhoea, low blood pressure and low basal metabolic rate is not suffering from primary hypopituitarism, but usually from anorexia nervosa. Sometimes in this disease the amenorrhoea precedes the anorexia by a few months. Wasting or thinness is not caused by hypopituitarism except perhaps in the late stages of the disease when it is due to anorexia.

The hypopituitary patient presents with tiredness, listlessness, undue sensitivity to cold, feelings of faintness, mental apathy, sterility, and impotence in the men and amenorrhoea in the women. On the other hand amenorrhoea or impotence may be the only symptom. The facies is characteristic: the skin being pale (due to lack of the melanocyte stimulating hormone), sometimes slightly yellowish, finely wrinkled, dry and inelastic with perhaps thinning of the eyebrow hair; the expression is one of apathy and lack of animation. The sexual hair is scanty and may be lost, due to deficiency of adrenal androgens and (in men) of restosterone. The blood pressure is low.

Hypopituitarism occurs far more frequently in women than in men because of childbirth. Collapse at delivery or a severe post-partum haemorrhage causes thrombosis of the pituitary vessels and a post-partum necrosis of the anterior lobe (Sheehan's syndrome). Sometimes the symptoms of hypopituitarism develop some or even many years after this episode and consist of a vague invalidism—debility, fatigue, listlessness, amenorrhoea and a little anaemia. The diagnosis will be missed, which is tragic in these days when treatment is so effective, unless inquiry be made concerning events at childbirth in the past.

#### Infantilism

There are numerous causes of infantilism; for example, chronic intestinal disease giving rise to malabsorption, chronic infections, metabolic diseases, chronic heart, lung and kidney disease and malnutrition, but the commonest are primary failure of gonadal development and hypopituitarism. Most cases of pituitary infantilism appear to be due to a congenital defect causing insufficiency of the growth and gonadotrophic hormones, but the pituitary fossa should always be X-rayed for the presence of a craniopharyngioma.

Pituitary infantilism is distinguished from primary gonadal infantilism as follows—in the pituitary type there is shortness of stature, but the proportions of the body are usually normal; that is, the span is equal to the height and the measurement from the crest of the symphysis pubis to

the ground is the same as to the vertex; the axillary and pubic hair are absent, due to deficiency of adrenal androgens through lack of the anterior pituitary luteinising hormone which stimulates their production. In primary gonadal infantilism the patient is either of average height or tall with relatively long arms and legs, hence the span is greater than the height and the measurement from the crest of the symphysis pubis to the ground is greater than to the vertex; the axillary and pubic hair are present but usually scanty. The testes in pituitary infantilism are of the same size as those of a normal prepubertal boy, whereas in primary gonadal infantilism they are absent or the size of a small pea, except in pubertal gonadal failure when they are of the normal infantile size. Turner's syndrome (gonadal dysgenesis), which occurs far more frequently in females than in males, is characterised by shortness of stature (genetic), infantilism, development of axillary and pubic hair and various congenital abnormalities, especially webbing of the neck and cubitus valgus.

A not uncommon condition is delayed puberty which causes considerable concern to parents and patient, more especially when the patient is a boy, for he is often mocked at school by schoolmates who are better endowed. His height is normal and his testes are of the normal infantile type; but if he happens to be short the diagnosis from pituitary infantilism, which is permanent, is impossible: one has to treat the infantilism and watch developments.

Dwarfism without infantilism is usually genetic. If a patient with dwarfism is seen before the normal age of onset of puberty the genitalia are naturally infantile and it is impossible to say whether the patient will turn out to be a case of pituitary infantilism or not. The pituitary fossa should always be X-rayed to determine the presence of an organic lesion.

Hyperthyroidism

The bedside diagnosis of a classical case of hyperthyroidism presents no difficulty; it is the milder type and masked hyperthyroidism which may lead to error. Two common disorders which sometimes mimic it are an anxiety state and the climacteric, for in these conditions the clinical features may be nervousness, sweats, hot flushes, palpitations, loss of weight, tachycardia and tremor. An added difficulty would be the presence of a simple goitre. Spasmodic upper lid retraction may occur in an anxiety state and in hyperthyroidism eye signs and thyroid enlargement may be absent. Points in favour of the diagnosis of hyperthyroidism, although they may not all be present, are a feeling of heat, a preference of cold weather to warm, a good appetite in spite of a loss of weight, a slight stare or glistening of the conjunctivae, a systolic bruit over the thyroid

gland, a 'machinery' murmur just above the medial end of the clavicle and about half an inch from the lateral lobe of the thyroid (Lian-Mills sign), a forcible cardiac impulse, a raised pulse pressure, a fine as opposed to a coarse tremor and a raised pulse rate during sleep. I have seen a patient with simple goitre and pulmonary tuberculosis; (little or no cough, loss of weight, sweating, tachycardia) mistakenly diagnosed as having hyperthyroidism.

The diagnosis of hyperthyroidism may be missed because of the prominence of a particular feature, the hyperthyroid state being hidden. Forms of masked hyperthyroidism are various and include those presenting with atrial fibrillation with or without congestive heart failure, hypertension, diarrhoea, glycosuria, myopathy, myasthenia gravis and psychoses. Another type, known as apathetic hyperthyroidism, occurs in middleaged patients, usually women, and is characterised by apathy, absence of exophthalmos but a slight stare, no enlargement of the thyroid gland, tachycardia and some pigmentation of the skin: so it may be mistaken for Addison's disease.

Hypothyroidism

The myxoedematous facies is unmistakable the lask of expression, the puffiness round the eyes, pale yellowish skin and malar flush. However, the diagnosis may be overlooked because the circumocular oedema may be thought to be nephritic (there may in fact be evidence of renal impairment as a coincidental complication), or if anaemia or mental disturbance is the outstanding feature. On the other hand, the circumocular oedema may be thought to be due to myxoedema when actually the condition is exophthalmic ophthalmoplegia, the oedema masking the exophthalmos, and some normal people look so dull and heavy as to give the impression that they have myxoedema. The facial changes of myxoedema are so slow in their development that a medical practitioner who sees the patient frequently may not be aware of the change or the patient may not consult a doctor because she and her relatives think that the symptoms are part of the process of ageing. One woman (she was not a patient) who brought her son to the Endocrine Clinic was spotted as having myxoedema by her croaky voice and another under similar circumstances because she was wearing so many clothes on a warm day.

By no means all patients with hypothyroidism have a myxoedematous facies and it should be mentioned here that thinning of the eyebrow hair is not diagnostic of hypothyroidism. When the diagnosis is not obvious, inquiry should be made concerning undue sensitivity to cold (if cold sensitivity has always been present it does not count), shedding of scalp hair in women, dryness of the skin and slowing of mental and physical activity.

The pulse pressure is often reduced and there is usually a bradycardia, but occasionally the pulse rate is normal or even raised. A valuable sign in the diagnosis of hypothyroidism is slowness of the ankle jerk and of the other tendon reflexes, particularly in relaxation. Myxoedema should be thought of in patients complaining of aches and pains in their limbs and in the carpal tunnel syndrome

Hyperparathyroidism

In the diagnosis of hyperparathyroidism the physician has to rely on the biochemist and radiologist, but if this disease is not thought of, obviously the diagnosis will not be made. Often the disease is not thought of. For months or years patients may suffer from aches and pains in their back and limbs due to hyperparathyroid osteoporosis, but attributed to "rheumatism" or "neuritis". It is now well known that estimation of the fasting serum calcium should be done in patients with renal calculi to exclude hyperparathyroidism as a cause.

Symptoms that are produced by the hypercalcacmia consist of fatigue, anorexia, constipation, muscular weakness, hypotonia, polyuria, polydipsia, headache, metal disturbance and keratitis. The modes of presentation of hyperparathyroidism are diverse: the commonest are renal calculi and the bone disease (generalised osteitis fibrosa) causing limb and back pains and tumours, particularly in the jaws, metacarpals, metatarsals and the ends of the long bones. Less common forms are peptic ulceration, hypertension due to renal damage caused by nephrocalcinosis, polyuria and polydipsia due to hypercalcuria, chronic pancreatitis due to calcification in the pancreas, dyspnoea, tachycardia and chest pain due to calcareous deposits in the pericardium, myocardium or lungs and mental disturbance.

#### Hirsutism

Hirsutism falls into the following categories—simple, constitutional or idiopathic hirsutism, by far the commonest, the adrenogenital syndrome caused by an adrenal tumour or by adrenocortical hyperplasia and ovarian diseases; that is the Stein-Leventhal syndrome and the androgen-producing tumour, the arrhenoblastoma.

Simple hirsuitsm is the result of either increased sensitivity of the hair follicles to androgenic stimulation or a slightly increased secretion of adrenal androgens. There is no treatment for this condition apart from depilation. In most cases the excessive growth of hair is limited to the face with perhaps a few hairs on the breasts, but the amount and distribution of the hair are by no means diagnostic, since there may be an extension of the pubic hair to the umbilicus and on to the thighs as is seen in true virilism. Diagnostic features are normal menstruation and non-

enlargement of the clitoris.

In the adrenogenital syndrome, due to increased secretion of adrenal androgens, the excess hair is usually more widespread than in simple hirsutism and although sometimes the hirsutism is not all that marked, the pubic hair is always of the male type. Usually the clitoris is enlarged and there is amenorrhoea, hypomenorrhoea or oligomenorrhoea, but occasionally there is no obvious clitoral hypertrophy and, more rarely, menstruation is normal, rendering its differentiation from simple hirsutism impossible without further investigation. Further investigation is also necessary to decide whether the condition is caused by an adrenal tumour or by adrenocortical hyperplasia. The clinical picture produced by an arrhenoblastoma is the same as that of the adrenogenital syndrome and therefore in cases of virilism it is often necessary to ask the gynaecologist to make a pelvic examination to determine whether an ovarian tumour is present.

The Stein-Leventhal syndrome in my experience occurs less frequently than adrenocortical hyperplasia, but more frequently than an adrenal tumour and an arrhenoblastoma. It appears to be due to the production of androgen as a result of imperfect synthesis of oestradiol by ovaries which are usually enlarged and contain multiple follicular cysts with proliferation and luteinisation of the theca interna. The full clinical picture consists of primary or, far more commonly, secondary amenorrhoea or oligomenorrhoea, sterility, hirsutism, obesity and palpable ovaries, but there are variations. An essential feature is amenorrhoea or oligomenorrhoea which gets progressively worse and occasionally the amenorrhoea is followed by menorrhagia. Sterility is the rule, although the patient may have had one or two pregnancies before the onset of the disease. Hirsutism occurs in about 50 per cent of cases and obesity much less frequently. A pelvic examination for palpable ovaries is essential, but sometimes they may not be felt.

#### Conclusion

I have endeavoured to show that one can go a fairly long way in diagnosis at the bedside and although further investigation is usually necessary, the observant physician will be able to limit the number of investigations required. If more care were taken in bedside diagnosis it would spare the patient from being referred to the wrong consultant. For instance in recent weeks I have had one patient with myxocdema who had originally been sent to the Eye Department because of her circumocular oedema and another patient with the same disease who was referred to the E.N.T. specialist because of her husky voice. The diagnosis of myxocdema was made in these departments.

This article is introduced by J. L. Howgego of the Guildhall Library and consists of contributions from the following: John Bradley Hutton of Booth's Distilleries, Ltd.; Michael White of De Beers Consolidated Mines, Ltd.; C. P. Dumenil of Peter Dumenil & Co., Ltd.; N. H. Ormerod of Gallaher, Ltd.; Tom Tullett of the "Daily Mirror"; Chief Superintendent T. J. Howard of Snow Hill Police Station; J. E. F. Fox of Whitbread & Co.,

> IT HAS long been a source of bewilderment to many people that there seems to be very little relationship between the various ways in which London is divided. Neither the municipal boundaries, the police districts, the water board areas nor the

postal districts correspond.

E.C.1 embraces the site of four great monasteries—Charterhouse, now an old men's hospital with a famous public school in Surrey; Greyfriars, transformed by Edward VI into an equally famous public school now in Sussex; St. John, Clerkenwell, Priory of the Order of St. John of Jerusalem; and St. Bartholomew the Great, founded by Raherus in the reign of Henry I and now the oldest hospital in England. The priory church of St. Bartholomew is all that remains of the monastic buildings and is, apart from St. John's Chapel in the Tower, London's oldest church.

The historical interest of E.C.1 does not, however, lie only in its monasteries. In the north the name of New River Head commemorates the achievement in 1613 of Sir Hugh Myddelton, who cut a forty-mile channel to bring water from Hertfordshire to Clerkenwell. In the south stood Newgate, not only a gate but a prison until it was pulled down in 1776 and superseded by the great prison in the Old Bailey which bore its name, while to Giltspur in 1791 was removed the Wood Street compter, or sheriff's prison. Giltspur Street took its name-and its previous name of Knightrider Street-from the people who passed through it in mediaeval times to joust at Smithfield. Pye Corner, where the Great Fire of 1666 is said to have halted, was

Behind St. Bartholomew's Church is Cloth Fair, which was in earlier times the trading section of Bartholomew Fair. The Fair was founded when the priory was built and in due course came to include a flourishing market for horses, cattle and farm machinery which had developed near the City borders. Like other fairs it had a section devoted to the amusement of its visitors, and by the early nineteenth century this section threatened to swamp the more serious side, and the City Corporation abolished the Fair, transferred the livestock market to Islington in 1851 and in 1868 opened the present Smithfield dead meat and poultry market, the largest of its kind

Just over the border of E.C.1 the goldsmiths and silversmiths congregated in Cheapside, where their shops can be seen in the engraving by James Basire from a lost contemporary painting of the coronation procession of Edward VI. They fabricated objects in precious metals and gems for personal adornment, tied up the wealth of rich merchants and societies in beautiful works of art and in earlier days performed the primary functions of a banker. Also just over the border were the areas devoted to journalism and publishing. Grub Street, or more politely Milton Street, became firmly associated with hack journalism in the eighteenth century, while Paternoster Row housed the publishers who up to the second world war sent more literature than any other European city out into the world. Fleet Street, the cradle of the English newspaper and still almost entirely given over to the Press, is in E.C.4, but it has tributaries like Shoe Lane and Farringdon Street which reach out into E.C.1, and to-day one of the nation's most popular newspapers has its headquarters in Holborn

Although the Worshipful Company of Brewers has always had its Hall just over the border of E.C.1, Chiswell Street-safely inside-has, since, 1749, contained one of Britain's most famous breweries. Not far away in Golden Lane was built in 1804 the Genuine Beer Brewery, but like the rest of the former buildings in that street it has gone, making room for the strange variety of modern residential blocks which can be

seen there to-day. Away to the north in St. John Street a wellknown distillery has since 1828 been producing a stronger beverage, while the same pure, white and essentially London spirit has flowed forth from another famous distillery in the same area for more than a cen-

To pass from drinking to smoking, the sale of tobacco is mentioned by Ben Jonson in his play "Bartholomew Fair". It seems, however, to have flourished more in the eastern fringes of the City, across the river in Bermondsey and in the fashionable parts of Westminster than in E.C.1. There are, nevertheless, records of tobacconists in the early eighteenth century in places as near as Cannon Street and "Alt Fisch Straate" (now Knightrider St.), and the Tobacco Pipe Makers' Company had its headquarters

in London Wall.

To-day the face of E.C.1 is changing from day to dayperhaps more than any other part of Central London. The Barbican area is being transformed from a desolate warstricken waste to a towering assembly of modern apartment blocks, giant office blocks and a cultural centre. Meanwhile the old trades go on to make a growing contribution to the prosperity of the City and of London as a whole.

#### MEAT

THE market has been operating since the early days of the 14th century and was originally an open space without the City walls, known as Smoothfield and used for the auctioning and bartering of livestock and produce brought to the City by farmers from surrounding districts. Citizens were recommended to make their daily visits to the markets, for side shows and entertainments were also available and, on occasions, it was possible to witness a more

horrifying spectacle, as Smoothfield was adjacent to the traditional site for the burning of martyrs.

Nevertheless, it was, as today, an open market in which the vendor offered his goods at a hoped for price against which the would-be purchaser made a bid and by process of offer and counter offer, a bargain would be made and the produce changed hands by verbal agreement between the salesman and the purchaser—their word being considered a bond which is as effective today as it was so many hundreds of years ago. Quite obviously in recent times the market and the volume of produce handled have grown, although the basic principles of selling remain the same.

The produce no longer arrives solely from surrounding districts but from the outlying counties and Scotland. There is also imported beef from S. America, lambs from Australia and New Zealand and the finest quality veal from Holland. In recent years, beef and pork has also been reaching the markets from Central Europe, including such countries as Yugoslavia and Poland, arriving in Smithfield in excellent condition without having been frozen at any stage of the journey. South America and New Zealand meats are also reaching the markets having been kept at chill temperatures.

The London Central Market, as it is now called, opens at midnight when pitching-that is the unloading of the meat starts. There are no mechanical means of handling and at the busiest time of the market, normally Monday morning, between 2,500 and 3,000 tons of produce are carried to the individual stalls by porters, sold and then carried back to the market vehicles for distribution to the customers.

The majority of the stalls have their early displays completed by 2 a.m. and the market

salesman's day begins then. It is usual for the buyers to appear from 2.30 to 3 o'clock onwards. The intervening time allows the salesman to assess the quantity and quality of the meats which he will be expected to sell during his morning and also to assess the value and the strength of prices throughout the market before the arrival of his early customers, the majority of whom will be his personal friends.

Being to all intents and purposes an auction market, every pound of meat and produce pitched must be sold by the close at mid-day and the salesman must, therefore, be a man who is capable of assessing the likely demands and negotiating his sales in order to clear his shop to the best advantage not only to his own company but to the purchasers who will require meat of their own specification. It is, therefore, important for the salesman to recruit customers whose requirements will cover a large range of cuts and quality of produce in order that his stall may be cleared by mid-morning.

It is not a career which would appeal to many, but when the shops and stalls have been cleared at the end of the day, and the accounts balanced-for all produce sold must be paid for daily in the tradition of the market-there is a great deal of satisfaction in knowing that you have been handling the finest quality of meat in the world, maintained your friendship with producers and customers upon whom your livelihood depends and contributed to the tradition of fair trading, which has been the foundation on which Smithfield Market was built over 500 years ago, and which has been jealously guarded ever since.

#### SNOW HILL

TN your August Journal I read A an article headed "Could vou have been a school master?" For that matter, "Could you have been a policeman?"

Ignoring the inherent dislike of working shifts around the clock many readers no doubt would consider themselves suitable material, and they would therefore join many others, male and female alike, who for the past months have been filling the correspondence columns of the daily and weekly newspapers with inaccurate articles on the merits and demerits of the police of today. Trials of infamous persons and train robberies provide a certain respite from these carpings of professional correspondents.

It has been said that a police-



"Round the fountain."

man of today cannot compare with his counterpart of years ago. This is nonsense. The task of constabulary duties are more exacting today than they have ever been. The liberty of the subject is a cliché used since the signing of the Magna Carta, but never have the members of the public been more aware of their lawful rights, together with many unlawful ones, than they are at the present time. This the police applaud as it is of vital importance to keep authority in its correct position and perspective, in order to avoid a police state. Further, the internal combustion engine has brought in its wake thousands of complex regulations. Their enforcement has been foisted on the police service and resulted in the relations with certain of the motoring public sinking to its lowest ebb. What is the cure for this? You tell me!

Looking back over the past 29 years I must admit that the policeman of teday could not hold a candle to officers of years ago when size, weight and thirst are considered.

In the City we have been successful in keeping a reasonable height standard, but I am sorry to see that other forces have not been so particular. In 1934 six feet was the absolute height minimum and although I am 6 feet 2 inches I felt like a whippet when standing alongside the monumental giants who made up the rank and file. Heights of 6 feet 5 inches and 6 feet 6 inches were commonplace and it is not surprising to hear that the incidence of assault on police was very low.

To retain such bulk, the size of the meals and the amount of liquid consumed by these men had to be seen to be believed. Beer thirty years ago had less water content and was at a reasonable price. Being teetotal in those days I often watched in amazement the number of pints consumed in a short space of

time. Bud Cannings was my favourite, five pints in a space of ten minutes flat was his regular habit much to the amusement of the younger element.

City policemen have always held a sincere affection for Bart's and all that it means. Nationalisation may have blunted many of the pleasantries, but it is to be hoped that the friendly reception a City policeman enjoys when visiting the hospital may long continue. Bart's must be one of the oldest hospitals and as the City of London Police was the first land police force in this country we do have something in common: let us keep it that way.

#### NEWS

GET many callers. Some L are discharged prisoners, some hate the police, many have useful information and some are idiots. One man called into the office and asked to see me. When asked his business by the commissionaire he replied "personal". He filled in a visitor's slip. It read: "E. D. Sims, Hampton Crescent, Gravesend." Mr. Sims sat framed in a redleather armchair, a well-built man of about 30, his slightly curly reddish hair brushed back from his forehead which was glistening slightly with sweat. He looked at me from behind horn-rimmed spectacles. His shirt was wide open, revealing a huge tattoo of an eagle in flight. 'Good morning," I said.

"What can I do for you?"

He spoke quietly: "I want to confess to a double murder!"

"Whom have you killed?"

"A man and woman, on the marshes at Gravesend."

As he said this he stood up. I was sitting a yard away. I noticed his washed-out khaki trousers, his big boots and his light-brown raincoat. He pulled out a beige, woman's handbag, a red and blue plastic wallet, and two gold-coloured wristlet watches, one man's and one

woman's. Then he sat down again and lit the stub of a hand-rolled cigarette.

"How did you kill these people?"

"I had a shotgun and two knives, but I strangled them," he said.

"Where are the gun and the knives?"

"I threw them away on the marshes."

I searched him and made him sit down again while I opened the door to get someone to keep guard. Edward "Dixie" Dean, a crime bureau photographer, was passing, and I called him in while I spoke to Roland Watkins, news editor. He organised a call to the police and I returned to the waiting room. Sims was still sitting down and did not appear to have moved.

"Why did you come here?" I asked.

"I wanted to get it off my chest. I wanted to tell someone."

There was a pad of copypaper on the table. I pulled it towards me and said: "Perhaps you would like to tell me about it."

He still spoke quietly. He gave his full name and address and said he was 28 years old.

"It was a man and a woman," he said. "Teenagers, I think, I attacked them on Denton Marshes, Gravesend, about 300 yards from Denton Isolation Hospital. I had a sawn-off shotgun. I held them up and strangled them."

He pointed to a parcel wrapped in newspaper on the table. I had noticed it before and thought it probably contained sandwiches.

"That parcel contains parts of their bodies," he said. "I removed skin."

Sims pointed to the handbag, the wallets and the wristlet watches.

"I took them from the people," he said. The wallets were empty of money.

"Did you take any money?"

I asked.

"Yes. I took about ten shillings from each wallet."

"When did this happen?"
"It was between 8.30 and 9.30 p.m. last night. I took the skin off with a knife. I toppled the bodies into a ditch. When I went home to my mother, my sister and my brother-in-law I threw the gun into a drainage ditch alongside the canal. I threw the shotgun cartridges

with it."

I stopped him talking at this point as reporter Hugh Saker opened the door and beckoned me outside. He told me the police had found the body of a girl at Gravesend and that police were on their way from Snow Hill station. The dead girl was Lilian Edmeades. Saker came into the room with me and Dean went off to organise pictures

I offered Sims a cigarette which he declined.

"I've been on a diet," he said. "I must have something to eat." He pulled an apple from his pocket and started munching.

I asked him what he did after the murders.

"I stayed at home," he said.
"But I could not sleep. My
mother saw I was worried. This
morning I went to work, taking
the parcel and the handbag with
me. I couldn't work so I
knocked off and came up here.
I have had the idea of murder
for some time and I have walked
around thinking about it. I have
had the gun about four years
now."

He was beginning to become restless. He continually moved his feet under the chair and beads of sweat still glistened on his face. I asked if there was anything more he would like to tell me.

"Last night," he said, "I walked around and I saw this young couple walking up the canal path. I told them to lay face down on the path and put

their hands behind their backs and I tied their wrists up with strong twine. Then I made them stand up and walk along the canal path. We cut across the marshes under the sea wall. I made them lay face down and tied their ankles to their . ."

I stopped writing because Detective Inspector Lloyd and Detective Sergeant Newdick entered the room. But as they came in Sims finished his story "...hands and then I strangled the man, then the girl."

Later that evening the body of Malcolm Johnson was found and Sims was charged with

On 29th November, 1961, Sims was found not guilty of capital murder but guilty of manslaughter "by reason of diminished responsibility". He was sentenced to 21 years' imprisonment.

#### GIN

TO work in a gin distillery might seem an ideal job, but the product is not available to employees for unlimited sampling! Apart from the obvious reasons, it is far too expensive for that, thanks to prohibitive excise duties.

Yet that is not to say that a gin distillery is not a very pleasant place to work in: it is, if it is as modern as the Red Lion Distillery, in Britton Street, E.C.1, close to Bart's.

This distillery was opened in 1959 to replace the ancient one of the same name in Turnmill Street which was badly bombed during the Blitz.

The daily routine at our distillery goes like this. The stills are filled in the morning with pure grain spirit—we use none other—and into the "flavouring stills" go the precise quantities of juniper and coriander seeds, essential ingredients of gin, that are required, plus the certain special ingredients which are the secret formula of Booth's. Each gin company has



Part of the still-room at the Red Lion Distillery.

its own differing formulae.

No flavouring goes into the "rectifying stills". The stills are then padlocked by the officer of H.M. Customs and Excise, for, while all the spirit is fully duty-paid, the distillery is under rigid Customs control.

In the base of the stills are coils of pipe which are steam-heated. The process of redistillation then commences. Each "flavouring still" in use is linked to a "rectifying still" in such a way that eventually flavoured and unflavoured rectified (re-distilled) spirit are mixed. This is gin.

At the commencement of redistillation, however, spirit too pungent ("heads") to be palatable comes from the condensers and this ("feints") is not directed into the gin receiving tanks but goes into separate tanks. The same happens with the weak spirit coming through at the end of the day's run through the stills (the "tails"). These "heads" and "tails" will subsequently be rectified again. It is only the "middle cut", the central best section of the day's distillation, that becomes gin.

The art of the gin distiller rests largely on knowing what part of the day's "run" shall become gin and what shall be put aside for further rectification. It is on rare gifts of the sensory organs that the quality of gin ultimately rests, which is why there are so few really fine gins; that, plus experience and traditions proudly maintained.

When the gin has been blended in huge tanks, much of it is placed in oak casks. We are the only firm to employ this costly process which produces the pale golden gin that is peculiarly "Booth's". Scientifically speaking, gin should gain nothing from resting in wood, and this shows the difference between theory and practice, because this unique process does mellow the gin, giving it special

smoothness. Our distillery also produces, to a different formula, "High & Dry", a clear gin of exceptional "dryness". This does not go into casks but into steel drums.

At this stage the gin is about double the strength at which it will be bottled. In casks or drums, it is taken to our bonded warehouses and bottling plant at Brentford, where "Booth's" will be stored for mellowing.

Meanwhile, in the laboratory of the distillery samples of the day's distillations are carefully tested and then stored for future reference. Here, also, tests — both scientific and by taste—are carried out on samples sent in from our eleven overseas distilleries where "High & Dry" is distilled. No overseas "High & Dry" may be released until it has passed rigorous quality control in London.

#### **TOBACCO**

NOT so long ago the manufacture of tobacco goods was one of the main industries of what one may roughly describe as Central London. Now, within the comparatively short space of a few post-war years, most of the bigger manufacturers have moved out.

But we are still within a stone's-throw of Holborn Hill where the original John Lloyd established his tobacco business as far back as the year 1785. That site, incidentally, was required for the building of Holborn Viaduct in 1866. Then by moving along to Holborn Bars, Lloyd's became the first house to manufacture tobacco actually within the "City Walls".

Business expansion called for another move to the present site in 1900. If you now follow your nose around the E.C.1 postal district — and this is quite literally true because of the fragrant scent in the air—you can scarcely fail to find yourself outside the home of Old Holborn.

The home of Old Holborn

was not, of course, always associated with this now predominantly popular and successful line. When the production of beer gave way to that of tobacco in Clerkenwell Road some sixtytwo years ago nobody had ever even thought of, much less heard of, Old Holborn.

Those were the days of pipes and cigars, with cigarettes still only a junior partner in the smoking business — and definitely either machine-made or expertly hand-made cigarettes at that. The individual hand-rolling of cigarettes which now accounts to such a great extent for the outstanding sales of *Old Holborn* was very much a thing of the future.

We were primarily concerned with manufacturing pipe tobaccos in those days. There were several brands, some of which for one reason or another enjoyed purely localised sales. One was a great favourite with the herring fishing fleet, and extra supplies had to be rushed at short notice to Lowestoft, Aberdeen, Fleetwood or wherever the fleet might put into port!

Then, shortly after their move to Clerkenwell, Lloyd's brought out that sturdy old veteran Bondman which over the intervening years has proved such a steady seller among purely pipe tobaccos. Later came Skipper, a navy cut flake, to support such time-honoured shag tobaccos as Showboat and dear old Magpie. Finally, in the thirties, came Old Holborn.

A mixed shag, primarily marketed loose in and around its native London from 1 lb. tins, Old Holborn did not by all accounts promise at first to be anything like such a big seller as it has since proved. It now enjoys nation-wide distribution and, if not seen so much in the North as in the South, this is only because the proportion of roll-your-owners is appreciably higher in the South.

The processing and manufac-

ture of Old Holborn are much the same in the initial stages as for other types of tobacco. For the benefit of lay men who may be unfamiliar with the procedure, its various stages may be summarised as follows: 1. Vacuumising (airing out and steam-pre-conditioning to make the leaf supple), 2. Rumbling (conditioning), 3. Pooling Types of Tobacco, 4. Blending, 5. Liquoring and Flavouring, 6. Filler Passing, 7. Cutting, 8. Panning and Cooling and 9. Packing.

Probably the main reason for Old Holborn's popularity with roll-vour-owners is the enormous amount of time and trouble devoted to quality-in particular the ridding it of that bugbear "stem". In a pipe smoking tobacco or even in a machine-made cigarette the intrusion of an odd sliver of socalled "wood" coming literally from the stem of the tobacco leaf may well be tolerated, if not actually overlooked, but to the roll-your-owner it is an unpardonable intrusion, hindering the smoothness and compactness of his rolling.

#### DIAMONDS

HATTON GARDEN has always been the centre of the cut and polished gem trade in this country. Gems are sold in the Diamond Bourse and the Diamond Club which-like the Stock Exchange-are also clubs to which members are elected. Cut gems, which may be bought from all over the world, are often carried around by dealers in little leather pouches or in "briefkers" - folders of waxy tissue paper in different colours for different gems, diamonds always being displayed against white paper.

Dealers buy the uncut or "rough" gems from bigger dealers, who in turn buy from The Diamond Trading Company, which is part of De Beers' Central Selling Organisation at



Above: Sawing a diamond. Right: Polishing the facet of a diamond.

2 Charterhouse Street. Sales, or "sights" of uncut diamonds are held there every month and dealers and manufacturers, having aspplied for quantities of different sizes, shapes, colours and qualities of stones, are offered parcels as nearly as possible according to their requirements. Buyers then either accept or reject the "sight" outright, though the latter is very rare.

The Central Selling Organisation, which markets - principally in London-80 per cent of the world's diamond production, sells at fixed prices agreed between producers and sellers, and periodically reviewed. This system of price stability protects the whole diamond industry and trade - the mining companies, individual diggers, governments substantially dependent on diamond exports for earnings of foreign exchange, the cutting industry and traders, and indeed all owners of diamond jewellery. It is a system which is particularly appropriate to a luxury article, and has worked well for many years. It owes its existence firstly to Cecil Rhodes and then to the late Sir Ernest Oppenheimer.

The diamonds arriving in London are sorted in The Dia-

mond Trading Company's office under a north light; artificial light is never used. Diamonds are weighed in carats (there are 142 carats to the ounce), and are sorted according to four criteria, size, shape, colour and freedom from imperfections. Colours, which may range from yellow and brown to the very rare greens, pinks and blues usually lessen the stone's value, unless of a particular rarity. Small unbroken stones under 1 carat are known as "melee" and broken and blocky pieces as "cleavages". The larger stones, i.e. those 15 carats and above, which are becoming progressively rarer, are valued individually.

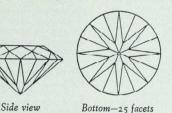
When the buyer has bought his "sight" he will then either cut the stones himself or re-sell them. The main cutting centres of the world are Belgium, Israel, U.S.A., W. Germany, South Africa, Netherlands, France and the U.K. About half the 150 or so workers in this country work in and around Hatton Garden in two cutting factories.

The characteristic shape of a rough stone is an octahedron, like two four-sided pyramids joined base-to-base, which is sawn in two. The "brilliant"



cut, the most popular, was developed to take this shape into account and looks like an inverted pyramid. This involves cutting and polishing the diamond with exact angles to its facets and depth so that the maximum light is reflected. The rough stone is sawn with a very thin circular saw on which diamond dust and oil is sprayed. As the wheel cuts into the stone the resultant dust serves to cut further, but up to one-half of the rough stone's weight may be lost in the sawing and in the polishing of the facets, 58 in all, on a "brilliant", a "marquise"

or pointed-oval shape and a rectangular "emerald" cut. Odd-shaped stones may have a natural cleavage line and can be separated in two by a sharp tap at exactly the right place, but nowadays sawing is more common. The final polishing is done by holding the diamond against a revolving cast-iron wheel coated with diamond dust and oil. Most diamonds are finally set in engagement rings, and whether they cost £15 or £15,000, they will, if cared for, always remain beautiful because, as you know, "A Diamond is Forever".



#### BEER

Top-33 facets

of a brewer," said Mr. Shardlow, Second Brewer at Whitbread's, "are observation, an inquiring mind, attention to detail, and the ability to get on with, and control, other people." But beyond this, he pointed out, the trend in brewing today is towards academic qualifications. He can foresee the day when a degree will be almost essential to anybody considering brewing as a career.

Mr. Shardlow explained that under the pupilage system in the brewery trade, a pupil is placed under the guidance and instruction of a Head Brewer. At first he may do every job in the Brewery, from cleaning the fermenting vessels to shovelling grain. But in return the Brewer will impart to his pupil his accumulated knowledge and experience of how the malt, water

—always referred to in the brewery as liquor—hops, sugar and yeast are transformed into different beers.

Following a year at the Retford Brewery, Worksop, Mr. Shardlow spent two years at Birmingham University, taking a diploma course in Brewing and Malting. After eleven years with the company, his present job "tends to be administrative, directing the efforts of the Brewing Room, and looking after whatever needs looking after". He works office hours-which may have to be stretched when occasion demands. But as brewing is a round-the-clock process, one of the six shift brewers at Chiswell Street is on duty day and night.

Mr. Shardlow has special responsibility in three departments of the Brewery.

Milling-Malt is barley which

has been allowed to germinate, then at a critical stage the germination is stopped, by heating the grain, which is then cracked to allow the liquor to get at it.

Mashing — Mixing the malt and hot liquor to produce "sweet wort".

And Fermentation—By this stage sugar and hops—for flavour—have been added to the "sweet wort", to produce what is known as a "hopped wort". Yeast is then added to this to bring about fermentation.

Another of his responsibilities is stock control—making sure that the right amounts of the rights beers are available all the time and he also arranges which yeast is to be "pitched" (used) during the current day.

Daily, Mr. Shardlow inspects part of the Brewery with the Head Brewer, and they test and sample the beers currently available. A responsive palate and a good eye for the appearance of beer are all part of the brewer's inh

Besides the normal administration of the Brewery, Mr. Shardlow attends two committees a week. One is the Brewing Sub-committee, where brewers, bottling store technicians and chemists discuss brewing policy. The second committee gives the key to the very heart of Mr. Shardlow's job. It discusses the behaviour of the yeast being used.

Yeast is a living thing and an important part of the brewer's task is to take into account the variable behaviour of the yeast. Malt, too, is variable. Perhaps it is for this reason that one talks of the Brewer's Art, rather than the Science of Brewing.

Mr. Shardlow sums it up like this: "Our job is absorbing and interesting because it involves a living process which cannot be predicted. No two brews are exactly alike. Our job is to spot these variations and to cnsure that the beer sold is always consistent."

SPECIAL DEPARTMENTS. VI.

#### DEPARTMENT OF THORACIC SURGERY

by O. S. Tubbs

THORACIC SURGERY is a relatively new specialty. Prior to 1930 operative treatment for diseases of the chest was limited almost entirely to patients suffering from wounds or pleural suppuration. During the next decade resection of lung tissue became an established practical procedure and Bart's got away with a flying start due to the pioneer work of the late Mr. J. E. H. Roberts, who had returned from the 1914-18 war with a large experience of the management of war injuries of the chest. During the first half of this period Mr. Roberts had the stimulating support of the late Mr. H. P. Nelson, a brilliant New Zealand surgeon, who was Chief Assistant to the "Green Firm" and who was appointed Thoracic Surgeon to the London Hospital in 1935, this being the first occasion on which a Thoracic Surgeon was appointed to a London Teaching Hospital. Before this all chest surgery was performed by general surgeons. Alas, Mr. Nelson died tragically the same year from

When war broke out in 1939 Thoracic Surgical Units were formed throughout the United Kingdom and the staff of Bart's was made responsible for developing one of these units at Hill End Hospital where the work continued for twenty-one years. During this period surgery of the heart developed not gradually but in sudden bursts, each spurt forward being dictated by the discovery that yet another cardiovascular lesion was amenable to surgical relief. Bart's may reasonably claim a share in this progress, for the successful closure of a persistent ductus arteriosus in December, 1939, was the first case operated on in

During the last ten years "Open Heart Surgery "-that is, surgery on the valves of the heart or within the chambers of the heart under direct vision-has progressively developed and such "open operations" are now carried out twice a week at Bart's. In April, 1962, the Thoracic Surgical Unit moved at last from Hill End to the third floor (Vicary Ward) of the new Queen Elizabeth II block. This sumptuous ward includes 4 rooms each with 4 beds, 4 single rooms and a ward of 10 beds, making a total of 30 beds. In practice one of the four-bedded rooms is used for patients requiring intensive nursing care: all patients (male and female) who have a major chest operation are received into this room and are retained there until they no longer require constant attention. This allows the concentration of skilled nurses and of apparatus required for the care of seriously ill patients and lessens the disturbance to patients who have progressed further in their convalescence.

Clinical Work

Surgery of the lung is chiefly concerned with the diagnosis and treatment of malignant disease, for lung abscess and bronchiectasis have become relatively rare conditions and effective drug therapy of tuberculosis has almost excluded the need for surgical treatment in this disease. In contrast the incidence of bronchial carcinoma continues to rise so that at the present time one out of every four deaths from malignant disease in England and Wales is due to cancer of the respiratory organs. Consequently there is a fairly heavy demand on beds in Vicary Ward for treatment of patients suffering from bronchial carcinoma. Although only about one third of the patients so afflicted are amenable to surgical resection the results of resection are less gloomy than is generally supposed, for approximately one third of the patients treated by resection are alive and free of evidence of recurrence at the end of five

Infection of the plcural cavity is much less frequent than it was before the last war and drainage operations for empyema are not often performed: if a plcural effusion fails to resolve with medical treatment resection of the empyema cavity ("decortication") after control of the infection is often preferable to drainage. Vicary Ward also receives a few patients suffering from diseases of the oesophagus or from hiatus hernia.

However, by far the greatest demand for beds is for patients with lesions of the heart or intrathoracic vessels which require surgical correction. On average about two-thirds of the beds are occupied by such patients. Cardiovascular surgery is a stimulating and exciting subject for it continues to advance at a rapid pace and consequently it should appeal to the young surgeon who has stamina and determination.

It is interesting to contemplate the clearance of each hurdle in this specialty, starting with closure of the persistent ductus (1938), followed by resection of aortic coarctation (1944), then the palliation of symptoms associated with Fallot's tetralogy by anastomosing a systemic vessel to the pulmonary artery (1945), followed by the successful relief of mitral stenosis (1948), of pulmonary stenosis (1948) and of aortic stenosis (1950). The first successful suture of an atrial septal defect occurred in 1948 (by a closed method). In 1952 "conventional hypothermia" (cooling the patient

to 30°C.) was first used to operate under vision within the heart—to repair an atrial septal defect. In 1953 the function of the heart and lungs was taken over for the first time by a heart-lung machine while an atrial septal defect was closed. Since this time a machine of this type has been used to permit the surgical correction of more and more complicated cardiac abnormalities. In 1959 Mr. Charles Drew of the Westminster Hospital described a ethod of cooling the patient to 12°C., using the patient's own lungs as the oxygenator.\* And now there is a great flush of enthusiasm for replaying irreparably damaged valves by a prosthesis or, in the case of the aortic valve, by a homograft. At Bart's the first operation for replacing an aortic valve by a prosthesis was carried out in October this year and the patient's progress at the time of writing continues to be satisfactory.

Clearly, successful cardiac surgery depends very greatly on accurate diagnosis and shrewd assessment as to the suitability of the patient for surgical treatment. With the able and enthusiastic co-operation of the Radiologist, Dr. G. Simon, this is carried out by the Staff of the Department of Cardiology who meet with their surgical colleagues for a couple of hours every Saturday at 9 a.m. Visiting doctors are always welcome at these meetings.

Success in Thoracic Surgery cannot be achieved without the highest standard of anaesthesia. Fortunately, at Bart's this is always willingly provided. In particular, in those patients submitted to open heart surgery, Dr. T. B. Boulton has accepted the responsibility not only for the anaes thesia but also, in collaboration with Mr. R. L. Hurt, for the running of the machinery used for perfusion. In addition he and the assistants in the Department of Anaesthesia are constantly available for advice on the management of any patient who is maintained on an artificial respirator following operation. There is usually at least one such case in the ward.

Thoracic operations are performed on all week days except Wednesday and Saturday and clinical students in their second or third year are welcome to atend these sessions.

Out-patients are seen on Monday afternoons (Mr. I M. Hill) and Wednesday mornings (Mr. O. S. Tubbs). In view of the great variety of physical signs demonstrable in the patients who attend the clinics, it is unfortunate that these patients are not used for undergraduate teaching.

[\* See R. L. Hurt's article in the Supplement of the St. Bartholomew's Hospital Journal, October, 1963.] Teaching

At present each student comes for one ward round lasting two hours during his second year of clinical work. In addition the students doing the Preliminary Course at the start of their clinical years come to Vicary Ward for one session for the demonstration of physical signs. This lamentably small amount of teaching is a hang-over from the days when the Thoracic Surgical Unit was accommodated at Hill End. The Dean now has plans to integrate the special departments into the teaching programme.

#### Research

In a subject which is changing so much there is obviously an almost unlimited field for research. At present Mr. R. L. Hurt is working on the peripheral vascular resistance during hypothermia and Dr. Josephine Cook from the Department of Haematology is studying the blood changes which occur during extracorporeal perfusion. Recently money has been made available for a major research project on valve replacement and for problems associated with perfusion and hypothermia. Now the difficulty is to find the workers to carry out the research.

Opportunities in Thoracic Surgery

As Thoracic Surgery has only developed during the last thirty years it is natural that Consultants working in this specialty are on average younger than those working in most other subjects and consequently few vacancies have occurred due to retirement. Thus, during the last ten years, there have been a number of highly competent Senior Registrars ready for Consultant appointment who have been kept waiting unduly long before obtaining promotion. This situation should be remedied in the near future for there are a number of Consultants in Thoracic Surgery approaching the age of retirement and the prospects for a man of quality starting in a Senior Registrar post at the present time should be excellent, but there are very few suitable applicants for such posts, presumably because the younger men have seen the plight of those long delayed before gaining promotion. Now is the time to step on the ladder of Thoracic Surgery.

Staffing

The present staff of the Department consists of two part-time Consultants (Mr. O. S. Tubbs and Mr. I. M. Hill), one Research Assistant (Mr. R. L. Hurt), one Senior Registrar (post vacant), one Junior Registrar (a College appointment which provides rotation with other Departments every three months) and two House Surgeons (one of whom may be pre-registration).

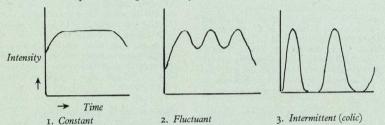
#### ANTI-COLIC by Joe C. Smith

The Shorter O.E.D. defines colic as "severe paroxysmal griping pains in the belly, due to affections of the bowel or other parts" derived from "the colike . . . ingendreth in a gutte named colon". By common usage the term is applied to an intermittent pain in the abdomen.

Truly intermittent abdominal pain in which the patient is free of pain between the paroxysms is characteristic of intestinal pain especially that associated with obstruction of the bowel. This is real colic.

Unfortunately the term colic is also applied to pain arising in the biliary and renal tracts especially that pain associated with a stone in the lumen of the common bile duct or ureter. The pain experienced in these conditions is very rarely intermittent in nature and is probably caused by distention of the viscus rather than by ischaemia of the muscular wall in spasm. It is difficult to imagine the minute amount of smooth muscle in the wall of the common duct contributing much to the severe pain of biliary col . . . sorry, bile duct pain.

Pain can be represented diagrammatically as follows—



In a recently published series of fifty cases of biliary pain and fifty cases of renal pain, in only one case (of biliary pain) was the pain similar to the third type in the diagram!

The term colic is used by members of the lay public (patients) to describe any severe

abdominal pain. It is easy to imagine the following scenes taking place.

Patient. I've got a pain in my belly.
Student. What sort of a pain is it?
Patient. It's a colicky pain.

Student. (writing). Ah . . . a colicky pain.

Scene 2 (later).

Consultant. What is this patient's complaint?

Student. He has abdominal pain, Sir.

What sort of a pain is it?

Student. A colicky pain, Sir.

Consultant. What does he mean by that?

Student. He means the pain is . . . er . . . colicky.

It is apparent that in the above example the use of the word colic has prevented further thought on the part of the student about the nature of his patient's pain. If he had to avoid the use of the word colic he might have enquired more deeply into the mode of onset, the exact type and duration and the mode of cessation of the pain.

I submit therefore that the terms biliary colic and renal (or ureteric) colic are inaccurate and misleading and would be better not used at all. They are however deeply ingrained in medical terminology and will be very hard to oust. New terms will have to be coined that are not only accurate but are sufficiently striking to gain general acceptance. Biliary pain and ureteric pain sound too mundane to be elevated to the heights of a medical diagnosis.

Perhaps some erudite reader will come forward with a pair of acceptable names?

#### CONSULTANTS' PAGE

Reflections of a retiring Sub-Dean

by H. Wykeham Balme

THE Royal Hospital of Saint Bartholomew, with its associated Medical College, ought to be a really powerful and important force in the civilised world. Medicine, as a result of the magnificent technological advances in recent decades, is now at last able to offer genuine benefits to diseased and injured people. Power like this brings its own responsibilities, and revered institutions like ours are looked to to provide the statesmen to wield it.

Our seniors have not done us very well in this respect in the past, for they have allowed a sad decline to occur in the status of the doctor at the very time when his ability to promote the health and welfare of mankind is rising faster than ever. The Royal Society no longer admits prominent doctors to its Fellowship unless they are primarily scientists; knighthoods, baronetcies and peerages are conferred upon doctors more because of the social importance of their patients or the political value of the committees they preside over than because of their own distinction in their own fields; the ordinary run of consultants and specialists do not count for much and are hard pressed to send their sons to reasonable schools; and general practitioners, if they do not watch their step, rank somewhere below the family butcher and above the retail tobacconist, despite their self sacrificing acceptance of the need for doing evening surgeries for the sake of the working community.

We now need to train men so that they not only know their subject well and are good doctors, but so that they will also be able to practise their profession with pride, be of rounded and respected judgement, and be able to insist, from a position of strength, on being properly appreciated for the work they do. Strength of character, with a Bostik-like adherence to the correct principles and ordinancies of his vocation, is as necessary to today's young doctor as an ability to grapple successively with the laws of physics, the formulae of biochemistry, and the management of the breech presentation. He needs, to put it pedantically, to be a difficult man to push around.

Horace, in an Ode, recorded that the Younger Generation was Going to the Dogs, and there is a perpetual disagreement over the comparison of today's students with yesterday's. They ought to be better, if the technique of selecting them is efficient, but unfortunately this is a task that is inherently most difficult. It is made even more so by the medical schools themselves, who, in competition with each other for the future Gees and Pagets, interview applicants ever earlier and now bring up schoolboys of sixteen to have their life potentialities assessed. Fortunately, Medicine is not difficult and the vast majority of students get by with plenty to spare.

What they have to spare is rightly put into energetic pursuits outside the walls of the hospital, especially after the marathon of the second M.B. has been safely run. Some pursue intellectual activities and some women, but for the pursuit of the ruggedness of character that is so important for a future doctor one feels that the in-fighting of rugby football has not undeservedly won its place in the extra-curricular curriculum.

The curriculum itself aims at producing a totipotent graduate, uncommitted as to how he will develop, ready for postgraduate training, able to work out his own future but conscious of where to look for help and guidance when in doubt. About a third of the graduates finally go into general practice, and there is at last rather more in the way of guidance and special training for them than there used to be.

The speed of change in Medicine is so great that students must be trained to continue learning after leaving Hospital and to think clearly enough to distinguish between sense and nonsense in the journals they read, the consultants they speak to, the post-graduate courses they attend, the colleagues with whom they talk shop and the television programmes they have to endure later on. Those who were hard crammed to "A" Level at school, with organised hours for preparation or homework, must learn to work on their own when they first come here, and the Big Brother attitude that is present in

the pre-clinical departments is necessary for this reason. On the clinical side they are much less closely supervised—so much less so that the majority of their teachers find great difficulty in even knowing their names (especially since name badges were voted so thalamically out) let alone their ability. Of their Students' Union activities still less is usually known, and though perhaps this is just as well in many ways, I feel

myself it is rather a pity.

Nonetheless this attitude of freedom encourages the great majority, who have plenty of good sense, to make their own adult way in the clinical side; and when they get out to Regional Board Hospitals during their last year, and have to fend for themselves, they strikingly benefit very greatly from learning from patients rather than from professors. The not so sensible bite the dust, but are picked up by the Medical and Surgical Tutors. Some of these failures are plain unlucky in examinations, and a few are just dull, but some I fear have clearly been bone idle, either from stupidity or from conceit. These ones I do not admire very much, for whether or not they have been in receipt of grants, they have just as surely been paid by the taxpayer to learn the art of medicine as I am being paid by him to practice it. I fully agree with the principle that their grants should thereupon cease, just as I should demand my money back from the shop if I bought a radio from it that did not work.

Some of the students marry quite early, and I think (pace the Vicar of Leeds) that this can be quite a good thing, though I am not so sure about the women. One does not race a horse that is being used for breeding. The women students themselves are of decorative value, and it is quite nice to have them about, though it is a pity that such a disappointingly low proportion of them ever settle permanently into full time practice; but presumably the same applies in other faculties also. I think they help a bit by improving the manners and social graces of the men and it is very sad when the odd ones choose to go beatnik. Mostly, however, they get over this stage in Charterhouse

and induce their boy-friends to act with more decorum too.

I wish though, we could persuade them to be more punctual! The commonest cause of this maddening unpunctuality is conceit, the student thinking himself above his peers, and the next is immaturity, a revolt against school discipline still remaining long after it ought to have settled down; it argues a basic inefficiency that is not a good thing in a future doctor, and it can only persist as a habit if the perpetrator is quite unconcerned

by the fact that he is being extremely rude.

Of the manners of the students in general, however, there can be little cause for complaint. My impression is that they are every bit as courteous as their predecessors, and that their ethical standards are higher. We are not renowned as a great scientific school, but we have a reputation for good doctoring that our present generations of students will undoubtedly uphold, and probably enhance. It is my guess that the Royal Hospital is in the process of actually becoming the important force in the world that it ought to be, and though I am now resigning from my post as a rather retiring sort of Sub-Dean, I do not feel in any way that I am retiring with a feeling of saddened resignation.

#### WATCH-HOUSE IN GILTSPUR STREET

by Nelly J. M. Kerling

Some time ago one of the evening newspapers carried an article on the new vicarage of St. Scpulchre outside Newgate in Giltspur Street, which is called the Watch-House, and was originally built in 1791. Badly damaged during the bombing in 1941, it has only recently been restored and turned into a house for the church's new vicar. The editor of the newspaper, obviously intrigued by the name of the house and wondering what or who was being watched, found an answer to his queries in a short history of the parish of St. Sepulchre, a copy of which can be seen in the church. According to this book the Watch-House was built to prevent bodies from being taken away from the churchyard for dissection by surgeons and students of St. Bartholomew's Hospital and others. This is a gruesome story which may well have fired the imagination of the editor's readers, but which raises some doubts in the minds of those who know something about the history of the City of London.

It is important that there was already a Watch-House near the church of St. Sepulchre before 1791. In 1720 John Strype published an enlarged edition of John Stow's 16th-century survey of the cities of London and Westminster in which he says when talking about the parish church of St. Sepulchre: "there is a Watch-House built by consent of the Diocesan and Vicar, at the instance of the Parish, at the South-east corner of the churchyard, on Snow Hill." This Watch-House, which must have been near the present Holborn Viaduct, was most likely used by the City watchmen who, from about the middle of the 13th century, were appointed to carry out the nightly watches in the wards of the City. By the end of the 18th century Skinner Street was planned, leading from Giltspur Street to Farringdon Street on the line of the later Holborn Viaduct, to enable the traffic to avoid the steep ascent of Snow Hill. (This street was removed when Holborn Viaduct was built in 1867.) It is possible that the old Watch-House had to be pulled down to make room for this new scheme for, in 1791, a new Watch-House was built not on Snow Hill but on the North-east side of the church facing Giltspur Street.

For some years the old watchmen must have continued to use this Watch-House of 1791, but when the new police force was organised by Sir Robert Peel in 1829, the system of City watchmen came to an end. Yet the Watch-House was probably also occupied by the new police, for it is not until 1890 that it is first mentioned in the London Directory of that year as a dwellinghouse for the sexton Henry Hart, who lived there until 1893, when he was succeeded by the sexton Daniel Lovett.

Though this Watch-House of 1791 was certainly not built to prevent the stealing of bodies from the churchyard, it is not impossible that the watchmen or the police occasionally arrested "body snatchers" who had stolen a recently-buried body, hoping to sell it to someone interested in anatomical research. When, however, in 1832 the Anatomy Bill was passed, which brought better regulations, this unpleasant trade disappeared. The official records of this Hospital do not mention the subject. One can, of course, argue that some things are better not written down, though if there had been some official trouble because of arrests made by the Watch-House police, the Governors would have taken action and some evidence would have appeared in the detailed minutes of the Journals. It seems much more likely that the Medical School was supplied with bodies of criminals and that any surgeons or students dealing with "body snatchers" did this as private people and not as members of the staff of this Hospital at a time when John Abernethy was the leading surgeon.

#### MEDICINE AND OXFAM

by A Special Correspondent

The second of two articles about Oxfam.

Oxfam has expanded in scope and organization since its small beginnings in 1942. Primarily an emergency fund-raising body, it has naturally always been concerned with the medical supplies rushed to the scene of earthquake or flood. Nowadays it can devote its funds to non-emergency undertakings. Of a total of £155,739 coming under the heading of "Medical Aid", in the last financial year, half went to the sup port of individual hospitals and half to other medical projects, some of which, like the African and Medical Research Foundation with their mobile clinics in Kenya and Tanganyika, have abandoned a policy of hospitalization. As might be expected, Africa received the lion's share—£86,650 in comparison with India's £35,601. The balance of medical aid—£11,236—is shown in the grants list of the Overseas Aid Department opposite the Near East.

Oxfam's chief contribution to Medicine in backward countries is its ability to assume the burden of the field-worker's financial worries. No doctor can be expected to divide his attention efficiently between his clinic and his next supply of vaccines. White man's magic is, happily, a co-operative affair at its best, a powerful chain can be forged linking the fund-raising body to the man on the job either directly or through a medical conference.

Oxfam's connections with established medical organizations have a wider significance than the practical one of transferring supplies and funds from one spot to another. A Famine Relief officer has experience in facing the most hopeless cases of need. Even if he cannot yet draw up blueprints for solving the problem of unrelieved suffering, he does consider it with a cool head. And he can take advice. The British Leprosy Relief Association's good offices, for instance, have ensured a continuity for some time in Oxfam's work for leprosy victims. Consultation and the vetting of schemes by experts means that money is spent with more confidence.

St. B.H.J., December, 1963

On the practical level, an organization like Oxfam can supply the deficiencies that are endemic in operations in under developed countries. Housing for staff, kitchen facilities, and costs for poor patients without the support of a welfare state are examples of the necessities which Oxfam funds have provided. The provision of food both for in-patients and out-patients is a constant headache. To find no improvement in the condition of patients because their diet is grossly in-adequate is discouraging. From the Campbell Hospital of the Church of South India comes an appreciation of an Oxfam grant: "The contrast, now that we are able to give more free food, is striking. The fact that more of our poorer patients are now well-fed is also a factor in improving morale throughout the hospital".

Among individual grants of money made last year by Oxfam to specifically medical projects were: £4,100 for the cost of food distribution to 6,000 leprosy sufferers in Sierra Leone, £10,000 to the Flying Doctor Service of Africa, £3,500 to help finance, over a period of three years, a mobile eye-clinic in Aden under the Royal Commonwealth Society for the Blind.

It may augur well for the future co-operation between Medicine and Oxfam, that medical aid grants for the first half of the current year are 50 per cent. higher than those for the same period last year. £106,670, the figure in question, is not to be sniffed

#### UP TO THE MINUTE, IN A MOMENT

Bringing wet, winter weather, the November winds stripped bare the plain trees round the fountain. In the first two or three chilly-fresh days of the month it was somehow depressing to see the trappings of Christmas commercialism being erected in Oxford Street.

On 3rd November, Sir Alec Douglas-Home's three children followed a trend and renounced their titles: on the following day the Cambridge Union announced the admittance of women after a majority vote by the men. Most odd, no doubt given another decade or two, they will find themselves in the Pitt Club. On 16th November, Ian Fleming sued the Daily Sketch for publishing the penultimate chapter of his next book; doubtless that newspaper did put an idea into some people's heads.

November was a good month for the byclection pundits. On the 8th the Conservatives held Kinross and on the 7th and 21st the Socialists won Luton and held Dundee. The Tory percentage of the poll dropped by 15.6, 10.8 and 8.8 respectively in the three elections no wonder the pundits are always right! From the day of Kinross Sir Alec and his men started ralking big and promising bigger about a dozen and one hot issues. At the same time it became increasingly clear that the Unions, ever an embarrassing handicap to constructive socialism, will force **Mr. Harold Wilson** into making a stand against the independent nuclear deterrent. Even now this just might lose them the next General Election.

On 21st November President John F. Kennedy went on a peace mission to Dallas, Texas, on the 22nd he was assassinated on a sunny afternoon in Dallas and on the 25th Mrs. Jacqueline Kennedy and the world buried him in the National Cemetery, Washington.

It was on the 9th and 14th of November that Mr. Timothy MacElwain did a double by downing a yard of ale in a world record of 9.5 seconds and becoming Chairman of the Students' Union all in one week.

Mr. William Garson, captain of the Boat Club, tells your sporting correspondent that the Club has recently matched its rowing successes with a first-class dinner which was presided over by Professor E. F. Scowen. The dinner, falling on the same night as the Nursery Productions (report in next issue), was very well attended, the food and wine were good and members of the Club were obviously very pleased that Professor L. P. Garrod was able to come to propose a toast to the Club. At the United Hospitals' Regatta on 20th November, two days before the dinner, the Club was able to enter four Novice IVs, one of which was subsequently stroked to victory by Mr. J. S. Lilleyman.

The Rugby Club finished the Cornish tour (report page 396) by defeating R.N.C. 16-0. After this they had a bad run for two or three games and several controversial changes were vindicated by the 23-0 win over U.S. Chatham, a strong side. The Club's "B" XV, captained by **Mr. Richard Atkinson**, has had six consecutive wins: before that it had won only a game in three seasons.

The Men's Hockey Club seems to be breaking even on goals as well as matches. Mr. Partick Kingsley has scored three-quarters of the home goals. Messrs. Ian Pect and Andy Barclay have been playing well consistently and the team was unfortunate to lose a close 1-2 to St. Thomas's Hospital in the first round of the Hospitals' Cup, their winning goal striking the top right-hand corner of the net.

STOP PRESS—The 30th November was a victorious day for Bart's first teams; the Men's Hockey won 1-0, the Soccer team 6-0 and the 1st XV beat Woodford 16-0.

B.O.A.C. resignations being quite the form, it was only fitting that the opposition should call for **Mr. Amery's** in the Commons, late on the evening of 2nd December.

3rd December.

#### **NEW PENGUIN BOOKS**

The Moon and Bonfires: Cesare Pavese. 3s. 6d.
The Gold Rimmed Spectacles: Giorgio Bassani. 3s.
Memoirs of a Dutiful Daughter: Simone de Beauvoir.

Iron in the Soul: Jean Paul Satre, 4s, 6d.

This quartet from Penguins has mixed origins and graces; two are translations of modern Italian novels, the third is a part of Satre's trilogy on Freedom, and the last is another retrospective catharsis of Simone de Beauvoir's. Giorgio Bassani, a contemporary Italian novelist, justly renowned in his country as Author and Prizewinner, is well translated in *The Gold Rimmed Spectacles*. This is a bitter little story about an ageing Dr. Fadigati, known among the townspeople as a homosexual. He is accepted as such, but this acceptance does not involve tolerance, and when inevitably there is public humiliation, suicide is the only escape allowed him in his pathetic misery. The description of this agonising figure is done in a detached way by a Jew, who is also exposed to public distaste. Jew and homosexual—they form an incongruous, justly bitter pair who realise that acceptance is very far from tolerance, and that the seeds of destiny make each as he is, in this human bondage. It is a fatalistic theme which carries depressing over-tones, but one which is perhaps a lesson in charity.

a lesson in cliently.

Cesare Pavese, often linked with Moravia, was originally employed as a translator of the English Classics. It is some form of justice, after his tragic suicide, that he should in turn be presented to the English. The Moon and Bonfires is not his best novel, but it is no less a valuable contribution to Modern Italian Literature. It is the story of one of Italy's many prodigal children, who has returned after twenty years in America. He sees the land and the peasants in a new perspective, and comes to understand the meaning of their existence squeezed with blood and sweat from an improvident Nature. This is no bucolic farce like Clochmerle; Pavese sees nothing in the dignity of manual labour, no noble savage, only the strife that must needs be the lot of the improverished Italian peasant. Again the seeds of destiny militate against the future. Hope is a species of happiness—there is

none here.

There is little that remains undisclosed about the agony of Mme de Beauvoir's puberty, though this latest book Memoirs of a dutiful daughter is the most comprehensive document to date, following The Second Sex

and The Mandarins. During the middle-teens, of which this book is a detailed account, she suffered the usual tribulations that growing flesh is heir to, and has unwisely been tempted to commit to paper once again her obsessions with "Sedgox". It is a pity, for her explorations in existentialism have gained her a justified reputation which is not enhanced as a pedestrian racontrice. Slices of life however artistically strung together do not constitute a major work, and inevitably after nearly 400 pages it brings a hand to the mouth and lead to the eyelids. However the book is interesting from a number of viewpoints; firstly as an insight into the intellectual milieu of pre-war Paris, secondly as a guide in the never to be determined relationship between herself and Satre, and thirdly to students of psychology who wish to make a speciality of the adolescent female. In this last respect, but in no other, is it an excellent primer. Let us hope for better in her next literary pregnancy.

Satre's tertium opus in Roads to Freedom, written in 1950, is Iron in the Soul. Following the age of Reason and the Reprieve, this novel is concerned with the thoughts and actions of many of the same characters during the fall of France. Matthieu is still exploring the meaning of freedom, and paradoxically he appears to come nearer to a solution in defeat, than in the previous anticipatory novels, where the absence of action makes reading for the would be existentialist an acid test of his industry. It is essential to have some knowledge of the existentialist movement in order to enjoy the discipline which Satre demands of his readers. Basically it is a denial of the pre-eminence of reason among motives. We worship reason, we teach reason, and by the same token we do the most atrocious things in the name of reason. The overbearing superiority of reason as a motive has not led humanity to the paradise of cool clear logic, instead it seems to have pushed civilisation considerably nearer atomic annihilation. If reason is not to have pride of place in the motivation of humanity, as the existentialists believe it should not, then there must be created a substitute philosophy which can include the irrational contingencies of the human condition, which the classic philosophies avoid. From this nul sounding plateau have Satre and de Beauvoir jumped with great success. Iron in the Soul with this inadequate synopsis in mind, is transformed from a surrealistic procession of tits, lips and thighs into an exciting climax of the trilogy.

Patrick Smith.

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Seven Gothic Tales, Isak Dinesen. Penguin 5s.

The book contains seven short stories by the Danishi writer Baroness Bliscen, who died in 1962. Written in 1934, these stories are more products of the Romantic Age at its height. They are all liberally endowed with phaetons, landaulets, counts, nobles, cardinals unrequited, unsuccessful and unfortunate love affairs and ghosts. They all belong to a period between 1810 and 1820 and it is difficult at times to believe their modern

They are written with great clarity and wit and despite their length and discursive element they are very readable and make an agreeable change from the terse, ungainly and inelegant writing which abounds today. Richard Swain.

#### OTHER REVIEWS

The Practice of Geriatrics (1963). John Agate, M.A., M.D. (Cantab.), F.R.C.P. William Heinemann Mcdical Books, Ltd. Price 50s.

In a community which is becoming increasingly more elderly the care of the aged becomes a steadily more important problem. Dr. Agate's book is all the more welcome therefore for putting geriatrics in perspective, and defining the special needs and difficulties of the old. This is an excellent guide to their care, with particularly helpful chapters on senescence and its variations, posture and gait, and indications for surgical and community care. The book is designed more for the geriatrician or the general practitioner with a practice containing many elderly folk. It is perhaps too detailed for the medical student with other than a particular interest in the subject, and then needs to be read by him in conjunction with a textbook of general medicine. It contains many useful references, but has an irritating habit of mentioning drug dosages sometimes in the metric system, with the apothecarie's in brackets, and sometimes vice versa. Some might diagree, too, with his indications for the use of streptomycin in this age group. Apart from such minor irritations, however, this book is to be thoroughly recommended.

Anaesthetics for Medical Students by Gordon Ostlere and Roger Bryce-Smith. Pp. 121 plus index. Published by J. & A. Churchill. Price 12s. 6d.

This is the fifth edition of a book first published in 1949. In 120 pages the authors have succeeded in giving a concise and interesting account of the main principles and methods of anaesthesia. Their aim has been to provide the medical student with details of safe and reliable techniques and this they have achieved in a volume that is easily read and often amusing. So many small books of this type become simply a catalogue of "dos and don'ts" that this book makes a refreshing and welcome change.

This book can be definitely recommended, especially in view of its reasonable price.

A Modern Textbook of Personal and Communal Health for Nurses by M. A. Priest. Published by Heinemann. Price 15s.

This useful book, in a revised edition, with an improved if rather longer title, is welcomed by nurses and their tutors. It is the textbook of choice for so many because it gives the information that nurses need, with a simple but sound explanation. The text also covers their syllabus for Part I of the General Nursing Council's Preliminary State Examination, and this book should prove popular when the proposed new General Nursing Council syllabus is brought into effect.

The changes and additions throughout this second edition, especially with regard to Domiciliary Health and Welfare Services bring these sections up-to-date. There is need for constant revision here bringing the attention of the nurse to the changing needs of individuals and groups in the community.

All readers will appreciate the giving of tem-perature readings in Fahrenheit and Centigrade scale and measurements in Metric and English

M. M. Ebdon.

#### SPORTS NEWS

#### December

Wed., December 4th Soccer 1st XI v. Royal Veterinary College (U.L.) (A)

Sat., December 7th

Rugby 1st XV v. Old Cranleighians (H)
Rugby "A" XV v. Blackheath (H)

Wed., December 11th Soccer 1st XI v. St. Thomas's Hospital (U.H.L.) (A)

Sat., December 14th Rugby 1st XV v. Old Askeans (H) Rugby "A" XV v. Old Askeans (A Soccer 1st XI v. Guy's Hospital (U.H.L.) (A) Hockey 1st XI v. Tulse Hill (H)

Sat., December 21st Rugby 1st XV v. King's College School O.B. (H) Rugby "A" XV v. King's College School O.B. (H)

Sat., December 28th Rugby 1st XV v.. Old Rutl.i.shians (A) THE SQUASH CLUB

The Squash Club has two teams. The first team has an extensive fixture list, which includes many Hospitals and some leading Squash Clubs such as The Jesters, Escorts and Roehampton. In addition to these "friendly" matches, we enter for the Cumberland Cup, which is a league. Bart's are in the fourth and lowest division, and last year came bottom. This year our hopes and prospects are considerably better. There are five other teams in our Division, and we play each team twice in the season. The fixture list has increased this season, and we have several second team matches. Matches are played on Tuesdays and Thursdays in the evenings. Trials are held at the beginning of the season to survey new

talent. This year we have found several keen Freshmen, especially from Oxford and Cambridge.

The Club does not meet or train as such. Being an individual game, it is left to the individual to attain the required standard of fitness and ability to gain a place in a team. However, coaching is arranged with leading professionals, including N. Khan.

Bart's also enters for the Hospitals' Cup, which is held by St. Thomas's who beat Middlesex in last season's final. St. Mary's provide a strong

challenge with a very good team this year.

Our players include J. C. Mitchell, who is outstanding at first string. He plays for the United Hospitals and London University, and for Surrey on occasions. Dr. K. Bowles is second string, but is not eligible for the Hospital Cup. D. Latham is a much improved player after training throughout the summer. A. D. Edelsten is the fourth string. M. A. Downham and C. Edwards are promising players from Oxford and Cambridge respectively, who have room for improvement.

The two courts at Charterhouse Square are as good as any in London. There is a door fee of sixpence for a game of squash, and anyone who is student or staff can book a court. This is done at the porter's desk in College Hall.

Squash appears to be an increasingly popular sport, and attracts those who require a rapid, efficient and enjoyable form of exercise.

SOUASH CLUB

The 1st team began well this season by winning the first four matches, which included beating Kensington Close in Round One of the Cumberland Cup. K. Bowles showed remarkable tenacity against the Bar. After losing his first two games 5/9, 6/9, he needed to win the next three to win the match for us, which he did by 10/8, 9/2, 9/4. The team appears to be stronger and much more fit than last year. M. Downham and C. Edwards have joined us from Oxford and Cambridge, and we can still call upon K. Bowles for the club matches. D. Latham is much improved after playing in the summer. J. Mitchell and A. Edelsten are yet to be beaten in a match this

The 2nd round of the Cumberland Cup was an excellent and very close match which we lost 2/3. The result depended on Mike Downham, playing No. 3 string. After losing the first 2 games, he fought back to level at 2 games all, and went

down in the 5th after expending much energy. Team: J. C. Mitchell; K. R. Bowles; D. Latham; A. D. Edelsten (capt.); M. A. P. S. Downham; C. Edwards.

Results: v. O Paulines, won 4/1; v. Bar, won 3/2; v. Kensington Close, won 3/2; v. Westminster Hospital, won 5/0; v. Middlesex Hospital, lost 2/3.

2nd Team: S. Thomas; M. Kettlewell; M. Graham; D. Chesney; G. Savage; R. Bolson. Results: v. Aspro, won 4/1; v. Westminster Hospital, won 3/2; v. Middlesex Hospital, lost

#### RUGBY CLUB

Saturday, 12th October. 1st XV v. Old Blues. Home. Won 20-6.

On a hot Autumn day at Chislehurst, the Bart's XV made a very lethargic start and soon found themselves six points down from a penalty and a try. C. I. Smart, however, rallied the pack and with some fine covering the scrum kept the visitors away from the Bart's goal line and pushed them back to their own "25". A fine penalty kick by Gibson was soon followed by a pushover

After half-time, with the sun and wind behind them, Bart's soon took the lead when Goodall pounced on a loose ball and crashed over for a try, which was unconverted. Then from a short penalty Savage scored a very good goal by punting over the full-back's head and racing on to touch down. Several more attacks were launched by the centres and Johnson came close to scoring several times. A penalty by Gibson and a try in the corner by Orr, after a line out, completed Bart's total of points.

Team: E. D. Dorrell; E. Sidebottom; P. E. Savage; S. M. Johnson; S. G. Harris; A. T. Letchworth; D. Chesney; D. J. A. Gilmore; M. Revill; A. J. S. Knox; T. Bates; M. M. Orr; I. A. Gibson; C. J. Smart (capt.); D. Goodall.

Wednesday, 16th October. 1st XV v. Cambridge University LX Club. Away. Lost 6-8.

Against a very strong side, which included an Old Blue and several University players, Bart's played very well indeed. The pack contained their opposite numbers and Revill hooked very well indeed. The backs, however, were more concerned with defensive play and lacked attacking moves. After Cambridge had opened the scoring with a try, Harris replied with a wonderful penalty kicked from the half-way line. A goal by Cambridge was shortly followed by a penalty from Gibson. The score remained 6-8 despite more attempts at penalty goals and a fine effort at a pushover try which was foiled by the quick

collapse of the Cambridge pack.

Team: E. D. Dorrell; E. Sidebottom; P. E. Savage; S. M Johnson; S. G. Harris; A. T. Letchworth; D. Chesney; O. J. A. Gilmore; M. Revill; A. J. S. Knox; T. Bates; M. M. Orr; J. A. Gibson; C. J. Smart (capt.); D. Goodall.

#### Saturday, 19th October. 1st XV v. Old Haberdashers. Home. Won 9-3.

On another hot Saturday afternoon, which had welcomed the spectators at Chislehurst, Bart's scored in the first thirty seconds when Harris scored in the corner from a cross kick by Letchworth. The enthusiasm of the team, however, slipped and shoddy tackling allowed Old Haberdashers to equalise. Harris shortly put Bart's ahead with a fifty-yard penalty and finally Gibson kicked another penalty to make the score 9-3. Although the match was won, certain aspects of the game require attention. Often in this game the forwards stormed well into the opponents' half and gained possession for the backs; this advantage was lost by bad passing or close tackling. If this problem can be overcome then this side, which is a good one, should do very well in the Hospitals' Cup.

Team: E. Sidebottom; S. Harris; S. M. Johnson; P. Bradley-Watson; A. T. Letchworth; D. Chesney; D. McPherson; M. Revill; A. J. S. Knox; T. Bates; M. M. Orr; D. Gibson; C. J. Smart (capt.); D. Goodall.

#### Saturday, 26th October. 1st XV v. Esher. Lost 13-8.

In a fast and open game, with both sides running and tackling hard, Esher came out on top scoring a dropped goal and two goals to two tries by Bart's.

Both Gibson and Harris, who have been kicking well this season, were unlucky with attempts that could have given Bart's an early lead. Instead it was Esher who scored first with a dropped goal from their fly-half. Orr replied with a try which followed a burst on the right wing by Harris. After this, Esher had slightly the better of the play mainly because they opened up their play and slipped the ball more than Bart's did. During this period they scored two goals. A rally by Bart's in the last quarter of the game resulted in Bates crashing over from a line out.

> Savage; S. M. Johnson; S. G. Harris; A. T. Letchworth; D. Chesney; D. A. McPherson; M. Revill; A. J. S. Knox; T. Bates; M. M. Orr; J. Gibson; C. J. Smart (capt.); D.

Team: E. D. Dorrell; E. Sidebottom; P. E.

The Extra A, under the leadership of R. L. Bown, have made a fine start to the season, winning four of their five games so far. There is a strong core of regulars in this team in which several preclinicals features, and members of the House supplement the team now and again.

#### **CORNISH TOUR—1963**

A party from the Rugby Club twenty strong with numerous camp followers, travelled down to Cornwall where they met Penzance and Falmouth. The six-day tour finished up at Dartmouth where the Navy acted as hosts.

The Hospital team gave a good account of itself at Penzance. They played the open rugby that is always appreciated in Cornwall. Unfortunately, the luck was with the Cornish men, who opened the scoring when D. Michel, the veteran scrumhalf, placed two beautiful high punts in front of the Hospital goal for his centres to burst over and score. Some good running and backing up by Bart's, however, opened up the home defence, but only one try resulted from this-though several were lost on the final pass. A penalty kick completed all the points Bart's were to score, but Penzance charged down three defensive kicks from the base of Bart's scrum to finish with nine-

The re-arranged back line with Savage on the left wing, Letchworth in the centre and Gratton, new this term, at fly-half, showed some promise; the pack showed that few hospital packs will beat them in the tight.

The rest of the stay at Penzance was highlighted by S.E. gales, which helped to cover the hotel with spray on the Sunday evening high water, and the training session on the beautiful white sands of Sennen Cove on Monday morning. It was unfortunate that this resulted in a damaged knee for our second row forward, whilst the other went down with influenza.

Bart's met Falmouth on the Monday evening under floodlights with a re-arranged pack. The result of this match, 6-0 to Falmouth, was disappointing in that it was a victory for the "kick and rush" type of rugby that Falmouth play. Their tactics consisted of pouncing on Bart's mistakes and playing safe to avoid mistakes themselves It was to Bart's credit that they refused to play the same way, but continued to play attacking open rugby despite the very close marking. With some more adroit kicking, the Hospital might well have won this game, but at least they showed that the spirit in which the game is

played determines the character of rugby and no

amount of new legislation-being considered at

the present time by the International Body-will alter this fact.

Social activities on 5th November were severely restricted by the presence of two police squad cars and half a dozen policemen. The rowdy return at 4 a.m. of five of the party from two French trawlers in Falmouth harbour had alerted the police the previous morning. The party left, however, on Wednesday without incident and travelled to B.R.N.C., Dartmouth. There, all bad fortune was with the opponents and Bart's weathered a shaky start to amass sixteen points. All points were scored by the backs and each time the movement started from a quick loose heel. In the second half Gibson left the back row to excel at full-back in place of the injured Dorrell, and despite fierce attacks the line was uncrossed. Thus the result was 16-0. In the evening a pleasant time was spent in Dartmouth town despite entreaties by the Navy that Torquay should be visited. Later that night the flagpole was once again conquered!

Tour Party: E. Sidebottom; E. D. Dorrell; S. G. Harris; S. M. Johnson; P. E. Savage; N. J Griffiths; A. T. Letchworth; D. Chesney; D. Pope; O. J. Gilmore; M. Revill; A. J. S. Knox; J. A. Gibson; D. A. McPherson; T. Bates; M. M. Orr; D. Goodall; C. Grafton.

#### SOCCER CLUB

Saturday, 5th October. St. Bart's 1st XI v. Swiss Mercantile. Lost 1-5.

For the first match of the season Bart's fielded four freshmen, namely, Layton-Smith, Thew, Turner and Sutton. It was immediately obvious that all were capable footballers despite the result.

Bart's took an early lead when Phillips crossed the ball low from the right to Herbert in the centre, who placed the ball wide of the goalkeeper. Soon, however, the Swiss took command and were leading 3-1 at half-time.

In the second half Bart's had the vast majority of the play, but failed to penetrate the retreating Swiss defence. At the other end Bart's defence tended to "play square" and as a result two Swiss breakaways produced goals.

Team: Layton-Smith; Vartan; Thew; Offen; Savege; Turner; Phillips; Mumford; P. Herbert; Sutton; McGechie.

#### Saturday, 12th October. St. Bart's 1st XI v. Queen Elizabeth College, University League. Won 5-1.

Bart's had an easy victory on the notoriously small O.E.C. pitch at Petersham. At first we found it difficult to avoid crowding amongst our forwards, but once this was overcome Bart's had most of the play. A well taken goal by Herbert

gave the Hospital the lead. Another shot from Herbert was deflected into the goal by a defender, and Sutton chased a long ball to score a good opportunist goal before half time. After the interval the game slowed down and despite continual pressure, only two more goals, from McGechie and Offen, were added.

Team: Layton-Smith; Vartan; Thew; Rawlinson; Mumford; Turner; Dorritt; Offen; Herbert: Sutton: McGechie.

#### Saturday, 19th October. St. Bart's 1st XI v. Royal Dental Hospital, U.H. League. Draw

The game started at a furious pace which, surprisingly, was maintained for most of the match. In the first half play was about equally divided between the two sides. Bart's were unfortunate not to score when Sutton hit a post and the ball rebounded into play. The Bart's goal remained fairly free from danger due particularly to the sterling defensive efforts of Mumford and Thew.

The second half saw a change of the pattern of the game with R.D.II. rarely clearing the ball from their own half. The Bart's forwards seemed reluctant to shoot, but even so were unlucky not to score; the crossbar was hit on two occasions.

Team: Layton-Smith; Vartan; Thew; Offen; Mumford; Turner; Phillips; McGechie; P. Herbert; Sutton; Dorritt.

#### Wednesday, 23rd October. St. Bart's 1st XI v. University College Hospital, U.H. League. Won 4-2.

For this match the Bart's team played some of their best football so far this season. The forwards combined well and soon had the U.C.H. defence at sixes and sevens. An excellent move, starting in our defence, resulted in Herbert scoring the first goal. The lead was increased when McGechie pushed the ball in after a goalmouth scramble. Offen then scored from a through pass by Herbert to make the score 3-0. Bart's then eased up a little and U.C.H. quickly took advantage of this, scoring from the left wing. However, before half time Herbert made the score 4-1 after a move involving most of the Bart's forward line.

Early in the second half U.C.H. scored again and although the Bart's game deteriorated the defence managed to contain their forwards.

#### Saturday, 26th October. St. Bart's 1st XI v. Middlesex Hospital, U.H. League. Lost 0-1.

Of all the games so far played this is, perhaps, the one the team would most like to forget. Early in the first half a delayed pass back to the goalkeeper resulted in a goal for Middlesex. During the rest of the half Bart's had a slight territorial advantage.

The second half was full of incident, but no goals-the Middlesex cross-bar was hit on no fewer than four occasions. Again the Bart's forwards were held by a packed defence, and one felt that they needed the experience of the absent captain to overcome this.

Team: Layton-Smith; Vartan; Thew; Offen; Savege; Turner; Dorritt; Mumford; Sutton; P. Herbert: McGechie.

#### Wednesday, 30th October. St. Bart's 1st XI v. West Ham College, University League. Won

This was throughout a rather scrappy game. Bart's playing without much urgency for most of the time. West Ham took the lead, through loose marking in the Bart's defence, towards the end of the first half.

Early in the second half Sutton placed a low cross from Dorritt wide of the goalkeeper to even the score. Shortly afterwards Dorritt did well to beat the goalkeeper and left back from a pass by Herbert to make the score 2-1.

Team: Layton-Smith; Vartan; Thew; Offen; Mumford; Turner; Phillips, McGechie; P. Herbert; Sutton; Dorritt.

#### RIFLE CLUB

Report for 1962/63 season

The Rifle Range

The season, one of our most successful, started at a disadvantage. At the beginning of the season the Hospital Governors had told us that they required our small-bore rifle range, in the hospital, for the storage of hospital records and that they would give us a month's notice to leave. Thus we had to limit our entries in postal competitions and restrict our shoulder-to-shoulder matches to the early part of the season.

In the New Year, however, they very kindly told us that we could finish the present season in the range, but would have to leave on 31st March, 1963. Towards the end of the season, the Students' Union heard of our plight and renewed efforts to keep the range were made with great success.

We now start the 1963/64 season as we did the last with the Governors giving us a month's notice should they require the range.

The Season

Thanks to an "A" team of superb shots, all of whom unfortunately have now left, the Rifle Club had a most successful season. This team, consisting of H. R. Petty, A. M. Ward, A. J. B. Missen, K. S. Wise and A. J. Austin, started by reaching the quarter final of a National competition open to all British clubs; a magnificent achievement. We then won all our shoulder-toshoulder matches both at Home and Away. We

regained the Hospital Championship and won a local league open to London clubs. A detailed analysis of our shooting follows.

United Hospitals' Winter League

We entered 3 teams. Our "A" team won every match in the 1st division taking the Hospitals' Championship from the Westminster, who had won it the previous season. As mentioned above, it will be some time before we again have such a fine team as Ward, Missen, Petty, Austin and Wise. H. R. Petty was the top scorer in this league with an average of 98.1. He also won the Hospitals' Individual Championship. Ward was 3rd and Wise 4th in this Individual Champion-

ship.

The "B" team won three of the seven matches reaching 5th place in the 1st division beating the "A" teams of "The London", St. Mary's and St. Thomas's Hospitals. E. Carden and D. W. G. Earle were top scorers in this team both having an average of over 97.

A "C" team in which some 15 members of the club shot at some time was not so successful as the "A" and "B", winning only 1 match and tying in another to reach 5th place in the 2nd division. They did, however, beat the "B" teams of St. Mary's and St. Thomas's in this division.

United Hospitals' Knock-out League

Six teams of three members were entered, the "A", "B" and "C" teams being in the 1st division and the "D", "E" and "F" in the 2nd division. The "A" team of Ward, Missen and Petty won their division knocking out the University College Hospital "A" (who had beaten our "C" team in the 1st round and our "B" team in the 2nd round). The "D" team were runners-up to the U.C.H. "B" team in the 2nd division. It looks, from these results, as though U.C.H. may replace the Westminster Hospital as being our greatest rivals.

London Small-Bore Rifle Association Winter League

We were placed in Division 19 for this league, but our "B" team of E. Carden, P. F. Tatham, D. W. G. Earle, F. J. R. Hardy and S. R. Morison were very successful, winning 9 of the 10 matches, only losing the last match because one of the team was unable to shoot and his substitute was not so experienced. Silver spoons went to all members of the team as well as their substitutes.

E. Carden was a top scorer in this league.

City of London League (Division 12)
In this league, our "A" team in a relatively high division were fortunate in coming 3rd after shooting 21 weekly matches winning 12, tying in 2 and losing 7. In one match, the team of five (Ward, Missen, Petty, Austin and Wise) reached a score of 494 out of a possible 500-an exceptionally good achievement.

Shoulder-to-Shoulder Matches

All seven matches, three of which were shot as Away fixtures, against local London clubs, including University College Hospital, were won by the club comfortably although we usually only sent our 2nd VIII. We hope to have more of these matches in the coming season to enable our new members to obtain very valuable shooting

Lady Ludlow Cup Competition

This cup, awarded to the member with the highest average for the season, was won by A. J. B. Missen, in his last year of shooting, with an average of 98.01. Runner-up was H. R. Petty, also in his last year, with an average of 97.81.

Mrs. H. J. Waring Cup

This cup, awarded to the member, who, having shot more than 10 match cards each year for two years, shows the greatest improvement as calculated using the Macrae charts.

E. Carden won the cup increasing his average from 92 to 96, and K. S. Wise was runner-up, in-

creasing his from 94 to 97.

Monthly Spoons Awarded on a similar basis to the Mrs. H. J. Waring Cup. Only two were awarded this season; to E. Carden and D. W. G. Earle.

United Hospitals' Rifle Club

St. Bartholomew's Hospital was well represented in the U.H. team this season. Nine members shot for U.H.: A. M. Ward on six occasions, H. R. Petty five times, K. S. Wise and F. J. R. Hardy three times and the remainder once or

1963-1964 Season

Thanks to a large influx of keen freshers, the coming season should be most active. All students at Bart's who are interested will be sure of a fine welcome should they pay us a visit in the range under the Hospital.

CROSS-COUNTRY RUNNING CLUB

With P. Littlewood and N. Pott involved with finals and D. Tunstall-Pedoe away in India until Christmas it seems that the run of success enjoyed by the club in the last few years is now on the decline. However, at present we lie 5th in the U.L. League (Division 1); last year we finished second. and with the help of our newcomers, R. Markham and P. Brackenbury, we hope to improve on this. We still provide more runners than any other hospital for the United Hospitals Hares and Hounds fixtures, P. Littlewood, N. Pott, T. Foxton, R. Sanders and R. Thompson having run for the 1st team. T. Foxton has run for London University. We hope to be at full strength and at our fittest by February 1st to win the Kent-Hughes Inter-Hospitals Cup for the fourth year in succession.

Saturday, 12th October, University College Invitation Relay held at Parliament Hill Fields. This relay is run around a 1.6 mile lap, and a

fine warm day with no mud on the course meant that very fast times were almost sure to be re-

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corded. Barton, of King's College, succeeded in equalling the course record of 8 mins. 1 sec. P. Littlewood ran a fast first lap for us, finishing in 6th position. R. Sanders lost three places on the second lap, but these were made up and another gained by T. Foxton on the next, who in doing so ran our fastest lap. At the end of the fourth lap we had dropped to 12th with R. Phipps running, but one place was gained in the fifth by R. Markham and this position was maintained by R. Thompson in the last lap to bring us in 11th of 36 teams, many of which were from Universities, in a time of 55 mins. 26 secs. Borough Road College won in 50 mins. 31 secs.

The individual times were: -

Lap 1 P. Littlewood 8 mins. 37 secs. R Sanders 9 mins, 16 secs. 8 mins. 30 secs. T Foxton 10 mins. 3 secs. R. Phipps 5 R. Markham 9 mins. 25 secs. 6 R. Thompson 9 mins. 29 secs.

T. Walsh, P. Littlewood, T. Foxton and C. Fielding between them constituted an "All Stars" team which finished in 25th position with a time of 58 mins. 16 secs.

#### Wednesday, 19th October. University League (Poly. Mob Match) held at Parliament Hill

We were very much below strength in this important match, P. Littlewood having twisted his ankle, and N. Pott away climbing. The 61-mile course was very fast and the weather was very fine and hot. Hampstead Heath at this time of year provides most enjoyable running with the trees displaying their autumnal colours, and it is to here that we try and escape the grime of London when training on Wednesday afternoons. All the London University Colleges and Technical Colleges run in this race, which with about 250 competitors finishing the course, tends to be a procession. J. Farrington, the European Junior Cross-Country Champion won in 33 mins. 59 secs. T. Foxton ran well to finish 10th in the league in a time of 37 mins. 16 secs., but it was a shame that no one could back him up.

The positions and times in the League Match were as follows: -

10th T. Foxton 37 mins. 16 secs. 39 mins, 24 secs. 31st R. Sanders 41 mins. 37 secs. 61st F. Hardy 76th R. Thompson 42 mins. 13 secs. 43 mins. 49 secs. 110th R. Phipps 45 mins. 7 secs. 134th T. Walsh

As a result of this race, the first League Match, we are 5th in Division 1. 35 teams finished.

1. University College 320 points 282 " 2 L.S.E. I

3. St. Mary's College I 239 237 4. King's College 5. St. Bartholomew's H. 219 ,,

#### HOCKEY CLUB

Wednesday, 9th October. 2nd XI v. St. Mary's Hospital "A" XI. Lost 3-1.

Although the opposition included many 1st XI players in their team, Bart's were territorially dominant throughout the game, but seemed unable to make the final penetration.

#### Saturday, 12th October, 2nd XI v. Beckenham 3rd XI. Lost 10-3.

As one Bart's player did not appear we were forced to play without a goalkeeper. In spite of this tactical and psychological disadvantage, Bart's gave a spirited performance especially in the first half, in which the score was only 4-3 in Beckenham's favour.

#### LADIES' HOCKEY CLUB

At an extraordinary General meeting held on 24th October the following were elected: -President: Mr. D. F. Ellison-Nash; Vice-Presidents: Dr. A. G. Stansfeld; Dr. G. E. C. Francis.

#### Saturday, 5th October. St. Bart's v. Chislehurst Beavers. Draw 3-3.

This was an encouraging start to the season. Most of the team had not played together before, as many of our experienced players have now qualified. The opposing side appeared to have the upper hand for most of the game, but we were able to force a draw.

We hope that many of our new players will continue to play with the same enthusiasm.

Team: E. Neach; J. Young; S. Kotting; J. Bell; P. Kumar; C. Foot; C. Metcalf; J. Burne; V. Church; J. Williams; M. Newbold.

#### Cambridge Tour Friday, 25th October to Sunday, 27th October. v. Magdalene College. Lost 0-7.

v. Cambridge University 2nd XI. Won 7-3.

v. Queen's College. Drew 2-2.

The match against the University was an extremely good one and Bart's deserved their success. The forward line was particularly strong and played well together. The opposition goals, however, were due to lack of co-ordination in our defence. Goals: S. Minns, 4; E. Saunders, 2; M Newbold, 1.

Teams were taken from: S. Minns; J. Swallow; E. Saunders; J. Young; M. Newbold; C. Lloyd; P. Kumar; S. Kotting; J. Bell; C. Foot; S. McDonald; B. Bean; R. Sturgess; V. Church; M Gunn.



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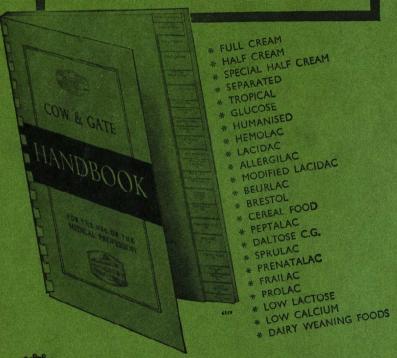


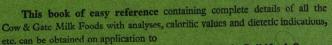


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Annotation, Lancet, 1963, 1, 1366

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HAIL, HAIL TO THEE, bright bubble crystalline. Thy shape cylindrical, thy texture fine, Thy domed ends and cincture neatly placed To indicate a scarce existent waist,
And, on that waist, a spot of great import
That shows where pressure rightly may be brought! (Were other waists so opportunely mapped Methinks there would be fewer faces slapped). Age cannot wither thee (has someone writ Something like that before?)-no careless slit Be made in thee by needle or by knife, Nor acid's tooth abbreviate thy life Fit temple art thou for that lissom djinn That, uncontaminated, rests within! The slightest pressure, properly applied. Divides thy house, and flings the portal wide. Then forth it glides, the lithe, unsullied coil That thou hast kept intact and free from soil. More flexible than this was never suture Prepared by man, nor shall be in the future! Swift to the needle joined, it straight commences To close the gap in somebody's defences. Thus, though the patient may be under-dressed, She'll have a stitch or two-and those the best! And ever after, ruefully she'll smile, When little lambs are frolicking the while, Thinking, "For healing's sake they give their gut, an' Will never live to be described as mutton!" Vol. LXVII No. 11. November 9th 1963



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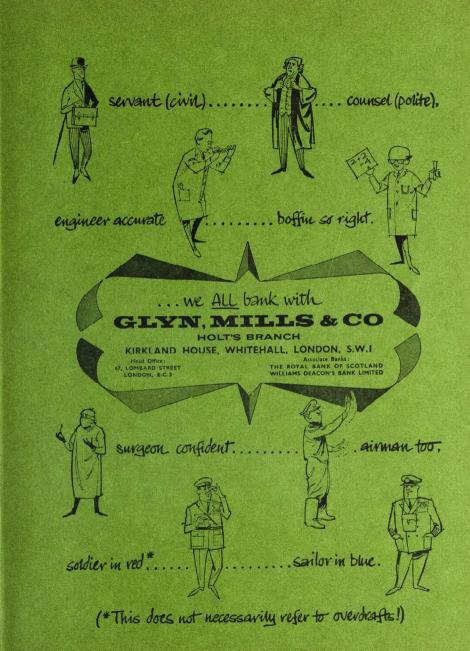
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