

Recent advances in cardiology, by David Weitzman	184
Recent papers by Bart's men Suppl. 5, vii, Suppl. 6, xiii; Suppl. 7, xiv; Suppl. 8, xiv	
Relief of pain in labour, by T. B. Boulton and P. V. Cole	367
Retinoblastoma, by H. B. Stallard	Suppl. 7, i
Review of stethoscopes	408
Richards, N. C. G.: An interesting obstetrical history	505
Rifle Club	524
Roberts, G. F.: <i>Obituary</i>	323
Robertson, J. D.: Charing Cross Hospital	161
Robins, S.: British Medical Students' Journal, <i>Corres.</i>	45
Robinson, J. O.: Alterations in Casualty Department	149
Rose, L.: <i>Corres.</i>	406
Rotblat, J.: The contribution of physics to radiotherapy	326
Rothnie, N. G.: Fibrinolysis	58
—: Scandinavian visit, 1963	134, 194
Round and about, by N. C. Lee, <i>Corres.</i>	174
Rugby Club	33, 79, 117, 165, 215, 522
Rugger Club Ball	30
Rugger myth, by B. Lask, <i>Corres.</i>	127
Rugger myth? and Blue stockings? by T. J. McElwain, <i>Corres.</i>	173
Sahlgrenska Hospital, Gothenburg, Sweden, by K. O. Obrant	74
St. Bart's? by M. Atkinson, <i>Corres.</i>	3
St. Bartholomew's Hospital, Examination paper	209
Salsbury, A. J.: Circulating malignant cells	Suppl. 6, i
Sanders, R.: William Hogarth (1697-1764)	157
Scandinavian visit, 1963, by N. G. Rothnie	134, 194
Scobie, J. D.: East African safari	143
Scott, R. Bodley: (<i>portrait</i>)	153
Search for old drugs in British Guiana, by D. P. Moody	464, 500
Seddon, H. J.: Pott's disease	14
Shooter, R. A., see Burrows, H. Jackson, and Simon, G.: Some comments on the radiological findings in patients with back ache	343
Sims, Gillian: Bell ringers, <i>Corres.</i>	273
Single, double or group? by Mrs. H. M. Weaver	378
Soccer Club	34, 79, 119, 166, 216, 268, 520
Some comments on the radiological findings in patients with back ache, by G. Simon	343
Some contributions of radiobiology to radiotherapy, by Patricia J. Lindop	382
Some surgical problems of elderly patients, by G. L. Bohn	52
Spackman, W. C.: The day Kut fell	456
Special Departments	67, 107, 303, 428
Sports Day, 1964	314
Sports News	33, 78, 117, 165, 215, 265, 315, 353, 397, 435, 480, 519
Squash Club	82, 121, 169, 225, 316, 521
Squash Club (Ladies)	170
Staggered holidays, by R. E. Atkinson, <i>Corres.</i>	229
Stallard, H. B.: The Eye Department	107
—: Retinoblastoma	Suppl. 7, i
Stewardson, M. P.: Battersea Drama Festival Story, P.: The clinical significance of platelet antibodies	Suppl. 8, i
Students, hospitals and prizes in the nineteenth century, by W. Radcliffe	503
Students' Union, Annual Report	459
Surgeon comments, by M. Birnstingl	242
Surprise of general practice	10
Swain, J. R.: The Eric Gill design for the cover of the Journal	18
Swimming Club	35, 81, 224, 316, 359, 488
Syndrome of multiple motor accidents, by R. Courtenay-Evans	247
Syntax, by T. E. Osmond, <i>Corres.</i>	229
Szillard, Leo: <i>Obituary</i>	323
Talo-calcaneal interosseous ligamentous apparatus, by P. S. C. Bunning	Suppl. 8, i
Teaching and patients, by Malcolm Donaldson, <i>Corres.</i>	488
Telling the relatives, by Malcolm Donaldson, <i>Corres.</i>	174
Tennis Club	268, 316, 356, 401
Tennis Club (Ladies)	31
Thornton, J. L.: John Abernethy, 1764-1831	287
—: Percivall Pott (1714-1788)	...
Three months in India, by D. S. Tunstall Pedoe	205, 29
Tiger at the Gates	15
Todd, I. P.: International bonds, <i>Corres.</i>	36
—: Whither Bart's? <i>Corres.</i>	8
Treatment of students' wives, by H. Wykeham, <i>Corres.</i>	46
Tredinnick, W. D., see Cull, P. G., and Tribulations of John Abernethy, by A. W. Franklin	283, 33
True facts, by L. P. Garrod, <i>Corres.</i>	4
Two specimens of particular interest from the ductless gland secretion, by W. J. Hanbury	Suppl. 8, i
Unqualified assistant in 1895, by C. Corfield	23
Up to the minute in a moment 7, 51, 90, 132, 171	17
View Day, 1964	23
View Day Ball	203, 23
Visit of the Chancellor of the University of London to Charterhouse Square	24
Vox	282, 325, 366, 424, 446, 488
Waiting room, by R. F. Crandell	33
Wareham, Truda: The Department of Physiotherapy	5
Weale, F. E.: Bonesetters, 1963	3
Weaver, Mrs. H. M.: A Conservative view of the National Health Service	42
—: Single, double or group?	37
Weitzman, David: <i>Obituary (with portrait)</i>	36
—: Recent advances in cardiology	18
Weitzman Memorial Prize, by H. A. Isenberg, <i>Corres.</i>	40
Wessex Rahere Club	176, 40
White, C. J.: The problems in obstetric anaesthesia	40
Whither Bart's? by I. P. Todd, <i>Corres.</i>	8
Whither general practice? by R. Gibson, <i>Corres.</i>	40
Whither shall we wander?	307, 347, 381, 418, 463, 51
Widows and orphans of medical men, by W. Lloyd, <i>Corres.</i>	48
Wine Committee	46
Wine Committee Tour de France	34
Women's Guild, by Marjorie M. Oswald, <i>Corres.</i>	40
Words of dying men, by T. J. Clogger	50
Wormall, Arthur: <i>Obituary (with portrait)</i>	27
Wyatt, A. P.: Lymphangiography in a case of bilateral chylothorax due to chronic lymphatic leukaemia	44
Year in Southern Rhodesia, by G. Gardos	49

EDITORS

January - June	T. P. DUTT
July - December	C. J. KELLY

PUBLICATIONS COMMITTEE

Chairman: Dr. A. W. FRANKLIN.
 Deputy Chairman: Dr. G. H. FAIRLEY.
 Editor: T. P. DUTT.
 Review Sub-Editor: G. R. A. HAMILTON.
 Social Sub-Editor: Miss J. BELL.
 News Sub-Editor: C. J. KELLY.
 Sports Sub-Editor: G. HAIG.
 Photographic Sub-Editor: B. C. P. LEE.
 Manager: G. O. GFY, Jr.
 Assistant Manager: J. R. SWAIN.
 Women's Representative: Mrs. A. R. BAILEY.
 Nurses' Representative: Miss M. IRONSIDE.
 Charterhouse Representatives: A. R. BAILEY,
 G. W. LIBBY.

CONTENTS

Editorial	1
Correspondence	3
22nd A.G.M. of the B.M.S.A.	4
Looking Back	6
Up to the Minute, in a Moment	7
Percivall Pott by John L. Thornton	8
A Background for Percivall Pott by W. R. Le Fanu, M.A.	12
Pott's Eponyms	14
The Excavations by Nelly J. M. Kerling	19
The Nursery Productions, 1963	21
Current Trends in Obstetrics by John Beattie	22
Treatment of Non-Specific Inflammatory Diseases of Connective Tissue by G. D. Kersley, O.B.E., M.D., F.R.C.P.	27
Rugger Club Ball	30
Behind the Scenes: V.—Physiotherapy	31
Sports News	33

EDITORIAL

It should not be necessary to present an excuse for recalling the great men of the past, for men in any age can learn from the lives of their successful predecessors; but today, when iconoclasm is the fashion and reverence is outmoded and "square", perhaps such an excuse may be called for.

Today, even those great historical pointers of medical literature, the eponyms, are being lost. Hunter's canal is no more and with it has gone Gimbernat's ligament, Breschet's canals and even Abernethy's fascia. In spite of the purge of eponyms from the medical scene, however, one name stands inviolate, the terms Pott's disease and Pott's fracture appear on as many diagnosis boards as ever.

In the history of St. Bartholomew's Hospital there are many great names and it would be in-

vidious to try to choose any one as the greatest, but in any such attempt the name of Percivall Pott must surely come high on the short list.

Taught by Edward Nourse and, in his turn, teacher of John Hunter, the figure of Pott stands as a milestone in medical history. Whether because of his own efforts or because of his position in time it matters not, he marks the period of revolution in thought from the old methods of Hippocrates to the modern art of surgery.

Percivall Pott was born on 6th January, 1714, and this year marks the 250th anniversary of that occasion. It is fit that, at such a time, we should remember this man, whose works did so much to make the name of Bart's famous throughout the world.

People matter

One of the greatest complaints levelled, by both patients and General Practitioners alike, against the present medical service is that when a patient is referred to hospital he very often has to spend a considerable length of time in that hospital, often time during which he is neither being seen nor treated. This has given rise to a considerable amount of discussion, some of it heated, over the past few years.

As an illustration of the complaints, a G.P. recently referred the wife of a doctor, an ex-Bart's nurse, to a Bart's out-patient clinic. Her appointment was for 12.45 p.m. and she arrived in good time; she was not seen until 2 p.m. and did not leave the building until nearly 5 p.m. No doubt many G.P.'s can cite similar cases, especially as it is the more unusual cases that one recalls.

Many people, when making these complaints, point out that some hospitals give the time of 9 a.m. to all the morning patients and then sort them out when they arrive. This is undoubtedly a bad system but it is pointless to consider here all the possible methods used in all the hospitals of this country and we shall confine our remarks to those relevant to the situation at Bart's.

There is some research being carried out at Guy's into the problem, which should produce information which can be applied to our own system. The research workers have divided the time spent by the patient at the hospital into three phases, phase one being the period from when the patient enters the gate to his arrival in the consulting room and includes the time spent in registration. Phase two is the time spent in the consulting room, and in phase three the patient is undergoing various special tests including X-rays and blood tests.

The researchers found that the average time spent in hospital was about two hours in all, but

that one patient in fifteen would be out in less than one hour while one in five would take more than three hours. They found that there was very little difference between the surgical and medical patients with regard to phases one and two, that is from the time of entering the hospital to the time of leaving the consultant—this averaged about 50 minutes.

Phase three, however, differed very considerably between the two groups, medical patients spending an average of 50 minutes on having special tests while surgical patients averaged only 15 minutes. This can easily be explained, bearing in mind that these times are averages, for many surgical patients can be diagnosed fairly confidently on clinical examination while medical patients may have to undergo several special tests before a final diagnosis can be reached.

It is important to remember that, at both Guy's and Bart's, one of the time-consuming factors is the teaching of students and this naturally alters the situation at teaching hospitals from that appertaining in other places.

It is often said that the Staff and students in a teaching hospital regard the patient as being there for teaching purposes alone; this presents only half the picture, for teaching, though primarily for the benefit of the students, also materially improves the position of the patient. It is very much easier to convince oneself that one understands a problem than it is to explain it to others and make them understand. Thus, every student has a very real responsibility to the patients upon which he is taught; he should not note down everything which the consultant or registrar says, with blind acceptance, rather, he should give each point serious consideration and then, if there is anything which he does not understand or with which he disagrees, he should say so. All teachers must realise that such active participation from the student benefits all concerned: the patient—his case is considered more fully, the student—his query is clarified, and the teacher himself, for there are few tasks more disheartening than trying to teach a completely passive audience, one never knows how much they have really understood.

Such procedures inevitably lengthen the time spent in phase two, in the consulting room, for the patient may be clerked by a student, and therefore more fully, albeit less expertly, than he would have been by the consultant and, in addition, the consultant will often teach on the patient, and in so doing take up time which might have been spent on the next patient. Such factors can only partially be allowed for by the appointments system, for some patients will be unsuitable for

teaching while other cases may not have been seen before by the students and therefore take longer. This not only increases the time of that patient in phase two but also lengthens phase one for subsequent patients.

There can be few staff or students who have not, at some time or other, walked through Surgery and felt, or even commented, that some patients spend an iniquitously long time just sitting waiting, but can we really improve the situation or would efficiency mean "mass production"?

"People matter"—of course they do, but so long as medical students have to be taught on patients—and what other satisfactory way is there—the individual must be prepared to sacrifice some of his time for the good of future generations of his kind.

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 5 and send it to us.

In recent months we have attempted to widen the appeal of the *Journal* by including articles of a more general nature than hitherto, as well as more up-to-date news. We hope to continue this trend by reporting the activities of old Bart's men, both within the profession and outside it. To this end, we would be grateful if any readers with interesting information about Bart's men would communicate with the Editor.

We gratefully acknowledge the receipt of the following contemporary publications: *Black Bag*, *Boston Medical Quarterly*, *British Rheumatism Review*, *Broad Way*, *Bulletin of the Medical Society of the County of Kings and Academy of Medicine of Brooklyn*, *Bulletin of the School of Medicine, Maryland*, *Bulletin of the Tokyo Medical and Dental University*, *Charing Cross Hospital Journal*, *Chicago Medical School Quarterly*, *Elixir*, *Epsomian*, *Guy's Hospital Gazette*, *Inominate*, *Japanese Journal of Medicine*, *Journal of the Faculty of Medicine Baghdad*, *Journal of the Indian Medical Profession*, *Journal of the Medical Women's Federation*, *Journal of the Oslo City Hospital*, *London Hospital Gazette*, *Manchester Medical Gazette*, *Middlesex Hospital Journal*, *Newcastle Medical Journal*, *News and Notes from the New York Medical College*, *Oxford Medical School Gazette*, *Physiotherapy*, *Royal Dental Hospital Magazine*, *Queen's Medical Review*, *Royal Free Hospital Journal*, *St. George's Hospital Gazette*, *St. Mary's Hospital Gazette*, *St. Thomas's Hospital Gazette*, *Snakes Alive* and *Stethoscope*.

ST. BART'S?

Sir,—You have let me down. I confidently refer the Editor of the *Journal of the American Medical Association* to the *Hospital Journal* as being an irrefutable source of what is right and proper (which is Bart's and not St. Bart's, and with an apostrophe), and no sooner do I do it than I receive the copy of October 12, 1963, open it by chance at page 317, and there spread all over in bold face is St. Bart's, St. Bart's, St. Bart's. Am I to understand that this, in my day unforgivable, solecism is now acceptable? St. Bartholomew's, yes; Bart's, yes; but St. Bart's, no, no, no. Well, at least you have kept the apostrophe. But I dread to think what Rahere would have had to say about "St. Bart's", for by repute he was a man of very definite opinions and, as King Henry's jester, probably no mean wit. Oh for his cap and bells! Lacking them, I must sign myself prosaically.

Yours faithfully,

MILES ATKINSON,
36 East 36th Street,
New York 16, N.Y.

[Our apologies!—Ed.]

20th November.

Calendar

JANUARY

Wednesday, 1st: New Year's Day.

Sat. & Sun., 4th & 5th: Dr. G. W. Hayward
Mr. A. W. Badenoch
Mr. H. J. Burrows
Dr. K. A. Bowen
Mr. A. P. Fuller

Sat. & Sun., 11th & 12th: Dr. A. W. Spence
Mr. E. G. Tuckwell
Mr. J. N. Aston
Mr. G. Ellis

Sat. & Sun., 18th & 19th: Mr. J. W. Cope
Prof. E. F. Scowen
Prof. G. W. Taylor
Mr. H. J. Burrows
Dr. R. W. Ballantine

Sat. & Sun., 25th & 26th: Mr. R. F. McNab Jones
Dr. R. Bodley Scott
Mr. A. H. Hunt
Mr. J. N. Aston
Dr. I. Jackson
Mr. J. C. Hogg

The Physician Accoucheur on duty for the month of January is Mr. J. Beattie.

Engagements

COLTART—JONES.—The engagement is announced between Timothy McCallum Coltart and Eileen Elizabeth Anne Jones.

SCOTT-BROWN—HAWKES.—The engagement is announced between George Graham Scott-Brown and Margaret Hawkes.

Birth

PAGE.—On 16th November, to Carolyn (née Deeks) and Captain J. P. A. Page, R.A.M.C., a son.

Death

CUTLACK.—On 16th November, Allan Russell Cutack, M.R.C.S., L.R.C.P., aged 56. Quaiified 1932.

22nd ANNUAL GENERAL MEETING OF THE B.M.S.A., NOVEMBER, 1963

The 22nd Annual General Meeting of the British Medical Students' Association was held from 7th-11th November at the Grosvenor Hotel, Edinburgh. The President of the Association, Mr. Kingsley Reid of Edinburgh University was in the chair. The meeting was attended by 85 delegates, representing medical students from all over the United Kingdom, and two observers from the Denmark Medical Students' Association. Professor Brotherton, Dean of the Medical Faculty at Edinburgh University, was elected Honorary President for the year 1963/64, and the retiring President Sir George Pickering, President of the B.M.A., and Dr. E. R. C. Walker, the Scottish Secretary of B.M.A., were elected Honorary Vice-Presidents of the Association.

The meeting opened with a report from the International Secretary, Mr. Ian McKee, who revealed that the number of students travelling abroad to do clinical clerkships had increased from 25 in 1953 to 250 in 1963. Such an increase has called for extensive re-organisation in the International Secretariat and represents a most important function of B.M.S.A. Moreover the International Secretary has been elected the Director of the Standing Committee on Professional Exchange by the General Assembly of the International Federation of Medical Students' Associations. This means that B.M.S.A., through him, is responsible for the co-ordination of world arrangements for student travel to other countries, which last year concerned some 3,000 students.

Last year the National Clinical Conference was held in Glasgow and was acclaimed a great success by the meeting. This year it is to be held in Sheffield. The Students' International Clinical Conference and the Tropical Medical Conference are to be combined this year and held in London.

The next important item for discussion was the future of the British Medical Students' Trust. This is a trust that has been in existence now

for about five years, the chief aim of which is to provide money in the form of scholarships for student clerkships abroad. It is hoped to extend this activity so that British medical students will be able to work in developing countries and the meeting decided to expand the work of the trust and to start an appeal for £40,000 to this end.

The Association is greatly concerned with the question of medical education. The Education Officer, Mr. Mark Casewell, presented the meeting with a report which is to be circulated to Deans and other authoritative bodies concerning elective periods.* The future duties of the Education Officer were defined at the meeting and the importance of closer relations with the ministry and with hospital and university authorities was stressed. It is the duty of this Officer to represent to these bodies the opinion of B.M.S.A.

At the Annual Dinner held on Saturday, 9th November, in the Hall of the Royal College of Surgeons of Edinburgh, the retiring Honorary President invested the new Honorary President. Medical Education was the theme of the speeches which followed. Professor Brotherton suggested, somewhat light-heartedly perhaps, that medical students organise their own curricula; he referred to the Jonathan Miller effect! Professor Sir Derrick Dunlop, a guest of the Association, pointed out that if the staff and students are of the best then the curriculum was more or less irrelevant. Mr. Kingsley Reid hoped that B.M.S.A. was increasing the responsibility of the medical student. He said that if doctors were dissatisfied with medicine in this country nothing would be gained by their emigrating, rather, they should remain and make their protests heard. The dinner had a decidedly Scottish flavour and was greatly enjoyed.

Mr. Jeremy Cobb, of Cardiff University, was elected President for the coming year.

The following arrangements for 1964 were made:

National Clinical Conference in Sheffield—17th-20th March.

Tropical Medicine Conference in London—15th-17th July.

Student International Clinical Conference in London—5th-26th July.

This year there will be several publications available to B.M.S.A. Members:

Introducing B.M.S.A.

Directory of Student Appointments—information about pre-clinical and clinical clerkships in non-teaching hospitals, where residence for students is provided free of charge.

* Further information and copies of the report may be obtained from the B.M.S.A. representatives.

How to go abroad—information about clerkships in hospitals abroad, pre-clinical and clinical summer schools in Scandinavia, and also on how medical students may obtain reduced travel rates.

B.M.S.A. Identity Card—this provides a means of identity for medical students who wish to obtain reduced travel rates and concessions on the Continent.

These are all free and may be obtained from representatives or direct from B.M.S.A. Office, B.M.A. House, Tavistock Square, W.C.1.

FIFTY YEARS AGO

From the Bart's Journal of January, 1914

In our last issue we called attention to a meeting of students of the University of London which was held with the intention of commending the report of the Royal Commission. This meeting was, as we explained, adjourned. The new meeting was held on December 5th.

No notice of this meeting was sent to the Hospital, and it was only by accident that we heard of it on the morning of the same day.

We suspected that the promoters, in their anxiety to carry their motion, had of malice aforethought attempted to keep in ignorance those whom they suspected of opposition. The time was too short for us to gather our forces together, but we felt that protest was necessary, and that an amendment from the medical students ought to be moved, so, with but one or two supporters, we attended the meeting and entered the lists.

There were probably between 1200 and 1500 students present altogether, and, having secured permission to ascend the platform, we sent forth our protest against the exclusion of the medicals from this so-called *representative meeting*.

The secretary rose, and replied that there were so few medicals present at the last meeting that he did not think it worth while to notify them.

The students present, however, did not swallow this pill, and, on their sporting instincts being appealed to, they passed an amendment on behalf of the medicals to the effect that the report of the Commission, in as far as it concerned medical teaching, was not entirely satisfactory and needed revision.

Ref.....

BANKER'S ORDER

To..... Bank Ltd.

.....branch (address of your bankers)

Please pay to the National Provincial Bank Ltd., 59, West Smithfield, E.C.1 branch, for the credit of the St. Bartholomew's Hospital Journal Account the sum of £...../.....s./.....d.pounds
.....shillingspence (amount in words) on the.....day of.....

(month) of EACH YEAR, commencing 19..... until this order is cancelled by me. If the date of this first payment shown here is past, please make the first payment on receipt of this order.

This authority cancels all previous instructions.

..... (name and qualifications)
..... (BLOCK CAPITALS)
.....
..... (Please sign over a 2d. Stamp)
..... (address for Journal)
..... (date)

PLEASE NOTE—The completed form should be returned to the Manager of the Journal.
WE WILL SEND IT TO YOUR BANKERS.

LOOKING BACK

To say we can look back over 25 years as Ward Sisters at Bart's certainly labels us as veritable Methuselahs—but a survey of these years can certainly produce some interesting comparisons.

Is there anything that has not changed? Perhaps our uniform is the really stable factor in our lives—apart from a dress an inch or two shorter and a cap that daringly shows a little more hair, a Sister looks the same to-day as she did more than 25 years ago. Legs are perhaps a trifle more elegant in nylon than they were in lisle, although the younger generation are doing their best to discard this modern asset!

For someone coming back for a first visit since the 1930's the changes would be staggering—emancipated Sisters living out in flats, driving or cycling around the Square—earning a salary at last comparable with other professions instead of the princely sum of £80 per annum we had when first in blue.

Would there be regrets for some things we have lost? Assuredly yes, for the stream of progress must always destroy in its wake much that was precious.

So we are sad as we remember the white counterpanes with the Bart's crest, the "pros." dove-grey frocks, the dignity of evening dinner in the Sister's dining-room served by impeccably-dressed maids, with Grace said by the Deputy Matron, the "monkey jackets" of the students, the ritual of morning prayers said to Nurses and maids by the Night Sisters and our pride in our own equipment (in this day of disposal and centralization). What else would stagger a visitor from by-gone days?

She would, of course, be overwhelmed by the number of Sisters: (we were a fairly select band of 48, now we are a more impersonal crowd of 83, with a Nursing Staff numbering 740), by the excellence of the Nurses' off duty and Study Blocks replacing lectures in off duty time, the tremendous improvement in the variety of amenities available to patients, in the quality of meals for everyone, and of course the turn-over in all departments has vastly speeded up. In the 1930's we kept our hernia patients in Hospital for three weeks—they progressed from bed to couch, to chair, to feet, and were washed by the Nurses until stitches were removed. There were three septic wards in the Hospital; perhaps one of the most amazing things is to realise that we do not need special wards for all the breast abscesses, the huge carbuncles, the Smithfield porters with hands or arms drained through and through with Carrel-Dakin tubes, and the young people with osteomyelitis, but in spite of the absence of antibiotics most of these patients recovered, even if their stay in Hospital was somewhat prolonged.

We started by doing dressings with our fingers, progressed to forceps and now we enter the C.S.S.D. era with everything in paper packs. Drugs were relatively few and simple, a tonic, a brand of iron, a few sedatives, analgesics, and heart stimulants. Now the choice is so huge, the use so liberal, the fancy so free and the side effects so alarming one could wish for the "good" old days! A blood transfusion was a major event entailing laying up a table over night, needing 24 hours notice; now the Houseman is considered inefficient if he cannot finish inside 10 minutes!

We had Martin the bath-man who came round with his portable tub to immerse the "septics" at the bedside, all very coyly done with a vast mackintosh over the bath up to the patient's chin.

The younger generation probably do not realize the vast strides made in radiotherapy and anaesthesia; vomiting was one of the most distressing things we had to deal with and very few drugs to help.

One wonders how quickly many of the changes within the Hospital would have come but for Hitler's intervention. The Hospital was divided between the City and St. Albans with the severance of much red tape almost over-night. Since 1948 we have had to re-fashion ourselves to post-war conditions and the National Health Scheme. We hope our patients notice little difference between the atmosphere of the old voluntary Hospital days and now our enforced allegiance to the State, but we are conscious of insidious change which does not all seem for the good of Bart's.

Twenty-five years as Ward Sisters—have we even managed to keep out the Consultants at 12 midday!

N.G.D., M.T.H. & E.C.H.

UP TO THE MINUTE IN A MOMENT

December, the final fling of the dying year, was chosen for the first British attempt at long range weather forecasting and we were warned to expect a cold, dry month with freezing fog. This dismal prophecy is proving only too true.

On 1st December the results of the Australian and New Zealand General Elections were announced, the governing parties being returned to power. Speculation as to the date of our own election continues and the diminishing Labour lead as shown in the opinion polls seems to indicate that the longer the Tories postpone the election the better they will do. If the Conservatives are returned then nobody will deserve a knighthood more than **Mr. George Brown**.

News from the Antipodes also figured highly in the sporting pages as the Australians finally resolved the throwing controversy with the public sacrifice of **Ian Meckiff**.

On 3rd December it was announced that **Princess Margaret** had joined the Royal Baby Race.

An excellent reception was held on 4th December in Gloucester Hall to mark the enrolment of the millionth blood donor in this region of the National Blood Transfusion Service. The meeting was presided over by **Rear Admiral P. K. Kekewich, C.B.**, a governor of the Hospital, who welcomed the guests to Bart's. **Sir Graham Rowlandson, M.B.E., J.P.**, Chairman of the North East Metropolitan Hospital Regional Board, thanked the various firms, banks, factories, and government departments who have helped the service in the past. Sir Graham then presented silver badges to donors who had given 25 or more donations of blood. Dr. H. F. Brewer, Senior Lecturer in Clinical Pathology, emphasised the continuing need for blood by the hospitals and said that, at 7,000 bottles per year, Bart's used more than any other London Hospital.

Information about Hospital plans is all too often acquired only by hearsay, however, the following comes to us from **Mr. Goody**, Clerk to the Governors. The Ministry of Health have agreed that the Out-patient department will be entirely rebuilt after 1971. In the meantime they are making capital available to renovate the Casualty Department on a grand scale, starting in 1964. The first step is to move the students into the New Abernethian Room.

The beams supporting the floor of the Great Hall have been in position for two and a quarter centuries but the floor will only support 150 people. Work has now started on strengthening the floor and thus making the Hall available

for 350 people. Central heating, amplification for lectures and talks, and local lighting circuits will be incorporated at the same time. When completed, the Hall will provide a first-class centre for conferences, study days, and similar events. When the work on the Great Hall is finished the Clerk's House will be re-designed internally to provide a Consultants' Common Room, a Committee Room and a space in the basement for a permanent display of archives.

On 4th December the Soccer Club drew 2-2 with the Royal Veterinary College, while the Mens' Hockey 2nd XI beat Middlesex in the Junior Cup 1st Round Replay.

The Rugger Club Ball was held in College Hall on the night of 5th December and was judged a success by all; it is reported on page 30. The Ball was organised, it appears, by **Mr. Jeremy Gilmore**, the club's social secretary. Two days later the 1st XV beat the Old Cranleighans 13-5, thus winning four matches in succession. Bart's play Charing Cross in the Hospital Cup on 9th January at Richmond.

On 6th December **Miss Christine Keeler** was sentenced at the Central Criminal Court to nine months' imprisonment for perjury. Will this be the final round?

On 9th December two former Ghanaian Ministers and a former executive secretary of the ruling Convention People's Party were acquitted of treason charges and two others were sentenced to death. Two days later the President of the Court, the Chief Justice of Ghana, was sacked by **Dr. Nkrumah**.

On the 11th, **Mr. Frank Sinatra**, an American singer, paid £85,000 to kidnappers for the return of his nineteen-year-old son, thereby setting off a dispute between the Los Angeles police and the F.B.I. who, on the 14th, arrested three men in this connection. The Soccer Club beat St. Thomas's 5-3, a good omen as they hope to meet them in the semi-final of the Hospital Cup, having first disposed of Westminster on 22nd January at Chislehurst.

The Dumfries by-election result, probably the last before the General Election, was announced on 13th December and another safe Tory seat became a marginal one.

On Sunday, 15th, Bart's was represented on the B.B.C.'s programme "Down Your Way" by the Steward, **Mr. A. Brett**.

The black, woolly spiders, which have been on sale from street traders in London's West End for several years, have now been re-named—**BEATLES**.

15th December.

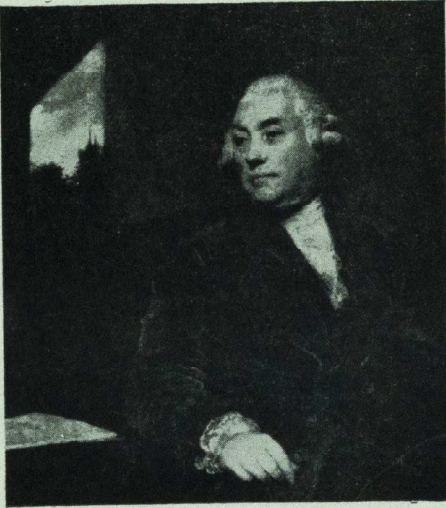
PERCIVALL POTT (1714-1788)

by John L. Thornton, Librarian

LOOKING back over the centuries one is sometimes struck by characters standing out prominently above the heads of their contemporaries. Some were inconspicuous in their own generation; others achieved fame and maintained it long after death; many others were regarded as the leaders of their profession, possibly on account of their successful practices, but were quickly forgotten after their deaths. A few achieved distinction in their lifetimes, and with the course of time their reputations have been enhanced as a result of closer investigation of their achievements. One such was Percivall Pott, Surgeon to St. Bartholomew's Hospital.

Sir D'Arcy Power published a pedigree of Percivall Pott, which was supplemented by an article by W. H. Challen, and it would appear that the Pott family originated in Cheshire. Percivall Pott's father was a London notary and scrivener, and married Elizabeth Houblon, a widow with one daughter, on the 23rd of November, 1712. Their only son was born on the 6th of January, 1714, in Threadneedle Street on the present site of the Bank of England. The original house has since been pulled down, probably between 1766 and 1788. In 1717, when Percivall was only three, his father died leaving less than £5, but fortunately Dr. Joseph Wilcox, Bishop of Rochester, and a distant relative of Percivall's mother, took the boy under his patronage.

About 1720 Percivall was sent to school at Darenth in Kent, and spent seven years there. It was intended that he should become a clergyman, possibly because of his patron, but this was not his ambition, and on August 1st, 1729, Percivall Pott was apprenticed to Edward Nourse (1701-1761), surgeon at St. Bartholomew's Hospital, the



The Portrait of Percivall Pott by Reynolds.

sum of 200 guineas being paid as a premium for the seven years apprenticeship. Nourse gave lectures on anatomy at London House in Aldersgate Street, and later from other addresses, and thought highly enough of his apprentice to make him his prosecutor. In 1736 Pott's apprenticeship terminated, and on September 7th he was admitted to the Freedom of the Company of Barber-Surgeons, despite the fact that he was not present at the time appointed for his examination. On the same day he received the Great Diploma of the Barber-Surgeons. That year Pott hired a house in Fenchurch Street and began

private practice, his mother and step-sister living with him.

On April 7th, 1739, Percivall Pott was a candidate for the post of assistant surgeon at St. Bartholomew's Hospital, but secured only 41 votes compared with the 202 gained by the successful applicant, John Townsend. It was not until March 7th, 1744/45, that Pott was appointed to the Hospital, when he was opposed by Stafford Crane, Francis Wm. Manatom and Philip Stevens. Meanwhile, before May 1st 1738, he had moved to Bow Lane, and in that year took the livery of the Barber-Surgeons' Company, paying the usual fine of £10. He later became an active member of the Corporation of Surgeons when this was formed in 1745, and was obviously making a name for himself in the profession.

In 1746 Pott's mother died at the age of eighty-six, and he now married Sarah, daughter of Robert Cruttenden, on the 27th of June, 1746, and they had nine children, one of whom died a few months after birth. One of the daughters, Mary, married (Sir) James Earle; one of the sons, Joseph Holden Pott, became Archdeacon of London, and another, Robert, was the despair of

his father, and died in India following an undistinguished career as a solicitor and a notorious one as a rake. All the children were well educated, and descendants of several of them achieved distinction in various fields.

On the resignation of James Phillips, Pott was appointed full Surgeon to St. Bartholomew's Hospital on November 30th, 1749, a position he was to hold with distinction until his retirement in 1787. The year 1756 saw him living in Watling Street, and it was in January of that year that he was thrown from his horse in the Old Kent Road, suffering a compound fracture of the tibia, the bone being forced through the integuments. Calmly directing two chairmen to fetch poles from Westminster to form a stretcher with a door he had purchased, Pott was then carried through Southwark and over London Bridge to his home. Preparations were made for amputation, but, shortly before the start of the operation, Edward Nourse arrived and decided to apply more conservative treatment, which was successful. It was during his convalescence that Pott began to write his first book, a treatise on ruptures, and it is possible that the name of Percivall Pott would be little known today had not his accident stimulated him to occupy his time usefully by writing. Several of his books were translated into foreign languages and reproduced in American editions, and the name of Pott was as well known on the Continent as in London.

In 1764 Pott was elected a Fellow of the Royal Society after contributing a paper on an uncommon case of hernia of the urinary bladder, including stone. He had become a Member of the Court of Examiners of the Company of Surgeons (1761), Under, or Second Warden of the Company in 1763, and Governor of the Company in 1765. About this time he instituted a course of lectures at his home in Watling Street, which was later conducted in a room provided in the Hospital. Pott had a villa at Neasden and spent some of the autumn months at Bath. In 1769 he purchased a house in Lincoln's Inn Fields, and lived there until 1777 when he moved to Princes Street, Hanover Square. The retirement from practice of Sir Caesar Hawkins resulted in much more work for Pott and within a few years he had the largest surgical practice in London. His lectures attracted foreign pupils, and his writings, some of which were translated into Dutch, French, German and Italian, increased his popularity abroad. His portrait by Reynolds was exhibited at the Royal Academy in 1785, and in the following year Pott received the first honorary diploma issued by the Royal College of Surgeons, Edinburgh. On September 9th, 1787, the Royal Col-

lege of Surgeons of Ireland presented to him a silver box containing the Freedom of the College. By then, however, Percivall Pott had begun to shed some of his surgical work. On July 12th, 1787, he resigned his appointment at St. Bartholomew's Hospital, and at a dinner given in his honour by the Hospital, the President, the Rt. Hon. Thomas Harley proposed a toast to the retiring surgeon. Percivall Pott rose to his feet, but was so overcome by emotion that he had to sit down without replying. He was nominated a Governor by the President, and was sent the traditional green staff.

The following was written by a pupil of St. Bartholomew's Hospital on the resignation of Pott:—

ST. BARTHOLOMEW'S LAMENTATIONS*

Ye wretched Creatures whom my Walls contain!
(How much more wretched now shall be your lot)
Cease to bemoan your agonising pain,
And join with me to mourn the loss of Pott.

Who with the keenest eye and steadiest hand,
And the best Judgement Nature could bestow,
For fifty years has well supplied the land
With wooden legs and such sad sights of woe.

Heavens! when he lopped a limb to save a life,
Or freed a bladder from the galling stones,
Death fled affrighted when he seized the knife,
And the weird sisters trembled at his frowns.

But he, serene, amidst the Blood and cries
Of the poor wretch with horrid fortunes fired
Could calmly turn about—and bless your eyes
Or damn them either—if the case required.

Lives there the man who can supply his place
With half the dignity which he could boast?
For who could operate with so much grace?
Or with such blest assurance rule the roast.

What now shall gain Bartholomew renown?
For all my riches can avail me not,
What brought each leaden-headed lad to town?
What drew them hither but the name of Pott?

Shall Pitts, Earle, Blicke parade my wards alone,
And not a Pupil follow at their heels?
Shall Long and Harvey set a broken bone?
Oh no! Kind Heaven, defend us from such ills.

Still Pott shall grace the dictatorial chair,
Shall teach e'en blockheads in his art to shine,
Still to my walls in flocks they shall repair,
Still laugh at Hunter and still pity Cline.

Pott still continued to see private patients, and on December 11th, 1788, after visiting a patient twenty miles from London he caught a chill and took to his bed. Feeling better a few days later, he went out but became delirious. At intervals his observations were sound and on the seventh

* See notes on page 11.

day he remarked: "My lamp is almost extinguished; I hope it has burned for the benefit of others". The next day, December 22nd, Percivall Pott died.

His lamp had, indeed, burned for the benefit of others. He had bridged the gap between barber-surgeons and surgeons and given the lie to those who considered surgeons to be uneducated morons compared with the university-educated physicians. Pott had been brought up to appreciate the classics and his writings acknowledged the work of his predecessors. He had read Fallopius, Hippocrates, Paulus Aeginetas and Rhazes. His numerous pupils included John Hunter, Charles Blicke and John Abernethy, and among his patients were Dr. Samuel Johnson and David Garrick.

On January 7th, 1789, the earthly remains of Percivall Pott were buried near those of his mother beneath the chancel of St. Mary Aldermanbury, Row Lane, where the following inscription written by his son, Archdeacon Joseph Holden Pott, may still be read, despite severe damage to the church during the war:—

In Memory
OF PERCIVALL POTT, Esq., F.R.S.
Surgeon of St. Bartholomew's Hospital during
Forty-two Years,
Who departed this Life, December 22nd, 1788, aged 75.
He was
Singularly eminent in his Profession,
To which he added many new Resources, and which
he illustrated
With matchless Writings.
Let Posterity revolve the Sum of his Experience,
That the World may still enjoy the Benefit of his
Successful Practice.
He honoured the collective Wisdom of past Ages:
The Labours of the Ancients were familiar to him:
He scorned to teach a Science of which he had not
traced the growth;
He rose, therefore, from the Form to the Chair.
Learn, Reader, that the painful Scholar can alone
become
The Faithful Teacher.
But his studies had a double Issue:
Whilst he gathered the Knowledge of his Predecessors,
He perceived their Errors, and corrected them;
He discovered their Defects, and supplied them.
Original in Genius, prompt in Judgment,
rapid in Decision,
He directed Knowledge to its proper Ends;
But pursued them when the Aids of Information
were exhausted;
The last Steps, therefore, and great Improvements,
Were his own.
His integrity is before his Judge;
Without it, his Skill might have profited Mankind,
But could have claimed no Record within these Walls.
His private Virtues,
His signal Tenderness to his Family,
Completed an Example,
Amiable, Useful, Great.

Born two-hundred-and-fifty years ago, Percivall Pott served this Hospital "man and boy for half a century", and greatly enhanced its reputation. His name has been appended eponymously to several conditions, including "Pott's disease", "Pott's fracture", and "Pott's puffy tumour", so that he could not readily be forgotten. "Who was Pott?" is not an uncommon question addressed to students, but must also be a question difficult for their teachers to answer. We have little personal knowledge of him that might have been gleaned from diaries or letters, and those writing about him have been very contradictory. He is worthy of a full-scale biography or at least a thorough investigation into the facts of his career, his influence on his contemporaries, on his pupils, and on the subsequent development of surgery. We have his writings, which contain a wealth of fascinating material relating to the social conditions of his times; we have portraits of him by Sir Joshua Reynolds in the Great Hall, by George Romney at the Royal College of Surgeons of England, and several others, though the authenticity of some is suspect; and we have several modern sketches of his life and writings that collect together information previously recorded without seeking out original sources.

Pott stood out in his own generation as a good lecturer who taught at the bedside, and whose writings were valued for their readability as well as for their sound teaching. He attacked quacks, the plague of his period, and condemned the excessive use of the cautery. Using few instruments when operating, his surgery was conservative, and he was critical of those whose favourite pastime was to attempt to "beat the clock" when amputating. Although for a time engaged in a heated argument regarding priorities with the Hunters, Pott appears to have successfully avoided most of the quarrels prevalent at that period among members of his profession. In fact, at the time of their dispute, William Hunter wrote of him: "He has treated me for the most part with the language of a gentleman for which I thank him."

A family man, Percivall Pott had treated his mother with great consideration, and deferred marriage until after her death. His children and grandchildren adored him, his pupils and colleagues spoke highly of him, and his successors have found nothing to criticise in his lengthy career devoted to surgery. When he died, among his papers was found a small box containing the money left by his father, together with an account of all the fees received during his career. Percivall Pott was successful, but not pompous. He wrote: "Our fathers thought themselves a great deal nearer to perfection than we found them to be;

and I am much mistaken if our successors do not in more instances than one, wonder both at our inattention and our ignorance. Notwithstanding all our late improvements, there is still ample room to exercise all the powers of many succeeding artists, and to furnish them with large opportunity of acquiring honour to themselves, and of doing much praiseworthy service to mankind."

Humility is a characteristic too seldom encountered in surgeons, but it did much towards creating a character that was admired during life, and which has become enhanced with the passing of the years.

Works

Percivall Pott's books included *A treatise on ruptures*, 1756, which went into four editions; *Observations on that disorder of the corner of the eye, commonly called fistula lachrymalis*, 1758, and four later editions up to 1775; *Observations on the nature and consequences of wounds and contusions of the head*, 1760, containing the original description of "Pott's puffy tumour"; *Practical remarks upon the hydrocele*, 1762; *Remarks on the disease, commonly called a fistula in ano*, 1765, which also went into four editions; *Some few general remarks upon fractures and dislocations*, 1768; *Observations on the nature and consequences of those injuries to which the head is liable from external violence*, 1768; *Collected surgical works*, 1771 (4 vols.), and several other editions up to 1819; *Chirurgical observations relative to the cataract, the polypus of the nose, the cancer of the scrotum*, [etc.], 1755; *Remarks on that kind of palsy of the lower limbs, which is frequently found to accompany a curvature of the spine*, 1779, which is usually given as the source for the first description of spinal curvature due to tuberculosis, but this was also described by Jean Pierre David (1737-1784) in 1779; and *Farther remarks on the useless state of the lower limbs, in consequence of a curvature of the spine*, 1782.

Sources of Information

Brown, John R., and Thornton, John L. Percivall Pott (1714-1788) and chimney sweepers' cancer of the scrotum. *Brit. J. Indust. Med.*, 14, 1957, pp. 68-70.
Challen, W. H., Sir James Earle, Kt., and Dr. [sic] Percivall Pott. *Genealogists' Magazine*, 12, 1955, 86-88, 126-128.

Earle, Sir James, A short account of the life of Mr. Pott. *The chirurgical works of Percivall Pott. A new edition [etc.]*, Vol. 1, 1808, pp. iii-xli.
Horder, [Lord] Thomas J. The life and works of Percivall Pott. Being the Wix Prize Essay for the year 1894. *St. Bart's Hosp. Rep.*, 30, 1894, pp. 163-187.
Jones, Arthur Rocyn. Percivall Pott. *J. Bone Jt. Surg.*, 31B, 1949, pp. 465-470.
Kelly, Emerson Crosby. Medical Classics, Vol. 1, iv, 1936, contains a chronology of Percivall Pott; a bibliography of his writings and of biographies of him; and reprints of his *Remarks on . . . palsy of the lower limbs*, *Further remarks, and Some few general remarks on fractures and dislocations*.
Lloyd, G. Marner. The life and works of Percivall Pott, 1714-1789 [sic]. *St. Bart's Hosp. Rep.*, 66, 1933, pp. 291-336.
Peltier, Leonard F. Percivall Pott and Pott's fracture. *Surgery*, 51, 1962, pp. 280-286.
Potter, John M. Percivall Pott on head injuries, 1760. *St. Bart's Hosp. J.*, 64, 1960, pp. 331-333.
Power, Sir D'Arcy. Epoch-making books in British surgery. IX. The works of Percivall Pott. *Brit. J. Surg.*, 17, 1929-30, pp. 1-6.
Power, Sir D'Arcy. Pedigree of Percivall Pott, F.R.S. *St. Bart's Hosp. J.*, War Ed. 2, 1940-41, pp. 19-21.
Power, Sir D'Arcy. Eponyms. VII. Percivall Pott: his own fracture. *Brit. J. Surg.*, 10, 1922-23, pp. 313-315.
Power, Sir D'Arcy. Pott, Percivall (1714-1788). *Dictionary of National Biography*, 46, 1896, pp. 207-211.

Notes on St. Bartholomew's Lamentations

Pitts, Edmund. Asst. Surgeon, 1760. Surgeon, 1784-1791.
Earle, Sir James. Asst. Surgeon, 1770. Surgeon, 1784-1815.
Blicke, Sir Charles. Asst. Surgeon, 1779. Surgeon, 1787-1815.
Long, William. Asst. Surgeon, 1784. Surgeon, 1791-1807.
Harvey, Sir Ludford. Asst. Surgeon, 1784. Surgeon, 1807-1824.
Cline, Henry. Surgeon at St. Thomas's Hospital. Hunterian Orator in 1816-1824. Pupil of John Hunter.
Hunter, John. Founder of Experimental Surgery 1728-1793.

A BACKGROUND FOR PERCIVALL POTT

by W. R. Le Fanu, M.A.,
Librarian, Royal College of Surgeons of
England

LOOKING at an earlier century is very much like visiting a foreign country less advanced than our own. No light but candles, no transport but horses, no piped hot-water, no sanitation, no hygiene. Yet Samuel Johnson, Pott's contemporary, remarked that "when a man is tired of London, he is tired of life".

The London of 200 years ago would seem fairly familiar to us in its street plan and many of its buildings, but we should find it inconceivably dirty and offensively smelly. At the time it must have seemed a city renewing itself in spaciousness and splendour. Sir Christopher Wren's rebuilding of the City went on for forty years after the Fire of 1666, and in Pott's boyhood new streets and squares with fine private houses were spreading into the "west end". The lordly landowners whose properties lay between Piccadilly and Oxford Street were exploiting the demand for houses by leasing their land for building; Burlington, Grosvenor and Berkeley have left their names on familiar landmarks, only partially rebuilt in our time. North of Oxford Street and Cavendish-Harley estate was laid out during Pott's early life in streets with names well-known to generations of doctors, and the Portman estate further west was built over as he grew older.

More directly interesting to Percivall Pott must have been the modernisation of St. Bartholomew's Hospital itself between 1730 and 1759. The spacious central square, replacing a series of small courts, is typical of this expansive age; James Gibbs's noble building remains almost unchanged on the west side of the Square. Early in the century old St. Thomas's had been rebuilt in formal quadrangles, long since destroyed; it must have looked somewhat like St. John's College, Cambridge. All through Pott's life new hospitals were being built throughout London and in every large city; they were the chief expression of the humanitarian spirit which redeemed a cruel and complacent society. Most of these hospitals were single blocks of building, such as we see at St. George's (1733), handsome exteriors with large well-lit wards. They were not meant to be comfortable or inviting, and the patients were treated like workhouse inmates. The weekly inspection

by the house-committee was concerned with discipline, anxious that patients were not smuggling drink into the hospital.

The contrast of wealth and poverty was extreme. The well-to-do were more ready to patronise luxurious craftsmanship and more ostentatious in their clothes and carriages and houses than at any other period. The poor were totally illiterate, living in squalor in little streets among the great houses, not in separate suburbs; England was not yet divided into Disraeli's "two nations". A static grading of society was complacently accepted and those who could not compete were shamefully neglected. Though the Courts were incorruptible and every Englishman free before the law, there was an ever-growing schedule of crimes with disproportionately retributive punishments. Public executions were frequent outside Newgate Prison, close to the Hospital. Criminals who were not condemned to death might be sold to the tobacco plantations in America to work as slaves for the term of their sentence, or else die of typhus in prison. Only in the 1770's did John Howard begin his campaign for prison reform.

In spite of lacking sanitation or realising the lack, England remained fortunately free from great epidemics. Bubonic plague did not return after 1665, and cholera did not arrive till the early nineteenth century. Excessive gin-drinking in the 1740's was thought to have pushed up the death-rate rapidly and Hogarth campaigned for beer-drinking instead. Some well-off men certainly drank too much wine, for drunkenness carried no social slur. But spirits were heavily taxed from 1751, and people began to abstain on moral grounds also. Tea-drinking became popular in all classes. Dr. Johnson at his various dining-clubs always drank lemonade. Snuff-taking was universal, but smoking went wholly out of fashion. Food was reasonably plentiful and cheap, though the poor were often content with cheese in place of roast beef.

Endemic smallpox was the worst scourge of all classes. The attempts to control it by inoculation with its own matter formed the one public health project of the century. Characteristically, this was not a public undertaking in our sense,

but a series of independent efforts by individual physicians, such as Daniel Sutton of Ingatestone in Essex. The problem was only tackled scientifically by Edward Jenner at the very end of the century (1798), and that too was the effort of one country surgeon. Such small-scale individual work was typical of the eighteenth century in all the sciences. We see men consolidating and classifying knowledge, making experiments in many directions, but achieving no real break-through till about the end of Pott's lifetime.

The late Humphrey Pledge in his well-known *Science since 1500* remarked of the eighteenth-century: "One might have expected after Newton a great burst of discoveries. What came was a long period of slightly stunned assimilation. An observer born early in the century, and making the Grand Tour, would have been an old man before he came across, in the Paris of Lavoisier, anyone worthy of Newton. It was a century of long ripening of ideas, of growing specialisation and concentration."

Many of the fields exploited in the nineteenth century had been opened in the seventeenth: the microscope had been developed, bacteria discovered, tissue-forms and even cell-structure observed; but all lay fallow for a hundred years. Electricity, already adumbrated by Dr. William Gilbert in 1600, is one of the few sciences which notably advanced in the eighteenth century, but there too the real development began, a decade after Pott's death, with Galvani. The leading biologists, Buffon and Linnacus, were systematisers and classifiers, while new knowledge accumulated from the travels of such as Pallas in North Asia or Banks in Australia without provoking new modes of thought. John Hunter's museum was a giant scheme of systematisation, displaying the forms of life through all classes of animals including man, and through all their organs and systems. John Hunter hardly used a microscope, though he used a thermometer in his experiments on hibernation in the 1770's. But the clinical thermometer was only introduced by Aikin and Currie in the 1790's, when Pott and Hunter were dead, and even then it took half a century to grow popular. Yet craftsmanship was at its height: English clocks and chronometers were the very best, and other mechanisms could easily have been developed.

Albrecht von Haller, the most productive and influential man in eighteenth-century medicine, was equally a systematiser. His vast *Elements of Physiology* recorded all that was known in that

subject. He was the first to accept the challenge from the rising flood of scientific publications, and devised means to analyse them. There is no single "discovery" which we attribute to Haller or Hunter or Morgagni, the great recorder of pathological observations, as we link the circulation with Harvey or antiscipsis with Lister. Surgery similarly was consolidated, not startlingly advanced. Pott's own contributions, to which his name is attached, were more to pathological knowledge than surgical method. The first great development of modern surgery came in the next generation, through John Abernethy, Astley Cooper and Charles Bell.

Medical education was, however, greatly improved. Not only in technical matters, but also in general cultivation and social consideration, there was a marked rise in the position of the surgeon. Charles Bernard (1656-1710), surgeon to St. Bartholomew's Hospital, was the first surgeon who was also a cultivated scholar. Caesar Hawkins, surgeon to St. George's, and the same age as Pott, was the first, in 1778, to be created a baronet.

Hermann Boerhaave of Leiden, clinician, botanist and chemist, who died in 1738, had attracted pupils from the whole civilised world, and had established standards for medical knowledge and training. Previously such a man as the famous Dr. John Arbuthnot could rise to a leading London practice on purely theoretical learning. Boerhaave's example was followed by Alexander Monro, first of the dynasty of anatomy professors at Edinburgh; Monro's excellent course of surgery lectures drew mainly on French practice. In London, William Cheselden (1688-1752), surgeon to St. Thomas's, was reprimanded by the Company of Barber-Surgeons in 1714, the year of Pott's birth, because his private classes drew students away from the Company's lectures. Corporate bodies, which had flourished in earlier times, were dormant and only re-awoke in the new century. The Royal Society and the Royal College of Physicians fulfilled their nominal duties but had temporarily lost their initiative. The Surgeons separated from the Barbers in 1745, but their own new Company was little more than an examining board, and expired in 1799, to be reconstituted as the Royal College of Surgeons. Private medical schools, and private teachers in the public hospitals, drew the young men. William Hunter's anatomy school in Windmill Street was unrivalled for two generations and Pott's own lectures were eagerly followed.

Pott's Eponyms

Pott's Disease

by H. J. Seddon, C.M.G., D.M., F.R.C.S.,
Director of Studies at the Institute of
Orthopaedics

There are nice degrees in eponymy. The most notable is when a man's name goes unchanged into the language, though, if Guillotin, Boycott and Quisling are anything to go by, the distinction may be unenviable. For a name to become an adjective comes perhaps next and Percivall Pott is memorialized to this day on the other side of the Channel in his *Paraplégie Pottique*. Throughout the world he is best known as the man who first described tuberculous disease of the spine.

So striking a condition as an angular deformity of the spine accompanied by paralysis of the legs could hardly have failed to attract the attention of earlier observers. There is a clear description of tuberculous disease of the spine in Hippocrates, though, oddly enough, none of its most dramatic complications. In 1570, Jacques Dalechamps, of Lyon, wrote a treatise on surgery in which he described what was almost certainly Pott's paraplegia, and in 1632, Marcus Aurelius Severinus—an engaging name—mentioned that a hump in the back could cause paralysis of the legs. But it was Pott in 1779 who gave the first clear description of the disorder in his *Remarks on that kind of palsy of the lower limbs which is frequently found to accompany a curvature of the spine and is supposed to be caused by it*.

At that time, and indeed until Koch's discovery of the tubercle bacillus in 1882, there was a good deal of confusion about the nature of the various disorders that we now know to be caused by tuberculosis, which was hardly surprising in view of the protean manifestations of the disease. People had talked for centuries about what they call scrofula, a term applied most commonly to tuberculous glands in the neck. But there were scro-

fulous joints too, and Pott recognised that the disease in the spine was probably of this nature.

In the museum of St. Bartholomew's Hospital there are two specimens attributed to Pott; a dry segment of the spine showing destruction of the vertebrae and bony fusion (Fig. 1); and a short length of spinal cord, preserved in spirit, which is narrowed in the middle, but showing no signs of inflammation (Fig. 2). Yet, although Pott was familiar with the morbid anatomy of the tuberculous spine, he did not get very far in elucidating its pathology; this had to wait until 1827 when a Frenchman, Ollivier, published an account of his post-mortem studies and pointed out that the paraplegia was usually due to compression of the cord by an abscess or granulation tissue. But Pott made up for this by the accuracy of his clinical observations. Without knowing why, he discovered that, unlike most other forms of paraplegia, this kind could recover spontaneously.

However, Pott had an itch to interfere. A Dr. Cameron, of Worcester, had come across a passage in Hippocrates (which I have been unable to find) in which he mentioned that a paralysis of the lower limbs could be cured by an abscess in the back or loins. Bouvier—in 1858, long after Pott—noticed that the appearance of an abscess sometimes heralded recovery from the paraplegia. To-day we know the reason for this. If the compression of the cord is due to an inflammatory mass it follows that when an abscess tracks away from it, towards the surface, a spontaneous internal decompression of the cord is likely to take place. Pott and Cameron tried the effect of an artificially induced abscess and their efforts met with success. At first Pott favoured the introduction of an irritant—a large kidney bean—to produce a "suppuration from underneath the membrana adiposa" somewhere in the region of the deformity; in his later cases he used a cautery. It did not occur to Pott that the enforced rest necessitated by a stay in hospital and the dis-

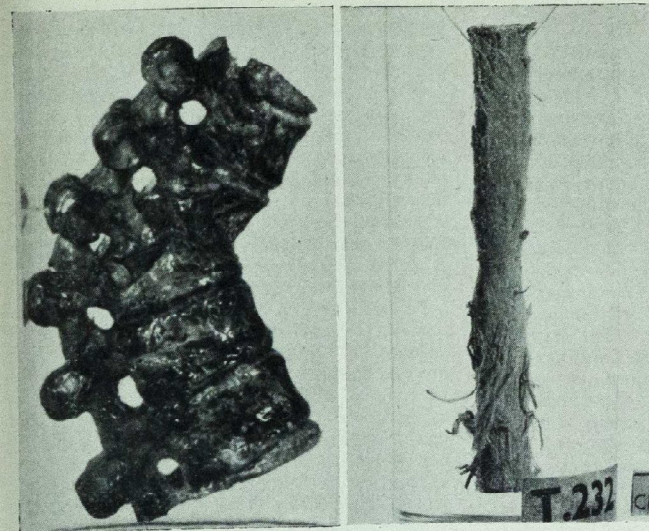


Fig. 1 (extreme left)—Dry specimen of spine showing destruction of the vertebrae and bony fusion.

Fig. 2 (left)—Specimen of spinal cord showing narrowing in centre.

Both specimens are in the Pathological Museum of St. Bartholomew's Hospital and are attributed to Percivall Pott.

(By courtesy of the Curator of the Museum and the Dept. of Medical Photography.)

comfort resulting from such treatment was the most potent factor in the recovery of his patients.

An almost unknown surgeon in Rouen, Jean Pierre David, was on sounder lines. In 1779, the year in which Pott published his famous paper, David wrote a dissertation in which he described tuberculous disease of the spine and insisted that the proper treatment was rest. Eighty years later a more famous Frenchman, Bouvier, did his best to up David and down Pott. He compared what they had written: "Which conforms more closely to the actual facts? Which indicates the attentive observer, the impartial critic—in a word—the true physician?" Bouvier went on to say that the advocate of counter-irritation, cauterization—a form of treatment popular among the Arabs—was none other than the illustrious Pott "whose illusions or vanities have been translated into every language"; the other, the apostle of rest, the observer of Nature, was the humble David whose writings had remained unnoticed—collecting dust on library shelves—for too many years. But it was no good, and in

France the disease of the spine still remains obstinately, *le mal de Pott*.

Pott's second paper (1782), *Further remarks on the useless state of the lower limbs in consequence of a curvature of the spine* amplified and, to some extent, corrected his earlier observations. The arms as well as the legs might be paralysed, Mr. Parke, of Liverpool, having seen two such cases; and paraplegia might occur in the absence of deformity. He said that paraplegia was not associated with the "deviations from right shape to which growing girls are so liable", by which he undoubtedly meant scoliosis.

When the disease healed, ankylosis of the spine occurred; "the thing aimed at is the consolidation and union of the bones . . . This is the sine qua non of the cure". Here he was on firm ground and this remains the aim of treatment. The process can be hastened by operation; nevertheless, it is still salutary to recall an excellent Pottism, that "Time and patience are very requisite, but they do in this case, as in many others, accomplish our wishes at last".

Pott's Fracture

by J. N. Aston

Percivall Pott can be said to be one of the early pioneers of orthopaedic surgery, a field where Bart's has always been to the fore. The first step taken by the Hospital was in 1583, when John Izard was appointed official "bone-setter".

Percivall Pott is perhaps best known in association with Pott's Fracture of the Ankle, which he described in 1768 in a paper entitled *Some few general remarks on Fractures and Dislocations*.

A Pott's Fracture is caused by forcible external rotation and abduction of the foot, occurring when the patient is moving forwards. The original illustration accompanying the paper (Fig. 1) gives a fairly clear impression of the injury.

Three structures are damaged, the extent depending upon the severity of the injury. Firstly, the lateral malleolus is invariably fractured, the line running obliquely upwards and backwards. Secondly, if the force continues the foot is abducted thereby either breaking the medial malleolus transversely or tearing through the medial (deltoid) ligament of the ankle. Lastly, if the foot is also displaced backwards, a posterior marginal fragment from the tibial articular surface is sheared off, the fracture line running almost vertically upwards.

There are, therefore, three degrees of external rotation fractures of the ankle. The first degree is where the fibula alone is fractured and, as only one structure has been injured, displacement cannot occur (Fig. 2). In a second degree Pott's fracture two structures are injured, one on either side of the ankle, with two elements of displacement, both abduction and external rotation (Fig. 3). The third degree fracture involves three structures, the lateral malleolus, the medial malleolus or medial ligament, and the posterior fragment from the tibia, which is sometimes known as the "posterior malleolus". In this fracture the displacement is three-fold — backwards, laterally (abducted), and externally rotated. (Fig. 4.)

A first degree fracture is not serious, the fibular fracture invariably unites in three to four weeks. Treatment is mainly symptomatic and three weeks in a below-knee walking plaster-of-Paris cast usually suffices. Second and third degree Pott's fractures require the maintenance of perfect reduction. Occasionally, when the medial ligament has been ruptured, momentary reduction during the course of radiological examination may mask the severity of the injury. Careful clinical examination is therefore necessary because, while in a

first degree fracture swelling and tenderness are mainly on the outer side of the joint, in second degree fractures signs will be present on both sides of the joint.

Manipulative reduction, in the reverse direction from that which caused the injury, is usually employed, followed by eight to twelve weeks immobilisation in a below-knee plaster cast. Open reduction, with internal fixation of the medial malleolus using a screw, is often necessary, as when the check radiograph after manipulation suggests that a flap of periosteum is interposed. A persistently displaced "posterior malleolus" may also require internal fixation.

Percivall Pott, in his original instruction on reduction advises "if the position of the limb be changed . . . with the knee moderately bent, the muscles forming the calf of the leg, and those which pass behind the fibula and under the os calcis, are all put into a state of relaxation and non-resistance . . ." In practice this is carried out by placing the anaesthetised patient with the affected leg hanging over the end of the operating table. This allows the surgeon, seated opposite

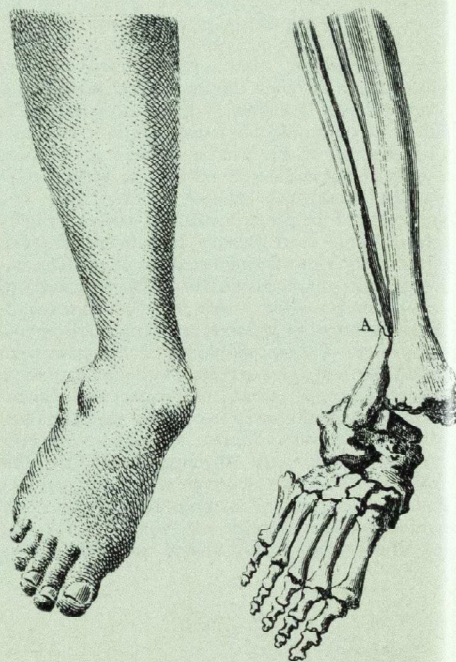


Fig. 1. Pott's original illustration.

(Reproduced by courtesy of the British Journal of Surgery)

the end of the table, to rest the foot on his knee. In this position, reduction is achieved by drawing the foot forward and inwards with one hand curved round the heel, while the other exerts pressure on the inner side of the tibia. The plaster cast is then applied and carefully moulded as it sets.

After removal of the plaster some stiffness is

usually present and swelling may occur but, in many instances, these merely cause inconvenience and soon disappear. When, however, the displacement has been severe and the damage both to bone and soft tissue has been extensive, a course of vigorous mobilising exercises, possibly assisted by some purposeful occupational therapy will probably be required.

These diagrams each show (left) anterior view of right ankle and (right) lateral view of right ankle. In Fig. 4 the fibula has been omitted from the lateral view for clarity.

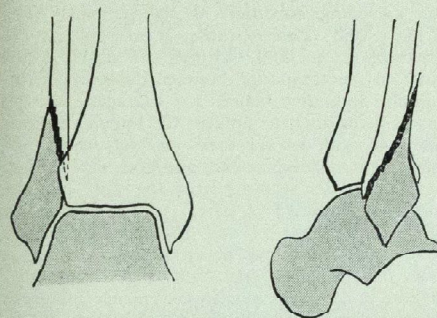


Fig. 2 (left). First degree fracture. The fibula is fractured. There is no displacement.

Fig. 3 (right). Second degree fracture. Both malleoli are fractured. The foot is abducted and externally rotated.

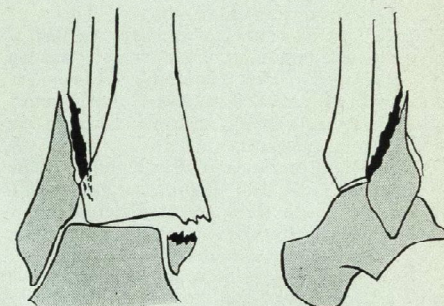
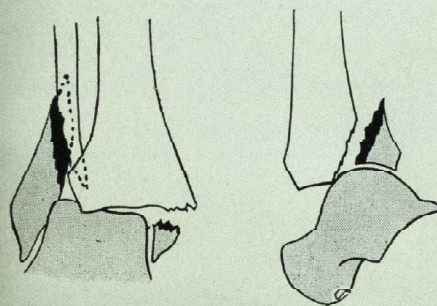


Fig. 4 (left). Third degree fracture. Both malleoli and the posterior tibial fragment (the posterior malleolus) are fractured. The foot is displaced backwards and is abducted and externally rotated.



Pott's Puffy Tumour

by W. J. Hanbury, M.D.

Brief references to the condition known as Pott's puffy tumour can be found in many standard text-books of surgery and pathology. It is usually mentioned under the heading of extradural or subcranial abscess, or under the broader categories of meningitis, pachymeningitis or intracranial suppuration.

An extradural abscess may result from infection following a fracture of the skull, osteomyelitis of the skull, suppurative otitis media, frontal sinusitis, a blow on the head or an infective lesion of the scalp. An abscess may develop several weeks after an injury and give rise to toxæmia and signs of increased intracranial pressure. Suppuration occurs between the dura mater and the bone, and the skull is itself involved in the inflammatory process. If there is no open wound immediately over the site of the abscess, the overlying scalp may become swollen, firm and tender due to inflammatory oedema of the soft tissues. This type of swelling is what Percivall Pott first described in 1760 as a "puffy tumour", and may be diagnostically significant as a pointer to an underlying extradural abscess. The word "tumour" in this instance was used by Pott to denote its basic meaning, a "swelling", and not a "neoplasm". The relationship between an extradural abscess and localised inflammatory oedema of the overlying scalp is shown in the accompanying diagram.

No mounted specimen of Pott's puffy tumour is available in this hospital's Pathological Museum, although there are examples of osteomyelitis, osteoperiostitis and fractures of the skull, as well as of extradural haemorrhage.

Pott's original description of the condition is to be found in his book—"Observations on the Nature and Consequences of Wounds and Contusions of the Head, Fractures of the Skull, Concussions of the Brain, etc".* This work, a copy of which is in the Medical College Library, is fascinating to read, is of great historical interest and contains much sound advice. Unfortunately,

* Printed for C. Hitch and L. Hawes, at the Red-Lion, Paternoster Row, M.DCC.LX.

references to, and descriptions of, localised puffiness of the scalp are not confined to one section of the book, and there is no index for finding them quickly. In Sect. II (Of Contusions of the Head) Pott distinguishes one type of injury from another, and in citing the type of case when "there is neither fracture, commotion, nor extravasation, and the scalp is neither much bruised nor wounded", he describes a delayed onset of symptoms and (p. 38) "if no means preventive of inflammation are used, the part struck swells, and becomes puffy", and he goes on to describe the underlying detachment of the pericranium, the dead look of the bone, the detachment and inflammation of the underlying dura mater, and the worsening condition of the patient. "The primary and original cause of all this, is the stroke upon the skull. By this the vessels which carry on the circulation between the scalp, medullium, and dura mater, are damaged, and no means being used to prevent the impending mischief, or such as are used proving ineffectual, that communication ceases, and both pericranium and dura mater separate from the skull, inflame, and become putrid". Later (p. 52) Pott refers again to the type of case in which there is a delayed re-appearance of symptoms following a blow on the head, and states that "mischief" may be in the brain substance, ventricles, between the membranes, or on the outer surface of the dura mater. He continues, "of the three former I do not know any certain indications, but of the latter I think there is one which may almost be deemed so; I mean a puffy tumor of the scalp.

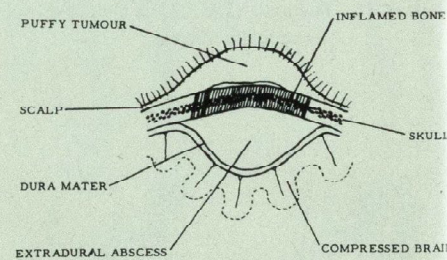


Diagram showing the relationship between an extradural abscess and Pott's puffy tumour.

and the detachment of the pericranium from the skull under such tumor. These appearances following a blow, and attended with quickness of pulse, restlessness, and shiverings, generally, I had almost said infallibly, indicate an inflamed or sloughy state of the dura mater, and the matter between it and the cranium". Pott explains (p. 54) what he means by a puffy tumour of the scalp as "a confined, circumscribed swelling of the integuments, produced by the collection of a fluid between the pericranium and skull, of little more extent than the separated part of that membrane, not very tense or renitent, the quantity of fluid, which makes the elevation, being but small in proportion to the size of the tumor". Further references to the scalp becoming puffy are made (pp. 126 and 129) in connection with fissured fractures of the skull which have escaped immediate notice.

THE EXCAVATIONS

by Nelly J. M. Kerling, Archivist

Whenever substantial digging is carried out in the hospital there is a possibility that some of the medieval foundations may be found which will enlarge our scanty knowledge of the original plan of the buildings. We know little about the layout of the early hospital, since the drawing of maps in the modern sense did not begin in England until the 16th century and although the hospital archives are fortunate in possessing a few maps made before 1600, the earliest plans of the actual buildings were not produced until 1617. It can, however, be assumed that much of this map shows the medieval hospital since the Journals of the Governors, which begin in 1549, make no mention of any substantial rebuilding until after 1617.

Judging by this 1617 plan the trench which was dug recently between the Church of St. Bartholomew-the-Less on one side and the Clerk's and Steward's offices on the other, cut through the area on which the Great Cloisters stood.

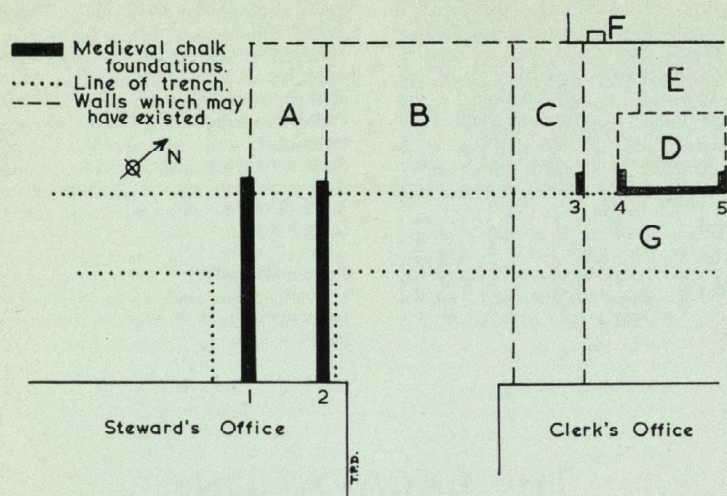
As regards the treatment of head injuries Pott emphasizes the importance of exploration and exposure, the application of the trephine, and adequate drainage to avoid an extradural abscess. These same general principles still apply to day, although a burr would be used instead of the trephine, and, of course, the problems of prevention, diagnosis and treatment have all been greatly eased by modern radiological and surgical techniques and by antibiotics. Pott's puffy tumour is therefore of lesser significance now than previously, and is probably seen more often in association with primarily infective, rather than traumatic, lesions.

Acknowledgement

I would like to thank Mr. R. Campbell Connolly for reading the manuscript and for his helpful comments.

When entering the hospital in former days by the main gate—which must have been in much the same position as today—one passed the Church and almost immediately entered the so-called Great Cloisters, the size of which has always been a matter of speculation. On the West side of the Cloisters, houses are indicated on the 1617 map which may have been some of the wards and which were separated from the Cloisters by a passage and a wall. On the East side, and therefore on the South side of the Church, there was a court, and the Church's vestry on the South aisle was built out into this court. The Church itself seems to have extended further South than in the present day.

We can recognise medieval foundations in this part of London because they generally consist of chalk. What has been found recently are the remains of two walls of chalk each about 18 in. wide and about 9½ ft. apart which ran from the Steward's office towards the North (Nos. 1 and



A. B. & C The Great Cloisters
D The Vestry

E The South Aisle
F Bricked up Entrance
G Court of Church

2), and the foundations of three walls at right angles with the Clerk's office (Nos. 3, 4 and 5). Wall No. 3 was pointing towards the Church slightly to the West of the bricked-up entrance under the tower, at a distance of about 35 ft. from wall No. 2, while wall No. 4 was 5 ft., and No. 5 was 18 ft., further East. In addition there seemed to be some chalk which could well have been part of a wall connecting walls Nos. 4 and 5. It is possible that walls Nos. 1 and 2 formed part of the Great Cloisters on the West side and that wall No. 3 was the outer wall on the East side. If that is true there would have been another wall about $9\frac{1}{2}$ ft. west of wall No. 3 leaving a space in the middle of the Cloisters of about 25 ft. These measurements are quite possible for the medieval Cloisters of this hospital.

Another possibility is that wall No. 1 was the wall separating the hospital buildings from the Great Cloisters and that wall No. 2 was the west wall of the Cloisters themselves. In that case the Great Cloisters would have been $9\frac{1}{2}$ ft. narrower which would make them rather small.

Wall No. 3 pointed slightly west of the bricked-up door of the Church shown in the

1617 map, which led out into the open and, we may now assume, into the court. The fact that walls Nos. 4 and 5 are 13 ft. apart is more difficult to explain. If there was a chalk wall connecting them, it must have been about 21 ft. from the present Church building. I said before that the South aisle of the Church was extended further south according to the 1617 map and that there was, in addition, a vestry on that side. This vestry was not a square room, the distance between the Church and the back wall being shorter than the distance between the side walls. My suggestion is that walls Nos. 4 and 5 are the remains of these vestry walls with the back wall 21 ft. from St. Bartholomew-the-Less as it stands today. If this vestry was indeed 13 ft. wide, this back wall must originally have been about 10 ft. away from the former south aisle, for this room could well have been 13 by 10 ft. If this is true the Church must have extended a further 10 or 11 ft. south. The trench seems to have cut through the court just at a line with the vestry's back wall.

Some human bones were found at the back of the Clerk's office. According to Professor

Spector they date from about the middle of the 17th century. It is quite likely that in that time the Church's court was used as a burial ground.

I am fully conscious of the fact that I am only guessing with the help of the little knowledge we have of the medieval buildings, yet I think that it is possible that we now know at least the position and width of the Great Cloisters. It was here that, on each Monday, those patients

assembled who were to be dismissed, a practice which survived until the early part of the 18th century. When this had taken place an equal number of the sick poor were admitted, provided that the physicians accepted them, and it is interesting to think that we can now more accurately place the position of buildings which played so great a part in the life of the hospital.

THE NURSERY PRODUCTIONS, 1963

from our Special Correspondent

The aim of the Bart's Drama Society's nursery productions is to give newcomers with a flair for the stage a chance to show their talents, encouraged and supported by the more seasoned performers. This year the productions were a credit to all concerned and of a much higher standard than previously. Nevertheless, of the three one act plays that were given, the first, Chekhov's "The Bear", was the least successful, largely because the players seemed in too much of a hurry. The plot, that of a landowner ensnared in love by a neighbour's widow who owes him money, requires quick changes in mood on the part of the two main characters. Mike Stewardson as Smirnov admirably conveyed the vacillations of a susceptible heart, though he would have been more effective if he had paused more between changes of mood. Judy Bell as Popova, the widow, began confidently but rushed the coquetting scene at the end so that it lost some of its force. Tony Roderick conveyed the astonishment of the old servant Luka quite well though the character was otherwise unconvincing.

With N. F. Simpson's "The Form" we were on more familiar ground for the Society has performed two of this author's plays before. This light-hearted spoof on bureaucratic form filling and nonsensical interviews was ably produced by Anthony Mann. Gavin Haig gave an excellent performance as a nervous client Whinby, awaiting an interview with the pompous Chacterson (Simon Philips) and biding his time by naively trying to interest the coldly correct secretary-receptionist Miss Haviour (Anna Page) in his innumerable photos of Tower Bridge. Later in

the piece, with the logic of nonsense, the roles were reversed and Whinby became boss replying to the questions of Chacterson in an interview reminiscent of the worst type of condescending television programme.

The triumph of the evening was undoubtedly Brian Lasks' production of Harold Pinter's "A Night Out"—a tragi-comedy of the desperate and unsuccessful attempt of a son to break loose from the influence of his domineering mother. John Lilleyman's performance of Albert, the "mother's boy", shy, frustrated and angry, never faltered throughout the play and Mrs. Stokes' gluey overwhelming attachment to her son was vividly portrayed by Vivian Onions. The smaller parts, in particular Albert's friends, were all surprisingly well acted and this was very noticeable in the office party scene. Mr. Lask disposed his cast well—always rather difficult to achieve when there are several groups of actors on a small stage. Ian Howat gave an amusing performance as Albert's boss, although tending to over-act at times. The girls at the party were faithful portrayals of their type and one could almost feel Albert's embarrassment as they teased him. A special word of praise should go to Elizabeth Macdonald who played the street-walker who picks up Albert after the party. The scene in this girl's room was one of the most crucial in the play. Albert had his moment of triumph when he made the girl go down on the floor and tie his shoe-laces, but, at the last, we saw him once more dominated by his mother before the curtain fell on a most enjoyable evening.

CURRENT TRENDS IN OBSTETRICS

by John Beattie

In common with many other branches of medicine, obstetrics has undergone remarkable changes in the last thirty years. It is necessary to review these briefly in order to elucidate the modern approach towards still further improvement in the safety of mother and child.

Reference to Fig. 1 will demonstrate the rapid fall in maternal mortality and still-birth rate since 1925. This success is partly due to the increasing efficiency of the blood transfusion service, the use of antibiotics and the waning virulence of the haemolytic streptococcus. Added to these is the increased safety of the lower segment Caesarean section and an entirely different approach to forceps delivery. The Royal College of Obstetricians and Gynaecologists is also largely responsible, in an indirect way, in encouraging the greatly increased interest of the general practitioner and others in post-graduate education.

Figure 2, when studied in conjunction with figure 1, will demonstrate that the remarkable improvement in the safety of both mother and baby has gone hand in hand with a considerable increase in the rate of forceps delivery and Caesarean section.

Jeffcoate³, in quoting these figures from the Liverpool Maternity Hospital, points out that babies previously born dead with forceps are now being delivered alive by Caesarean section, whilst those stillborn as a result of spontaneous delivery are now extracted alive with forceps.

Reference to Figure 3 demonstrates the increased safety to the baby in direct relation to more frequent forceps delivery which means that the second stage of labour has been shortened in many cases, thus avoiding the previous high

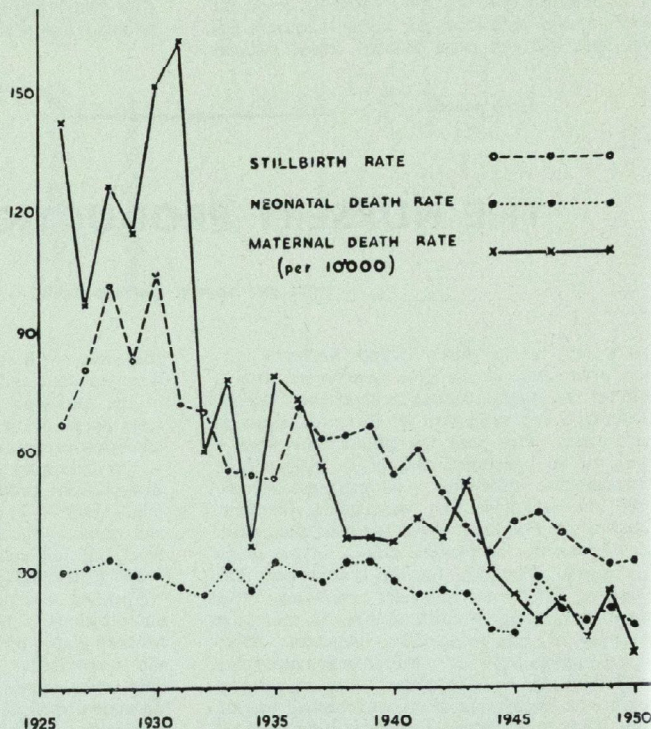


Fig. 1—Diagram showing the change in maternal and foetal results at the Liverpool Maternity Hospital over 25 years. (By courtesy of the B.M.J.)

incidence of foetal distress. Similarly, the lower segment Caesarean section operation is performed much more often, not only to avoid a difficult mid-cavity forceps delivery but, also, for other indications such as uterine inertia and delay in the onset of labour after surgical induction and for foetal distress if it occurs in the first stage of labour.

The obstetrician is constantly at risk with his colleagues, whether paediatrician, neurophysician or ophthalmic surgeon. This trend is demonstrated by recent work which suggests that excessive moulding of the foetal head during the passage through the maternal pelvis or by a

forceps delivery may force the medial side of the temporal lobe of the brain through the orifice in the tentorium cerebelli, thus producing damage and subsequent scar tissue in this area. There is evidence collecting that such trauma may cause epilepsy even ten years later. No wonder the obstetrician should never pull really hard on the obstetric forceps although, when difficulty arises, it requires courage to desist and arrange for a Caesarean section to be done.

The report on Confidential Inquiries into Maternal Deaths in England and Wales, 1955-1957² shows that, despite the greatly reduced maternal mortality which now exists, no less than 861 deaths (which were ascribed directly to pregnancy and childbirth) occurred in the years under review and of these 353, or 41 per cent., had avoidable factors associated with them. Deaths reported and assigned to the category "associated with pregnancy and childbirth" numbered 339 of which 57, or 16.8 per cent., had avoidable factors. It is a solemn thought that so many women died in relation to childbirth who might have remained alive if the doctors and nurses concerned had been better trained and if better facilities had been available.

With these figures in mind, how is the obstetric service in this country to be so improved that the maternal and foetal morbidity and mortality rate becomes even lower? The following are the major ways in which this ideal will be achieved.

Obstetric Education

The undergraduate is submitted to a fairly extensive course in obstetrics and gynaecology over a period of five months and two months of this

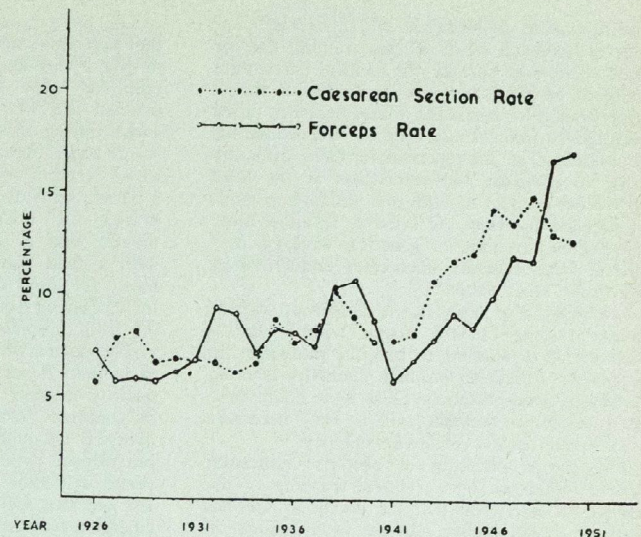
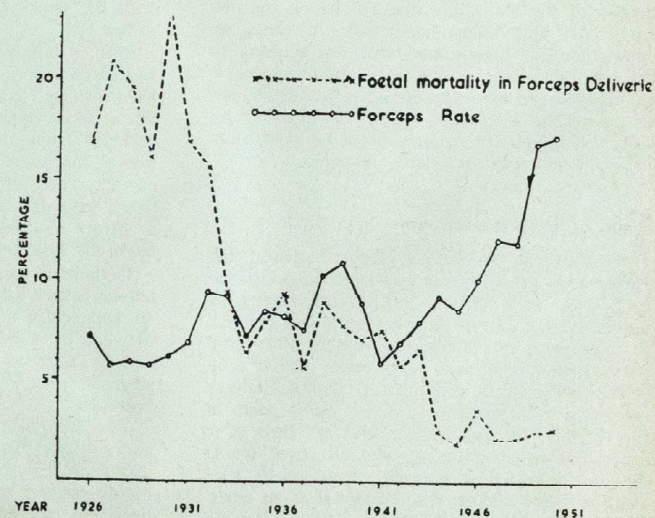


Fig. 2 (above)—Rates for Caesarean section and forceps delivery expressed as percentages of all births in the Liverpool Maternity Hospital over 25 years.

Fig. 3 (below)—Diagram showing the falling foetal mortality associated with forceps delivery. (Foetal mortality in this and other figures includes both still births and neonatal deaths.) (Both figures by courtesy of the B.M.J.)



time is allotted to residence in a maternity unit. It is difficult to see how this training can be extended in time because the medical curriculum is already over-full and new discoveries in almost every branch of medicine make demands upon the students' time. Those who are responsible for the planning of the curriculum have difficulty trying to persuade the enthusiasts at the head of each department of both pre-clinical and clinical subjects to prune the syllabus to allow more time for the teaching of genetics, virology, psychiatry, environmental medicine, endocrinology and many other subjects.

The practice of obstetrics is dangerous without special training but the doctor with a general qualification is allowed to practice midwifery in the home. Although masterly inactivity is often the key to good obstetrics, there is no doubt that, when action is necessary, it is very necessary indeed and usually of great urgency.

The future planning of obstetric education centres round the post-graduate teaching of the subject for it is then that the doctor at last has personal responsibility. If he is interested in practising obstetrics he will be extremely willing and anxious to absorb any knowledge and experience which comes his way. David Brown of Chelmsford is the great protagonist of this method of teaching and his resident appointments for general practitioners are much sought after. The future general practitioner obstetrician will have held a resident appointment in the subject and have obtained the Diploma in Obstetrics of the R.C.O.G. He will be on the obstetric list and many hope that, in time, no other medical practitioner will be allowed to practise midwifery unless he is qualified for it in this way and agrees to attend refresher courses at prescribed intervals. Many large maternity units throughout the country could be made suitable for such post-graduate education.

Home or Hospital Delivery

Although the Goodenough Report advised that 70 per cent. of confinements should be conducted in hospital and 30 per cent. in the home, the suggestion was out-of-date before it was printed. In some areas of London, the number of hospital confinements is already well over 70 per cent. of the total and the demand for hospital delivery is certain to increase. In some other parts of the country, the call upon midwifery beds is so great that many patients, who all agree would be best delivered in hospital, have to be confined at home and sent into hospital as an emergency if the need arises.

The protagonists of domiciliary midwifery, if they are knowledgeable on the subject, are bound to give a very long list of gravid women who are unfit for home delivery. This leaves a highly selected few who have been thoroughly investigated during the antenatal period and, if there is no suggestion of increased risk, are allowed to be confined at home. No longer do we treat a patient with uterine inertia and ruptured membranes for many days, ending with foetal distress and a difficult forceps delivery, often with a dead baby and a post-partum haemorrhage; for such complications are treated early by Caesarean section, and the patient is better off in hospital from the start.

The doctor who conducts only a few deliveries each year is inclined to feel a sense of false security in home delivery for many women may be confined before even a difficult forceps delivery is encountered. The experienced general practitioner who has practised midwifery for years, will know very well how extremely helpless one can feel in the home in the face of an emergency during labour and how much safer it would have been had the patient been delivered in hospital.

There is one excellent factor in home confinement in that the mother, as soon as the baby is born, is with her husband and children and, if she is well in the puerperium, the psychological effect is, of course, excellent. There is, however, a much greater risk in such cases of the mother getting back to housework too early and this is often the cause of a lumbar backache for the rest of her life.

Even in highly selected and apparently normal multiparae there is the risk of a post-partum haemorrhage, and who would prefer to treat this at home rather than in hospital? The figures obtained from an experienced "Flying Squad" prove conclusively that, in the case of post-partum haemorrhage, the risk to the mother from, say, anterior pituitary necrosis, increases in direct relation to the distance of the patient from the hospital.

If there is foetal distress in the first stage of labour, which occasionally is bound to occur in an apparently normal case, the chance of rapid delivery by Caesarean section in the first stage and by a rapid forceps delivery in the second stage is greatly enhanced if the patient is in hospital.

The ideal would seem to be a well equipped and suitably placed General Practitioner Maternity Unit in which a team of enthusiastic and highly trained midwives and doctors would deliver the mother under ideal surroundings.

The Midwife

There is a desperate shortage of midwives in this country and it is easy to find the reason. A highly trained, experienced and responsible nurse who is an expert in the subject, should command great respect and have a status and remuneration far above the generally trained nurse who is not a specialist. This has not, as yet, been recognised by the authorities concerned and, until it is, the midwifery service of this country will be in jeopardy. Many midwives today are so over-worked that they are at breaking-point and it is no wonder that recruits to this service are hard to obtain. Although the modern trend is for more women to be delivered by doctors than was so some years ago, the midwife is still as necessary as before for she forms the corner-stone of the speciality for the general practitioner and the specialist is not able to stay with the patient throughout her labour; a great responsibility, therefore, rests with the midwife to have a personal and continuous contact with the patient.

The shortage of maternity beds is so great in this country that the administrative authorities are pressing for the early discharge of the puerperal patient from hospital. Although with adequate care of the patient when she reaches home, both by doctor and midwife, this practice has been proved to be safe in some areas, many obstetricians think that it is not ideal for it is almost impossible to persuade the mother of a young baby, perhaps with other children in the house, to rest adequately so that her puerperium proceeds with physiological exactitude. Any woman who has just been delivered deserves complete rest from work and household responsibilities for at least two weeks. Rapid turnover in the local maternity unit simply means that more midwives are required for domiciliary visits and many nurses feel that it is unfair to expect them to look after such patients without ever having had any responsibility or interest in the patient beforehand, particularly at the delivery. This aspect does not encourage the recruitment of midwives.

The Future of Maternity Hospitals

Modern trends in this respect fall into two groups:—

The General Practitioner Unit: It has already been said that more and more expectant women are demanding delivery in hospital, followed by a short or long stay according to circumstance. The Royal College of Obstetricians and Gynaecologists encourages this concept and the general practitioner obstetrician is recom-

mended as the one who should bear the main burden as far as normal obstetrics is concerned. The future plan is for many more general practitioner obstetric units to be built to make an adequate country-wide service so that, eventually, almost all women will be delivered in this way. An ideal general practitioner unit should be placed in the grounds of, or nearby, the main obstetric hospital so that a specialist is available to give advice when the occasion arises, and to take over the patient into the main hospital should complicated treatment be necessary—the patient being returned to the general practitioner unit as soon as it is possible to do so with safety. Although this plan is an ideal one, it is obvious that many general practitioner obstetric units will have to be situated some distance from the parent maternity hospital and, in that case, a specialist must be available for consultation when requested by the general practitioner. Only apparently normal obstetrics will be conducted in such units; the grand multipara, the elderly primigravida and other patients with abnormalities will be booked for delivery in the main hospital.

The Specialist Maternity Hospital: The modern concept in this regard is shown in Figure 4 and the future developments at Birmingham² are quoted as an example.

The University Hospital is being built at the centre of an area of the population which com-

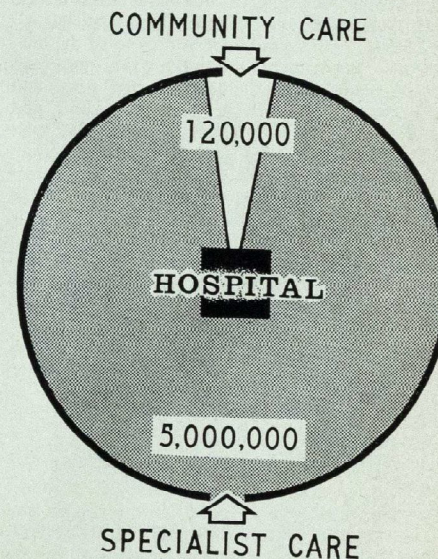


Fig. 4.

prises about five million, but the hospital, including the maternity unit, will be directly responsible for the care of a population of 120,000. It is of great value not only to the general hospital but, also, to the maternity unit and to the student to have a family responsibility for an area such as is visualised at Birmingham. Great gain could be obtained from research work in community care and environmental medicine in this area. From the obstetrical point of view, the status of the patient, the social background, living conditions, diet and financial resources have been proved already to have a direct bearing on the safety and fertility of the female population. Sir Dugald Baird⁴ has already done research on this subject at Aberdeen and there is further work to be done. The remaining population around the central hospital will be cared for by other large obstetric units, but there will be many special abnormal cases which will be referred to the teaching hospital where resources are at their best and specialists in all branches of medicine and surgery will be available under the same roof to deal with obstetrics complicated by other diseases. It is probable that future hospital development will proceed along these lines; there is nothing to be said for a maternity unit far distant from the other departments of a large hospital.

The modern obstetric hospital is a complicated organisation consisting of ante-natal beds, labour wards and beds for the puerperal patient, all preferably on the same floor and close to the out-patients' department. Ideally, the pregnant woman should meet the labour ward sister and nurses when she visits the ante-natal clinic and she should be shown the labour ward and nurseries; in this way, she gains confidence so that, when labour begins, she will arrive at the hospital and immediately feel in familiar surroundings and meet nurses and doctors whom she already knows.

There must also be facilities for dealing with abortion cases in the area for which responsibility is assumed, and isolation beds for those with puerperal pyrexia.

The obstetrician and the paediatrician now work in close liaison. The premature unit and paediatric department should be nearby with an intensive care unit attached. Cases of Rhesus incompatibility are now delivered only in a hospital where there are facilities for exchange transfusion.

Research

The recent National Peri-natal Mortality Survey, carried out under the auspices of the National Birthday Trust Fund in 1958, has de-

monstrated many causes of peri-natal mortality throughout the country. Space does not allow reference to this report in detail, but the causes of prematurity, congenital abnormalities, birth trauma, haemolytic disease, anaemia, intra-uterine foetal infection and other conditions, make fruitful ground for research with which the obstetrician must be intimately involved.

Further reference to the report on Confidential Inquiries—1955-1957—reveals that the four largest groups of deaths, which together account for two-thirds of the total, were due to toxæmia (22 per cent.), haemorrhage (17 per cent.), abortion (14 per cent.) and pulmonary embolus (13 per cent.). These figures are surprising for, about 25 years ago, sepsis was responsible for more than one-third of maternal deaths. Two new groups are also described, i.e. death after Caesarean section and death due to anaesthetic complications. This information gives a clue to the subjects which will occupy the research worker until such causes of death are better understood and remedied. Modern research can often only be done by a team of workers who have access to experts on ancillary subjects such as pathology, biochemistry, physiology, pharmacology, physics and electronics. This makes the large teaching hospital with a pre-clinical school on the premises an ideal place to carry out research work in obstetrics and usually workers in other disciplines become directly involved.

Mr. Donald Fraser has coined the term "cracked pitchers" to describe the numerous patients who are delivered at St. Bartholomew's Hospital with a complication not entirely due to the pregnancy. A list of such patients delivered at this hospital in the last twenty years makes formidable reading and includes such complications as myasthenia gravis, dissecting aneurysm of the aorta, many varieties of cardiac disease, massive bronchiectasis, nephritis, syringomyelia and disseminated sclerosis to mention only a few. The inter-relationship between pregnancy and these abnormal conditions gives rise to material for most interesting research. Inevitably such complicated cases upset the vital statistics of the department in a teaching hospital for the rare conditions which have to be dealt with increase the risk of morbidity, maternal mortality and foetal death.

Because of the need for a rise in the standard of obstetric practice in this country and because of the necessity for team work over a period of years to carry out many research projects, the University Grants Committee has often advised certain teaching hospitals to create professorial chairs in obstetrics and gynaecology. This re-

quires an adequate number of beds both for teaching purposes and research and it is probably ideal for about half of the available beds to be in charge of part-time consultants and the other half to comprise the professorial unit. In this way, the student gets the best of both worlds.

St. Bartholomew's Hospital is in crying need of a modern obstetrical and gynaecological unit with professorial beds in the grounds of the Hospital to replace our present wards which are situated in an adapted eighteenth-century building.

Some believe that the teaching hospitals should concentrate on the education of the undergraduate and leave other large units to give residential appointments and refresher courses for the general practitioner. This, probably, is wrong in principle and many think that the students, registrars and consultants alike benefit from the organisation of post-graduate courses from time to time.

Much thought has been given over the years to the increasing safety of mother and child in this country and in others where the mortality and morbidity rate of childbearing has already been enormously reduced. There is also the other consideration that many registrars from India, Nigeria, Ghana and other countries are trained

here until they reach consultant status. Many of the methods of complicated delivery in difficult cases which used to be called the obstetric art are now obsolete in this country for Caesarean section is much safer for mother and child because surgical facilities are available. An examiner in the final M.B. some years ago was wont to tell the astonished candidate that the only use for the cranioclast and the cephalotribe was to hang them in a crossed position above the mantelpiece in the dining-room. In some parts of darkest Africa this is not the right place for these weapons and others like them, and there is danger in not even mentioning their use when training the student and young graduate.

REFERENCES

- ¹ The Forceps Operation in Modern Obstetrics, T. N. A. Jeffcoate. Modern Trends in Obstetrics & Gynaecology, edited by Kenneth Bowes. Butterworth, 1955.
- ² Report on Confidential Inquiries into Maternal Deaths in England & Wales, 1955-1957. H.M. Stationery Office.
- ³ The Concept of a Balanced Hospital Community, Thomas McKeown. The Lancet, 5th April, 1958, 701.
- ⁴ The Evolution of Modern Obstetrics, Sir Dugald Baird. The Lancet, 10th Sept., 1960, 557; 17th Sept., 1960, 610.

NOTES ON THE TREATMENT OF THE NON-SPECIFIC INFLAMMATORY DISEASES OF CONNECTION TISSUE

by G. D. Kersley, O.B.E., M.D., F.R.C.P.

Introduction

This lengthy title, which is necessary to avoid offending the purists with such a name as Collagen Disease, covers a group of diseases that affect some 5 per cent. of the population and includes rheumatoid arthritis, rheumatic fever and spondylitis. In this article an attempt will be made to outline briefly their treatment. A word must first, however, be said on the conditions included.

The rheumatic diseases are grouped together partly because the same team, consisting of specialist physician, orthopaedist, physio-, hydro- and occupational therapists, welfare worker and builders of "aids", is often necessary for their adequate treatment and the group consists of i) the non-specific inflammatory conditions, ii) degenerative diseases of joints, iii) gout, and iv) a miscellaneous group once known as "fibrositis". Only the first of these will be discussed here.

In the non-specific inflammatory diseases some abnormality in immune body formation has occurred, sometimes as the result of genetic in-

fluences and sometimes brought on by stress. The group includes the syndromes of systemic lupus, polyarteritis nodosa, scleroderma, dermatomyositis, cranial arteritis, rheumatic fever, ankylosing spondylitis and non-specific polyarthritis. Polyarthritis can itself be divided, partly by estimation of the Rose-Waaler agglutination or Latex tests, into true rheumatoid arthritis, where these tests are usually positive except in childhood (Still's disease), and the polyarthritides often seen with such conditions as psoriasis, ulcerative colitis and Reiter's disease.

The treatment of these conditions show a basic similarity, though in rheumatic fever the allergen is known to be a streptococcus and the most serious complication is cardiac and these facts indicate treatment with long-term antibiotics (Benzathine Penicillin 1 million units monthly, Penicillin G. 200,000 units twice daily by the mouth, or Sulphadiazine 1 Gm. daily) and rest. Likewise in ankylosing spondylitis the accent is on posture, and perhaps Phenylbutazone (Butazolidin) or radiotherapy to relieve pain. In the lat-

ter case the benefit must be weighed against the risk of increasing the incidence leukaemia tenfold. Rheumatoid arthritis is, however, the commonest syndrome and perhaps provides the best illustration of deployment of therapy in this group of the rheumatic diseases.

Local treatment

Treatment of polyarthritis should be both local and general. Under the former heading is included spintage of inflamed joints to rest them and prevent deformity, mobilisation (perhaps in a warm pool), and correction of deformity, with heat to reduce pain and spasm, injections of steroids, and surgery. Apart from fixation (arthrodesis) and reconstruction (arthroplasty), of joints, enormous strides have been lately made in "soft tissue surgery" (various types of synovectomy, muscle division and tendon replants).

Aids to improve the use of diseased joints without causing increased damage and also modification of the home to allow the maximal independence of the cripple could be considered under this heading, but this would constitute a treatise in itself.

General treatment—Basic régime

The "internal" treatment of the patient may be broken down into three sequences. Firstly, rest, removal of stress, treatment of anaemia, which, in some 30 per cent. of cases, will require parenteral iron (100 mgs. iron should provide roughly the "pabulum" for 4 per cent. haemoglobin), and analgesics. In the latter category, aspirin is, of course, the first choice, but it may cause dyspepsia, minor occult bleeding or even severe haemorrhage, and a few patients are truly allergic. In the latter case paracetamol can usually be allowed, and in gastric irritation some form of aspirin such as a soluble salt taken in milk, enteric coated, or as the aluminium compound (palaprin) may be tolerated. Phenylbutazone (butazolidin) may occasionally be justified, but both its efficacy and toxicity are very unpredictable.

Long-term therapies

Where the disease is not controlled by this régime, there are two long-term therapies with rather similar qualities available—gold or "anti-malarials". Both take a considerable time before benefit may be expected; gold three months, and chloroquine phosphate or hydroxychloroquine one month. Both help some 50 per cent. of cases; both may be toxic, gold especially to the kidneys, skin and occasionally to the blood-forming tissues, while the "anti-malarials" may produce gastrointestinal, skin and ophthalmic complications. Both, unlike steroids, tend to improve the Rose-

Waler or Latex titre. Gold would be the obvious choice in a patient with digestive symptoms, and chloroquine if there were any renal damage or "allergy to the needle".

If gold is used it is given in weekly injections, starting with 10 and then 25 mgms. and soon coming to the maximal single dose of 50 mgms. of sodium aurothiomalate (myocrisin). The urine is examined weekly for protein and enquiry made about skin irritation. All being well, the 50 mgms. weekly is continued until 0.5 Gm. has been given (about 12 injections), and the interval can then be extended to every two weeks and continued for perhaps a year. Toxicity is a signal for stopping the medication immediately and, if it is severe, the use of B.A.L. to inactivate any gold in the system and steroids to reduce the reaction should be considered.

Chloroquine phosphate 250 mgms. daily or hydroxychloroquine (plaquenil) 600 mgms. may produce four types of toxicity—i) early temporary malaise and digestive upset—often passing off; ii) occasional skin reactions that do not regress unless the drug is stopped; iii) punctate corneal opacities causing mistiness of vision and haloes around lights, which disappear when the drug is stopped, and iv) very rare permanent retinal changes, only seen after long-term use. In view of these rare but serious complications it is inadvisable to use "anti-malarials" continuously for more than a year.

A.C.T.H. and steroids

The third line of treatment is the use of A.C.T.H. or steroids. They temporarily abolish the inflammatory reaction and are certainly justified where the disease is progressing towards crippledness in spite of other treatment, to cover an acute exacerbation, to allow the breadwinner to continue an essential job, or to keep a patient from becoming bed-bound and dependent on others, and in systemic disease they are life saving. There is also evidence that in the proper dosage they help to prevent erosion of joint cartilage. They are not analgesic, except in their anti-inflammatory capacity, and are therefore often best given with soluble aspirin.

A.C.T.H. has the advantage that it is more easily discontinued and that gastric and bruising complications are rare, but the frequent injections are a great nuisance, apart from the possible development of sepsis or allergy or immunity to the A.C.T.H. when such treatment has to be carried on for prolonged periods. It is also slightly hypertensive. A.C.T.H. is particularly valuable when it is hoped that only "a course" of treatment will be required.

Of the steroids, prednisone (or prednisolone)

is the all-purpose choice and the correct dose is the very smallest that will cure some 80 per cent. of the symptoms—usually about 7.5-10 mgms. per day; men tolerate a higher dose and climacteric women are particularly in-tolerant. The steroid should be given crushed with food and, in cases subject to dyspepsia, the enteric-coated variety or phosphate may be indicated. Occasionally some other steroid may be more effective in a particular case. Excessive weight or severe accompanying psoriasis may be an indication for triamcinolone, but it is more inclined to cause flushes and headaches and occasionally produces a myopathy.

The most important disadvantages of steroid medication are gastric disturbance, masking of inflammatory symptoms of other disease, osteoporosis—especially of the spine, weight gain, Cushingoid symptoms, bruising, upset of the psyche and of any diabetic tendency, and the danger of adrenal failure with stress on sudden withdrawal of the drug; but in the right case, correctly administered, their benefits far outweigh their dangers. They can be used together with gold or "anti-malarial" therapy when necessary.

An attempt has been made to outline a few of the facts of the treatment of this important group of diseases and to answer some of the questions most frequently asked by students and practitioners. Much has, of course, been left out—books have been written on the contents of each paragraph of this annotation!

INCOME DURING SICKNESS

by Brian Young, of the Medical Sickness Society

It is easy but it is also foolish for a young man to ignore the possibility of suffering a serious breakdown in health at some time during his life. If a professional man cannot practise because of sickness, all the knowledge and skill which he has acquired will be of no value. It is therefore important to arrange adequate insurance whilst still fit.

Before considering insurance of health it is desirable to know how long income will continue in the event of incapacity. In the hospital service the normal provisions for sick pay are as follows:

Length of Service	Months at full salary	Months at half salary
First 4 months	1	Nil
Next 8 months	1	2
2nd year	2	2
3rd year	3	3
4th-6th year incl.	4	4
7th-10th year incl.	5	5
After 10 years	6	6

In general practice, arrangements must be made for looking after patients in the event of incapacity. This will mean seeking a locum after a short time, if not immediately, and can be quite expensive. No doctor should run this risk without adequate insurance.

The general practitioner may arrange for benefit to commence from the first day of incapacity, although benefit is not paid for incapacity lasting less than seven days, or he may decide to stand the risk of short illnesses and arrange a Policy under which benefit commences after four weeks. An established Consultant, on the other hand, who would receive his salary in full for six months could arrange a Policy under which benefit commenced after six months' incapacity. Naturally, the longer the period for which incapacity has to last before benefit commences, the smaller the premium.

For adequate protection a "Permanent" or "Non-Cancellable" Policy is required. Renewal of such a Policy cannot be refused on account of severe claims—just when it is most needed. Such a Policy is naturally more expensive than the commonly offered Policy where renewal can be refused, but it is far more valuable.

The next point to consider is the amount of benefit required. An important factor is cost. Premiums increase with age, but once the Policy has been arranged the premium remains constant, so it is as well to arrange the cover you need as soon as possible. As an example, a man aged 25 could obtain benefit of £10 per week commencing immediately on incapacity for about 7s. 6d. per week. This would be for a Policy terminating at age 65. If benefit did not commence until after thirteen weeks' continuous incapacity, the cost would be about 4s. per week. You should consider how much you will need when you are ill rather than how much you want to pay whilst you are well.

A medical examination is usually necessary when arranging one of these Policies, but some companies consider small proposals without medical examination. They will, however, want to know what illnesses you have suffered. This is another reason for acting as soon as you can and whilst you are fit.

Policy Conditions are important. The most important is that which defines the incapacity for which benefit will be paid. It should be defined as total incapacity to follow the Insured's own occupation. It should make no difference whether incapacity arises from sickness or accident and all accidents should be covered. If the Policy did not give benefit in the event of an accident arising abroad whilst on holiday, or from following

a favourite sport, it would fail to give complete protection. Some Policies cover all flying risks, others only flying as a passenger. Risks not normally covered include war and intemperance.

Policies are available which entitled the Policyholder to participate in profits. Bonuses are paid out when the Policy terminates, according to the profits made by the office, and are quite independent of the claims made on an individual

Policy. These bonuses can be quite substantial.

Some companies have special schemes for students under which they offer a limited amount of benefit at very low rates of premium. With such a Policy, if a student were so unfortunate as to experience a breakdown in health before qualification, he would at least have some permanent cover.

Rugger Club Ball

by a Special Correspondent

CUSTOM has made it necessary for a writer, who aims at the Entertainment or instruction of his Readers, to assume such a character as is most able to excite Curiosity, raise Mirth, and procure Attention. Happening the other Thursday to pass by College Hall, I saw a Crowd, and enquiring the Reason of it, was answered by a hundred hoarse Voices at once; An Ball, an Ball. It was in truth the Annual Rugger Club Ball.

The gracious Gathering had a choice of Spacious Chambers in which to circulate, and the Beau Monde entertained itself in Conversation of Wit and good Sense at a Bar especially layed out in the Abernethian Room. The Decorations were planned in good Taste, and adequate to the Palate of a Connoisseur, heightened by sinuous snakes and black women—very freudian. The popular "Teddy" entertained us throughout the evening with a selection of songs.

Betook me to the Passage Bar to join the many valiant Pot-Punishers. Paid me a groat for a pot of ale and marked the Ladies. Was greatly struck by the array of many amicable Women of the Best Quality, festively dressed and revealing many charms. Whilst at the Bar spoke to my Party with great effect on the latest books published this month—A Comical and true Account of the Modern Canibals Religion—most interesting. The Company did take their tippie Bravely, and our jovial Tipsters were kept busy the Evening long.

Attracted by soundes of the Dance I repaired to the Chamber. The Minstrels of the London Jazz Sextet were right goode and dispensed their Music bravely. Inspired by the spectacle they played the Twiste. These modern Dancers have a Whiggish air with little enjoyment of a pleasurable sort. Despite this, however, the Assembly desported themselves with Abandonne.

An Hour before Midnight we did sit down, nigh on twenty-one score, for a sumptuous feast. The Supper Room resounded to the narly and many Japes induced by the Food and Wine. Some Blockhead spilt food on my Breeches;



Part of the Companye with the noble Bird.

T'was good we had no soup. A merry Wag, in troth! The Vittels were prodigious good and ample for the Cost, Turkeys from the Americas eked out with tender Ham and divers Meats. Wine also was at hand and I did not stint myself. A rich and darkly puddinge followed and we rose from the table well satisfied and much distended.

I was much diverted by the drawing of a Raffle, a common custom in these times. Many excellent and Agreeable Prizes were drawn, including a noble Bird and much fine liquor.

A new Entertainment called Cabaret was vastly pleasant and prodigious diverting—two young Ladies, mightily scanty clad, did perform right well? They were spoken of as Bellye Dancers and greatly took my Fancye. They did gyrate most sturdily and two Gentlemen of the House were persuaded to dance with them—right quickllye too did they present themselves.

Methought the Ladies did cast some mence looks but such a show is better done than to afflict the Companye with a Discourse.

Once more to the Dance. Encountered a Turk, or so it seemed by his Dress. I demanded Wine but was informed by the Rascal that the Bar was Shut. I helped my owne selfe with some crafte, and did exceeding well.

So past an evening of most solid pleasure. At two of the clock the Anthem was sung, and many departed in search of Chairs and Coaches—Cold night so straight home, then, wrap't up in clean linen—to bed well satisfied.

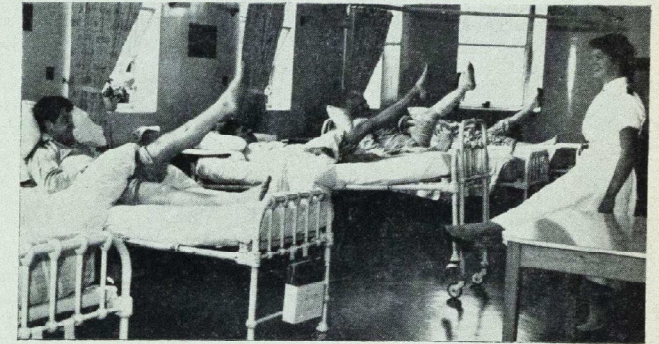
BEHIND THE SCENES: 5

THE DEPARTMENT OF PHYSIOTHERAPY

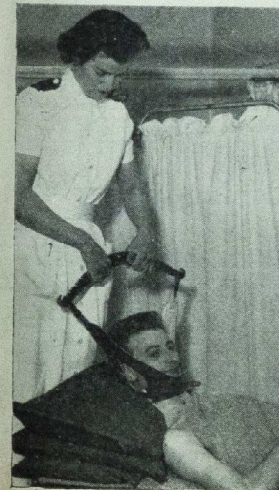
by Truda Wareham, M.C.S.P.

Physiotherapy consists of a wide variety of techniques, and patients are referred from nearly every Department of the Hospital. On an average day about 330 Out-patients attend, and another 350 In-patients are treated in the wards. The vast majority of patients need individual treatment with a specialised regime in order to gain the maximum benefit for their personal recovery but in the later stages of rehabilitation a class can give a more concentrated exercise programme, as well as providing the stimulus of competition.

The Physiotherapy Department is under the administrative direction of the Orthopaedic Department. Although not a training school, this is one of the largest departments of its type in the country. The staff consists of 31 full-time Chartered Physiotherapists, one Secretary, and three Clerk-receptionists. Before the last war, physiotherapy was divided into three quite separate units; massage, electrical and sunlight; each



A Ward Class undergoing general "maintenance".



Traction to the neck may sometimes be used to remove pain in the arm.

under a different medical director. In common with most hospitals, a single comprehensive department has emerged whose main therapy consists of remedial and re-educative exercise with massage, and electrical treatments applied as useful adjuncts. Ultra Violet Irradiation given in physiotherapy is still mainly under the direction of the Department of Dermatology.

At first the combined unit was situated in a succession of temporary places, finally settling in its present site over ten years ago. This building was originally the Surgery, and in those days was reached directly from the street outside. Later it was the Sisters' and Nurses' dining room until it was severely blasted in an air raid. When empty the Department gives the appearance of a large space but, once full of patients, it becomes evident that the area is far from adequate for coping with the present numbers. The gymnasium, in particular, is far too small. It is most desirable that a link-up should be made with the Occupational Therapy Department, so that fully combined rehabilitation procedures should be made available.

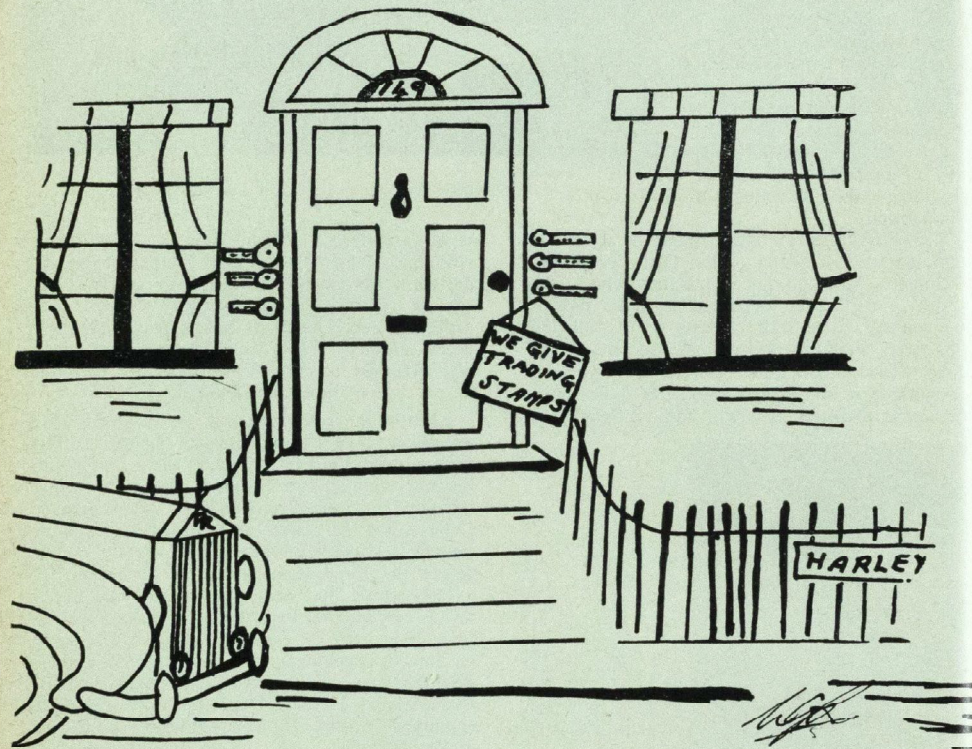
It is not possible in this article to discuss details of techniques, as the scope is too wide. In most cases physiotherapy is given to show the patient by demonstration, persuasion and practice, how to regain, as nearly as possible, normal functional activity, passive treatments being used mainly in preparatory phases. The

ages of our patients vary from the new-born to the aged. (Geriatric work is becoming increasingly important.) The disability may be as small as a broken finger, or as severe as a total paraplegia. A "treatment" such as post operative breathing exercises may take only five minutes, and be repeated two or three times a day, or it may last an hour in the case of disseminated sclerosis. The patient may be critically ill in a recovery room, or bouncing with good health and attending an ante-natal instruc-

tion class. A young man with a rugger injury needs a very different approach from a man in the depths of anxiety and gloom with widespread psoriasis.

After removal of a lumbar intervertebral disc the emphasis is entirely on maximum mobility, but an acute rheumatoid arthritis may be referred mainly for the physiotherapist to make splints.

From these examples it may be seen that physiotherapy is varied, interesting, and of considerable value in the total work of the Hospital.



NEW PENGUIN BOOKS

Daughters in Law by Henry Cecil. Published by Penguin Books. 3s. 0d.

Alibi for a Judge by Henry Cecil. Published by Penguin Books. 3s. 6d.

I have always been a fan of Mr. Cecil's legalistic whimsey and it was with pleasure that I turned to these two books. On form, Cecil possesses a remarkable ability to wind his way through intricacies of the British legal system, explaining it to the reader as he goes along and yet making his situations funny.

In "Daughters in Law" he succeeds beautifully. The plot concerns a pair of brothers who love twin sisters, both of whom are lawyers. The brothers' affair is thwarted by their own father who has a pathological hatred of lawyers and the legal machine. The way in which the girls get their prospective father-in-law to accept them is deftly handled. It seems to me that Cecil at his best is one of the few writers today who can approach P. G. Wodehouse

when it comes to literary elegance combined with a fine sense of the ridiculous, and in this novel he seldom puts a foot wrong.

Unfortunately, "Alibi for a Judge" does not succeed so well. This concerns a judge who, feeling that he has given an unfair decision, sets out to redress the wrong that he had done to the defendant. In this novel the writer's legal knowledge is too great for his sense of humour and, although there are flashes of Cecil at his best, too much of the book is taken up with long explanatory sections in which English law is clarified for the reader. In the end I found that my sense of humour had deserted me and felt that Mr. Cecil had fired far too many legal broadsides.

Therefore I strongly recommend "Daughters in Law" as an example of Cecil at his comic best, but I think that "Alibi for a Judge" does not succeed, at any rate as a piece of humorous writing.

T. J. MacElwain.

(More book reviews on page 39.)

SPORTS NEWS

SPORTS DIARY

JANUARY, 1964

4th January

Rugby 1st XV v. Nottingham (A).

Rugby A XV v. Streatham (H).

Soccer 1st XI v. London Hospital (H).

8th January

Soccer 1st XI v. Institute of Education (A).

11th January

Rugby 1st XV v. Taunton (A).

Rugby A XV v. Wasps (A).

15th January

Soccer 1st XI v. School of Oriental and African Studies (A).

18th January

Rugby 1st XV v. Cheltenham (A.M.) (H).

25th January

Rugby 1st XV v. Old Whitgiftians (H).

Rugby A XV v. London Irish (A).

Soccer 1st XI v. Royal Free Hospital (H).

RUGBY REPORTS

Saturday, 9th November, v. Old Alleynians.
Away. Result: lost 0-26.

Not even the presence of a B.B.C. film unit could inspire the team to shake off their post-tour lethargy and, on a very muddy pitch, the Old Alleynians scored 26 points without a reply from Bart's. The main reason for the defeat lay with the pack, for though playing well in the tight scrum, they failed to cover ground and support the backs in defence and attack. The Alleynians did not have outstanding players, but always seemed to have three or four men to one Bart's player when a loose scrum was formed or a passing movement developed. This accounted for the heaviest defeat Bart's has suffered for three seasons. Fortunately it is a fault

which can easily be rectified by every member of the team making much more effort.

The film unit of the B.B.C. came along to film rugger scenes as a background for a documentary film on surgeons to be shown in the New Year. John Gibson staged a conversion kick before the match and shots were taken during the game.

Team: E. Sidebottom; P. E. Savage; N. J. Griffiths; A. T. Letchworth; S. M. Johnson; C. A. Grafton; D. C. Chesney; O. J. A. Gilmore; M. Revill; A. J. S. Knox; B. Doran; K. M. Stephens; J. A. Gibson; D. Goodall.

Saturday, 16th November, v. Cambridge City.
Away. Result: lost 5-19.

Cambridge City, a new fixture for Bart's are a very fine side, led by R. E. G. Jeeps, who was Captain of England two years ago. They have had a successful season and in this match we learnt the reason. A heavy, mobile pack was led from behind by Jeeps who, by very good touch kicking, gained ground for his pack and then supplied his backs with a fine service. The backs ran fast and straight and Hancock was notable in the centre. It was a pity that Bart's should have played carelessly against such a team; ten points were forfeited by elementary mistakes inside our own 25 yard line. In general the defence was more spirited than in the previous week but many attacking moves were spoiled by dropped passes and failure to back up and support the man with the ball. Our five points came from a foot rush which Johnson finished by diving over the line.

Team: M. E. Fryer; E. Sidebottom; A. T. Letchworth; S. M. Johnson; N. J. Griffiths; C. A. Grafton; D. Chesney; O. J. A. Gilmore; M. Revill; A. J. S. Knox; T. Bates; C. J. Smart; J. A. Gibson; M. Redfern; D. Goodall.

Saturday, 23rd November. v. U.S. Chatham. Away. Result: won 23-0.

With memories of last season's victory of 53-3 against U.S. Chatham still fresh, Bart's were initially surprised at the quality of the play of our opponents. Fortunately, this disadvantage was never exploited although Chatham played with spirit and attacked many times. Bart's then settled down and came near to scoring several times before Goodall and Griffiths worked a fine scissors movement and Smart took the final pass to score. Gibson converted. The half-time score was thus 5-0.

After the interval the Hospital pack played very well and gave the backs plenty of possession. This was put to good use and three more tries were scored. First Sidebottom entered the line and broke through the centre. Next Savage side-stepped most spectacularly and made a fine break; Letchworth, following up, took a good pass and scored under the posts. Finally Pope broke round the base of the scrum in our own half, kicked high ahead, collected the ball on the bounce and raced 40 yards to touch down. Gibson converted all three tries and also kicked a penalty.

Team: E. Sidebottom; D. Goodall; N. J. Griffiths; P. E. Savage; S. M. Johnson; A. T. Letchworth; Pope; O'Kane; B. H. Gurry; A. J. S. Knox; T. Bates; T. Bucknill; A. P. Ross; C. J. Smart; J. A. Gibson.

SOCCER CLUB

2nd November. 1st XI v. Institute of Education. Result: lost 0-3.

From the start of the game it was obvious that this was not Bart's day. The defence was shaken early on by some crisp football by the Institute forwards, and afterwards never managed to hold them completely. After some twenty minutes, during which neither side gained much territorial advantage, the Institute scored from a move that began on their right wing.

After half-time the picture was very much the same. The Bart's forwards were never very effective and the Institute helped themselves to another two goals.

7th-9th November. CAMBRIDGE TOUR

7th November. v. Trinity Hall. Result: Lost 4-5.

Bart's had a midfield advantage throughout the game and have only themselves to blame for losing. Trinity Hall scored from the kick-off and again ten minutes later; both through defensive errors. Shorey reduced their lead five minutes before half-time, but Trinity Hall restored their two-goal lead, again through a defensive error, shortly afterwards.

After the interval Shorey scored again and Sutton equalised after collecting the ball in front

of goal and dribbling around the goalkeeper. Bart's increased their pressure and looked set for victory until they allowed Trinity Hall to score from two breakaways. Dorritt scored for us before the final whistle.

8th November. v. Peterhouse. Result: won 4-1.

Against Peterhouse the Bart's side quickly settled down and played some very good football. The defence gained control of the Peterhouse forwards and play was mostly in our opponents' half. By half-time Bart's were leading 2-0 and looked set for a comfortable win.

The second half continued in the same way; the lead being increased to 4-0 by two goals from Herbert, one an excellent ground shot, from the edge of the penalty area, the other a penalty. Peterhouse scored about five minutes from the end of the match.

9th November. v. St. John's. Result: lost 0-3.

This was by far the best game of the tour. The football was of a high standard and it was played at a faster pace than the previous two games. St. John's pressed hard throughout the first half, but failed to score, due mainly to excellent defensive work, particularly on the parts of Layton-Smith and Thew.

The second half opened in a similar fashion, but after ten minutes Bart's were reduced to ten men due to an injury to Herbert. The extra burden proved too much for the defence and St. John's soon scored. They later added two more goals.

13th November. 1st XI v. Royal Veterinary College. Result: lost 4-5.

Bart's were obviously suffering from an excess of football, and allowed the opposition to build up a three-goal lead before fighting back. By half-time their lead had been reduced to 2-3 through goals by Turner and Sutton.

Shortly after half-time, Bart's managed to equalise, but then tended to rest on their laurels, even though they had most of the play. Two breakaways were enough to secure a 5-3 lead for the Royal Vets'. Shortly before the final whistle Offen added another goal for Bart's.

CROSS-COUNTRY CLUB

Tuesday, 19th November. Selwyn College Road Relay.

Last year we gatecrashed on this event to be the first College outside Oxford and Cambridge to participate. This year all the London Hospitals were invited to run, but we were again the only London college to reach the start. The course consists of four legs of a 2½-mile lap on the roads around Selwyn College. The rain luckily held off for the race although it rained for a good part of the journey there and back. T. Foxtan ran the first lap for us, and having

lost his glasses while running for London University the previous Saturday, succeeded on this occasion in losing his shoelaces. However, in spite of this handicap, he ran our fastest lap, finishing in 10th position. R. Sanders gained one place on the second lap and R. Thompson held this to bring us in 9th at the end of the third. N. Pott ran the last lap and produced a very fast finish to give us a final placing of 10th. Trinity College, Cambridge, won with T. Johnston running their last lap. A. Heron and M. Turner tied for the fastest lap of the day in 11 mins. 31 seconds, the latter bringing in Queen's College, Cambridge, for second place. 67 teams entered.

Lap	Position at end of lap	Time
1.	T. Foxtan 10	12 mins. 15 secs.
2.	R. Sanders 9	12 mins. 59 secs.
3.	R. Thompson 9	13 mins. 16 secs.
4.	N. Pott 10	13 mins. 2 secs.

Wednesday, 20th November. v. Charing Cross Hospital v. College of Estate Management at Cobham.

This was a new event on our fixture list, Charing Cross Hospital organising the race over a very pleasant 5½-mile course through Oxshott Woods. Since we did not know the way we had to stay with our hosts over the first mile to consult them frequently as to which way to go, there being a complete absence of markers, but then three Bart's men were able to go ahead with T. Napier from Charing Cross, who in turn was dropped in the last couple of miles, the leading three Bart's men coming in together in 35 mins. While this is a creditable performance, cross-country running is a team event and we would not have been able to win so convincingly if it had not been for the other members of the team running their best, R. Phipps providing our fourth scoring man, and while the others do not score, it does help to push the opposition further back by their good efforts.

1st=R. Thompson	35 mins.
=R. Sanders	"
=T. Foxtan	"
4th Charing Cross	36 mins.
5th College of Estate Management	37 mins.
6th College of Estate Management	37 mins.
7th College of Estate Management	38 mins.
8th College of Estate Management	38 mins.
9th R. Phipps	39 mins.
11th P. Brackenbury	40 mins.
14th T. Walsh	41 mins.

17 runners completed the course.

Result:—

1st—Bart's—15 points
2nd—College of Estate Management—26 points
3rd—Charing Cross Hospital—39 points

SWIMMING CLUB

From the depths of despair of the last report, the future of the club has brightened immensely with the new academic year. We have recruited some swimmers from amongst the present company and collected as well a good number of freshmen. Suddenly the Club finds itself with a surplus of material—no-one outstanding, but all keen and competent. This, in itself, has raised some problems to start with, but for anyone keen on joining, attendance at the training session at 3 p.m. on Wednesday afternoons in Gloucester House is essential as well as at U.L.U. on Saturday mornings.

The increased membership has assured us of a 2nd water polo team and we have two full teams entering the U.H. and U.L.U. swimming championships. Further, we have now set our sights very clearly, both on overtaking St. Mary's and winning the U.H. water polo league and the swimming championships.

We started the season well when we entered a relay team in an Invitation Race at Marshall Street Baths, consisting almost entirely of newcomers, and were unlucky to come 3rd to Charing Cross and St. Mary's. We overcame this slight disappointment in our next relay race when we beat the Royal Free and the School of Pharmacy at Ironmonger Row Baths by three-quarters of a length.

The water polo league started reasonably well, but the 1st team has not really hit peak form yet, and the 2nd team, consisting entirely of newcomers, is learning very rapidly and portends well for the future.

Last June, Matron kindly doubled the amount of time available to students for use of the pool in Gloucester House. This factor, combined with the best intake of Freshers for a long time, has served to produce the largest and most enthusiastic Bart's Swimming Club for many years. Half of its members use the Nurses' Pool for training on four days a week, and on Wednesday afternoons, the intensity of the training has to be seen to be believed!

In the U.L.U. Championships, we were placed 4th, the winners being Guy's, who, with the acquisition of two internationals, have inevitably come into their own. Owing to the non-arrival of 2 members of the Medley-Relay team and the last minute withdrawal of one of our finalists from his event, five valuable points were lost which would have taken us up to third place in the University. D. Shand is to be congratulated on winning the Diving for the fifth year, and A. Gordon for coming second in his first term here.

We were forced to concede the United Hospitals' Championships to Guy's, and an unfortunately bad swim in the second leg of the Medley-Relay lost us the two points required to overhaul St. Mary's. Diving honours once more went to Bart's with Ruoss and Shand gaining as many points as the next four competitors combined.

At the time of going to press, the 1st Water-Polo team has been defeated only by Guy's, whilst the 2nd team, composed entirely of inexperienced players, shows much promise. With such abundant enthusiasm and potential the Bart's Swimming Club intends to put itself back in its rightful place as the top Hospital, and begs both physical and vocal support during the next few months.

The following have represented the Hospital this season:—

Britton	Groves
Hanley	Kettlewell
Castleden	Simmons, M.
Lask	Quinn
Hillier	Garson
O'Kane	Ruoss
Shorey	Gordon, A.
Haig	Miss Tyler
Pogmore	Miss G. White
Shand	Miss P. Milledge
Knight	Miss S. Tillman
Gibbs	

HOCKEY CLUB

Results

26th October. v. Barnes H.C. Draw 2-2.

2nd November. v. C.I.A. Lost 5-3.

16th November. v. Bexley Heath. Lost 2-1.

20th November (Cup Match). v. Middlesex Hospital. Draw 3-3.

Report

On Wednesday, 20th November, Bart's played a very close and exciting first round Cup Match against The Middlesex Hospital. Bart's soon went into the lead but then seemed to relax and our opponents replied by scoring two goals before Bart's could equalise. In the second half The Middlesex Hospital had another breakthrough to lead 3-2. It was only when faced with defeat that Bart's really woke up and some dynamic play by the forwards soon achieved results, the match ending in a draw. The match will be replayed early in December and on our home ground. Bart's will go all out to claim the match and eventually the Cup as well.

Cup Team: S. Campbell-Smith; R. Browne; G. Benke; T. Billington; M. Nightingale (capt.); T. Chant; S. Heyward; A. Edelsten; W. Castle-den; W. Field; M. Brueton.

THE MEDICAL PROTECTION SOCIETY

ADVICE · DEFENCE
& FULL INDEMNITY
FOR DOCTORS
& DENTISTS AT HOME
& OVERSEAS

Founded 1892

50 HALLAM STREET · LONDON · W.1

Secretary: Dr. H. A. Constable.

Tel: LANGHAM 9241



For improved control of petit mal

ZARONTIN

often succeeds where other therapy has failed

ZARONTIN* (ethosuximide Parke-Davis) provides dramatic and effective control of most *petit mal* seizures—even in patients previously resistant to therapy.

ZARONTIN is supplied as soft gelatin capsules, each containing 250 mg. ethosuximide, in bottles of 50 and 500—and also as a syrup (one teaspoonful or 5 ml. contains 250 mg. ethosuximide), in 240 ml. and 2 litre bottles.

Detailed literature discussing dosage and side effects is available on request.

*Trade Mark

PARKE-DAVIS

PARKE, DAVIS AND COMPANY, HOUNSLOW, MIDDLESEX. TELEPHONE HOUNSLOW 2361
O-1184

CRICKET CLUB AVERAGES—1963

BATTING:

Name	No. of Innings	Times Not out	Total Runs	Highest Score	Average
R. S. A. Thomas ..	27	4	899	139*	38.70
D. J. Delany ..	12	2	300	79*	30.00
J. A. Harvey ..	9	1	172	49	21.51
N. Griffiths ..	9	3	127	48	21.23
C. P. Vartan ..	19	5	271	48*	19.35
R. Higgs ..	9	1	146	43	18.25
D. J. Abell ..	12	0	209	51	17.40
R. M. Wood ..	9	0	152	60	16.90
D. J. Goldie ..	12	1	179	41	16.27
E. Sidebottom ..	9	1	119	42*	14.89
W. H. Pagan ..	15	1	175	39	12.50
N. D. Offen ..	27	3	296	39	12.34
J. R. Harrison ..	18	5	156	43	12.00
I. Peck ..	9	0	102	31	11.33
H. Phillips ..	22	2	189	40	9.45
C. J. Smart ..	12	7	43	23	8.60

Also Batted: J. Cannon, T. Bates, E. Abell, C. J. Richards, M. Waterworth, J. Davies, R. Powles, T. Herbert, P. E. Savage.

* indicates 'not out'

BOWLING:

Name	Overs	Maidens	Runs	Wickets	Average
C. J. Richards ..	54	10	183	13	14.76
P. E. Savage ..	68.5	12	210	14	15.00
C. P. Vartan ..	265	73	729	42	17.36
C. J. Smart ..	154.1	26	528	30	17.60
J. A. Harvey ..	56	8	159	9	17.66
D. J. Abell ..	104	18	368	19	18.76
J. R. Harrison ..	281.4	58	855	40	21.18
D. J. Delany ..	41.4	4	190	4	47.50
N. Griffiths ..	51.0	4	244	5	48.80

Also Bowled: N. D. Offen, M. Rimmer, J. Mitchell, P. A. R. Niven, R. Higgs, K. Rawlinson, H. Phillips, A. T. Letchworth.

I would like to subscribe to the St. Bartholomew's Hospital Journal and enclose 25s., the annual subscription. Please send the Journal to:—

Name Send this to: The Manager,
Address St. Bartholomew's Hospital,
..... St. Bartholomew's Hospital,
..... London, E.C.1.

MORE NEW PENGUINS

U.S.A. For Beginners by Alex Atkinson and Ronald Searle. Published by Penguin Books. Price 3s. 6d.

To write a book, albeit a light-hearted one, about a country to which one has never been is an interesting experiment, but one that is fraught with difficulties. It is therefore very much to Mr. Atkinson's credit that his book has a factual ring about it as well as making excellent reading. Having said this, I must state that I preferred the earlier book, "The Big City", which is also by Atkinson and Searle. Ronald Searle supplies the illustrations and this fact usually makes any book worth buying; in "U.S.A. for Beginners" his drawings are well up to standard.

John Kelly.

The Jengnu Pennings by Paul Jennings. Published by Penguin Books. Price 3s.

There can be few more soul destroying jobs than having to produce a humorous article every week; week after week, year after year there is the constant struggle to obtain that most intangible of qualities. The weekly column of Paul Jennings in "The Observer" is well known because it consistently achieves a high standard and it is from this source that most of the articles in "The Jengnu Pennings" are taken. This is a book which must be read in small doses, a book that can be picked up and savoured from time to time.

John Kelly.

OTHER REVIEWS

Handbook of Histopathological Techniques by C. F. A. Culling. Published by Butterworth and Co., Ltd.

This text book is well known to be one of the best accounts of general histological techniques. The second edition is noteworthy for the addition of up-to-date chapters on the histochemical detection of enzymes, fluorescence, exfoliative cytology and chromosome techniques. The microscope itself is adequately dealt with and the techniques of fluorescent microscopy, polarizing and phase contrast methods, are all described. Another chapter worthy of praise is the comprehensive and well laid out account of the central nervous system.

The book might be criticised on the grounds that the author does not always enlarge on the practical difficulties which attend some of the techniques described—difficulties well known to those who practice such methods as autoradiography, of which Mr. Culling gives a brief account. Clearly, however, the concise treatment of these techniques is deliberate policy on the part of the author and is aimed at keeping the book a reasonable length and suitable for use by technicians studying for their final histopathological examinations. Although this will remain its major function, the clarity of the author's approach and comprehensive indexing gives the book an added usefulness as a work of reference.

W.G.S.

10 MINUTES HOLIDAY A DAY

The **RELAXATOR** — The wonderful unique design of the "Seat of the Century" is the perfect answer to induce quick, complete relaxation, banish mental tension, restore physical energy. 'UNWIND' from the stress of modern living.

Delivered in rigid pack-away carton.



Accepted by the Council of Industrial Design

To relax properly your head needs to be lower than your feet, the body suspended in a special curve. This is just one relaxing position you can get with this life-long investment for leisure. Elegant, light and portable.

Write for FREE folder to Dept. BH 2

LODGE OF LONDON

TRADING ESTATE, WEST MOLESEY, SURREY

Antibiotic and Chemotherapy by Mary Barber and L. P. Garrod. vii plus 366 pp. Published by E. & S. Livingstone, Ltd., Edinburgh and London. Price 35s.

For many years Professor Garrod's friends have hoped that he would find the time to record his great experience of antibiotics and their use in medicine. That he has now joined Dr. Mary Barber in writing Antibiotic and Chemotherapy will be a source of pleasure and instruction to them and to all who are concerned with antibiotics and their use in the treatment of patients. The first part of the book deals with antibiotics and related drugs. Each drug is described in some detail and, as might be expected, particular attention has been paid to the variations of activity against different bacterial species. The second part of the book is practical, suggestions being made for the treatment of infections in the various systems of the body.

Antibiotic and Chemotherapy is recommended with pleasure and without reservation.

R.A.S.

NEW BOOKS for the NEW TERM

THE NORMAL CHILD

Some Problems of the First Five Years and their Treatment

By R. S. ILLINGWORTH, M.D., F.R.C.P., D.C.H., D.P.H.

New (Third) Edition. 52 Illustrations. Ready shortly. 40s.

GENERAL PATHOLOGY

A New Book. By J. B. WALTER, M.D., M.R.C.P., and M. S. ISRAEL, M.B., B.Ch., M.R.C.P., D.C.P.

952 pp. 264 Illustrations. Just Ready. 100s.

Holland & Brews MANUAL OF OBSTETRICS

New (Twelfth) Edition. By ALAN BREWIS, M.D., F.R.C.P., M.S., F.R.C.S., F.R.C.O.G.

61 Plates (12 Col.) 388 Text-figures. 90s.

CHILD HEALTH AND DEVELOPMENT

By various authors. Edited by R. W. B. ELLIS, O.B.E., M.D., F.R.C.P.

New (Third) Edition. 93 Illustrations. 56s.

Shaw's TEXTBOOK OF GYNAECOLOGY

Eighth Edition. By JOHN HOWKINS, M.D., M.S., F.R.C.S., F.R.C.O.G.

4 Colour plates. 451 Text-figures. 40s.

An Introduction to PRACTICAL PSYCHIATRY

By C. M. B. PARE, M.D., M.R.C.P., D.P.M.

8 Illustrations. Ready Shortly. 25s.

PRACTICAL HAEMATOLOGY

New (Third) Edition. By J. V. DACIE, M.D., F.R.C.P., and S. M. LEWIS, B.Sc., M.D., D.C.P.

90 Illustrations. 40s.

Johnston's SYNOPSIS OF REGIONAL ANATOMY

New Ninth Edition. Edited and revised by ROGER WARWICK, B.Sc., Ph.D., M.D.

20 plates and 19 text-figures. 30s.

HUMAN PHYSIOLOGY

By F. R. WINTON, D.Sc., M.D. and L. E. BAYLISS, Ph.D.

Fifth Edition. 228 Illustrations. 47s.

PRINCIPLES OF EPIDEMIOLOGY

New (Second) Edition. By IAN TAYLOR, M.D., M.R.C.P., D.P.H., and JOHN KNOWLEDEN, M.D., D.P.H.

36 Illustrations. Ready Shortly.

ANAESTHETICS FOR MEDICAL STUDENTS

By GORDON S. OSTLIERE, M.A., M.B., F.F.A.R.C.S. and ROGER BRYCE SMITH, M.A., D.M., F.F.A.R.C.S.

New (Fifth) Edition. Just Ready. 12s. 6d.

A PRACTICE OF GENERAL ANAESTHESIA FOR NEURO-SURGERY

By R. I. W. BALLANTINE, M.R.C.S., L.R.C.P., D.A., F.F.A.R.C.S., and IAN JACKSON, M.R.C.S., D.A.

68 Illustrations. 27s. 6d.

J. & A. CHURCHILL LTD., 104 GLOUCESTER PLACE, LONDON, W.1

From the day you qualify . . .

THE MEDICAL DEFENCE UNION

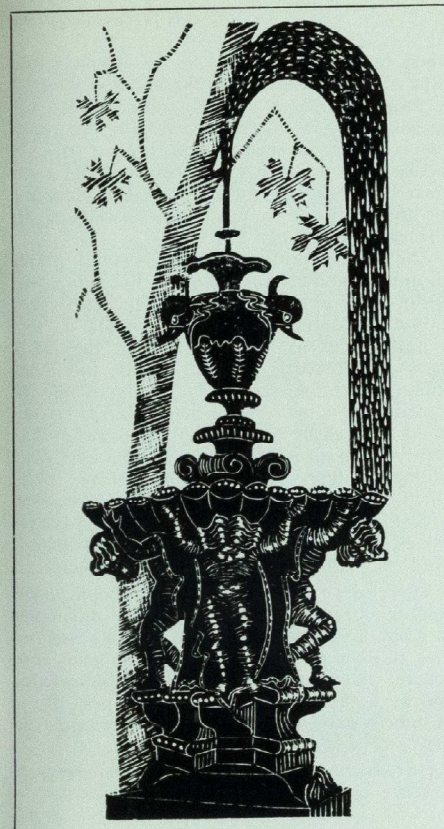
The oldest and largest organisation of its kind in the world

Secretary: PHILIP H. ADDISON, M.R.C.S., L.R.C.P.

Dental Secretary: A. H. R. ROWE, B.D.S., F.D.S.

Tavistock House South, Tavistock Square, W.C.1.

Telephone: EUSton 4244/7



CONTENTS

Editorial	41
Correspondence	43
House Appointments	49
Matron's Ball, 1964	50
Up to the Minute in a Moment	51
Some Surgical Problems of Elderly Patients by Gordon L. Bohn	52
Bonesetter, 1963 by F. E. Weale	54
Fibrinolysis by Norman G. Rothnie	58
Pot-Pourri, 1963	61
Nigerian Expedition by 2nd Lt. I. C. Nicholson, R.A.M.C.	63
Special Departments: VI: The E.N.T. Department by R. F. McNab Jones	67
Planning Considerations by John Goody	68
Sir Richard Owen by Prof. A. J. E. Cave	71
Other Hospitals—4: Salilgrenska Hospital by Karl Ola Obrant, M.D.	74
Sports News	78

PUBLICATIONS COMMITTEE

Chairman: Dr. A. W. FRANKLIN.
Deputy Chairman: Dr. G. H. FAIRLEY.
Editor: T. P. DUTT.
Review Sub-Editor: G. R. A. HAMILTON.
Social Sub-Editor: Miss J. BELL.
News Sub-Editor: C. J. KELLY.
Sports Sub-Editor: G. HAIG.
Photographic Sub-Editor: B. C. P. LEE.
Manager: G. O. GEY, Jr.
Assistant Manager: J. R. SWAIN.
Women's Representative: Mrs. A. R. BAILEY.
Nurses' Representative: Miss M. IRONSIDE.
Charterhouse Representatives: A. R. BAILEY.
G. W. LIBBY.

EDITORIAL

THE SEVENTH AGE

*What is the worst of woes that wait on age?
What stamps the wrinkle deeper on the brow?
To view each loved one blotted from life's page,
And be alone on earth, as I am now.*

Lord Byron

(Childe Harold's Pilgrimage)

The problem of the elderly patient in modern society has, in recent years, received a good deal of very necessary attention but, in spite of this and the resulting social developments that are gradually coming about, the aged patient will continue to present a growing medico-sociological issue for many years to come.

The great fear of a person who sees old age approaching has always been that of loneliness and, though no substitute for a loving and understanding family, the general practitioner can provide much comfort to this group of patients. It may be difficult for the busy practitioner to spend time and trouble discussing problems with patients who are beginning to slow down in thought and speech but who are otherwise healthy but it is vital to the future well being of the patient that he should do so. If the practitioner knows his patients well he will be in the best possible position to advise and reassure them in later years and he will also be more easily able to observe the first changes due to organic disease, and this may make all the difference between an early diagnosis and an early demise. There is also a great advantage in that, although the elderly often find it difficult to make good contact with recent acquaintances, they enjoy talking to those in whom they have confidence and the doctor who provides this opportunity will be

amply rewarded for the time spent by the gratitude of his patients.

The lonely, old person has a great tendency to become shut off from the world of reality and comes to live in the past and it is essential that such people should have visitors and be encouraged to go out and meet others of their own age group. It is natural that they should remember and talk about their lives but they must never be allowed to loose their contact with the present and any such suggestion must be gently but firmly denied. This may present a strain to any other people living with the patient as the delusions of the past may constantly recur and therefore require continual refutation, but adequate explanation from their doctor will almost always enable the family to understand the principles involved. Above all, neither the family nor the doctor must ever allow themselves to regard the patient as having reached "second childishness and mere oblivion".

Depression too is very common in the aged and may show itself as irritability, tearfulness and insomnia. These patients often respond well to anti-depressive drugs, with sedation if necessary. An essential part of this treatment, as in all others of elderly people, is continual reassurance and encouragement, but any trace of condescension must always be avoided.

The management of the elderly patient with organic disease must also follow different criteria from those employed in the younger age groups. Diagnosis in these patients is often made difficult by a typical presentation and the occurrence of multiple pathology is very common. Patients with minor complaints must be prevented from becoming chronic invalids as this will not only impose a great burden on the family and on the doctor, but may even result in the development of more serious symptoms being regarded as neurotic until too late.

In the more serious cases the practitioner must appreciate that many old people are made very much worse by putting them into hospital, for in the wards they are cut off from their familiar surroundings and this may greatly increase any depression or disorientation which may exist. Nevertheless, the establishment of geriatric wards has eased the situation and hospital treatment under these conditions may be very successful, especially if the patient has no relatives or friends who are willing to make the effort and the sacrifices which would inevitably be required if the invalid were nursed at home. It is also important to realise that

when the patient comes out of hospital and returns home a period of rehabilitation is often necessary. Changes in the attitude of the relations are, in this respect, even more important than changes in the outlook of the patients themselves for, once the dependant has been moved to hospital, there is a great tendency for the relatives to wash their hands of all further responsibility.

The vast majority of people would prefer to die at home and attended by their own doctor but a recent survey (Hughes, 1960) showed that only half of the deaths in this country occur at home. Some of the other cases undoubtedly require skilled and continuous attention such as it is impossible to provide at home, but a much larger group could quite easily be accommodated in familiar surroundings provided that their relations were willing to help with elementary care. The social services now available can cope with almost any illness at home and the district nurses, home helps and other facilities are all available to help the general practitioner.

There are over five million people aged sixty-five or more in the country and this figure is going to grow still larger. It is essential that all doctors, but especially those going into general practice, should have a good knowledge and at least some practical experience of the problems and difficulties to be overcome in the care of the old patient.

[An article on the surgical problems of elderly patients appears on page 52].

CHANGE

Once again the *Journal* presents a new face to its readers—we have a new cover. This is the fifth since we abandoned, in January 1961, the faithful but very worn block of the Henry VIII Gate and each new cover has been liked by some and disliked by others; this is inevitable for, with a readership such as ours, it is natural that opinions should differ.

Of greater importance however is the suggestion that a changing cover reflects instability within the *Journal*. In fact, these changes result not from instability but from flexibility; the fault with the *Journal* in the past few years has been not instability but excessive stability and an unwillingness to alter in response to changes in the outside world. Today the average doctor is inundated by a vast mass of reading matter and it is no longer good enough for a hospital journal to merely bear the name

of the hospital on the cover and contain material of purely parochial interest, it must be prepared to compete in the battle for its subscribers' time. To this end we have recently increased the number of members of the Journal Publications Committee in an effort to widen the scope and increase the collective experience of the Committee.

The *Journal* itself has also altered. We now try to be as topical as possible. The long printing schedule of nearly a month presents difficulties in this attempt but by short circuiting the schedule with certain items, such as *Up to the Minute in a Moment*, we hope to be up to date even if it means that a few errors do slip through un-corrected.

We have expanded the range of material published to include something of both the purely medical and the purely social in each issue, as well as at least part of the spectrum between.

We have made use of varying type faces in the *Journal* in order to assist the reader in finding articles of interest to him personally and also in an attempt to make the individual pages more attractive.

It is usual to conclude introspective editorials of this type with an exhortation to all readers to put pen to paper. We do not believe that such requests ever meet with success and we shall not waste words. We do point out however that destructive criticism, though not a worthless creature as it is often made out to be, is, even at its best, only a second best.

Correspondence

PUBLIC IMAGE

Sir,—I should like to congratulate you on your editorial in the current number of the *Hospital Journal*.

I wish you all success.

Yours sincerely,

R. A. BUGLER
107 Bents Road,
Sheffield, 11.

17th December.

Sir,—Your remarks in your editorial of the December issue prompt me to express my long-felt annoyance of the fact that our *Hospital* provides no facilities for private patients. As I have nothing to do with the N.H.S. and have to arrange for my patients' hospital accom-

modation, during 1963 I have sent cases to Guy's, St. Mary's, the Middlesex, St. John's and St. Elizabeth's and St. Anthony's, all under the care of Members of the Staffs of those Hospitals, whereas I would have preferred to have had them treated in Bart's by my contemporaries.

As I see the problem, a wing for private patients can only result in benefit to our *Hospital* and teaching, and to the patients, whom the State services appear to regard as the least important factor in the scheme.

Yours faithfully,

Dr. P. B. PALMER,
The White House,
Godstone, Surrey.

17th January.

Sir,—I cannot refrain from protesting about your Editorial, "Public Image".

Surely it is true that if anything at all has changed in the last twenty years it is the public attitude to prestige and the kind of patronage which you advocate.

There is a much more worthy and finally more certain way of gaining prestige and creating a favourable public image and that is by increasing the contribution we make to the advancement of knowledge and the elimination of disease according to our various professions.

I am not attempting to judge our present position at Bart's but I am suggesting that "sporting, social and academic cream of varsity" if this order is to be taken as an indication of priorities.

By all means let us be more courteous to the Police and to the Lord Mayor of London but do not make the mistake of thinking that our public image depends on impressing one small group however influential it may be.

Yours sincerely,

A. L. BRADSHAW,
Senior Physicist,
Radiotherapy Dept.,

17th December. St. Bartholomew's Hospital.

[Regrettably, Mr. Bradshaw seems to have missed the point of the Editorial which was written with no intention to decry the sentiments expressed in his letter.

Of course we must strive towards the elimination of disease and we would be failing in our obligations to our profession and to ourselves if we did not do so.

But this, alone, is not enough.—Ed.]

SIR ANTHONY BOWLBY

Sir,—I very much regret that in my letter to you of August I have given the impression that Mr. E. G. Stanley of Salcombe, South Devon, is no longer amongst us. I am afraid I came to this entirely wrong conclusion owing to the fact that I heard nothing of him for over 50 years and therefore very wrongly concluded that he was dead. I have written a personal letter to him expressing my apologies and sincerely hope that he will understand.

Yours faithfully,

LANCE W. BARLOW,
Johannesburg.

7th December.

GENERAL PRACTICE TEACHING

Sir,—I was delighted to see the Notice in the Journal of December regarding this subject.

The teaching of General Practice to final year students can bring nothing but good. There are many "Old Bart's Men" in General Practice, like myself, who have been wondering when Bart's was going to do something along the lines now suggested and I am sure that we will now be greatly encouraged.

Student attachment schemes to General Practitioners which are already working in many Teaching Hospitals throughout the country have been praised on all sides. They give the student an insight into good General Practice and I am sure have been the means of attracting many excellent people in to General Practice that might otherwise have been lost.

Yours faithfully,

Dr. G. S. R. LITTLE,
2 Shooters Hill Road,
Blackheath, S.E.3.

17th December.

POTT'S FRACTURE

Sir,—As the text of your article on Pott's Fracture does not tally with the diagrams which accompany it, one can assume that there has either been a misprint or a failure on someone's part to remember his anatomy. If one looks closely, the obvious mistake lies in the fact that one is looking at the bones of the left ankle, not the right. The shape of the talus or astragalus, might be confusing at a cursory glance—as it looks like the calcaneum and talus, fused for simplicity. (One is looking at the posterior view of the left ankle in each case!).

Yours faithfully,

R. L. COOPER,
College Hall.

1st January.

[We thank Mr. Cooper for drawing our attention to this error.—Ed]

PERCIVALL POTT

Sir,—I feel some diffidence in correcting such an accurate and tireless historian as Mr. John L. Thornton, but Percivall Pott's memorial tablet is not in St. Mary Aldermanbury, but in St. Mary Aldermary. This is in the triangle bounded by Watling Street, Bow Lane and Queen Victoria Street, and would therefore have been his parish church. The tablet is on the south wall behind the choir stalls.

HAROLD B. LEE,
Long Running,
7 Warren Hill,
Loughton, Essex.

3rd January.

Mr. Thornton writes:

Mr. H. B. Lee rightly points out that in my article on Percivall Pott I wrongly stated that he was buried in St. Mary Aldermanbury when I should have written St. Mary Aldermary. Several biographers have given different titles to this church, and otherwise confused the issue, but I saw the inscription there some years ago, and should not have fallen into this error.

THE TRUE FACTS

Sir,—Dr. Geoffrey Bourne, in that entertaining and valuable record of a bygone age, "We met at Bart's", has introduced a very improbable version of the story of my dealing with the excreta of lions. He is the second author to do so, Richard Gordon having mangled it even more severely in one of his novels. May I place the true facts on record?

Almost exactly forty years ago, desirous of studying the faecal flora of a purely carnivorous animal, I wrote to the Superintendent of the Regents Park Zoo, asking for his help. I expected to be invited to the lion house to help myself. Instead, my wife rang me up a few mornings later to say that a van from the Zoo had delivered a large and evil-smelling parcel at our house, then in Gloucester Terrace, W.2. In it was a box containing what appeared to be the entire sweepings of a lion's cage. I fetched it and made cultures forthwith, and these confirmed my belief that on such a diet the aerobic flora would be exclusively coliform, whereas I had already found that in a herbivorous animal, the horse, it consisted largely of streptococci. In those days an "excess of streptococci" in the faeces was supposed to have some mysterious connection with chronic arthritis and other ills, and these experiments

were in part an attempt to explode this idea, although their results were of interest in other ways. They are recorded in the *St. Bartholomew's Hospital Reports*, 1925, 58, 53.

I am, Yours faithfully,

LAWRENCE P. GARROD,
2, The Crossways,

6th January.

Radlett.

CANCER REPORT, 1948-1952

Sir,—We are gratified to see Sir Geoffrey Keynes' generous review of the Cancer Report in the October Journal and also Mr. Harvey White's letter in the subsequent issue, asking how the Journal could assist the project.

It should perhaps be pointed out that the publication of the Report, although undertaken on a commercial basis, was only made possible by a generous grant from the Endowed Funds of the Hospital. The best way on ensuring the co-operation and the support of the Governors for any future Reports is, to put it bluntly, by selling as many copies as possible of the first.

But apart from these financial considerations we would be glad to have the comments of your readers; they will be equally welcome whether they draw attention to misprints or whether they offer constructive suggestions for the future. Perhaps Mr. White would like to start the discussion.

For the sake of accuracy we should point out that the full title is "Saint Bartholomew's Hospital Reports: New Series Volume I: Cancer Report 1948-1952".

Yours faithfully,

A. W. FRANKLIN,
M. P. CURWEN.

Editors.

BRITISH MEDICAL STUDENTS' JOURNAL

Sir,—Three and a half centuries ago, the Elizabethans held that a man was truly educated only once he had committed his knowledge and thoughts to paper. But for much of the raw material to feed into his mind during education, he was dependent upon the writings of his predecessors and even contemporaries. Even since then, educated persons in all spheres have contributed to the constantly climbing spiral of knowledge. Each generation has little opportunity to repay its debt to those preceding it, but payment may be made indirectly by contributing to that fund of knowledge and general interest.

The British Medical Students' Journal offers

a unique country-wide medium for any, or even all, the 12,000 medical students of the British Isles to play a part in this essential feature of every educated generation. If two minds working in proximity feed and complement each other, imagine what reaction the thoughts, opinions, observations, discoveries, creations and compositions of even a hundredth of all these medical students could engender in their fellows.

The Editorial Board welcomes at any time the comments of, or preferably, articles from, any student who is feeling the stirring of his private Muse.

Yours faithfully,

STEPHEN ROBINS,
Director of Publications, B.M.S.A.,
B.M.A. House, Tavistock Square,
London, W.C.1.

B.M.S.A. VISITS

Each month the London Region of the British Medical Students' Association organises visits to various places of medical interest sited in and around London. Since Bart's is a constituent member school of the London region group, all Bart's students are eligible for places on the visits. In most cases the cost is 2s. 6d. and the students are expected to find their own transport. When the visits are further afield, such as those organised to the National Spinal Injury Centre at Stoke Mandeville, or the Plastic Surgery Centre at East Grinstead, travel is generally by coach, and the cost is necessarily a little higher.

Details of visits can be found on the B.M.S.A. notice board.

The following visits have been arranged for February and March:

Wednesday, February 26, 2 p.m.—Tea provided: Chester Beatty Research Institute, Institute of Cancer Research, London, S.W.3.

Wednesday, March 18, 2 p.m.: Institute of Psychiatry, The Maudsley Hospital, Denmark Hill.

Applications for places on the visits should be made to Diane Gorvette, Women Student's Cloak-room, by February 17th and March 9th respectively.

PUBLIC WELFARE FOUNDATION**Undergraduate Prize Competition**

The Council of the College of General Practitioners is happy to announce that the above competition which has been held each year since 1957, will now become a permanent activity of the College. The competition is open to any senior medical student in any medical school in the United Kingdom and Eire. Three prizes of £100, £75 and £50 respectively are awarded each year, and in addition to a cheque for £100, the first prize-winner has book tokens to the value of £10. Applicants are asked to give a case history, with a suitable commentary, of one or more patients who they have seen in general practice. The patient may, but need not, have been admitted to hospital. The student is required to have seen the patient on three or more occasions in the patient's

(Continued on page 46)

Calendar

FEBRUARY

Sat. & Sun., 1st & 2nd: Dr. E. R. Cullinan
Mr. C. Naunton Morgan
Mr. H. J. Burrows
Dr. T. B. Boulton
Mr. A. P. Fuller

3rd February: Copy Date for March Journal

Sat. & Sun., 8th & 9th: Dr. G. W. Hayward
Mr. A. W. Badenoch
Mr. J. N. Aston
Mr. F. T. Evans
Mr. J. W. Cope

Sat. & Sun., 15th & 16th: Dr. A. W. Spence
Mr. E. G. Tuckwell
Mr. H. J. Burrows
Dr. R. A. Bowen
Mr. R. F. McNab Jones

Thursday, 20th Feb.: Dr. G. F. Abercrombie will lecture at 12 noon on the "Family Doctor".

Sat. & Sun., 22nd & 23rd: Prof. E. F. Scowen
Prof. G. W. Taylor
Mr. I. N. Aston
Mr. G. Ellis
Mr. J. C. Hogg

Thurs. 27th Feb: Boat Club Ball—Charterhouse

Sat. & Sun., 29th & 1st: Dr. R. Bodley Scott
Mr. A. H. Hunt
Mr. H. J. Burrows
Dr. R. W. Ballantine
Mr. A. P. Fuller

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

On Friday 21st and Saturday 22nd of February, at 7.30 p.m., in Gloucester Hall, the Drama Society will present "Tiger at the Gates", by Jean Jiraudoux. Translated by Christopher Fry.

(Continued from page 45)

own home or in the general practitioner's consulting room, and to have been introduced to the patient, in the first place, by the family doctor concerned. In presenting his material, the student should give adequate consideration to both the clinical and social aspects of the patient's problem. He is encouraged to discuss the case thoroughly, before writing it up, with the general practitioner concerned. This presentation should include an adequate and concise summary of the salient features.

The material (approximately 1,500 words) should be written or typed on one side only of quarto paper. Adjudicators will allot marks to each essay on the following basis: clinical presentation maximum 30 marks, assessment of the social aspects of the patient's problem maximum 20 marks, the candidate's apprecia-

Engagements

BALFOUR—GRAY.—The engagement is announced between Anthony Balfour and Valerie Gray.

GILLESPIE—VICTORY.—The engagement is announced between Michael Gillespie and Anne Victory.

HUDSON—GARNETT.—The engagement is announced between Martin Frederick Hudson and Susan Mary Garnett.

MITCHELL—THOMPSON.—The engagement is announced between Roger John Mitchell and Angela Helen Thompson.

Marriages

BENNETT—BOYD.—On December 14, Ben Stuart Bennett to Christine Evelyn Boyd in St. Bartholomew's the Less.

HURT—BLACK.—On September 21, Raymond Lambert Hurt to Olivia Mary Somersall Black.

Births

BOOTH.—On December 23, to Jean (née Jenner) and Dr. David Booth, a daughter (Helen Margaret), a sister for Kathryn.

DOSSETOR.—On November 26, to Dr. and Mrs. John Dossetor, a daughter (Moirá Margaret), sister to Frances, John and Clare.

DUFFY.—On November 30, to Juliet (née Burdett) and Dr. Tom Duffy, a daughter (Juliet Mary).

GIBBON.—On December 2, to Ruth (née Alexander) and Dr. Raymond Gibbon, a son (Robert Alexander).

GREEN.—On November 25, to Joy (née Bignell) wife of Dr. Henry Green, a daughter (Rachel Catherine Harrison).

tion of the general practitioner's role in diagnosis and management maximum 20 marks, summary maximum 20 marks, and 10 marks are allotted for the adjudicator's own comments.

Application forms and further particulars may be obtained from the Dean's Office of the student's medical school or from the Secretary of the Undergraduate Education Committee of the College of General Practitioners, 14 Princes Gate, Hyde Park, London, S.W.7. The closing date for the competition is 1st May, but application may be sent in at any time.

THE COLLEGE OF GENERAL PRACTITIONERS
14 Princes Gate, Hyde Park, London, S.W.7
December 1963

MAKIN.—On December 15, to Julie (née Cowley) and Dr. Edward Makin, a son (Alistair James).

WHITE.—On November 25, to Susie (née Wright) and Dr. Roger G. White, a daughter.

WILLIAMS.—On November 12, to Frankie and Colin Williams, a daughter, (Alison Jane).

Deaths

BREWER.—On December 28, Frederick Henry Wormald Brewer, F.R.C.S., L.R.C.P., aged 82. Qualified 1910.

DINGLE.—On November 20, Dr. P. A. Dingle, C.B.E., M.R.C.S., L.R.C.P., aged 82. Qualified 1905.

GRINDLEY.—On December 10, Dr. Robert Walter Guy Grindley, M.R.C.S., L.R.C.P., D.A., F.F.A.R.C.S., aged 58. Qualified 1939.

LAIDLAW.—On December 11, Frank Fortescue Laidlaw, M.A., M.R.C.S., L.R.C.P., aged 87. Qualified 1909.

LUNN.—On December 23, George Maurice Lunn, F.R.C.S. Qualified 1941.

MARTIN.—On November 17, P. H. Martin, A.F.C., B.M., B.Ch., F.R.C.P., D.T.M., D.T.H., aged 67. Qualified 1924.

TURNER.—On December 11, Lt.-Col. Charles Harold Turner, D.S.O., R.A.M.C. Qualified 1900.

Changes of Address

Dr. G. M. Besser, to 19, Lonsdale Square, Islington, N.1.

Dr. B. Burns, to Montgomery House Medical Centre, 83-85, Infirmery Road, Sheffield, 6. Telephone 25244/5.

Major T. A. Dodd, to 245, Bellevue Road, Southbourne, Bournemouth. Telephone Bournemouth 49716.

Appointments

The President of Brazil has conferred upon Mr. H. B. Stallard the Order of the Southern Cross.

Royal College of Surgeons of England

Diplomas of fellowship were granted to the following: C. A. C. Charlton, J. K. K. H. Chong and J. A. Neely.

University of London

The title of professor emeritus has been conferred on Dr. A. Wormald, F.R.S., who held the chair of biochemistry at St. Bartholomew's Hospital Medical College from 1936 to 1963.

NEW YEAR'S HONOURS

The following honours were awarded in the New Year's Honours List:—
Knight Bachelor.—Herbert John Seddon, C.M.G., D.M.Oxon., M.B.Lond., F.R.C.S.

C.B.E. (Civil).—William Cooper Gissane, M.B.Sydney, F.R.C.S., F.R.A.C.S.; Robert Gwyn Macfarlane, M.A.Oxon., M.D.Lond., F.R.C.P., F.R.S.; Frederick Herman Aitken Walker, M.B.Cantab., F.R.C.S.

O.B.E. (Civil).—Douglas William Cowley Gawne, M.D. Cantab., F.R.C.S.

EXAMINATION RESULTS

University of London Final M.B., B.S. Examination October, 1963

Pass

Benison, R. S.	Nash, A. V.
Bousfield, J. D.	Newstead, F. B.
Brewer, C. L.	Phaure, T. A. J.
Bridger, C.	Pope, F. B.
Cannon, J. P. G.	Richards, C. J.
Challis, J. H.	Robertson, A.
Evans, J. P.	Ruoss, C. F.
Frank, A. J. M.	Sewell, J. B.
Glover, D. N.	Sibunruang, S.
Jennings, M. C.	Smith, I. R.
Littlewood, P.	Stephenson, T. P.
Lloyd, C. M.	Tandy, W. R.
McPhail, L. M.	Waterworth, M. W.
Miller, A. J.	Ying, I. A.

Part I. Supplementary Pass List

Abayomi, I. O.	Howat, I.
Abell, E.	Hunter, D. L.
Bailey, R. G.	Jackson, J.
Bean, B. E.	Kenyon, S. P.
Bodley Scott, D. D.	Knox, A. J. S.
Bond, J. V.	Kohli, S. C.
Bown, R. L.	Letchworth, A. T.
Burnham-Slipper, C. J.	Matthews, J. M.
Cadle, D. R.	Phillips, M.
Da Silva, H.	Platt, N. D.
Frears, C. C.	Reeve, D. R. E.
Fry, D. E.	Ritchie, R. H.
Gilkes, J. J. H.	Salisbury, N. S.
Groves, R. J.	Shearman, J. K.
Haig, G.	Shorey, B. A.
Hampshire, R. J.	Sutton, D. R.
Harper, D. R.	Thoroughgood, J. E.
Hillier, E. R.	Tucker, A. K.

Part II.

Abayomi, I. O. Latham, D.

Part III.

Davies, W. A. M. Scriven, P. C.
Latham, D. Wan Ping, I. H.
Savege, P. B.

Part IV.

Abayomi, I. O. Savege, P. B.
North, P. J. Scriven, P. C.
Poore, P. D.

**Conjoint Board
Final M.R.C.S., L.R.C.P. Examination
October, 1963**

Challis, J. H.	Pass	Wan Ping, I. H.
Brewer, C. L.		Nash, A. V.
Lloyd, C. M.		Pope, F. B.
Scriven, P. C.		Miller, A. J.
Catlin, J. L.		Newstead, F. B.
Benison, R. S.		

Supplementary Pass List

Pathology		Thoroughgood, J. E.
Matthews, J. M.		Tucker, A. K.
Platt, N. D.		Groves, R. J.
Phillips, M.		Haig, G.
Ritchie, R. H.		Hillier, E. R.
Reeve, D. R. E.		Fry, D. E.
Salisbury, N. S.		Da Silva, A. H.
Shearman, J. K.		Bean, B. E.
Sutton, D. R.		Cadle, D. R.
Howat, I.		Bailey, R. G.
Jackson, J.		Abell, E.
Letchworth, A. T.		Bown, R. L.
Knox, A. J. S.		

Medicine		Sewell, J. B.
McPhail, L. M.		Pott, N. H.
Abayomi, I. O.		
Smith, I. R.		

Surgery		Sewell, J. B.
Ying, I. A.		Pott, N. H.
Smith, I. R.		

Midwifery		
Bousfield, J. D.		

Obituary

'A FINE SURGEON, A GENTLEMAN'

First published in *The Guardian Journal*, Friday, October 4, 1963.

Ald. John Llewellyn Davies was "a fine surgeon, a true gentleman and a great Christian," said Mr. F. C. Hunt, senior surgeon, at a special memorial service for hospital friends in the General Hospital chapel yesterday.

Mr. Hunt, paying tribute to the former Lord Mayor who died last Friday, said: "We admired Jack not only for his integrity of character and surgical skill, but for his quiet unassuming manner, his ready sympathy and understanding . . . always ready to help and give wise fatherly advice."

"He was admired, too, for his dry humour and skill as a raconteur, but perhaps most for the friendly and happy atmosphere he shed around him, and his gift for pouring oil on troubled waters."

One of his earliest memories of Ald. Davies, he said, was at Broxtowe on one Sunday evening. "He was calmly smoking a cigar and reading Boswell's life of Johnson."

Mr. Hunt spoke of Mr. Davies' early life. How he lived on a farm in Oxfordshire and gained his love of the open air, his extensive knowledge of bird life and his skill and joy in fishing and shooting—his life-long hobbies. And he spoke of his distinguished medical career, and his council work.

"His professional colleagues felt very proud that one of their members had made history in becoming for the first time the Chief Citizen of this city," he said.

He was also a great church man. "But above all he was a great family man. When he first met Dorothy McCaldin it was love at first sight—he met, wooed and married her in six weeks; and they remained devoted to each other."

Added Mr. Hunt: "We thank God for his full and dedicated life and the great services he has rendered to his hospital, his city and to humanity."

The service was conducted by the Rev. L. A. Rawlinson, Vicar of St. Ann's, and temporary hospital chaplain.

FIFTY YEARS AGO

From the Bart's Journal of February, 1914

As usual, the wards on Christmas Day were resplendent with visions of fairyland. From room to room one might wander, and come ever upon some fresh scheme of decoration or some original plan for distributing pleasures. In one ward it may be that the carnation and lily hold their own, in another paper, cunningly fashioned by patient and nurse, forms a canopy of wistaria, almost hiding with its delicate mauve blossoms the ceiling and the walls.

The entertainments by the various troupes and friends of the hospital were well up to par this year. Indeed several people who had passed many a Christmas Day beneath the roof of St. Bartholomew's remarked that, taken all round, they had never known a more entertaining series of entertainments.

In the morning there were two claimants to the title of "Father Christmas", one of whom was accompanied by a reindeer of somewhat fearsome appearance. Whether it was due to Father Christmas or to the reindeer we know not, but in one of the wards visited it is said that a little girl fled beneath the bed in terror, happily she was consoled when she was made to understand that the entertainment was for her most particular benefit.

Among the notabilities present was Mr. Winston Churchill. At least, he was introduced to us under that name. In spite of his correct "get-

up" and the general appearance, however, we should not have estimated the gentleman's age at more than six years. He carried a monocle—we are doubtful ourselves about this monocle, but as we do not know the First Lord of the Admiralty very intimately, we are not in a position to say whether it was a correct feature of the impersonation.

Perhaps the most curious part of the proceedings on Christmas Day is the first dinner. This takes place about 9 a.m.! No—it is not a late breakfast, but dinner, with turkey and plum pudding complete, and those who partake of it are the nurses on night duty. Even on Christmas Day the routine of work must

somehow proceed, and this early dinner is one of the necessary items.

One must not pass over these happenings without a word as to the organisation of all this festivity. The whole of it is almost entirely due to the sisters and to the nurses. For many a long day they have been working and quietly preparing for the great event, some of them making decorations, others dressing dolls, others perhaps making the harmless but necessary pin-cushions (these, for the Christmas trees)! Whatever the success of Christmas Day in St. Bartholomew's, let it not be forgotten that this success is chiefly due to our enterprising nursing staff.

HOUSE APPOINTMENTS

1st January to 30th June, 1964

Consultant Staff	House Officers	Male	Female
DR. E. R. CULLINAN	B. D. Hore	Rahere	Colston
Dr. K. O. Black	Miss A. V. Nash		
DR. A. W. SPENCE	A. L. Russell	Dalziel	Annie Zunz
Dr. N. C. Oswald	D. J. Delany		
DR. R. BODLEY SCOTT	D. Crowther	Harvey	Luke
Dr. W. E. Gibb	M. P. Stewardson		
DR. G. W. HAYWARD	E. A. Shinebourne	Smithfield	Mary
Dr. H. W. Balme	P. Stanley		
PROFESSOR SCOWEN	P. W. P. Butler	Stanmore	Garrod
Dr. A. G. Spencer	A. D. L. Guest		
MR. C. NAUNTON MORGAN	Miss G. M. Turner	Waring	Abernethy
Mr. D. F. Ellison Nash	T. R. G. Carter		
MR. A. H. HUNT	P. K. Leaver	Fleet Street	Hainsworth
Mr. J. O. Robinson	A. D. Stephens		
MR. A. W. BADENOCH	A. H. Knight	Bowlby	Heath Harrison
Mr. Ian P. Todd	N. E. Dudley		
MR. E. G. TUCKWELL	J. R. Newton	Rees Mogg	Paget
Mr. M. A. Birnstingl	K. S. Wise		
PROFESSOR G. W. TAYLOR	P. M. Perry	Percivall Pott	Lawrence
Mr. B. N. Catchpole	D. C. Dunn		
DR. K. O. BLACK	M. A. Perring		
MR. J. O. ROBINSON	T. P. Stephenson		

CHILDREN'S DEPARTMENT

Miss J. E. Dacie	Lucas
N. D. Barnes	Kenton

E.N.T. DEPARTMENT

D. B. M. Howells	Henry Butlin
P. W. Caine	

EYE DEPARTMENT

MR. H. B. STALLARD	J. R. Strong	Radcliffe
Mr. J. H. Dobree		

GYNAECOLOGY AND OBSTETRICS DEPARTMENT

MR. JOHN BEATTIE	R. H. T. Ward	(O) Martha
Mr. Donald Fraser	J. U. Watson	(O) Elizabeth
Mr. J. Howkins	D. N. Glover	(G) Sandhurst
Mr. G. L. Bourne		(G) Pitcairn
		(G) Harley

DENTAL DEPARTMENT			
MR. HANKEY Mr. Cowan Mr. Cambrook Mr. Schofield	M. R. G. Holmes	Fleet Street	Harmsworth
ORTHOPAEDIC DEPARTMENT			
MR. H. JACKSON BURROWS Mr. J. Aston	E. M. Hoare E. Sidebottom I. R. Smith	Hogarth Henry	James Gibbs
DEPARTMENT OF THORACIC SURGERY			
MR. O. S. TUBBS Mr. I. M. Hill	A. P. Ross H. White		Vicary
DEPARTMENT OF NEUROLOGICAL SURGERY			
MR. J. E. A. O'CONNELL Mr. R. Campbell Connolly	R. V. Jeffreys P. A. R. Niven		W. G. Grace
SKIN DEPARTMENT & SPECIAL TREATMENT CENTRE			
DR. R. M. B. MacKENNA Dr. P. F. Borrie	M. Britz	Smithfield	Mary
DR. C. S. NICOL		Rahere	Colston
DEPARTMENTS OF NEUROLOGY & PSYCHOLOGICAL MEDICINE			
DR. J. W. ALDREN TURNER	D. Gardner-Medwin	Stanmore Harvey Radcliffe Dalziel	Garrod Luke
DR. W. L. LINFORD REES Dr. C. M. B. Pare			Annie Zunz

MATRONS' BALL, 1964

The Grosvenor House Hotel was once again the scene of Matrons' Ball, which was held on January 8th, and, for weeks, talk of partners, dresses and the arranging of parties had filled the air around the dining tables, the Fountain and even the sluices.

By Wednesday the last minute preparations were under way and Bart's nurses took over the hairdressing department at Gamages. We are grateful to them for remaining open after normal hours to transform the late comers.

Relief night nurses had been found and, whilst the long suffering Night Sisters kept a watchful eye on our patients at the Hospital, we descended the grand staircase at the Grosvenor House to be greeted by Matron and the Treasurer.

Sidney Lipton and his band supplied music of both beat and more classical types, including an Olde Tyme dance or two. Long dresses

were much in evidence on the floor and added elegance to the occasion.

Dinner was served at 10.30 p.m. in the usual efficient manner; roast duck and green peas being the main course, followed by profiteroles au chocolat and coffee. One regret was that the photographer failed to visit all the tables before the end of the dinner.

After dinner we danced and twisted again, not only to the music of Sidney Lipton but also to the Carriibbean rhythms of a four man steel band.

The Cinderellas—the night nurses—slipped away as usual at the appointed hour, more quietly, it seemed, than ever before.

From the Eightsome Reel for the energetic to the Hitch Hike for the 'with it' faction there was something for everyone until 1.30 a.m. when we came to the end of a very enjoyable evening.

UP TO THE MINUTE IN A MOMENT

Pre-Christmas gaiety, whether natural or forced, tends to dominate the late December scene leaving room for little else. However, the fire on board the Greek liner *Lakonia* brought tragedy to Christmas. The fire occurred 100 miles north of Madeira; of over a thousand passengers and crew, ninety-one were known to be dead and sixty-four still missing a week later.

The first angry mass demonstration in Red Square for nearly forty years took place on the 18th December when African students protested at the death of a Ghanaian medical student, **Edmund Asare-Addao**, at the hands of Soviet citizens. The student is said to have been intending to marry a Russian girl despite the protests of her parents and friends. This could mark an interesting stage in the struggle for influence in the emerging nations.

On the 21st December, **Sir Jack Hobbs**, perhaps the greatest of all cricketers, and the first professional sportsman to be knighted, died at the age of eighty-eight.

The best Christmas news was undoubtedly the opening of the Berlin Wall; between the 19th December and the 5th January, over 1,200,000 visits were made. **Herr Willy Brandt**, Mayor of West Berlin, while welcoming the scheme, was at pains to avoid any steps that could be construed as implied recognition of the East German government.

Trouble broke out in Cyprus between Greek and Turkish Cypriots on the 20th December and on the 27th, at the request of that turbulent priest **Archbishop Makarios**, British troops started to fly out to the island. The country that so ill-treated the British Tommy only a few short years ago is very happy to see him back today.

In Accra on the 31st December **President Nkrumah** announced that a referendum would be held to seek approval to change the constitution and make Ghana a one party state, that party being his own Convention People's Party. This was another of the President's series of predictable mistakes. Also on that date the reeking corpse of the Federation of Rhodesia and Nyasaland was finally buried.

1964 is Election Year, Olympic Games Year, and also sees the visit of the Australian cricket

team as well as the arrival of all those Royal Babies.

On the 4th January **Pope Paul VI** became the first Pope to leave the Vatican since 1812 as he flew to visit the Holy Land. Throughout his pilgrimage he was mobbed by excited crowds. Meanwhile **Mr. Chou En-lai** continued an extended but largely unheralded visit to Northern Africa; the Chinese Premier's movements were anxiously watched by both Moscow and Belgrade.

Riots broke out in Panama between United States troops and Panamanians on the 10th January. Rebels overthrew the government in a bloodless coup in Zanzibar on 12th January; the Sultan, **Seyyid Jamshid bin Abdulla**, left the island in his yacht.

On 13th January British Railways received their annual shock when two inches of snow brought trains practically to a stand still. On the same day, at Bart's, the Trustees of the Welcome Foundation, together with **Sir Henry Dale**, O.M., G.B.E., M.D., F.R.C.P., F.R.S., were met by **Mr. Perrin**, President of the College, with his wife and members of the Executive Committee and taken on a tour of the Linear Accelerator Suite by **Professor Rotblat**.

In the world of sport, England were easily beaten 14-0 by New Zealand in the rugby international at Twickenham on January 4th, while in India the M.C.C. drew a dreary first test match. On the 9th January Bart's beat Charing Cross in the first round of the Hospital's Cup. **J. Gibson** gave Bart's a good start by scoring from a penalty kick after four minutes; mid-way through the second half **A. McLean** equalised with a penalty for Charing Cross. Soon afterwards **D. C. Pope** equalised on the ball from a loose heel and sent **P. E. Savege** over in the corner to clinch the match at 6-3. (Bart's meet Guy's in the second round at Richmond on the 4th February). The Boat Club renewed training on the 18th January for the Head of the River races in March.

As we go to press the headlines carry the news of yet another uprising. Just before dawn on the 20th the 1st Battalion of the Tanganyika Rifles mutinied and the resulting chaos was, as **President Nyerere** said on the 21st, a disgrace to Tanganyika.

(21st January).

SOME SURGICAL PROBLEMS OF ELDERLY PATIENTS

by Gordon L. Bohn, Reading.

ONE frequently hears comment nowadays about the large number of elderly patients that there seem to be in acute wards. We know that the average age of the population is rising steadily but this is obviously not a complete explanation for the rapid rise in the average age of the patients.

The following observations are based on a one-hundred-bedded, acute, general surgical department in a provincial non-teaching hospital. This hospital is the only one of its kind in the area and has to take all patients who need admission as there is nowhere else for them to go. It thus represents a more accurate picture than that seen in a London hospital where various processes of selection may be operating. Not included in the overall figures is a small number of cottage hospital beds used for simple surgery in younger patients.

To these hundred beds in 1951 there were admitted 413 patients aged seventy years and over; ten years later, in 1961, this figure had increased by more than 50 per cent to a total figure of 676. A census of these beds during recent months has shown that there is an average of 26 elderly patients in them at any one time. With a bed occupancy of about 85 per cent this means that one-third of the surgeon's patients are elderly.

The rising age limit

There are several reasons for this striking change. Most important of all is the fact that so much can now be done for elderly patients who are ill, thanks largely to advances in anaesthesia, transfusion and electrolyte treatment. Thirty years ago, which is as far back as I can remember, the elderly patient was very rarely operated upon and many of them did not even reach the surgeon, the relatives being content to accept the wise opinion of the family doctor that the end was near and that nothing more could be done. In those days a patient over the age of seventy very rarely had his prostate removed; an old man's retention was either treated in his home with a catheter or he was admitted to a Poor Law hospital where a supra-pubic tube was plunged into his bladder under a local anaesthetic in bed. He would eventually die, perhaps sooner, perhaps

later, but certainly in great misery and discomfort. Today it is quite common to remove the prostates of nonagenarians.

Even a mere twenty or so years ago, when we were first exploring the place of surgery in the treatment of gastro-duodenal haemorrhage, the age limit for operation was usually 65 perhaps occasionally it might go up to 70, but never older than that. The following case illustrates how this age limit has risen.

Case 1: Mr. W. G., aged 74 when first seen. He had a carcinoma of his rectum and was deemed too old for surgery. He was treated palliatively; two years later, the surgeons concerned had raised their sights and now regarded him as an acceptable case. Fortunately the growth was still operable. He survived the operation, lived for five years, and died in his sleep.

Co-existing conditions

There were many excuses for not operating on an elderly person. His heart was bad, or his arteries were bad, or he had a bad chest, or his blood pressure was raised or perhaps his prostate was enlarged. The surgeon nowadays is more realistic; he says to himself, what can you expect of a patient of 75? Of course he has all these troubles, but they are no longer contra-indications to surgery, but merely facts to be taken into consideration. Tremendous help is given here by the physician who can treat these degenerative medical conditions and improve the patient's fitness so that he can safely tolerate an anaesthetic and an operation.

Palliative Surgery

Another reason for the increase in the amount of work that is done on older people today is the realisation of the value of palliative surgery. In the old days this was limited to a supra-pubic cystostomy for retention, a colostomy for intestinal obstruction, or a gastro-enterostomy for a carcinoma of stomach. In the thirties they used to fail candidates for the Fellowship who dared to suggest that it was a good thing to remove a patient's rectum when he had metastases in his liver. There are many diseases in which the removal of the growth is the only satisfactory way of giving comfort to a patient with advanced malignant disease. Even if he only lives a few months, those

months can be made comfortable by the palliative removal of a carcinoma of the oesophagus, stomach or rectum. Some of the most distressing symptoms from which a patient can suffer are not amenable to drugs. Take, for example, the dysphagia of an oesophageal cancer; swallowing his food and drink is man's most natural pleasure. When that is gone nothing is left.

The acute abdomen

In the elderly patient the diagnosis of acute abdominal disease is often difficult. The patient is frightened and confused by his strange surroundings and much patience is required in order to obtain an accurate history. The physical signs of acute inflammation may be minimal. Many of the less common occurrences are relatively common in old people; dissecting aneurysm, mesenteric thrombosis, acute pancreatitis. But the common conditions still remain common. One is frequently meeting acute appendicitis in the elderly. The only point of note about it is that it seems to be prone to perforate early. Prompt surgery is imperative. The surgical aphorism teaches us that conservative treatment of appendicitis has no place either for the very young or the very old. The very elderly patient with an acute gall bladder is sometimes quickly cured by an old-fashioned cholecystostomy, but it is not an operation to be used in anyone who is reasonably fit.

Cancer Surgery

Here a slight alteration of one's plan of treatment is sometimes advisable. One is not over-anxious about one's five-year-cure rate in a patient who is already eighty years of age, and if one can simplify the operation a little without unduly reducing the completeness of it the patient may have a slightly better chance of surviving for another year or so.

Colon Surgery

There is a great deal of emergency colon surgery in old people. They are frequently seen with obstructive lesions or with peritonitis and it is very easy to make the wrong choice of procedure. Every case is different and one can merely mention some general principles.

1. As far as possible avoid multiple stage procedures. In other words try to shorten the patient's stay in hospital as much as possible.

2. If possible, get the tumour out at the first operation; you may not have a chance later.

3. Make use of the Paul-Mikulicz procedure and the Hartman procedure in old people.

Fitness to operate

When deciding on a patient's fitness for operation certain factors are more important than others. Thus, in general, a cardiac condition is much less of a contra-indication than chronic bronchitis. Most important of all is the cerebral circulation and the patient's mental state. One frequently hears remarks such as "Mother never really got over her operation; she has been a different woman ever since. I rather regret ever letting her go through it." This patient was probably already suffering from cerebral arterial disease and the operation hastened its progress.

Also very important in assessing the patient's fitness for surgery is the presence of obesity. Thin men and women in their eighties are excellent subjects for surgery. The most difficult operations can become easy and can be performed with great rapidity, but a fat person presents many serious hazards.

Multiple diagnoses become relatively common in the aged. It is not sufficient to find what appears to be the cause of the patient's chief symptoms; one has to keep looking. There may well be something else which is far more important, as the following cases will show:

Case 2: Mrs. C., aged 72, presented with severe abdominal symptoms and investigation showed not only gall stones but a chronic duodenal ulcer for which surgery was advised. Laparotomy revealed that she also had a carcinoma of the ascending colon.

Case 3: Mrs. D., aged 74, presented with an iron deficiency anaemia and occult blood in the stools. Investigation revealed a hiatus hernia which was treated conservatively. Three months later she was admitted as an emergency with an acute intestinal obstruction due to a carcinoma of the colon.

Case 4: Mr. M. C., aged 78, presented with a severe duodenal ulcer for which surgery was advised. He had also a little bleeding from "piles". The laparotomy at the time of his gastrectomy revealed that he also had a carcinoma of the upper rectum. Two months later his rectum was removed.

Certain multiple diagnoses are so common that they call for no comment, as for example the elderly surgical patient who, after his operation, is unable to urinate because of an adenomatous enlargement of his prostate.

Case 5: Mr. S., aged 74, presented with a carcinoma of his rectum. It was noted that his prostate was enlarged but was not causing any urinary symptoms. His rectum was removed and after the operation he could not pass his water and eventually had to have his prostate out. Histological examination of this showed it to be malignant. It was then noticed that he was becoming anaemic and

blood films showed a leuco-erythroblastic anaemia probably due to osseous metastases.

Case 6: Mr. E., aged 71, was admitted with retention due to a large prostate. His blood urea was 150 mgm. per 100 mls. He complained of various symptoms which were attributed to his uraemia. With an indwelling catheter his blood urea slowly settled to normal, but he was not as well as he should have been and eventually he died. Autopsy revealed a carcinoma of the body of the pancreas.

The next case is recorded not for anything that it teaches, but merely because it illustrates that there is no end to the multiplicity of complaints that can occur in an old person.

Case 7: Mrs. F. is now a hale and hearty 92 years of age. We first met her when she was a youngster of 79. She was admitted with a haematemesis and we learnt that she had had a short circuit for a duodenal ulcer in 1924 and had remained well since then. The bleeding responded well to conservative treatment and she remained fit for a year. Then she was admitted with an acute abdominal condition and was found to have perforated a gastrojejunal ulcer. She recovered well from this operation and a year later she turned up once more, this time with a carcinoma of the breast which was treated surgically; again she recovered well. The following year she

turned up with haematuria. Cystoscopy revealed a papilloma of the bladder which was fulgurated. Two years then elapsed and once again she was admitted as an emergency, this time with the symptoms of a small intestinal obstruction. Operation revealed that the obstruction was caused by an adhesion which had developed at the site of an oophorectomy which had been performed in 1905.

Although surgery achieves a considerable measure of success there is inevitably a residue of failures which can block one's beds for a very long time. There is a steady increase in the number of these patients and the danger is that badly needed acute beds will gradually become silted up by them unless they can be moved off elsewhere. This usually means asking for help from the Geriatricians who already have their own problems and are, understandably, reluctant to take over patients of this type, especially as many of them require much skilled nursing attention and specialised medical care. As the problem grows, so it seems necessary that every acute department will need its own long-stay annexe.

BONESETTER, 1963

by F. E. Weale.

HAROLD, her father, had to attend the recreation committee meeting and Fred, her uncle, was late with his car or might not arrive at all, so it fell to me to take Laura.

It was only two miles to drive and on the way Laura confided a certain nervousness. Her boyfriend, Sidney, had been to the bonesetter two months previously, with backache, too—some strain, the result of farming—and had been quite better since. Harold had taken her because of her own back. It had hurt for two months, low down, after falling down some stairs. The bonesetter had been too busy that particular night. Too many patients; he was making quite a name for himself. Tonight Sidney himself was busy, harvesting and drying for other farmers—his own had all been stacked—and he was very likely to go on till eleven.

It seemed an odd injury to go on for so long and to come on every morning. Until she showed me where it hurt her I thought it might be coccydynia. The pain didn't seem to interfere with any vital activities such as dancing, but in twenty-one-year-olds even genuine pains can be suppressed in the vicarious interests of procreation.

We turned off the main road, almost missing the turning in the dark, passed under the railway bridge, over a couple of cross-roads and

along a single-track lane banked high with hedges.

It was fortunate that Laura had been before, for I couldn't have found my way along the track alone.

It finished at the farm with a sharp turn. Two cars were there already, nose-to-tail, in a passage-way. We walked from where we had parked and squeezed between the other cars and the wall to enter another passage. Laura knocked on the door. It was nine-thirty, from across the yard we heard the milking machine at work, rather late for the cows. There was no reply, so we entered into a dark passage with several doors leading off. Laura picked the right one into the kitchen.

Some light, at last, greyly illuminating a stone floor which once had had some red paint wiped over it. Tonight it had about eight kittens and two fully grown cats gambolling on it. On the left was an old electric cooker with a kettle. On the right, a wooden table with some crockery and pencils. Beside the window in the far corner was a stone sink. There were two old armchairs.

We were greeted by the small, wizened, grey-haired farmer's wife, wearing an old green pullover. Her skin was pale and lined but in the shabby surroundings her hair seemed extra-

ordinarily well brushed and shiny. I was introduced as Mr. James, the husband of Laura's cousin, and explained that I was deputising for Fred who had failed to turn up. We were offered coffee which was surprisingly palatable.

Farmer Saltcombe, a visitor, was sitting beside the cooker, waiting for his wife to return. He wore gumboots, a clean white collar, the wings of which, in the absence of a tie, were fastened together with a copper clip. His coarse tweed coat covered a striped shirt. Such hair as remained was unevenly brushed towards the vertex.

We talked about the weather and about my son's christening, still fresh in my memory from the previous day.

"What did you call him?" the bonesetter's wife, Mrs. Langley, asked.

"Bernard".

"Very nice name".

She was trying to light a fire in the stove, using sticks and paraffin.

"It's fantastic," she continued, "whenever I try to make a fire without paraffin, I fail. My husband despises me for it!"

The bonesetter's wife, Mrs. Langley, struck me as a woman with a vocabulary, to which she gave free reign in the course of the evening, not entirely in keeping with a primitive and very secluded farm. There was, moreover, little indication of a West Country accent. When later she handed me the "Daily Telegraph" to read, I decided that she must have come, who knows by what quirk of fortune, down into a world of hard work where the living evidently had to be scraped together. There was no doubt, despite her small stature, that she had adapted herself to the hard work and primitiveness of her secondary status.

After some twenty minutes the door opened and in walked a woman wearing a heavy, grey, belted overcoat and a trilby impacted down to the ears, she turned out to be Mrs. Saltcombe. Her moustache was faintly visible in the dim light. Her voice creakingly and gradually joined in the generality of conversation. Music was coming from the small loudspeaker. A cat sat on it, pensively staring down as if bent on understanding jazz.

When farmer Langley, the spare-time bonesetter, also arrived, it must have been gone ten o'clock. By this time I was a little anxious to get on. He, however, a heavily-built man of almost acromegalic proportions, with deliberate slowness, began to offer round a box of cigarettes. I had left my pipe at home, but, so as not to seem too much out of it, twiddled my pipe-cleaning ensemble. It was my purpose not to give myself away as a doctor, and to

put the bonesetter as much at ease as my gauche acting would allow. As for "Mr." I had silently pacified my conscience in the light of the surgeon's proper appellation, and this made the planned deception a little bit easier.

"Been a terrible summer," I said, and other words to that effect.

"Do you want to know what I have to say about it?" growled the farmer, semi-mockingly, with a threatening gleam in his eye. I preferred not to, and with this he was well satisfied. He sank back into one of the two armchairs. The talk turned to agricultural implements, friction drives and various technical matters which I could not follow, and how, years ago, without mechanisation, the harvest was brought in nonetheless. With all the mechanisation this year, however, the corn was getting black, mouldy, and made the cows cough.

At last the farmer's wife got up and asked "Shall we start?"

"Yes," said the bonesetter, and Laura was led by the wife through the dark corridor to the theatre of operations. I visualised it, at the end of the corridor, opening into a fusty chamber, dimly lit, with a wooden work bench against the wall and a pile of "irons" in the corner.

When the wife came back the bonesetter extinguished his cigarette and made for the door. I got up, too.

"Do you mind if I come and watch?" I asked uncertainly.

He turned round in the doorway and suspicion crossed his face in unmistakable depth. After a moment he grunted:

"Are you a doctor?"

"Yes," I said. There was no point in a weak denial. He thought for a moment and then said:

"Are you broadminded?"

"I wouldn't be here if I wasn't."

"All right," he replied with more readiness, "Maybe I can show you something." Silently I prayed for more light.

Down a draughty dark passage and we entered a well-lit lounge in the middle of which stood an examination couch covered by army blankets. An electric fire adequately warmed the room. Laura, in her underclothes, was lying on the couch, half covered with a camel-hair coat.

The bonesetter slowly moved into position at the foot of the table. His wife provided the background music.

"My husband has an uncanny knowledge of bones," she intoned. "He has been doing this for years."

The bonesetter beckoned to me. Pointing to the feet he grunted "What do you see?"

I saw two silk-stocking feet. The left was slightly supinated.

"Bit twisted, isn't it," I queried.

"Agreed."

He looked up the legs, and his massive hands and fingers followed his gaze. The shins were grasped, the knees moulded and tested for antero-posterior instability. Then he grasped the left leg, flexed hip and knee after preliminary fingering of the hip-joint, and strongly abducted. The little wife leant over the opposite ilium for all she was worth for counter-traction.

The leg was brought down alongside the right.

"What do you see?" asked the bonesetter.

I saw two stockings legs, with the slip somewhat obscuring the hips. She wasn't lying straight. Her left foot appeared half an inch shorter. I said:

"Her left foot is shorter."

"Agreed."

We were getting on famously. He went on to say that he had pulled out legs by one, even two inches in an evening. Quite a few people had unequal legs.

"And don't know it," I helped.

"Agreed."

He scrutinised Laura further.

"When their legs are unequal," he went on, "what happens to their spine?"

"Makes it crooked," I said.

"Agreed. And mark you, they go around with these crooked spines, and when they get older their backs get worse and worse." This was for Laura to note. "So we'll have to get the legs the same, won't we?"

The wife moved to the other side, leaned on the left hip, and the bonesetter abducted the right hip until it obligingly creaked. Laura said:

"Oh my God!"

"If there is one bone out of place in the body," the farmer's wife continued, "trust my husband to find it. He has an uncanny knack for it." The leg was replaced alongside the other. They seemed the same length and eagerly I drew attention to his accomplishment.

Laura was then asked to turn on her stomach. The bonesetter delicately unhooked her brassiere at the back. "Do you want me to undress?" asked Laura.

"No, my husband is getting very good at this," cackled the farmer's wife.

He looked at the spine, at any rate that part which remained visible above her half-length slip. He fingered it. Something at the level of T6 attracted his attention.

"'Twasn't the first tumble you took when you fell down those stairs," he said with emphasis. Laura thought.

"I fell off a horse about five years ago."

"There you are," splashed the bonesetter's wife. "He knew."

"And I wouldn't be surprised if there were other falls." Laura couldn't remember for the moment. Turning to me, the bonesetter remarked:

"If you leave all these bones out of place, what's going to happen in later life? If nothing is done now, there won't half be suffering."

With further rotating, kneading movements of his right thenar eminence he seemed to attempt to twist each vertebral spine around its axis. Every now and again he leaned on this eminence. Some creaks came from the spine, some from his hands. I was able to remind Laura that these noises were what I had predicted for her. The bonesetter proceeded down the spine. In the mid-thoracic region, after some massaging sallies across the right sacrospinalis, he gave the appearance of being baffled.

"There's more trouble here. Adhesions. I mustn't tear them," he said. "I don't think I can get it all done today." Laura said:

"My pain is lower down."

The bonesetter was unperturbed. Scheuermann, Calvé flashed through my mind.

"I wish someone would put my shoulder right," he said, eyeing me. "This work needs strength." I looked blank. He gave more massage.

The session seemed at an end. But it wasn't. Laura, with brassiere reconstituted by the connoisseur's fingers, was asked to sit on the edge of the couch, feet dangling over the side. The bonesetter eyed her knees and asked me if I saw "it". I said "Yes."

Thereupon he grasped the right knee, abducted it, and with a medial rotation extended the knee in the manner of reducing a displaced cartilage.

"Do you see it now?" he asked. In the interest both of truth and co-operativeness, but not of foresight, I said "Yes, it looks the same as before."

This was a bit of a bombshell in the quiet progress of the session. The bonesetter said:

"It doesn't; it was out before. Have a proper look," and the wife joins in, "Oh, can't you see it?" I withdrew the cat from amongst the pigeons. "Frankly, I didn't look carefully in the first place." I had learnt my lesson. After all, the bonesetter wasn't obliged to have me there.

The wife recalled a little girl who had had

epilepsy from birth. The doctors had given her pills, but without her pills she was useless. Then the little girl had been brought to the bonesetter who had found a bone out of place in her spine—she didn't know which bone as she wasn't too well up in medical terminology, perhaps I knew?—anyway, her husband had manipulated this bone into place and her epilepsy had gone from that day onward. "I don't know how he does it; but he has a theory that these bones can cause pressure on the brain."

There followed some more manipulations of the knee, and subtle references to high heels. Hearty assent from me, old codger.

"There are twenty-eight bones between here and here, aren't there?" said the bonesetter, pointing from the big toe to the ankle joint. The number seemed about right and subsequent calculation indicated that it included the sesamoids.

"I have never counted them, but it is about that number," I agreed.

"And each one of them can give pain." The foot seemed a hotbed of trouble.

"That'll be all for today."

Laura got up and draped the camel hair coat over her shoulders. "How do you feel?" she was asked.

"Can't feel the pain now."

"My husband is very successful," cooed the wife, ever more like Papagena. But before the proceedings were quite closed, Laura was asked to stand in the corner with her back to us, holding her coat over her right arm.

"What do you see now?" I was asked again. I thought inspection could be done with.

I saw Laura with one knee slightly flexed, mannequinwise, the hips at different levels. The functional scoliosis was unmistakable.

"Bent back," I said.

"Agreed. Needs more work on it."

We went out, back to the dismal kitchen while Laura dressed.

I asked how he had started. One day many years ago he had met another chap who manipulated, and he picked it up. Practised in Birmingham, then Minehead for years. When war broke out he "didn't feel like stopping one of Hitler's bullets" ("my wife never forgave me"), he returned to farming and had been doing this ever since.

"But there is a lot of suffering to be relieved. Why don't you doctors do it?"

I explained that I just couldn't imagine a busy G.P. spending as long as he had done over individual patients.

"Just take Dr. Williams . . ."

"He nearly killed my son," growled the bone-

setter, "called his pain a pulled muscle, sent him—had to drive himself—to town . . ."

"Had appendicitis, peritonitis, and was on the operating table within half an hour."

"Agreed." I had previously heard the story, but hadn't realised that it had referred to his son Charles.

"I am getting on," he continued threateningly, "but not too old yet to settle with him."

It was time to change the subject.

"Getting many patients?" I asked.

"There's three tomorrow, three the following day, snowballing like. I shall have soon to make up my mind if I want to go on farming or change to bonesetting whole-time. I have put them away now, but I have letters of thanks from all over the country, even one from Greece. But listen, why don't you do some of this work?" he asked. "I have worked with doctors afore."

I would not presume to regard this as a veiled offer for partnership, but after admitting to having done some manipulations under general anaesthesia ("you don't need anaesthesia, I have done 300 backs without it") emphasising that this was not my present line, I was grateful to Laura for making her timely reappearance before I was fully involved in unprofessional conduct.

The next visit was arranged and we hurried out into the pitch dark. Feeling our way along the wall we felt for a step and then round a corner saw my car's sidelights.

The milking machines had stopped and the cows were making their way past my car to the pastures. We jumped in and I began to drive away when we came to a sudden halt for barbed wire had been stretched across the lane by which we had arrived to stop the cows wandering down it. I loosened the stake with which the barbed wire had been fixed to the gatepost and took it aside. A cowhand emerged from the darkness. He hoped my mudguards had not damaged his wire and said he would replace it when I had passed through. I thanked him. Laura was anxious not to tarry, it was the farmer's son, Charles, an ex-boyfriend of hers.

Next day Laura said that her back felt better. In the village they told me that the bonesetter sometimes got very violent, and might attack with knives. Twice at least had he been admitted to the local mental home. As for the poverty, some of it was due to being fined three thousand pounds for tax evasion. Others thought he had been defrauded by his accountant.

In this unbelievably rustic environment, these were more familiar ronchi.

FIBRINOLYSIS

by Norman G. Rothnie

FIBRINOLYSIS is the enzymatic liquefaction of fibrin or blood clot. It is an important physiological process which in recent years has been increasingly implicated in many, varied pathological processes. Its significance in the aetiology of certain diseases and the exciting possibilities of its use in treatment are to-day interesting clinicians more and more, not only in haematology but in many branches of medicine, surgery and pathology. It is my aim to relate, in what I hope is a simple way, the present day views on fibrinolysis.

As early as the 18th Century Morgagni & John Hunter, the father of surgical physiology, observed the incoagulable nature of blood in cases of sudden death. It was not until a century later that this was shown to be due to the digestion of fibrinogen and fibrin; the word **fibrinolysis** was coined for this process. However, clinical interest in the vagaries of fibrinolysis has only been aroused in recent decades.

The Mechanism

The transformation of blood from a liquid to a solid state depends on a complex chain of events which result in the conversion of plasma fibrinogen into a coagulum of fibrin. As this takes place, blood cells agglutinate and become incorporated into the clot and form a thrombus. Varying proportions of fibrin, platelets and other blood cells can occur in a thrombus so giving rise to the different pathological features of intravascular thrombi.

There is present in the circulation and in body tissues an efficient but complex enzymatic system which on activation can produce the dissolution of thrombi mainly by the active digestion of fibrin. This is effected by a proteolytic trypsin-like enzyme called **plasmin**, which is also capable of digesting other proteinous clotting factors such as fibrinogen. Plasmin is formed from an inactive precursor **plasminogen** which is present in the euglobulin fraction of the plasma proteins. The conversion of plasminogen to the active enzyme plasmin is brought about by **activators** which are normally present in body tissues (especially lung, uterus and prostate), in vessel walls, and in secretions; they are excreted in the urine.

They can also be isolated from bacteria, e.g. streptococci. Damage to tissue cells by surgery, trauma or infection releases activators into the tissue spaces and the circulation so activating the fibrinolytic process. The degree of fibrinolysis is proportional to the severity of the damage.

Nature has provided circulating inhibitors (**antiplasmins**) to limit this local and general fibrinolysis which, if left unchecked, could, by digestion of clotting factors, lead to a serious coagulation defect. Despite the variation in tissue activation, the development of fibrinolysis after most operations is well controlled by this efficient inhibitory mechanism. However, after operations on certain organs rich in activators, e.g. lung and prostate, excessive plasmin may be produced and the inhibitors may be overcome—a bleeding state results. Steady oozing occurs from the wound margins and pale poorly contracted clots form. A similar state can occur after total body perfusion with heart-lung machines for open cardiac surgery.

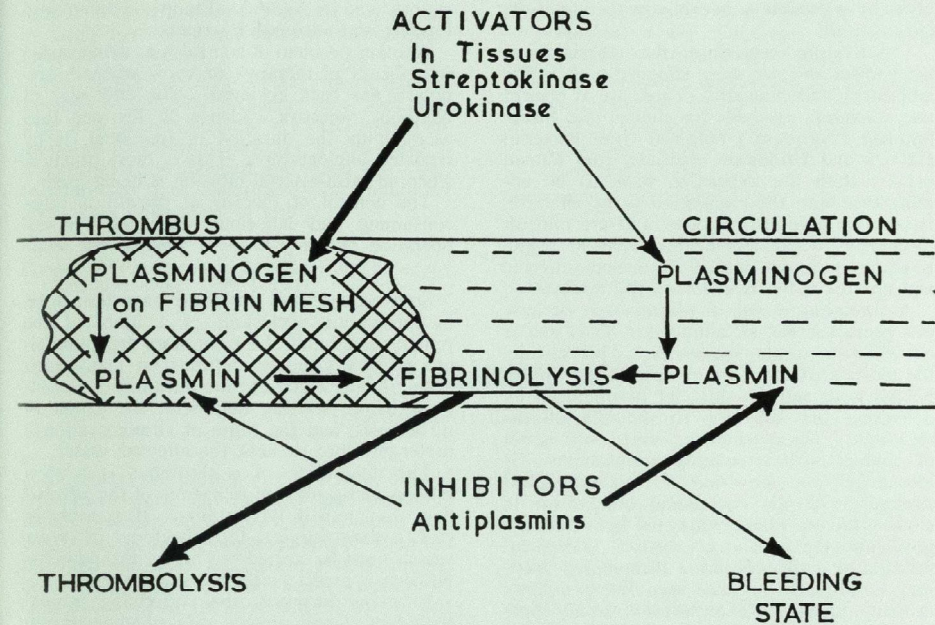
Usually the fibrinolysis is short lived post-operatively but it may leave the body seriously depleted of blood and precious clotting factors which must be replaced to ensure survival.

The effect of plasmin on the clotting mechanism opens up the possibility of harnessing its action for the treatment of thrombo-embolic disorders. More will be said of this later.

The Delicate Balance

It is now realised that in the healthy person there is a homeostatic equilibrium in the blood stream between fibrin formation (clotting) and breakdown (fibrinolysis); a delicate balance, which if tipped one way can lead to thrombosis or, if in the other direction, result in a bleeding state.

In the arterial system there is a thin fibrinogen-rich zone lying on the intima where this equilibrium is maintained. An upset in this balance has been invoked in a new concept of the pathogenesis of atherosclerosis. The decreased fibrinolytic activity that occurs with age and lipaemia allows fibrin to be deposited on the intima of the artery. This fibrin plaque impairs intimal nutrition and produces local



The mode of activation and inhibition of fibrinolysis and its clinical effects. Heavy arrows indicate the actions required for effective and safe thrombolytic therapy.

necrosis with subsequent fibrosis and deposition of calcium salts in the sub-intimal layers. As in the venous system, any damage to the endothelium encourages the adherence of platelets and the deposition of fibrin. This, together with slowing of the circulation and sludging of the blood cells, will lead to thrombosis. As John Hunter showed by isolating blood in a segment of normal vein, stasis itself does not produce thrombosis until the wall is damaged.

A defect in the fibrinolytic system has been implicated in hyaline membrane disease of the lungs in premature infants and fibrinolytic therapy has had some success.

Increased fibrinolysis plays an important physiological role locally in tissue inflammation and repair. Proteinous substances, as well as fibrin, are broken down and liquefied in haematomas, exudates and effusions, so allowing them to be cleared from the area of damage. The action of plasmin is limited to this area by the antiplasmins in the general circulation. A disturbance of its role in repair can give rise for example, to poor wound healing or to

impairment of recovery from lobar pneumonia.

A generalised increase in fibrinolytic activity occurs with exercise, severe tissue trauma and major operations, anxiety, adrenalin and sudden death—the causes are many and varied. What happens if the activity gets out of hand has already been described.

Therapy

The use of the fibrinolytic system in the treatment of thrombo-embolic diseases is of particular interest in view of the controversy which exists over the usefulness of present day anti-coagulants. However, the harnessing of fibrinolysis presents two main problems; firstly, to find a suitable means of activation, and secondly, to develop a simple way of controlling it. Both these problems are being extensively explored by experts in many branches of science and medicine.

Activation

It is generally agreed by the fibrinolytic experts that it is preferable to stimulate fibrin-

olysis by **activators** rather than by the use of the enzyme itself.

Activators reproduce the physiological mechanism and are more effective both in the laboratory and clinically. There are at present two activators available for clinical use: **Streptokinase** ("varidase") obtained from bacterial extracts and **Urokinase** obtained from human urine. Both are expensive, have to be administered into the circulation to be effective, have a variable critical dose, and are difficult to control. Urokinase being human in origin, is to be preferred because it is non-antigenic and non-toxic, but it is not readily available.

A thrombus is rich in plasminogen because this precursor has an affinity for fibrin and is adsorbed on to the meshwork. Theoretically the most satisfactory way of producing thrombolysis is to activate this clot plasminogen by delivering the activator to the site of the thrombus. The plasmin so formed in it is out of contact with circulating antiplasmins. It also avoids the activation of circulating plasminogen with the consequent breakdown in clotting factors which happens if activators are given into the general circulation. The local infusion of activators into a thrombosed vessel may be practical in some sites, but is difficult in many others. Such an infusion is only effective against a recently formed thrombus and is of no use once the clot has undergone organisation.

A generalised increase in fibrinolytic activity may be of help as a means of anticoagulation and many drugs have been found to increase fibrinolysis. The sulphanyl ureas (e.g. tolbutamide), anabolic steroids, androgens and prednisone do this, but the response is only temporary. The search for a suitable oral drug is continuing.

Control

The effective dose of activator necessary to bring about lysis of a clot varies from person to person and with its route of administration. Throughout treatment screening tests are essential to control overaction of the fibrinolytic system. The clinician therefore requires the close co-operation of the haematologist to provide him with information about the degree of lytic activity and the level of available clotting factors in the general circulation. The control of activator dosage and the replacement of a clotting factor such as fibrinogen depends on this very necessary information. Excessive fibrinolysis can be curbed by the administration of a potent antifibrinolytic, epsilon amino-

caproic acid (E.A.C.A.). Teamwork is required for pro and adequate treatment.

Another problem of control is to demonstrate the efficacy of therapy—to know when thrombolysis has been achieved. The only way of obtaining objective evidence of this, and thus ascertaining the duration of treatment, is by repeated angiography. This is most practical when an intra-arterial infusion is being used.

The control of therapy at present is time-consuming and laborious, requiring the co-operation of many hospital departments.

Uses

Streptokinase and urokinase have been used in thrombotic occlusions of a limb, of the retinal vessels and of the coronary and pulmonary arteries. Success depends on many variables among which are the duration of thrombolysis before starting treatment, the extent of thrombolysis, and the route of administration—preferably into or near the affected vessel.

The dissolution of a thrombus is a slow process and continued ischaemia of the affected part may impair its viability. If possible in such a case, surgical thrombectomy of larger vessels must be carried out before thrombolytic infusion is used to clear the smaller vessels.

In many instances the underlying intimal pathology is still present after effective thrombolysis. To diminish the possibility of a recurrence, it is therefore advisable to follow with anticoagulant therapy.

The possibility that fibrinolytic agents might be of use in the treatment of irreversible shock has been suggested. In such a condition thrombi occur in the small vessels; in certain organs this may cause irreversible damage.

One very encouraging use of fibrinolysis is in the treatment of traumatic haemorrhage into the anterior chamber of the eye. The instillation of activator will fragment the clot sufficiently for it to be washed out after a few minutes.

Fibrinolytic therapy has been used effectively to clear the fibrin deposition in and around the lower end of the Spitz-Holter valve for hydrocephalus, and in meningitis and ventriculitis. A streptokinase aerosol has been effective in hyaline-membrane disease of babies.

Urologists have used it to break up clotted blood and pus in the urinary tract.

Many specialists have made use of thrombolytic therapy, but the time for its routine use is not yet here. At present we lack an inexpensive and suitable activating agent and the techniques of laboratory and clinical control

have not been perfected, but one day it will be safely harnessed and new avenues of treatment will be opened.

For the sake of clarity I have tried to present a series of complex problems in a simplified way; a surgeon's eye-view of a fascinating new means of treatment. However, at the moment it seems that the cheapest and safest way—and certainly the most pleasurable—of stimulating fibrinolysis is a round of golf!

Some References

Cooper, J. F.—The surgical aspects of fibrinolysis. *Int. Abst. Surg.*, 1959, 108:417.

Cotton, L. T., Flute, P. T. & Tsapugas, M. J. C.—Popliteal artery thrombosis treated with streptokinase. *Lancet*, 1962, 2:1081.

Gans, H.—Thrombolysis & Thrombolysis—*Int. Abst. Surg.*, 1961, 113:513.

McNichol, G. P., Douglas, A. S. & Bayley, C.—Experience with streptokinase infusions. *Lancet*, 1962, 2:1297.

Symposium on Fibrinolysis—*Proc. roy. Soc. Med.* 1963, 56:407.

Report on Fibrinolysis Workshop 1963—Sponsored by Leo Laboratories at Queen Mary's Hospital, Carshalton (to be published).

POT-POURRI, 1963

from our Special Correspondent

OF course the producers put a great deal of hard work into writing and preparing their Christmas ward shows, but couldn't they display just a little more originality? Time has hallowed the song and dance routine as the bread and butter of the shows, knockabout comedy providing the sandwich filling. In this Year's Pot-Pourri the bread and butter seemed rather stale, and the sandwich filling, with some notable exceptions, meagre and unappetising. Gilbert and Sullivan (heaven's gift to harassed producers) and "Salad Days" were plagiarised once again and the choreography appeared stilted and lifeless. Surely in these days of the mass media, television ought to provide producers with plenty of new ideas on how to liven up the old routines. Some of the trouble is, I feel, partly due to the self-consciousness of the performers on the big stage at the Cripple-gate as opposed to the cosy atmosphere on the wards, and partly to lack of confidence in their ability to act together as a team. They should always remember that, however poor the material, if song and dance numbers are put over to the audience with confidence, gaiety and punch, the show will probably be well received.

The clerks opened the evening's entertainment with their show "Peer today, Hon. tomorrow." We were treated to some rather weak chorus numbers but the comedy element in the Cinderella interlude was well sustained with a good performance from the "hairy" Godmother.

Midder and Gynae followed with a show that was well written and confidently performed.

Dance routines were cut out and the novel idea adopted of having the chorus on stage in a jury box throughout the show but taking no part in the action. Cigarettes, drink, and the Hospital were tried by a dithering judge. David Shand's portrayal of the life of a cigarette was both original and really amusing, and his clowning as an unfortunate patient undergoing a methodical examination by a student was by far the best thing in the first half.

Considering the small number of performers, the Out-Patients show was tolerably good. Their "Twelve Knights of Christmas" (a list which somehow contrived to include Sherlock Holmes, King Arthur and the son of Steptoc!) involved a quick change routine—simple but effective.

Those taking part in the Kids show always have a difficult task for their performance must amuse young and old alike. Usually a compromise is worked out and the result is a miniature pantomime with a general appeal. This year the theme was Snow White and the Seven Dwarfs. The chorus numbers lacked cohesion and many of the jokes fell flat. However, what really matters in the Kids show is the clowning and this was, although not original, quite effective.

Elaborate costume or scantily clad slave girls will not conceal poverty of material as the Dressers presentation "Carry on Caesar," revealed. Except for a brief character sketch of Field-Marshal Montgomery as an ancient Roman general, the show as a whole was life-

less and tedious. In all fairness to the Clerks and Dressers it must be pointed out that many of the faults that arise in their performances are due to inexperience in mounting this type of Christmas entertainment.

The Finalists continued the classical theme with "Samson and Delilah." The chorus numbers were rendered with dash and gusto although their content was rather meagre; a good deal more could have been done, I feel, with the subject chosen. The best individual performance was that of Gavin Haig as Samson, and the "Weston Brothers" duet with interjection by Kim Stevens was amusing though perhaps a shade too bawdy for some tastes.

After the interval the Specials continued with what was undoubtedly the cleverest of the shows, its revue quality contrasting with the more traditional approach of the others. As this type of entertainment is comparatively new to the ward shows it has aroused the ire of the more conservative elements who think, unjustifiably I feel, its humour unsuited to the patients for whose benefit it is performed. I am inclined to agree that one or two of the sketches were a little too subtle to be appreciated fully on the wards. Nevertheless the grotesque humour of Messrs. Chapman and MacElwain in the last act of an imaginary 19th century opera "I Buffoni" was very well received. The concluding number, involving some advanced manoeuvres by a trio of poker faced gentlemen with pieces of card, was inventive clowning and all the funnier for that.

For some unknown reason (tradition again?) the House Show is always allowed to run for its full allotted time with no cuts. This means that unless the pace is sustained throughout there is bound to be some flagging of interest on the part of the audience. So often the House show is merely the pretext for members of the staff to appear in a motley assortment

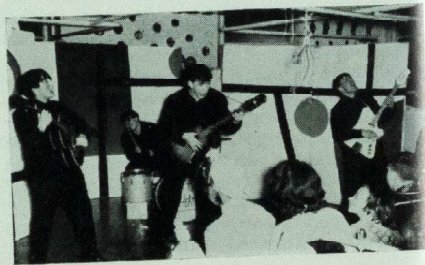


The House Show on the Wards.

of garb (monk's habit and hunting kit for example) often little related to the subject of the show. This year was no exception although, as always, the music was well arranged and sung with competence and zest by all concerned. The best song of the evening was rendered by John Stevens in the part of a ne'er-do-well student making a tryst with a nurse in the square. I wished that we had been spared some of the weaker lyrics in the choruses (references to Mr. Hunt and his shunt occur with monotonous regularity year after year). Isn't it about time too that jiggling up and down and rocking to and fro in chorus numbers was replaced by something a little more lively? I suppose it was inevitable that a certain group of Liverpoolian gentlemen should have their antics guyed sooner or later in the evening. The mime to two of their latest records was performed to thunderous applause from the audience and the frantic efforts of John Jailler on drums will not be forgotten in a hurry. The final chorus that followed was rather an anti-climax, its effect being lost due to too great a length.

The compères of the show (Ken Bowles and Brian Richards) were a great disappointment. The function of the compère is not just to fill in time between shows but to sustain interest throughout the evening. This, I'm afraid, they failed to do. We were treated to one or two weak jokes rendered almost inaudibly by Mr. Bowles and some rather flat singing to the guitar by Mr. Richards. They managed to raise a smile with a song about Matron's ball but ended flatly with a pathetic rendering of "If you were the only girl in the world."

Although the individual talent was better than in the past the Pot-Pourri this year was perhaps not as good as in previous years, but the faults were nothing that a little more liveliness and originality wouldn't improve.



NIGERIAN EXPEDITION

by 2nd Lt. I. C. Nicolson, R.A.M.C.

An account of a journey made by fifteen Officers and men of the 14th/20th King's Hussars in November and December last year.

IN August last year I was asked to join an adventure training exercise of the 14th/20th King's Hussars, at present in Libya. The main aim of the exercise was to cross the Sahara from Benghazi in Libya to Lagos in Nigeria—Mediterranean to Atlantic and back. My job on the exercise was to be medical officer. After obtaining permission from the Dean of St. Bartholomew's Hospital and from the Commandant of the Royal Army Medical College, I flew out to Benghazi at the end of October to join in the final preparations.

Our arrangements completed, we left Wavell Barracks at six o'clock on the morning of November 1st. We set off down the Tripoli road and our first stop was at Agedabia, 100 miles from Benghazi. An administrative hitch held us up here for a couple of hours, but when we moved off we motored all day and leaguered up a few miles east of El Noflieh.

Our night routine for the exercise was now established. Vehicles were parked up, beds laid out on the ground and the cooks prepared supper. We had a guard rota for each night in Libya, very necessary as the locals tend to be light fingered! In the desert the guard was mainly for time-keeping. Reveille was generally three-quarters of an hour before sunrise and move-off was at dawn.

On the second day we left the Tripoli road and turned onto Fezzan road, at Misurata. One of the trucks actually did leave the road, being forced off by a large oil company lorry.

Below: The Expedition's vehicles.



Above: Members of the expedition with relics of World War I at El Gatroun.

This tested our skill at vehicle recovery, but with a little ingenuity we were soon on our way. The Fezzan road has only recently been built to replace an old track linking Sebha with the Tripoli road, but already it has been washed away in places by the winter rains. In the Djebel es Soda the emergency tracks are quite hair raising. We reached the oasis at Sebha in the afternoon of the third day. Here we dumped the jerry cans we had emptied so far; we carried all our petrol, 2,400 gallons for the outward journey in jerrys. We also filled up with fresh water, for we were now heading out into Sahara and our water ration was one gallon per man per day for all purposes.

We headed south toward Umm el Araneb over some extremely rough tracks. We reached this place on the Monday morning and passed on quickly as the smell was powerful. The Mourzouk sand sea was now crossed to bring us to El Gatroun, which for us was the last village in Libya. From El Gatroun, with its Italian fort and First World War field pieces, we passed into a rugged and mountainous region of the desert which cost us several punctures. We reached the Libya/Niger border on the 6th November. There is no formal border post and only by compass bearings and an astro fix did we decide that we were on the Niger side of Mount Toummo.

The going so far had varied from djebel to fech fech, or sand sea. Djebel is very rough,

rocky going, which is ruinous to tyres and over which it is impossible to travel very fast. The next type of going is serir—this is either soft or hard. Serir is rather like gravel in appearance and when hard is excellent going over which it is possible to maintain speeds of 40 m.p.h. or more. The soft serir is also gravelly but the wheels sink deeper, and it is necessary to drop the tyre pressures to stop them going too far. Fech fech or sand sea is soft sand with a top crust of harder sand up to a few inches thick. Here tyres must be used at the lowest workable pressure, in order to spread the load and so not break the crust. Provided that forward motion is maintained and at as fast a speed as possible, the sand sea is relatively good going. It is possible, however, to be travelling over the sand at a good speed and suddenly sink axle deep.

How do you get out of sand when bogged? We had hooks on the sides of our truck from which hung sand channels. These are five-foot long steel strips which were originally used during the war to make emergency air-strips. The sand channel is placed flat with one end under the bottom of the wheel, and with the rest of the strip pointing in the direction of motion. This means that any sand round the wheels must be dug away before placing the channel; having placed channels at all four wheels, the driver drives out changing gear on the channels. More channels may be needed and these are placed on the move. The driver takes the truck to the nearest hard ground and the crew collect the channels and set off in pursuit of the truck. The worst time we had was when it took us an hour to make 500 yards, channelling much of the way.

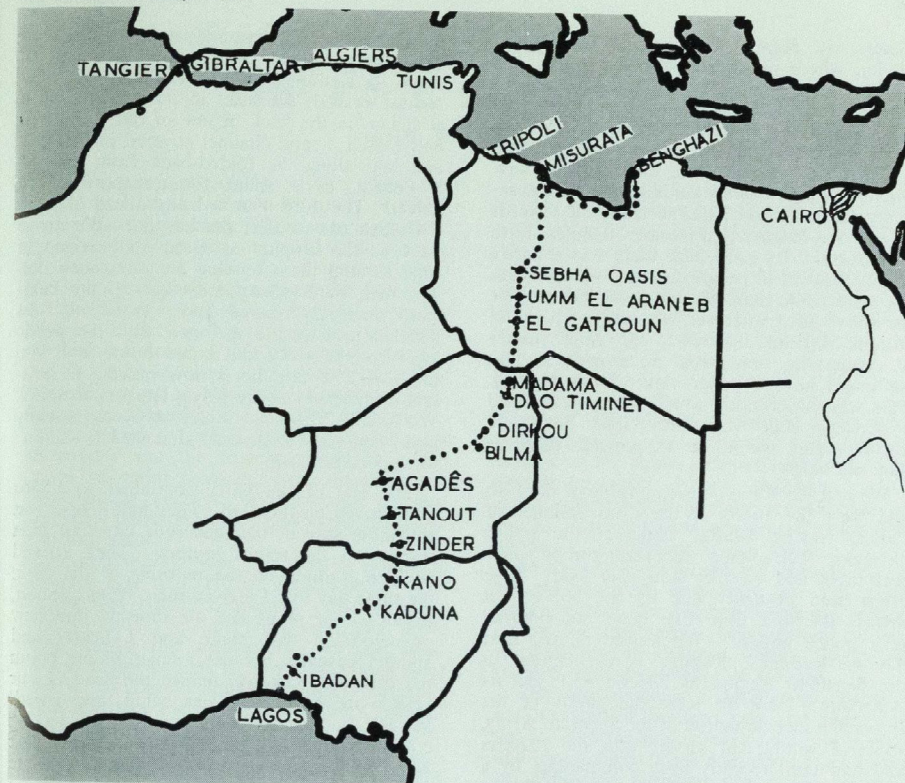
At Toummo we were held up by a vehicle breakdown and we lost some time. We moved on early on the morning of the 8th of November and arrived at the Niger border post of Madama at ten o'clock in time for our daily radio halt. Here our passports were stamped and visas examined. We left Madama in the direction of Bilma, about two days' march away; and we decided to travel by night as well as by day as our breakdown had put us behind schedule. About 50 miles out of Madama we visited an oil rig. Here we met a bearded Swede who had been in the German navy in the war. He spoke English, Swedish, German, French and Italian, and was married to a Czech. He entertained us with some welcome cold beer from the fridge in the air-conditioned messroom. He also gave us some useful information on our route and assured

us that the piles of stones and oil drums marked the local Route Nationale.

Reluctantly we left this fleshpot and pressed on into the wilderness. But for a fire in one of the trucks which burnt out the wiring we would have driven all night; our R.E.M.E. electrician did a splendid job and we were moving again before dawn. We now travelled over quite the roughest going so far, giving our trucks a considerable pounding, not to mention the passengers. It was on this section that we came to our first French fort, at Dao Timiney. Niger, though an independent republic within the Communauté Française, still retains the French Army to police the more desolate areas. When we started out we did not expect the French to take anything more than a cursory interest in us and as the fort at Dao Timiney was not one of our check points we drove past. But we were wrong, for we had only gone half a mile past when the officer commanding chased after us in his jeep and insisted that we came into his fort. We went in and the soldiers went off for showers, the first for nearly ten days. The officers were taken to the mess for a wash and breakfast. We had been expected and our welcome here was typical of what we were to receive from the French Army. The soldiers found that they could easily make themselves understood though only one of them spoke French and none of the French soldiers spoke English; beer is international.

We left Dao Timiney in high spirits, and when some miles on we had to stop because of a vehicle breakdown, I had my first patients. They found that the heat of the sun and French hospitality don't mix. Rest and plenty of water with some salt tablets soon had them cured. We moved on the next day to Dirkou, which is about 50 miles north of Bilma. It was Remembrance Day and we listened to the Cenotaph service whilst we repaired a vehicle spring outside an oasis; after an ingenious repair and the use of one of the tubes of my stethoscope to bleed the hydraulic brake system, we moved on. We arrived at the fort at Dirkou late that night. We had some maintenance to do the following morning and were invited to stay for lunch. As it was Armistice Day it was a special lunch that was laid on for our soldiers, with plenty of wine and beer. The officers fared equally well, but we had to leave. We moved on with our soldiers wearing uniform which they had exchanged with their French comrades.

We now came to what was reckoned by the French to be the hardest part of our journey,

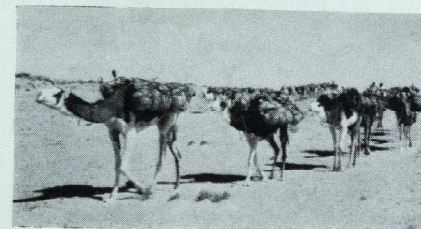


seventeen days to do what took us four, and the crossing of the Bilma sand sea. It took us four days to cover the 700 kilometers from Dirkou to Agadès, the actual sand sea crossing taking only two days. The French were most impressed. The sand sea was one of the loneliest places we passed through, miles and miles of nothing but sand and huge sand dunes. On our return journey we crossed some—this is great fun, but with some danger. Dunes are roughly divided into two types; seif and whaleback. Seif literally means sword, and one side of the dune will be gentle but there is a concave drop on the other side and if you try to drive over you will be killed. Whaleback has convex surfaces and presents no problem to the experienced desert driver. We passed a camel train of 1,000 camels coming from Bilma and going to Agadès, they took they have no water for their camels for much of that time.

By now we were out of the desert and into

the bush; in the country round Agadès we saw herds of gazelle and ostrich. The wild life was very plentiful and there were many exotic birds to be seen. We also met the Toureg, *les hommes bleus*, an ancient and proud race whose men still paint their faces and hands blue. After Agadès we joined the Hoggar track for Kano. The "Route du Hoggar" is the popular crossing of the Sahara and links

Below: Part of a camel train in the Bilma sand sea.



Algiers with Kano. We went via Tanout and Zinder, where we spent a pleasant night, and the last big village in Niger, Matameye, where we were presented with a bundle of sugar cane. We crossed the Nigerian border on the 16th to be welcomed by a customs official who would make an excellent civil servant anywhere, red tape was his guiding light. We eventually escaped from him and made off towards Kano. We leaguered up some 30 miles north of Kano and by good luck there was a native harvest festival in progress, which we attended. We were made most welcome and indeed stole the show since wherever we went a crowd of curious Africans followed; the chief master of ceremonies beat back the crowds so that we might have a better view of the dancing. This was closely akin to the antics performed in College Hall when the Alpha Beats are playing—they would be as popular there as they are here.

We reached Kano on the morning of the 17th and were the guests of the Commissioner of Police, staying Sunday night at the police barracks. The soldiers were taken out by police that night and one of them later said: "I've often been brought back by the police, but this is the first time I've gone out boozing in a police wagon." We moved on the next day to Kaduna. Kaduna is the capital of the Northern Region of Nigeria and also its Aldershot. Here we were the guests of the Reconnaissance Squadron of the Nigerian Army, some of whom had served with the Hussars and had until recently been commanded by a Hussar. They looked after us well and saw to it that the soldiers lacked nothing. We spent some time checking over our vehicles and were very pleased that they had taken the journey so well, especially as two had been classified as beyond economic repair. I visited the Kaduna Military Hospital to have a look round. This hospital was formerly run by the R.A.M.C. and was the best hospital in the north—it is now run by the Nigerian Army Medical Corps with assistance from the Pakistan Army Medical Corps.

We left Kaduna on the 21st for Lagos. Unfortunately, 56 miles out of Kaduna one of our trucks completely overturned on the laterite road and I had work to do. I was further up the road at the time and when I arrived I found that the two men in the front of the vehicle were both quite seriously injured but the soldier in the back was only dazed. The truck had actually rolled over the driver and fractured his pelvis and, later, abdominal complications were found. The vehicle com-

mander had dived clear and landed on his head—he was semi-conscious. We evacuated all three to Kaduna Military Hospital by what means we had: the head injury was put on a stretcher on the back of one of our 3-tonners, and I used a sand channel covered in blankets and laid along the folded-back front seat of a Peugeot, as a splint for transporting the driver. The third man was sent ahead of us in a civilian car to alert the hospital. We drove back to the hospital at speed and arrived in time to stop them sending an ambulance out. The men were subsequently seen by the Pakistani doctors, X-rayed and warded. It was decided to evacuate the man with the pelvic injury to the U.K., and I flew home with him on 24th/25th and he is now making a satisfactory recovery at the Royal Herbert Hospital, Woolwich. The head injury recovered rapidly and I flew back to Bengazi after we left Kaduna on our return trip.

The rest of the party continued to Lagos and arrived on the 23rd. They had a brief but enjoyable stay in that generous city and then started on the return journey. They arrived back in Kaduna on the morning of the 27th, the same day that I arrived there from London, by air. Four of us had an amusing interview on television that night, and I nearly had another casualty because a microphone boom fell over and narrowly missed the head of our vehicle mechanic who was being interviewed. We left Kaduna for Kano on the 29th, having collected our petrol for the return journey. At Kano we were the guests at a splendid barbecue laid on for us by friends we had made on our first visit.

Our return journey was over the same route as that by which we had come, which was rather a shame as we would have liked to have seen more of Niger and Nigeria. We had to be back in Benghazi on the 15th of December, so we could not spend much time sight-seeing on the way. In fact we would have arrived back on time but for the fact that the Press wanted to see us and photograph us *au naturel*. So we lost a day to the Manchester Evening News. We arrived back at Wavell Barracks at 5 p.m. on the 16th December, to be met by the C.O. and over half the regiment with champagne and beer. A hero's welcome.

As medical officer to the exercise I learnt much which cannot be taught or read up and I feel that it was a very worthwhile trip. I am grateful to the Dean and the Commandant for allowing me to go.

SPECIAL DEPARTMENT: VII

THE E.N.T. DEPARTMENT

by R. F. McNab Jones

THIS is a big speciality covering a wide range of pathological conditions many of which are extremely common. Those entering general practice discover that a considerable volume of their work lies in this field and many regret the brevity of their training in the speciality. Although it is regarded as a surgical speciality modern otolaryngologists require as much medical experience as they do surgical expertise and its study involves a knowledge of related specialities such as Neurology, Ophthalmology, Paediatrics, Dentistry and Plastic Surgery.

The variety of work offers something for all palates and the surgery ranges from the drama of major head and neck dissections to the scientific precision of microscopic ear surgery done under magnifications varying between $\times 6$ and $\times 25$.

Before World War II Bart's possessed separate Ear and Throat Departments. The former was largely concerned with the treatment of middle ear infections, much of it acute otitis media and mastoiditis. As the intracranial complications of those infections were almost invariably fatal the aural surgeon's main aim was the prevention of such complications by early and radical drainage operations. The introduction of chemotherapy and antibiotics much reduced the danger of middle ear infections and their complications and acute mastoiditis has now become a rare condition.

The two departments were amalgamated after the war and the out-patient work of the present combined department is carried out in a series of specially adapted rooms on the second floor of the out-patients' block which should become familiar to all students during their training. Some will perhaps qualify without visiting the new in-patient quarters in Henry Butlin Ward and the operating theatres in the Queen Elizabeth block if so they will miss seeing how well fortune has favoured our department in these respects.

While antibiotics have reduced the volume of mastoid surgery, the protection they offer is permitting a more conservative approach to middle ear infection so that aural surgery, with the help of excellent operating microscopes, is now attempting to preserve hearing in addition to eradicating infection. Operations designed

to reconstruct the sound conducting apparatus in the middle ear, and relieve deafness due to otosclerosis, have been developing quickly in the last decade. Another expanding frontier is neuro-otology which is primarily concerned with diagnosing and treating conditions of the inner ear and eighth nerve. In some countries the investigation of deafness (audiology) is now a speciality on its own.

Practice in diseases of the nose and throat has altered less than otology in recent years. The bulk of it consists of diseases of the tonsils and adenoids, sinus infection and malignant disease of the sinus, pharynx and larynx. The proper treatment of these neoplasms requires close collaboration between the surgeon and the radiotherapist, and our department is justly proud of its tradition in this respect.

Many E.N.T. conditions are amenable to out-patient treatment and there are six general clinics weekly. In addition, there are separate clinics for the special investigation of cases of deafness in children, nasal allergy and patients with disturbance of balance.

The department is a distribution centre for national health hearing aids and there is a weekly clinic to help supervise the proper fitting and use of these. Each consultant has a follow-up clinic on alternate weeks for malignant cases which is run in conjunction with a member of the department of radiotherapy.

There are four consultant and two registrar operating lists weekly. We manage to fill these lists with an in-patient capacity of only thirty-one beds because many are short-stay cases and this allows a rapid turnover. In 1962 1,157 in-patients were admitted to Henry Butlin Ward.

The speciality offers a busy, varied and interesting career with enough uncharted seas to satisfy the research-minded. The obvious scope for investigation at the present time is in neuro-otology, the prevention and treatment of deafness, and the chemotherapeutic treatment of malignant disease in the head and neck.

Teaching

Undergraduate training in this hospital is at present restricted to attendance at one out-patient clinic weekly for three months during

the second clinical year. This brief apprenticeship tends to give the student an unbalanced impression of the speciality. Fortunately in future curricula it is planned to increase the time allotted and this will give an opportunity for ward rounds and lecture demonstrations in addition to the present out-patient work. This should stimulate the student's interest and give him a better understanding of the subject.

Training

Few undergraduates are inspired with a burning desire to become an E.N.T. surgeon, possibly because they see so little of the working of the department during training. Most of us became interested in the speciality after doing an E.N.T. house job. This is certainly the obvious introduction but it is probably best to do general surgical and general medical house jobs first in order to arrive in the speciality with a good general grounding. If the prospect pleases and an otolaryngological dream is born then the aspiring consultant would be well advised to concentrate immediately on passing the primary examination for the F.R.C.S. The best and easiest method of preparing for this exam is to obtain a demon-

stratorship in Anatomy or Physiology. The most difficult way is to attempt it while working as a full-time E.N.T. registrar—many who pursue the latter course never surmount this initial obstacle. The Final Fellowship comes as a more natural hurdle than the Primary and the average period between qualification and the acquisition of this diploma is about five years.

Training is completed by obtaining a post as senior registrar and this is always associated with a teaching centre. At the present time there are good opportunities for getting consultant posts and few senior registrars need complete their four years of training before gaining promotion.

For those who are attracted to academic surgery there are at present two University departments in this country in London and Manchester. These have established full-time Chairs in the speciality and it is possible that the number of such units will increase in the near future.

The medical complement of our department is four part-time consultants, one senior and one middle-grade registrar and two house surgeons.

PLANNING CONSIDERATIONS IN CONNECTION WITH THE FUTURE REBUILDING OF ST. BARTHOLOMEW'S HOSPITAL

by John Goody—Clerk to the Governors

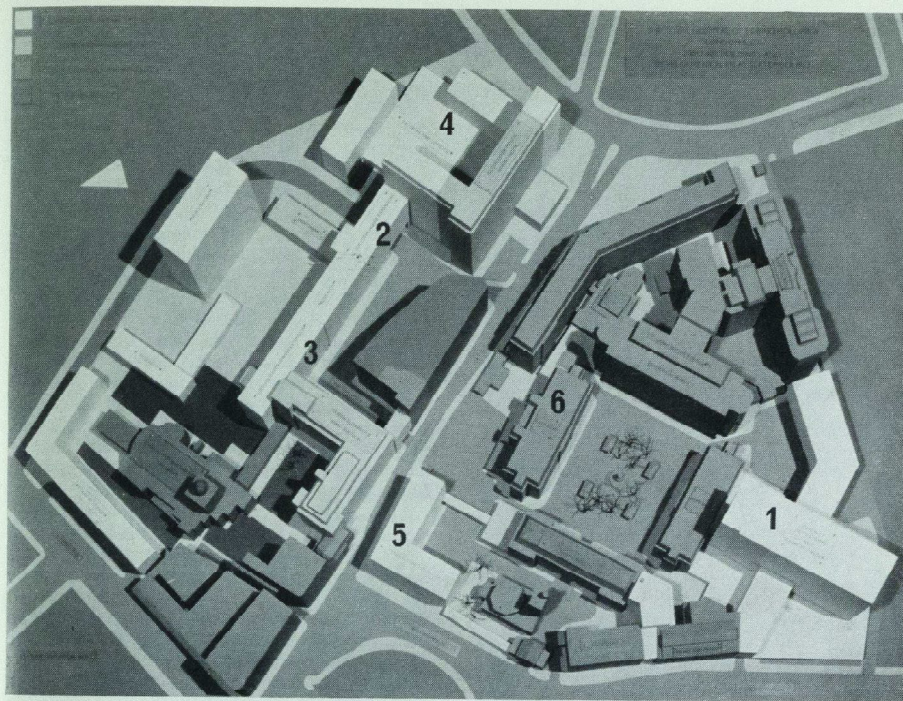
IN January, 1961, the Ministry of Health invited Boards of Governors of Teaching Hospitals to submit development plans for the next ten years. Before the hospital could respond to this invitation it was necessary to examine the development of the Hospital on a term of about fifty years. Each area had to be considered, firstly for its ideal use, secondly to see whether its present function was suitable and thirdly how it related to the larger plan. The purpose of this assessment was to ensure that the short term building programme would not frustrate the long term needs of the Hospital. This survey may have been tinged by a subjective approach due to the massive buildings already existing.

The primary physical considerations under which the Hospital operates are the need to provide space for the care and treatment of both outpatients and inpatients, and the supporting services. At the same time the teach-

ing needs of the Medical College must be observed and advantage taken of the opportunities for research permitted under the National Health Service Act, 1946.

The long term plan of how these relate to the home site and the adjacent precinct which is zoned for hospital purposes shows that the present out-patient and in-patient treatment areas are well sited for their purpose and that the Bartholomew Close area is suitable for limited ward accommodation and for development for nursing needs, research, works engineering, supply and catering services, and for residential accommodation.

A most encouraging augury for the hospital development was provided by the first review, approved by the Minister of Housing and Local Government in December, 1962, of the County of London Development Plan which reiterates, under a section dealing with areas of special character and precincts—"St. Bartholomew's



1. New Out-patient Department and remodelling of West Wing.
2. Extension to Nurses' Home.
3. Extension to Queen Elizabeth II Wing.

4. Catering Block.
5. General Purposes Block.
6. Rebuilding East Wing for Obstetric and Gynaecology.

Precinct. The Church of St. Bartholomew-the-Great, St. Bartholomew's Hospital and the contiguous area to the east into which the Hospital will expand. It is intended to preserve the character of the area adjacent to the Church and to encourage the precinctal atmosphere which is appropriate to the Hospital use."

In considering the recent history of the hospital it will be remembered that in May, 1961, all units separated by the war, were again reunited on the home site with the opening of the Queen Elizabeth II Wing and Gloucester House Nurses' Home. The ten-year plan, therefore, provided an opportunity to make a bid for the Hospital's most serious needs, a chance to secure both a measure of rationalisation and refinement of the home site and an opportunity to meet deficiencies.

With the foregoing in mind the Board decided to put forward the following proposals

shown on the adjoining photograph of a model of the area, to which has been added, at the request of the Medical College, a memorandum advocating the provision of a Psychiatric Day Hospital:

1. New Outpatient Department and remodelling of West Wing.
2. Extension to Nurses' Home.
3. Extension to Queen Elizabeth II Wing.
4. Catering Block.
5. General Purposes Block.
6. Rebuild East Wing for obstetrics and gynaecology.

In January, 1962, the Ministry of Health published "A Hospital Plan for England and Wales" giving particulars of the capital grants they were able to make available, and selecting the rebuilding of the Outpatient Department and a Psychiatric Day Hospital after 1971. Ministerial policy is to make substantial grants

to selected schemes rather than smaller grants severally. Nevertheless, in subsequent conversations the Ministry agreed to accept the following subsidiary commitments to assist the hospital over serious difficulties:

(a) The renovation of the Casualty Department in which 80,000 casualty patients are treated annually and which at present functions in under 1,000 square feet and through which nearly one million patients will pass before ultimate rebuilding takes place.

(b) An extension to the Department of Pathology to start before 1968, to meet the increased amount of work falling on the Department.

A personal opinion

At the present time only 15 per cent of the ward accommodation can be said to accord with modern standards. 61 per cent is older than a quarter of a century, and 24 per cent is grossly out of date. The latter includes the East and West Wings, which, in slogan terms, are contemporary with the construction of *H.M.S. Victory*.

The East and West Wings are "Gibbs' Pedestrian" and were completed after his death. Their charming façades and elegant fenestration mask their inner deficiencies. These wings present a problem from every aspect of operation. It is surely vital to the hospital that the wards which have served for over two centuries, affording comfort to countless patients, should be replaced by modern counterparts. They are believed to be the oldest accommodation in London in which patients receive specialist treatment.

The traditionalists may suggest retention of the façades. This is practicable if extensive underpinning takes place, but would leave 14-foot ceilings and insuperable problems of design behind these fronts if modern conditions are to be achieved.

The integrity of the Square was broken when the stone aprons at the corners were removed and the South Block demolished.

It is my personal opinion that it will be essential for these wings to be razed and modern buildings placed on these sites. These plans must be related not only to the adjacent buildings but to the whole site.

If this view is accepted the rebuilding of wards on the present sites will provide modern conditions for the care of patients and allow the creation of reserve areas, enabling older wards to be rebuilt and renovated, or relegated to less exacting physical use. The simple fact that continuous service must be provided emphasises the need to create reserve areas

where these same services can function temporarily. It has been shown elsewhere that the basic ward unit can be readily adapted for use for the clinical care of outpatients.

The Gibbs' North Block is of great architectural importance. The Great Hall is the finest room of its period extant in London, and there is ample evidence of the care Gibbs lavished on it. When the Hall has been strengthened and heated in complete deference to the refinement of its original concept it will accord perfectly with modern needs and will provide a centre throughout the whole year for those wishing to advance their subject by means of conferences, study days and so on.

The middle term plan must deal with the huge volume of the Department of Pathology and the Museum Block, where the massive proportions of the building squander floor space in relation to volume on an imperious scale. The artful sinews of the museum block are of cast iron, and preclude the introduction of extra floors due to weight.

The massive commercial building along Route 11 to the East of the Hospital to a height of 18 storeys—the encroachment on St. Paul's Cathedral by high buildings—the proposal by the General Post Office (successfully resisted by the Governors) to build a tower block two hundred and seventy feet high, and would have thrown the shadow of the sun at the equinox as far as the approaches to Smithfield Market. All these emphasise the need for the Hospital to build to a greater height to secure its share of light and air. Gloucester House Nurses' Home is twelve storeys high and can be said to be the first of the hospital buildings to acknowledge the trend towards higher buildings which must be pursued.

In fifteen years time on present showing nearly half the London Undergraduate Teaching Hospitals will be rebuilt on a scale of £14-16 million. The hospital cannot be treated in isolation from the developments among the London Teaching Hospitals elsewhere, or the building trends, which are evident in the adjacent area of the City. Further reckoning must be made of the needs of the Medical College, possibly reflecting an expanding University programme.

The purpose of this article is twofold. First to state what is intended for the immediate future, and secondly to express a personal opinion concerning certain trends relating to the long term development.

(The photograph is of a model of the hospital's future development. The original model was presented to the hospital by a benefactor).

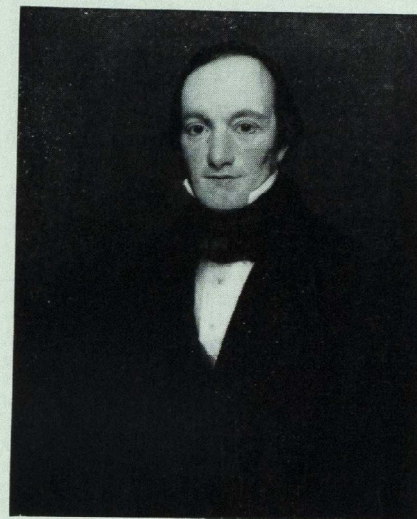
SIR RICHARD OWEN

by Professor A. J. E. Cave

THE decor of the Abernethian Room in College Hall has recently been enhanced by the installation of a portrait of Sir Richard Owen. The portrait, an original by Henry Pickersgill, R.A., depicting Owen in early life, has been presented to the Medical College by the Governors, the cost of its cleaning and re-framing having been generously defrayed by Rear-Admiral P. K. Kekewich, C.B., a Treasurer of the Medical College.

Though Owen's great reputation was made, not in clinical medicine, but in biological science, he nevertheless commands the filial devotion of all Bart's men since he was successively prosector to Abernethy, a student of the Hospital and later (1828-35) Lecturer in Comparative Anatomy therein. His fundamental achievement was his almost single-handed rescue of biological science in this country from the neglect, and even contempt, hitherto surrounding it, and his elevation of the subject in the national esteem to the dignity of a reputable scientific discipline. Owen's genius for morphological perception, his dynamic personality and his well-nigh incredible capacity for sustained labour, rendered him, throughout his scientific career, less an individual than a one-man institution, and certainly in later life he was, in popular estimation, the living embodiment of the man of science. He dominated contemporary British biology and his pioneer researches enhanced not only the development of that subject, but also Britain's scientific prestige abroad.

Born at Lancaster on 20th July, 1804, Owen attended Lancaster Grammar School. At sixteen he was apprenticed to a succession of surgeons, during which period his anatomical bent was early manifested. Before completing his apprenticeship, however, he matriculated at Edinburgh University and was fortunate to attend the extramural anatomical course given by Dr. John Barclay, who quickly recognised his pupil's exceptional qualities. A lasting personal bond was forged between the two and in 1825 Barclay sent the young Owen to London with an introduction to John Abernethy. Impressed alike by Barclay's commendation and by his visitor's personality, Abernethy immediately appointed Owen prosector for his surgical lectures. Thus Owen became a Bart's student, completing his medical studies



within the Hospital and obtaining his Membership (there being then no Fellowship) of the Royal College of Surgeons in 1826.

Owen's inclination was towards scientific enquiry, not clinical practice, but his problem upon qualification was to find any congenial field of employment. There was at that time no University of London or Natural History Museum, and the Zoological Society was but a newly instituted offshoot from the Linnean Society. Only the unique Hunterian Museum, in the custody of the Royal College of Surgeons in Lincoln's Inn Fields, could offer Owen an arena suited to his specialist talents: yet appointment to its staff seemed beyond attainment. Its Conservator was William Clift (last and most devoted of John Hunter's assistants), and his son, William Clift Junior, was Assistant Conservator with the right of succession.

Unsettled as to his future, Owen set up in practice close to the Museum (at 11, Cook's Court, Carey Street), gaining an increasing familiarity with the Museum's wealth of material and growing in friendship with the Clifts. Owen and Caroline Clift (the Conservator's daughter) fell in love and Owen was welcomed as a future son-in-law. Thus matters stood

when tragedy intervened. William Clift Junior sustained mortal injuries in a cab accident in Chancery Lane and died in St. Bartholomew's Hospital. The Assistant Conservatorship thus lay vacant and through Abernethy's discernment and influence Owen was appointed to the post (1827). Doubtless this same influence secured Owen's invitation (1828) by the Staff of St. Bartholomew's Hospital to the post of Lecturer in Comparative Anatomy, an appointment confirmed by the Hospital Governors in 1834 and relinquished in 1835 when he married and the duties of the Hunterian Professorship precluded continuance therein.

Successively Assistant Conservator (1827), Joint Conservator (1842) and Senior Conservator (1852), and as its first Hunterian Professor (1836-56), Owen served the Royal College of Surgeons for twenty-nine memorable years, at the end of which the College enjoyed high scientific repute, and Owen was, by acknowledgement, the foremost anatomist in Europe. His initial task was the formidable cataloguing of the immense series of Hunterian preparations, many of which, in consequence of Everard Home's destruction of the Hunterian manuscripts, required preliminary identification. Owen was therefore compelled to undertake a prodigious and intensive investigation into vertebrate and invertebrate morphology and to lay under tribute material from the Zoological Society and elsewhere. From this industry came an authoritative and ceaseless flow of memoirs, monographs and papers upon animal morphology which represented the greatest contribution to zoological knowledge to be made single-handed since Cuvier. This impressive output demonstrated Owen's grasp alike of structural detail and of biological principle. His early *Memoir on the Pearly Nautilus* (1832) caused his immediate acclaim as a master morphologist and his illustrated 5-volume *Catalogue of the Physiological Series* (1833-40) established new standards for such productions. His publications during this period represent a truly Hunterian investigation into the realm of animal morphology—detailed studies of an extraordinary variety of mammals, birds, reptiles, fossils, molluscs, brachiopods, crustaceans and entozoa far too numerous for citation here. Mention must be made, however, of such outstanding productions as his *Odontography* (1840-45), his *Lectures on the Comparative Anatomy and Physiology of Invertebrate Animals* (1843), his *Memoir on the Mylodon* (1842), his *History of British Fossil Mammals*

and *Birds* (1844-46), his monograph *On Parthenogenesis* (1849), his *Fossil Mammalia* (1844)—the report on material collected during the voyage of the "Beagle", and his classic *The Archetype and Homologies of the Vertebrate Skeleton* (1848).

During his College service Owen was elected (1834) to the Fellowship of the Royal Society and received from that body a Royal Medal (1846) and a Copley Medal (1851), while the Geological Society awarded him a Woolaston Medal. Cuvier's visit (1830) to the Hunterian Museum resulted in an invitation to Owen to visit Paris, where the next year he attended courses by Cuvier and Geoffroy St. Hilaire besides working in the laboratories of the Jardin des Plantes. From Prussia he received the Order "Pour le Mérite" (1851) and from France the Cross of the Legion of Honour (1855). Declining knighthood, he accepted (1842) from Peel a civil list pension of £200, which forty years later Gladstone augmented by £100. In 1852 Queen Victoria granted him Sheen Lodge in Richmond Park as his residence and therein he dwelt for the remainder of his long life.

Strained relations developed between the Conservator and his Board of Curators and in 1856 Owen resigned his Conservatorship to accept the newly created office of Superintendent of the Natural History Collections in the British Museum. The light administrative duties of this post afforded him time for the study of the unrivalled material in his charge and for the summarisation of the voluminous records accumulated during earlier years. This second period of Owen's scientific life (1856-1883) was dominated by concern for matters palaeontological. From his indefatigable pen came a series of classic monographs upon such topics as the extinct giant birds of New Zealand, upon recent and fossil marsupials and South American edentates, upon Purbeck mesozoic mammals, *Archaeopteryx*, the great auk, the dodo, and the cetaceans of the Suffolk Crag. Came also papers on anthropoid ape osteology and the monograph on *Chiromyx*. These works, notable contributions to zoology, palaeontology and taxonomy, require no present enumeration for they are familiar to all workers in these fields. Many of them were lavishly illustrated by large-scale (sometimes life-size) lithographic plates, the publication of which taxed the resources of the scientific societies to which they were submitted.

During this period Owen published John Hunter's *Essays and Observations on Natural*

History (1861) based upon Clift's copies of Hunter's original notes and upon his own early labours at the College. This was his tribute to Hunter whom he had learned to understand and revere both from the direct testimony of his father-in-law and from his own intimate preoccupation with the Hunterian Museum.

In 1860-68 appeared his *Anatomy and Physiology of Vertebrates* (3 vols.), a work based almost wholly upon his personal researches and still an unrivalled compendium of comparative morphology.

During this same period Owen assisted David Livingstone in the composition of his *Missionary Travels* (1857), received the coveted Prix Cuvier from the French Academy (1857), presided at the Leeds Meeting (1858) of the British Association, was elected foreign associate of the Institute of France (1859), lectured to the Queen at Windsor (1864) and to the royal children at Buckingham Palace (1865), delivered the first Rede Lecture at Cambridge (*On the Classification and Geographical Distribution of the Mammalia*, 1859), and visited Egypt for the first time in the Prince of Wales's party under Sir Samuel Baker's guidance (1869). He received the Baly Medal of the Royal College of Physicians (1869), the honorary Gold Medal of the Royal College of Surgeons (1883), the Brazilian Order of the Rose (1867) and the Belgian Order of Leopold (1873), as well as honorary degrees from Oxford, Cambridge and Dublin. He declined the Presidency of the Geological Society, and in 1873, the year of his wife's death, was created C.B.

Owen also served the public interest in various ways, as a member of the Government commissions on the health of the metropolis (1847) and on the Smithfield and other meat markets (1849), as a member of the organising committee of the Great Exhibition of 1851 and as a juror for raw materials at the Paris Exhibition of 1855. He devised the models of extinct animals for the opening of the Crystal Palace in 1855 for which he wrote a handbook (*Geology and the Inhabitants of the Ancient World*).

It is not surprising that his circle of friends and acquaintances was both wide and distinguished and included Lord John Russell, Prince Charles Louis Bonaparte, Charles Dickens, Sir Edward Landseer, John Ruskin, Dean Buckland, George Eliot, Sir James Paget, Jenny Lind and Alfred Lord Tennyson. Nor is it surprising that his striking physical appearance and his immense public reputation rendered

him a favourite subject for contemporary caricature.

Owen had long foreseen the desirability of removing the national collections from their unsuitable Bloomsbury quarters to some new building more fittingly adapted to their proper conservation and development wherein, also, provision could be made for the display of large cetacean specimens, for a physical anthropology series and for the delivery of lectures. He adumbrated his scheme to the British Museum Trustees in 1859, and thereafter laboured to win public and Government support for his proposals. Gladstone's sympathetic interest secured the acquisition of the present South Kensington site (1863), though not until 1881 was the new Natural History Museum opened to the public and not until recent years have Owen's recommendations concerning the cetacea, physical anthropology and a lecture theatre been implemented. Most appropriately, a full length bronze statue of Owen (by Brock) graces the staircase of the Central Hall of this greatest of natural history museums.

In the polemics which followed Darwin's publication of the *Origin of Species* (1859) Owen played a part usually deemed ambiguous or worse, from which his memory has suffered to this day. Huxley's championship of the Darwinian hypothesis rendered acceptance of "natural selection" the touchstone of biological orthodoxy and to "natural selection" Owen refused to subscribe. He attacked the *Origin* anonymously in the *Edinburgh Review* (1860) and provided others with the ammunition of onslaught. An instinctive Thomist, he recognised a First Cause (*Causa causans*) in Nature, operating through secondary causes: his arch-opponent Huxley halted intellectual argument from contingency and remained agnostic. From such fundamentally opposed philosophies stemmed much misunderstanding and acrimonious controversy, in which motives were mixed on both sides. Doubtless Owen, a pillar of "Establishment", was antipathetic to the mere deism and latent atheism in much of the new evolutionary doctrine, but his methods of attack displeased some. Single-handed against Huxley and his disciples, he fared ill in contemporary argument. But Owen, despite allegations and innuendoes then and since, was not an anti-evolutionist. Before Darwin's *Origin* he had recognised species "as exemplifying the continuous operation of natural law, or secondary cause, and that not only success-

(Continued on page 76)

OTHER HOSPITALS: 4

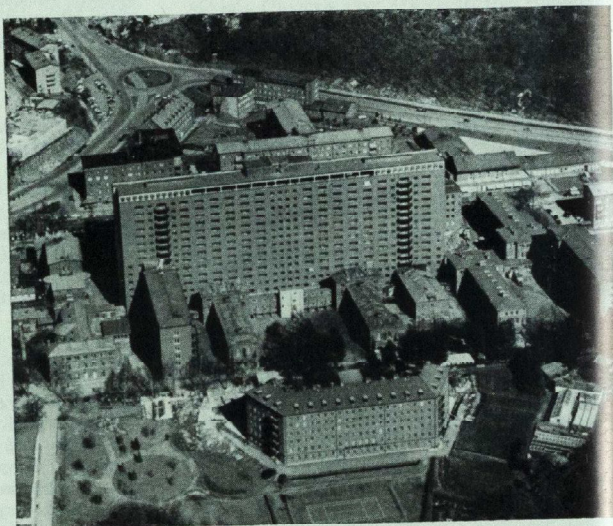
SAHLGRENKA HOSPITAL, GOTHENBURG, SWEDEN

by Karl Ola Obrant, M.D., Assistant Professor of Urology.

GOTHENBURG, with its nearly half-a-million inhabitants, is the second largest city in Sweden. The Sahlgrenska Hospital is the largest hospital in the city, and is the teaching hospital for the medical school of Gothenburg University. It is, at present, the most modern hospital in Sweden.

The hospital is named after Nicholas Sahlgren, manager of the Swedish East Indies Company. Sahlgren, who died in 1776, left a large sum of money to the town of Gothenburg. He did not, however, stipulate the precise way in which the money was to be spent, but merely stated that it was to be used for some philanthropic purpose in Gothenburg. A competition was announced to obtain ideas as to how the gift ought to be used. This competition was won by the mayor of Gothenburg, who, in an article dated 10th May, 1777, suggested that the donation should be used to provide the town's inhabitants with a hospital. From his very detailed article the following may be quoted as still being essentially valid—"in what better way can the sick be eased and helped than by communal hospitals, and what contributes more to the advance and growth of the art of healing than these?" The result of this article was the building of the original Sahlgrenska Hospital in a central part of the town. This hospital was first opened in 1782 and contained 24 beds.

The first doctor at the Sahlgrenska Hospital was Per Dubb, one of Gothenburg's greatest citizens. Dubb worked indefatigably in his aim to administer the hospital in the best possible



Sahlgrenska Hospital from the air.

way, an aim often difficult to fulfill due to lack of means. He induced his friend William Chalmers, a Principal Assistant Secretary of State, to bequeath half his estate to the Sahlgrenska Hospital. Chalmers belonged to one of the many families of British origin in Gothenburg which have played such an important part in the history of the city, and even of Sweden. William Chalmers is also remembered for his donations to Gothenburg's technical university, known by his name, and originally administered by his friend Dubb.

The first hospital building with 24 beds soon became inadequate for the town's needs, and in the nineteenth century it was twice moved to larger premises, to be finally established on its present site in the year 1900.

In spite of this it became apparent, after a

couple of decades, that the hospital's size was again inadequate. In 1935 a comprehensive rebuilding and enlargement plan was embarked upon. From that year until the outbreak of war in 1939 two hospital buildings were completed per year. At the end of the second world war, it once again became clear that the new extensions were insufficient to meet the demands being made upon them. This was due to two main factors: firstly, the rapid expansion of the city and the resulting increase in need for hospital accommodation, and secondly, the opening in 1949 of a medical faculty in the University of Gothenburg. This meant that the hospital now had to serve as a teaching hospital in addition to its other functions. Faced with the need for increased hospital accommodation, laboratories, libraries, and lecture-rooms, it was obvious that a fundamental reconstruction of the hospital must take place. It was suggested that the best solution to the various problems involved would be the erection of a new, large block containing a diversity of departments. This new block was to be sited centrally, replacing a number of older two-storey treatment pavilions. Building was started in 1952 and finally completed in September, 1959. The central block contains 820 beds, laboratories, out-patient departments, X-ray laboratories, and medical and surgical departments.

The advisability of extending an existing and fully functioning hospital by additional building in the middle of the hospital area is somewhat debatable. As all who worked at the Sahlgrenska hospital during this construction period could testify, it is a method which involves many difficulties. The theoretical aspects of a doctor's work are not aided by the sound of pneumatic drills in the wall outside his room. Nor can these disturbances be beneficial to newly-operated, and seriously ill patients. Now, after all these hardships, the building is complete, and the final result is a hospital which functions exceptionally well.

Sahlgrenska Hospital today has 2,315 beds. The number of in-patients per year is nearly 50,000. There are 19 different departments in the hospital, of these 2 are surgical and 3 medical. In addition, Rävlanda sanatorium, with its 70 beds, for urogenital tuberculosis, is attached to Sahlgrenska's department of surgery I.

The medical out-patients departments have some 30,000 visits yearly, while the corresponding figure for the surgical out-patients departments is nearly 50,000.

The X-ray departments are used by both in- and out-patient departments, so the total number of patients per year is high, reaching in 1962 a figure of 150,000. 25 doctors are employed in the X-ray departments working full-time, as do all the other doctors employed at the hospital.

The total personnel at the Sahlgrenska hospital was 3,700 in 1962. This figure includes 303 doctors, 2,040 nursing staff, and also technicians and administrative personnel.

The connections between past and present in medical care have been preserved by a special museum at the hospital. This museum occupies the same area as a normal treatment ward and is in the charge of Sister Ingeborg Kastman, Superintendent of Hospital Supplies, who has been largely responsible for the collection and care of the numerous exhibits which often prove of interest to foreign visitors. In the museum there is an authentic hospital interior from the nineteenth century, and instruments and records from the eighteenth and nineteenth centuries. One is struck by a comparison in running costs between the present day Sahlgrenska hospital, with its enormous current budget, and the costs of the original hospital as recorded in Per Dubb's unpretentious little note-book—the records of a careful householder with a not too large household. A visit to the museum shows, however, that the path of medical progress is not always so smooth—an authentic physicians' and surgeons' dining-room, from the turn of the century, exists, and the degree of comfort, and the vast quantities of food and drink to be found there, have little in common with the present day Spartan mess conditions. The term "stress" had not been discovered in the nineteenth century!

The Sahlgrenska Hospital became a teaching hospital in 1950, and this has naturally left its mark on the hospital itself, and the work carried out there. In immediate relationship to the hospital are institutions for anatomy, pathology, physiology and histology; many of the clinical laboratories are used for experimental research and there is an excellent university and hospital medical library.

The individual research worker no longer stands out so prominently in the present day team-work research. Nevertheless, the names of some workers at the Sahlgrenska Hospital must be mentioned individually:—

Jörgen Lehmann who was, until a year ago, head of the hospital's central clinical laboratory, and who discovered the anti-tuberculous effect of PAS.

Einar Ljunggren is internationally famous for his work on urogenital tuberculosis. On his initiative the Rävlanda sanatorium was established as a special hospital for urogenital tuberculosis in 1948, the first of its kind in Sweden.

Bengt Johansson, head of the plastic surgery department, has developed a well-known operative method for treatment of stricture of the urethra.

Ragnar Romanus has made many contributions to surgery, chiefly in the field of urology.

Lars-Erik Gelin, who introduced low viscosity Dextran, leads a research team working within a broad field of circulatory problems. Gelin is best known internationally for his work in rheology.

Erik Moberg is well known amongst orthopaedic surgeons for his outstanding work on surgery of the hand.

Cardiovascular research is carried out by Lars Werkö, specialising in medical problems, and Sven Roland Kjellberg, specialising in radiological problems.

SIR RICHARD OWEN

(Continued from page 73)

ively but progressively", and touching the biological questions of the day he "deemed an innate tendency to deviate from parental type . . . to be the most probable nature, or way of operation, of the secondary law, whereby species have been derived one from the other" (*Anat. Physiol. Verts.* 3, 807).

Nevertheless the opposition attacked him so successfully as to leave him somewhat isolated towards the end of his days. He certainly had his foibles; he was addicted to acrimonious controversy, was a powerful and determined opponent and, perhaps significantly, had founded no "school". His unfortunate slip about the hippocampus was ridiculed unduly by Charles Kingsley in his *Water Babies*, his stimulating vertebral theory of the skull was assailed with savage emphasis, his archetype concept was vehemently scorned and his attempted classification of mammals by cerebral structure was vigorously demolished.

In 1883 Owen retired from the British

Finally it is necessary to draw attention to the university bacteriological laboratory built adjacent to the Sahlgrenska Hospital. Orjan Ouchterlony is the head of this laboratory. Ouchterlony's diffusion-in-gel method for the study of serological processes is perhaps the most important contribution to medical research that has been made in Gothenburg during the last decade.

Sweden is a small country with a tradition of political neutrality. Therefore it is natural for it to be influenced by the differing cultures of the surrounding nations. West Sweden, and Gothenburg in particular, has a tradition of absorbing western influences, particularly those emanating from London, with which there are many contacts. Doctors in Gothenburg have thus always been stimulated by medical research and developments in London, and St. Bartholomew's Hospital is well known in this connection. There have been many Swedish doctors who have spent some time on studies in Britain, and, should there be interest in exchanges in the opposite direction, our British colleagues would always be welcome to the Sahlgrenska Hospital in Gothenburg.

Museum. The next year he was created K.C.B. and his civil list pension was augmented. In 1888 the Linnean Society bestowed on him its first Gold Medal. At Sheen Lodge he continued to write and to indulge his love for Nature in all her aspects until, on the 18th of December, 1892, he died of sheer old age. At his own request he was buried in his wife's grave at Ham, near Richmond, where his red granite tombstone may still be seen.

The nineteenth century triumph of the Huxleyan school of thought has prevented the appearance of any dispassionate appraisal of Owen's place in British biological science—his defects are still recounted, his merits often ignored, and his substantial contributions to knowledge taken for granted. It is good that such appraisal is even now being undertaken at American hands. None of Owen's contemporary opponents can match his accomplishment of output in zoology and palaeontology and no subsequent worker has rivalled his individual performance.

BOOK REVIEWS

The Operations of Surgery, Vol. 1. By A. J. Gardham and D. R. Davies. Messrs J. & A. Churchill. Price 100s.

It is most surprising that so much detailed information can be packed into a textbook of operative surgery such as Gardham and Davies'. The object is achieved in three ways: (1) By the use of straightforward line drawings which so markedly contrast with artistic impressions in other books on operative surgery; (2) by the use of double columns for each page, ensuring that a diagram can be sited close to its text; (3) by the avoidance of the urge to be encyclopaedic, yet still allowing a fair balance for divergence of opinion.

This is a book in which the reviewer has browsed for many hours, and will continue to do so for more. His colleagues agree that it is masterly, particularly in production. There are a few minor proof-reading insufficiencies with which it is pleasure to contend considering the solid worth rendered by this book. The authors' intention to be helpful is so clearly put across that some omissions, such as the abdominal approach for repair of diaphragmatic hernia, are readily recognised as reflecting honest opinion.

An important feature is that, although the cardinal subject dealt with is operative surgery, it is by no means a book on "cutting". Operative surgery should not be regarded as a specialised craft excluding all rationalisation. Its practice is closely interwoven with surgical anatomy and pathology; and therefore the plan of this book, including as it does many references to matters other than "cutting", makes it a great pleasure to read.

Volume 2, dealing with the remaining subjects of operative surgery is eagerly awaited.

F.E.W.

The Instruments of Surgery, by F. S. Mitchell Higgs and H. G. Radcliffe Drew. Pages 509. Wm. Heinemann. Price 105s.

The object of this book is to describe and illustrate a variety of past and present surgical instruments and pieces of apparatus. It has been designed chiefly as a standard textbook of the Institute of British Surgical Technicians. However, it also has a use as a reference book for those dealing with instruments in hospitals and for undergraduates.

Much of historical interest has been incorporated in the description and use of certain instruments. However, a brief survey of the evolution of other instruments (e.g. gastro-intestinal tubes) would give added interest.

Important clinical and operative details have been described where necessary to give a clearer picture of the use of an instrument. This could be enhanced in some instances by simple line diagrams but these must be of better quality and easier to interpret than those illustrating the technique of vascular suturing!

As would be expected in such a book, it is generously illustrated—1,134 figures to be exact. These are of a variable standard and a number could well be omitted. Many of those showing old and

obsolete pieces of apparatus together with their descriptions could be deleted without loss. In place of these could be photographs of more up-to-date and commonly-used instruments which, though described, are often not illustrated.

For the undergraduate this is a useful reference book, and, by looking leisurely through the illustrations without pondering too long on the text, it will also help him as a refresher for his examinations.

N.G.R.

Medical Embryology. Human Development—Normal and Abnormal. By Jan Langman, M.D., Ph.D. Published by Bailliere, Tindall & Cox. Price 70s.

It might be wondered whether there is a demand for yet another embryology text-book, in view of the fact that a number of established books of considerable academic merit are already available. Many of these, however, seem to have been written with a rather unrealistic concept of the requirements of the average medical student; so many text-books, written by experts preoccupied with scientific accuracy, tend to become rather discursive, obscuring the essential theme. Students may consult such books, but they read the smaller synopses.

Dr. Langman's book, while being concise and clear, is more than a synopsis and fills a real need. The story of development is unfolded lucidly and logically in just over 300 small pages, and practical medical applications are stressed throughout by following each account of normal development with a section of the commoner congenital malformations. Recent work is included and there are accounts of the aetiology of malformations and of chromosomal abnormalities. Some of the interpretations of developmental processes might not find universal acceptance and the approach is rather dogmatic, but this is not necessarily undesirable in an elementary book. Short lists of modern references at the end of each section provide a key to further reading for those requiring more information. The book is liberally illustrated with many line drawings—226 of them.

It can be highly recommended as probably the best available primer on the subject. The main barrier to its widespread use will possibly be the price which seems high for such a small volume.

O.J.L.

Physiology and Anatomy. With Practical Considerations. By Esther M. Greisheimer, B.S., M.A., Ph.D., M.D. Published by Pitman Medical Publishing Co. Price 60s.

As the caption on the dust-jacket announces, this American book is designed to meet the needs of "all students in the health fields". The general approach resembles that of British text-books of elementary anatomy and physiology written primarily for nurses; it is, however, considerably more elaborate and detailed, consisting of 894 pages with 430 illustrations.

The book is composed of alternating chapters on anatomy and physiology. The anatomy, which

systematic in nature, provides the structural basis for the physiology which follows, but would be quite inadequate for those—medical students in particular—requiring a reasonable familiarity with the regional anatomy of the body. Much more factual anatomy is included (perhaps too much) than is usual in books of this nature, but the systematic approach means that it inevitably fails to fit into a coherent whole and tends to become a mere catalogue of facts—there are 11 pages of tables in small print detailing the origin, insertion, innervation and action of almost every muscle in the body. Quite a lot of recent work, especially on fine structure, has been included. This desirable feature is perhaps rather unusual in an elementary book, for so often any new information is classed as mere detail and the old-established dogma is notoriously difficult to displace.

The book should prove useful, as a somewhat more advanced manual of the basic sciences, for professions such as nursing, physiotherapy, etc.

O.J.L.

The Oswestry Textbook for Orthopaedic Nurses.
Edited by F. Roaf and L. J. Hodkinson. Published by Pitman Medical. Price 35s.

The Management Committee of the Robert Jones and Agnes Hunt Orthopaedic Hospital, Oswestry, sponsored the publication of this textbook and are to be congratulated on this practical evidence of their interest in nurse-education. Pitman Medical have produced for them at 35s. a large (458pp.), well-illustrated and important book of outstanding value.

SPORTS NEWS

SPORTS DIARY

FEBRUARY, 1964

Saturday, 1st February

Rugby 1st XV v. Old Merchant Taylors (A).

Rugby "A" XV v. Old Merchant Taylors (H).

Soccer 1st XI v. West Ham College (A).

Wednesday, 5th February

Soccer 1st XI v. Westminster Hospital (A).

Saturday, 8th February

Rugby 1st XV v. Old Paulines (A).

Rugby "A" XV v. Radcliffe Infirmary (H).

Thursday, 13th February

Soccer 1st XI v. Lincoln College (A).

Friday, 14th February

Soccer 1st XI v. Worcester College (A).

Saturday, 15th February

Rugby 1st XV v. Metropolitan Police (A).

Rugby "A" XV v. Metropolitan Police (A).

Such a comprehensive volume could only have been produced by a team of authors, and there appear to be seventeen of them, of whom only three are nurses, so that the accent is on orthopaedics rather than on nursing. It is not immediately clear what prior knowledge the reader is assumed to possess, but no anatomy or physiology is included in the text, and the first chapter begins at once on congenital talipes with a discussion that involves a fairly detailed knowledge of the structure of the foot.

It is followed by a most interesting account of posture and growth disorders, infections and other bone conditions; back pain, and deformities of the hands and feet, beginning, "A patient's hand reveals his personality and occupation". Chapter 10, on the Problems of Trauma, has an excellent account of the way tissues repair themselves, followed by 20 pages on fractures. The chapter on injuries to the spine should be joined to that on the nursing of paraplegia if both accounts are to be fully appreciated.

Among outstanding contributions are those on the principles of splintage, and on plaster technique. Some aspects are of course less fully treated than others, and the section on aseptic technique and surgical nursing is thin and disappointing.

Although the views described are essentially those of this great hospital, all with any interest in orthopaedic care would benefit from studying this book, and the general nurse-training schools as well as the orthopaedic ones will appreciate it.

W.E.H.

Soccer 1st XI v. Queen's College (A).

Wednesday, 19th February

Soccer 1st XI v. Charing Cross Hos. (A).

Saturday, 22nd February

Rugby 1st XV v. Harlequins Wanderers (A).

Rugby "A" XV v. Old Paulines (H).

Soccer 1st XI v. St. George's Hos. (H).

Saturday, 29th February

Rugby 1st XV v. Rugby (A).

Rugby "A" XV v. Old Whitgiftians (A).

Editorial

THE ALPINE CLUB

A Climbing Club was begun at Bart's under the leadership of Dr. Finzi some sixty years ago. Membership has fluctuated considerably since, depending on the climbing talent in the

Hospital. The Club received a new lease of life in 1960 when John Dale and John Burridge took office. Since then the Club has both widened its scope and increased its numbers of skilled climbers.

Despite the slightly grandiose title, the Club exists to provide a means whereby members are able to enjoy a weekend's climbing for a reasonable sum. At present all meets are subsidised for expenses in excess of £2 0. 0. Not only climbers of any standard, but walkers too, are very welcome to join these outings.

The Club has a programme of approximately twelve informal meets a year. There are also close links with climbers outside the Hospital, thus providing a wide range of contacts. The Alpine Club claims to be the only mixed club in the Hospital, though this has never apparently had any deleterious effects on the Saturday evening celebrations at the local!

G.H.

RUGBY REPORTS

Saturday, 30th November. 1st XV v. Woodford. Result: won 14-0.

In past seasons Woodford have always given Bart's a close game and scraped home for a narrow victory. But this season Bart's clearly showed, in a clean, open, fast game, which was the better side.

In the first half many fine attacking moves nearly paid off and Savage lost possession of the slippery ball as he was crossing the line. Letchworth gave the Hospital a first half lead by dropping a very fine goal.

In the second half the back row supported the threequarters very well in attack and Goodall and Smart linked up with Griffiths, after the centre had broken through two tackles. Savage took the final pass from Smart to score between the posts. Gibson converted. Savage then went over in the corner following a good movement by the backs. The final hospital try was also made by the back row who dribbled the ball on after Harris was tackled by the wing. The rest of the pack was there to finish off the movement and score under the posts.

The defence of the hospital side was at its best and kept Woodford in check and rarely allowed them to develop movements.

Team: E. Sidebottom; S. G. Harris; N. J. Griffiths; P. E. Savage; M. Johnson; A. Letchworth; D. C. Pope; A. O'Kane; B. Gurry; A. Knox; T. Bates; M. M. Orr; J. A. Gibson; C. J. Smart; D. Goodall.

Saturday, 7th December. 1st XV v. Old Cranleighans. Won 13-5.

In the first five minutes, Old Cranleighans snapped on a Bart's mistake in their own half and ran half the length of the pitch to score between the posts. Despite this set-back Bart's played with great spirit and Gibson replied with a penalty. When, in the second half, a touch down by Harris was disallowed, the pack were so incensed by this "injustice" that they ran the five-yard set scrum over the line for a push-over try which was converted by Gibson.

At this point the Hospital side let their commanding grip on the game slip—a mistake commonly met in Bart's rigger. This can be a fatal error in an important game such as a Cup match. In this case it was not fatal but the Old Cranleighans did come close with two kicks at goal. This inspired the team to fight back and following a five-yard scrum Letchworth scored round the blind side. Gibson converted.

E. Sidebottom; S. G. Harris; P. E. Savage; N. J. Griffiths; S. M. Johnson; A. T. Letchworth; D. C. Pope; A. O'Kane; B. Gurry; A. J. S. Knox; T. Bates; M. M. Orr; J. A. Gibson; C. J. Smart; D. Goodall.

Saturday, 14th December. 1st v. Old Askeans. Lost 6-9.

Compared with the previous four matches this was a disappointing game with the Bart's backs having plenty of possession but unable to penetrate a closely marking opposition.

A dubious decision gave the Old Askeans a penalty kick which they converted. This was soon followed by a fine try by Bart's. Savage made an outside break and put Harris away in the corner.

Two penalty goals a-piece took the scoring up to 6-6 when the Askeans, following up a kick ahead, had a lucky bounce which wrong-footed the defence and they touched down for the winning try.

J. P. Davies; S. G. Harris; P. E. Savage; N. J. Griffiths; C. A. Grafton; A. T. Letchworth; D. C. Pope; A. O'Kane; B. H. Gurry; A. J. S. Knox; M. M. Orr; T. Bates; J. A. Gibson; C. J. Smart; D. Goodall.

SOCCER CLUB

Saturday, 16th November. 1st XI v. Queen Elizabeth College. Lost 0-3.

Due to injuries and Hospital commitments Bart's fielded a first eleven way below strength. However, all members put up a very good fight, and the score does not reflect the spirit

and effort of the team. Turner and Mc Gechie played particularly well at left-half and left-back respectively. Although injured, Thew, playing on the right wing, had several very close shots at goal.

1st XI v. King's College Hospital. 20th November. Won 3-0.

The King's forwards were dangerous early on, but, once the Bart's defence had mastered them, a large part of the game took place in the King's half.

Bart's had a lucky escape early on in the game when a King's shot rebounded from the foot of a post. However, the ball was quickly moved from defence to attack and Sutton slipped a through pass wide of the goalkeeper to put Bart's ahead. Herbert and Shorey added further goals before half time.

During the second half Bart's again had control of most of the game but failed to score.

1st XI v. King's College Hall. 23rd November. CUP MATCH. Won 3-2.

After Wednesday's fairly comfortable win, a display of over-confidence was likely for this important match. This is reflected by the score. It was throughout a somewhat scrappy game, and although Bart's had a territorial advantage for most of the match, they seldom achieved a high standard of foot-ball.

Bart's took the lead about 20 minutes after the start when Dorritt slipped the ball past their goalkeeper, having collected the ball from a good pass by Shorey. Soon afterward, Sutton half-volleyed a cross from the right wing into the net. King's reduced arrears just before half time.

Bart's pressed after half time until Herbert increased the lead to 3-1. The game seemed safe for Bart's at this stage, but about five minutes from the end King's scored their second goal and tried desperately to draw level in the remaining time.

Saturday, 26th November. 1st VI v. School of Oriental and African Studies. Won 6-0.

After the customary early defensive mistakes, Bart's settled down and took command of the game. At half time we were leading 3-0 with goals from Herbert and Sutton. The second half followed the same pattern with Herbert and Sutton adding a further three goals. Her-

bert played well throughout, scoring four goals, two of them excellent efforts from outside the penalty area.

HOCKEY CLUB

1st XI v. Orpington 1st XI. Saturday, 23rd November, 1963, at Orpington. Score 1-1.

Having won our last three matches, it was a great shame not to secure a win against Orpington. In past seasons the after-match summary was invariably "We had the opportunities, but the forwards just did not have the necessary finishing touch." On Saturday, this was very much the reverse. Our forward-line settled down after about fifteen minutes from the beginning, and were soon taking shots at the opposing goal. Here we came up against a calm "brick wall". The Orpington goalkeeper was a large man of 34 years' experience, who kept out numerous well-aimed shots, except one in the first half.

Following a clearance from our goalmouth by G. Benke, I. Peek passed a long shot out to the right-wing, where A. Bateman, with great speed, ran down the wing, slipped past two defenders, and passed in his usual manner just in front of the goalkeeper's pads, where P. Kingsley was waiting to tip the ball into the back of the net.

The score remained at 1-0 to us until five minutes from the end when a little muddling by the defence left the opposing centre-forward with the ball at his feet and an open goal, into which he successfully hit the ball.

If the score had been rewarded by a goal from each shot, we would undoubtedly have won by at least 20-7. All praise to their goalkeeper who frustrated our most tireless efforts.

Inter-Hospitals' Cup. 1st Round, v. St. Thomas's Hospital. Wednesday, 27th November, 1963, at Chislehurst. Lost 1-2.

We kept our heads, and really did play as a team—in fact, probably the best the club has played for a very long time—but alas to no avail.

St. Thomas's were without their international, N. Livingstone, due to a broken thumb, but the first 25 minutes' play was so evenly matched that there was no score at all. Our opponents scored the first goal from a mediocre shot which had our defence in a bit of a muddle.

In the second half, I. Peek passed a long shot out to A. Bateman at the right wing, who outpaced his man down to the twenty-five

line, passed to W. Castleden at right inside, who in turn passed to the feet of P. Kingsley in the goalmouth. The last-named took a desperate shot, and the ball made a very pleasing thud on the back-board inside the goal, leaving their goalkeeper stranded in the middle of the circle.

Ten minutes later, after A. Barclay had to go off the field with a badly cut eye (the presence of Mr. Jeyes was most reassuring here!), a short corner was awarded rather unfortunately against us. Their centre-half, Dillan, came down onto the ball like a ton of bricks and it skidded past H. da Silva's head into the top left-hand corner of the goal. Alas, we were now 1-2 down. Undaunted, we set about making up the gap. Further attacks were mounted by our forwards in no mean manner, but to no avail, and finally the last whistle went on a very disappointed Bart's team.

It is impossible to pick out any players of distinction for everyone played his best and most enjoyable game of the season.

Many thanks go to Mr. P. Jeyes for finding time to come down and support us, and in particular for his generosity towards our beer kitty.

We beat St. Thomas's 4-0 at darts!

SWIMMING CLUB

The main event in December was the University Water Polo Knock-Out Competition, for which we entered two teams. The second team (Hanley, Hillier, Knight, O'Kane, Kettlewell, Gibbs, Pogmore) were defeated in the first round by the London Hospital 5-2. The first team took things very easily and beat University College by the odd goal in five, in a slow but hard-fought game, during which three players were sent out (two from U.C., one from Bart's). In the second round, Britton, having suddenly recovered from an acute idiopathic fever, replaced the gallant Hillier, who in the first round, represented both teams, and we achieved a one-goal victory over Battersea.

We started the semi-final full of hope, but also in a hurry to get back to the Rugger Club Ball. Imperial College were a very good team, and in one of the most tightly-matched games of the season, with neither side giving an inch, the one chance offered was taken by an I.C. forward who managed to get a shot into the top right-hand corner of the goal that no goalkeeper could have saved. For the second season running we were defeated in the semi-final, but at least had the distinction of getting further than any other hospital.

Despite publicity, Bart's supporters totalled

THE MEDICAL PROTECTION SOCIETY

**ADVICE · DEFENCE
& FULL INDEMNITY
FOR DOCTORS
& DENTISTS AT HOME
& OVERSEAS**

Founded 1892

50 HALLAM STREET · LONDON · W.1

Secretary: Dr. H. A. Constable.

Tel: LANGHAM 9241

three, all girl-friends of members of the team. Considering that U.L.U. is but a 6d. Tube fare from Bart's compared to 3s. 6d each way to Chislehurst, the team were very disappointed at the lack of support of a relatively successful club. The first team was Britton, Lask, Shorey, Shand, Groves, Haig, Hillier, Quinn. Hillier has been awarded Swimming Colours.

SQUASH CLUB

Squash Report:

The team has continued to do well, and at the half-way stage of the season, has only two defeats to eight matches won. The two matches lost have unfortunately both been in the Cumberland Cup. Against Lensbury we found ourselves up against some experienced players: three of their team were over the age of 45! All our matches were closely fought, and we considered ourselves unlucky to lose 4-1. When they play us at home in February, we stand every chance of reversing that result. We are now in the top half of our Division in the Cumberland Cup, and the outlook is promising.

In the Hospitals' Cup, we have drawn Middlesex Hospital, our keen Cumberland Cup rivals.

Results

1st Team:

- v. Guy's Hospital, won 4-1
- v. Metropolitan Police won 3-2
- v. Westminster Hospital won 3-2
- v. U.C.H. won 3-2
- v. Lensbury lost 1-4

2nd Team:

- "A" v. London Visitors' Club, lost 2-3
- v. G.A.F.I.C.S. (Lloyds) lost 2-3

CROSS COUNTRY CLUB

Wednesday, 30th October, 1963. U.L. League, Division 1 match, at Barnet.

This was the second league match of the season and being run on the U.H. course, which we all knew well, we hoped for a good result. It was a cold day, but the ground was hard and fast times were recorded. J. Farrington of U.C. broke his own record for the 5½ mile course with a time of 28 mins. 4 secs. T. Foxton was our first man home in 4th position with a time of 29 mins., which is the fastest time ever run by a hospital runner. The race started on time, which is very unusual, with the result that N. Pott was late, but by performing a quick-change act on the starting

line he ran off neatly four minutes after the rest to be our last scoring man home. The course was not marked and although we had the advantage that we knew the way whereas much of the opposition did not, we only came 6th out of the ten teams competing, which is also our position in the League. We hope to improve on this since I.C. and Goldsmiths are very little ahead. We thank P. Brackenbury for holding the stop-watch. The times and positions were as follows:

- 4th T. Foxton, 29 mins.
- 23rd R. Saunders. 32 mins. 32 secs.

Wednesday, 4th December. Osterley Park Relay.

This is the fourth year that Borough Road College have organised this race, but this year the course had to be altered, due to the building of the M4 through Osterley Park, to a 3-mile course around neighbouring fields. Last year we were unable to run in this event due to fog. This year many members were clinically occupied, so we were only able to run a "B" team in a very mixed competition. 23 teams started and at the end of the first lap we were 10th, but on the second lap we dropped back to 17th, and although the last two runners ran well we were only able to make up two places to finish in 71 mins. 51 secs. Borough Road College won in 62 mins. 42 secs. with Trinity College, Cambridge, second just over a minute behind. M. Turner of Queen's College, Cambridge, ran the fastest lap of the day with a time of 14 mins. 31 secs. Our times were as follows:

Lap	Time	Position at end of lap
1	R. Sanders 16 mins. 48 secs.	10
2	B. Scott 20 mins. 24 secs.	17
3	R. Markham 17 mins. 2 secs.	16
4	R. Thompson 17 mins. 24 secs.	15

THE ALPINE CLUB

The traditional Whitsun meet in Cornwall was well attended by seventeen climbers, sun-bathers, and friends. Climbing on the Cornish sea-cliffs has a special charm because at high tide the approaches, and even the first pitches, are covered with water. This, and the company of a pack of basking sharks, induced some excellent climbing on those occasions when members could be persuaded away from the Logan Rock Inn.

On June 27th a party of six spent the weekend in Wales. Predictably enough, it rained

BARCLAYS FAMILIAR QUOTATIONS

'The sound is forced, the notes are few'..

And nothing, you think, could be more to the point as you survey the meagre results of your attempts to save money. The method, not the intent, was to blame. Notes set painfully aside and salted reluctantly away, retain a personal magnetism verging on the satanic

that demoralizes resolution and devastates the savings. Only one remedy is known. Discard the box, the tin, the teapot. Place the money instead in an account at Barclays Bank. Draw from it only as and when you need. Then watch the balance grow. The process is relatively swift, entirely sure, comparatively painless. And it requires only a minimum of resolution.



BARCLAYS BANK

'Money is our business'

In case you forgot, the quotation is from Blake's
'To the Muses'



solidly, making serious climbing uncomfortable. All but three of the thirteen "three thousanders" were climbed.

The Cambridge University expedition to Greenland was fortunate in having N. Pott as Medical Officer. In three months twenty-eight new peaks were conquered. Without doubt, Nick Pott's good humour, strength and technical ability contributed greatly to their success, as indeed it has to our Alpine Club.

No organised meets were held during August and September, though some members took to climbing in the Alps and Norway.

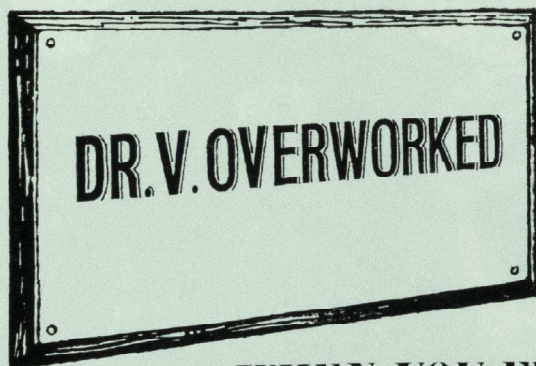
The first meet of this Winter season was held on the Gritstone, in October. Of the sixteen who attended, five were novices; but all showed considerable talent. P. Kennedy, especially, acquitted himself well. Saturday was spent on Froggat Edge and the Sunday at Stanage where "Right Unconquerable" and "Tower Wall" were vanquished.

Ten members visited Snowdonia the following week-end, staying at the University hut in Cwm Ogwen. We arrived very late and were not well received by a Bristol party who had booked the hut. Despite the high winds and rain, a good route was done on the Wasted that Saturday. The evening was spent in the

comfort of the nearby home of one of the party, where we were entertained by an unending series of dubious stories told by Helen (aged eight)! On the Sunday, we divided into two parties, one to Tremadac and one to the Main Wall on Cwm Glas. The latter was repulsed after six hours.

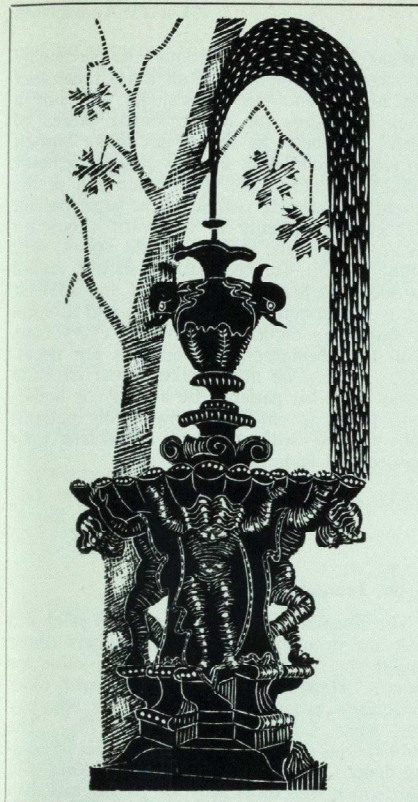
In mid-November we had an Anglo-American meet in Wales. A few easy routes were done on the Cromlich, giving the novices a good introduction to Welsh granite. Dusk fell earlier than expected and one rope of three had to descend the last few hundred feet in pitch darkness. Happily some campers came to their rescue with a storm lantern. A long trek was planned for Sunday, but was cut short by torrential rain. After a finger-freezing route on the Idwal Slabs, we returned soaked to our cars. With commendable professional detachment, we stripped and drove home suitably clad with towels. I fear the garage man at the Blue Boar will never be the same judging by his "Candid Camera" expression as one girl emerged from her car clad only in long hair, bare feet and a blanket!

At the time of writing, six members are experiencing the joys of the New Year in North Wales. M.O.A.



**WHEN YOU FEEL YOU'VE
TOO MUCH ON YOUR PLATE -**

relax with a GUINNESS



PUBLICATIONS COMMITTEE

- Chairman: Dr. A. W. FRANKLIN.
- Deputy Chairman: Dr. G. H. FAIRLEY.
- Editor: TREVOR P. DUTT.
- Review Sub-Editor: G. R. HAMILTON.
- Social Sub-Editor: Miss J. BELL.
- News Sub-Editor: C. J. KELLY.
- Sports Sub-Editor: G. HAIG.
- Photographic Sub-Editor: B. C. P. LEE.
- Manager: G. O. GEY, Jr.
- Assistant Manager: I. R. SWAIN.
- Nurses' Representative: Miss M. IRONSIDE.
- Charterhouse Representative: G. W. LIBBY.

EDITORIAL

THE PRACTITIONER'S POSITION

Since the war the position of the general practitioner within the community has been changing and in some cases patients are beginning to regard him, not as a responsible and qualified person able to deal on his own with the greater number of diseases but as an obstacle to be surmounted in the climb towards the summit of hospital consultant treatment. This changed attitude is the result of a number of factors, some unavoidable but some arising from the attitude of general practitioners themselves.

The National Health Service has frequently been blamed for the altered status of the G.P. and it is indeed true that, in general, people appreciate treatment far more if they have to pay for it directly than if they merely contribute a fixed weekly sum along with the rest of the population. This however is no argument against the principle behind the N.H.S. for it is evident that some patients could not afford the treatment which they require if they had to pay for it. Nevertheless, the system has resulted in the development in some patients of the attitude: "I've been paying my stamp all these years, now I want my money's worth." and sometimes this attitude may be taken over the most trivial complaints. This means that some patients have come to regard G.P.'s almost as a service laid on by the Ministry of Health and not as individuals at all.

Another factor is that with the enormous increase in the scientific side of medicine, G.P.'s are having to rely more and more on their local hospitals in order to have investigations

CONTENTS

Editorial	85
Up to the Minute in a Moment	90
The Mystery of the Peptic Ulcer by B. N. Catchpole	91
Around & About: 1—Ely Place by 'Argus'	94
Pathology and Clinical Medicine by E. M. Darmady	96
Elizabeth Blackwell by Rita M. Linggood	100
The Surprise of General Practice	101
Further Notes on the Treatment of the Rheumatic Diseases by G. D. Kersley	103
A Case Report by R. E. Farrow	104
The Eye Department by H. B. Stallard	107
The Department of Medical Illustration by P. G. Cull & W. D. Tredinnick	110
Other Professions—4: Could you have been a Clergyman? by Canon J. A. Fisher	112
Sports News	117

carried out and some patients do not appreciate that this is a result of the need for specialized equipment and technicians but may regard the referral as an admission by the doctor that he is not competent to diagnose the condition himself. In this respect some G.P.'s, especially those more recently qualified, are, understandably, at fault. The older practitioner learnt his medicine when the diagnosis, if it was to be made at all, had to be made at the bedside on clinical findings. There is a trend in teaching today to lay a great deal of stress on the investigations to be performed and though this is in itself laudable and very necessary in this scientific age, it is not always made clear to the student that these investigations are almost always done to confirm the clinical diagnosis. As a result the houseman and the young G.P. sometimes do not even try to arrive at a diagnosis before calling in the laboratory; regretably common is the attitude of mind which says: "We shall have to wait for the percentage haemoglobin result before we know if she is anaemic." This does not matter too much in hospital practice because the housemen are taught by their senior colleagues to make clinical diagnoses but in general practice the doctor is usually on his own with no incentive from above and a full waiting room.

Another change in recent years which has a bearing on the present doctor-patient relationship is the trend (largely American in origin) towards medical education of the lay public. It may be pleasing to see pictures of the "bus shelters" and the fountain on the television screen and to watch the proficiency of our surgeons and those of other hospitals but such programmes are, on the whole, not in the best interests of the medical profession. No one wishes to return to the insular and self-exalted attitudes which prevailed within the profession in previous centuries but it cannot be good for the morals of a patient undergoing an operation to know, in some detail, of all the complications which may result, especially as he will have little or no idea of their relative frequency of incidence. The only real exception is the education of mothers in the care of young children, for such instruction is undoubtedly very necessary. We shall only serve to accelerate the rise in neurosis by the 'do it yourself diagnosis' programmes. Such programmes and articles inevitably make the doctor's work harder, especially if they are combined with serials portraying the doctor's sex life in the sluices.

What can be done about the problem? Firstly, the doctor must at all times remember that his patients are individuals and not a series of figures on multicoloured pieces of paper. Secondly, he should not make himself too readily available; no one objects to being called out in the night if the condition of the patient warrants the call but if the same patient telephones frequently at awkward times for trivial matters the doctor should speak very firmly to him, for the patient should regard his doctor as his friend, confidant and advisor, not as his servant. Thirdly, he should attempt to come to a clinical diagnosis in every case, even if confirmatory investigations are necessary. Finally, he must make a real effort to get to know his patients, be he G.P. or houseman, for it is only by knowing his patients well that he will come to appreciate their worries and feelings.

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 122 and send it to us.

Correspondence

WHITHER BART'S?

Sir,—An undergraduate teaching hospital has special needs and responsibilities. In these days of rapid advance in medicine, the change of techniques in nursing and the altered focus in surgery, various extents of specialisation occur. One can mention sterile supplies, the use of pre-packed disposable materials, recovery units, intensive and progressive nursing care and the need for highly specialised apparatus in the specialised units. These surely call for much rethinking in planning

and building our Hospital in the future. They call for a careful assessment of what is the best patient care and student teaching in relation to specialisation.

I am concerned for the future of Bart's. Is there an embracing scheme for Hospital and College? One hears of this and that project but are they part of a comprehensive design? What is our aim for the future? As one of the younger members of the Staff I feel I should like to know this and how it is proposed it may be accomplished, but this information appears to be unavailable.

Perhaps, too, there is need for a revaluation of certain subjects taught to students. Some need expansion and some must be curtailed. Many subjects require a closer application to the teaching of Medicine, for after all we are attempting to teach a student to be a doctor.

Twenty-five years ago or more Bart's led as a hospital and undergraduate school; maybe it still does, but will it in the future?

Yours truly,

IAN P. TODD,
149 Harley Street,
London. W.1.

4th February.

THE NEW COVER

Sir,—You state that the changed cover of the *Journal* results not from instability but from flexibility.

This is certainly true as regards the shield which has become so flexible that it looks like a mini-minor which has been pushed by a lorry against a wall.

It has frequently been pointed out that the right to use this shield by the hospital is, to say the least, doubtful. If it is used, surely the least we can do is not to distort it.

Yours faithfully,

C. LANGTON HEWER,
33 Stormont Road,
Highgate, N.6.

6th February.

POT-POURRI, 1963

Sir,—Of late we have come to expect frank comment in the *Journal*; this was especially true of your review of the 1963 Pot-Pourri. Such pungent writing is welcome and we like it, but we quarrel with this report for three reasons: its anonymity, its inaccuracy and the

writer's apparent lack of Pot-Pourri experience.

In the case of theatrical review if the producers and the performers are to evaluate criticism reasonably they must know the identity and therefore the views and bias of the writer.

We hope the comment on the registrars competing was unintentionally cruel and inaccurate. They performed a difficult task with an unusual brevity and ample competence.

Just how many Pots-Pourri has your reviewer seen? We believe that the 1963 Pot-Pourri was far better than those of recent years and, in particular, better than the 1962 performance when two or three whole shows were embarrassingly weak and lewd. This year every show had something which justified its place in the show.

Yours faithfully,

GRAHAM CHAPMAN,
IAIN MATHESON,
IOM BOTTOMLEY.

11th February.

[We thank our three correspondents for their letter but would make the following points:—

i) *As a general principle, as at least one of our correspondents (T.B.) is well aware, members of the Journal staff write under the general heading of 'Our Special Correspondent', a policy also applied in certain reputable sections of the National Press.*

ii) *The letter names no inaccuracies but merely differences of opinion.*

iii) *In our opinion our reviewer possesses more than adequate experience both of previous Pots-Pourri and of other similar productions.—Ed.]*

BRITISH RED CROSS

The Medical Advisor of the British Red Cross Society, General Hilton-Sergeant, is at present looking for doctors for a second team for the Yemen. Any young, qualified men interested (preferably unmarried) should get in touch with the Director of International Affairs at the British Red Cross Society, 14 & 15, Grosvenor Crescent, London, S.W.1.

11th DECENNIAL CLUB

The 29th Dinner of this club will be held at Simpson's-in-the-Strand on Friday, April 24th, 1964, 7 p.m. for 7.30 p.m. Dinner jackets. Dr. H. S. Hiscocks will be in the chair. This is a General Practitioners' year and it is hoped that as many as possible will support him. The cards for the dinner will be going out shortly. Anyone who does not receive one or who wishes to know about the club should write to:

F. C. W. CAPPS, F.R.C.S.,
108, Harley Street,
London, W.1.

Calendar

MARCH

Sat. & Sun., 7th & 8th:

Dr. E. R. Cullinan
Mr. C. Naunton Morgan
Mr. Aston
Dr. Ian Jackson
Mr. Fuller

Sat. & Sun., 14th & 15th:

Dr. G. Hayward
Mr. Badenoch
Mr. H. J. Burrows
Dr. T. B. Boulton
Mr. Cope

Sat. & Sun., 21st & 22nd:

Dr. A. W. Spence
Mr. Tuckwell
Mr. Aston
Mr. F. T. Evans
Mr. McNab Jones

Sat. & Sun., 28th & 29th:

Prof. Scowen
Prof. Taylor
Mr. H. J. Burrows
Dr. R. A. Bowen
Mr. Hogg

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

Engagement

BATTERHAM—FISHER.—The engagement is announced between John Batterham and Diana S. Fisher.

Marriage

CHRISTIAN—DAWES.—On 11th January, Dr. Paul Brian Christian to Margaret Dawes.

Births

BEKEND.—On 8th January, to Judy (née Peat) and Dr. Peter Bekend, a daughter, a sister for Adam.

BUCHANAN.—On 7th January, to Maureen and John McKenzie Buchanan, F.R.C.S., a brother for Craig.

NOBLE.—On 11th January, to Sheila (née Nurse) and Dr. Mark Noble, a daughter (Claire Alexandra).

POPE.—On 11th January, to Shirley and Dr. John A. Ff. Pope, a son.

PRICE.—On 11th January, to Glenys (née Johns) and Dr. Richard Price, a son (Christopher Mark).

Deaths

BRAIMBRIDGE.—Clifford Viney Braimbridge, C.B.E., M.V.O., M.B.Cantab., F.R.C.S.E., D.T.M. & H., aged 71. Qualified 1916.

St. B.H.J., March, 1964

RAIL.—On 5th January, Dr. John Andrew Angwin Rail, M.B., B.S.McIb., aged 83. Qualified 1904.

APPOINTMENTS, ETC.

Royal College of Surgeons of England
Mr. C. Naunton Morgan was appointed Bradshaw Lecturer for 1964.

University of Reading

On May 15, the honorary degree of D.Litt. will be conferred on Sir Geoffrey Keynes.
Dr. W. R. Cattell has been awarded a Rockefeller Study Award for work in the U.S.A.

FIFTY YEARS AGO

From the Bart's Journal of March, 1914

It is perhaps a suitable moment for recalling to mind the old Theatre, which will soon be numbered among the forgotten dreams, and we have therefore much pleasure in appending herewith a few recollections with which Mr. Bruce Clarke has kindly provided us:

"My first recollections of the old Theatre were in the early seventies, our only general operating theatre as it was in those days. Operations were only performed on Wednesday and Saturday afternoons, except, of course, in cases of emergency. All the surgeons and assistant surgeons made a point of being present unless prevented by some important call. Operations were performed by them in the order of seniority. It was by no means an infrequent occurrence to have no operations on a Wednesday, but Saturday was rarely a blank day.

"The Theatre itself, until its present complete metamorphosis, has undergone but little change. The old deal floor was replaced by oak during the time that I was assistant surgeon. I well remember on that occasion suggesting an impervious mosaic floor, or something of a like nature, and being severely taken to task for it on the ground that it would be very cold to the feet.

"Perhaps the most striking change is in the garments of the operators. In those days an old cupboard under the gallery was devoted to surgeons' coats, which survived for many years, covered with caked blood and pus, until at length the Sister would use one which she deemed disgraceful as a shroud for an ampu-

St. B.H.J., March, 1964

tated limb, which was sent over to the P.M. Room for decent interment. She then, perhaps, tactfully substituted another, but little better, which the wearer promptly put on, like the Dominic's in Sir Walter Scott's novel, in blissful ignorance that his old one had been abstracted during the night.

"Each surgeon owned a peg in the coat cupboard, and his name was painted over it. I well remember seeing the name of Mr. Lawrence over one of the pegs. It was still visible through a coat of white paint by which it was partially obscured. Lawrence had only bid his adieu to the Hospital about eight years previously.

"Sir William, or Mr. Savory as he then was, never tired of referring to the great Lawrence and, if tradition is to be trusted, copied him in nearly every detail. Indeed, it was a tradition amongst the students of those days that the operating coat which he invariably donned was Lawrence's, so desirous was he that the mantle of Elijah should descend upon the shoulders of Elisha.

"Two operations invariably attracted a full theatre—lithotomy by Tom Smith, which we timed on our watches thirty seconds or more, and an amputation at the hip joint, which, incredible as it may seem, could be performed almost as rapidly. Five surgeons took part. One compressed the aorta, another seized the anterior flap, two more were ready with forceps—not Spencer Wells, for none existed in the instrument cupboard—and the operator wielded the long knife.

"On these occasions the patients were placed on a special operating table, said to be Percivall Pott's. It somewhat resembled the vaulting horse in a gymnasium, and was covered with black leather. The legs were painted red somewhat the colour of a country waggon; a tray pulled out filled with sawdust to catch the blood.

"I must not omit to mention the ring-bolts in the floor and on the walls for the fixation of pulleys for the reduction of dislocations. I think I once saw them used on a dislocated hip.

"And now we are face to face with the crowning point of our theatre metamorphosis. How soon will it need reconstruction?

"Tempora mutantur et nos mutamur in illis."

THE LEUCOCYTE'S LAMENT

The leucocyte was in a gland,
With inflammation red;
He grasped a comrade by the hand,
And with a sob he said:—

'Mid solitary follicles
I wend my weary way,
Deep down in crypts of Lieberkühn,
Far, far from the light of day.

'Alas! this aching nucleus
Can ne'er be free from pain,
While tissues hide the beauteous bride
I ne'er shall see again.

'A rosy-red corpuscle she,
The pride of all the spleen,
Her like in this dark gland I fear
Will never more be seen.

'A fierce bacillus captured her,
And reft her from my side,
Carbolic oil his plans did foil,
But ah! it slew my bride.

'With pseudopodia feebly bent,
And broken nucleus, I
Must turn to pus.' And speaking thus
He wandered forth to die.

* * *

Oh! lightly they'll talk of that leucocyte true,
As they label, and mount, and degrade him;
But little he'll reck, when with aniline blue
They have stained and in Canada laid him!

Anon. April, 1894.

Reprinted from "Round the Fountain".
Harassed students searching for light reading
could do worse than to send 3s. (postage 9d.)
to the Manager of the Journal for a copy of
this book.

UP TO THE MINUTE IN A MOMENT

The end of January brought more suggestions to improve the lot of the family doctor as on 24th January the B.M.A. put forward proposals to increase the salary of general practitioners. That the increase in the number of G.P.'s has failed to keep pace with the increase in population is a reflection of the unattractive conditions as much as of the inadequate remuneration; improvement of both is the only way to attract the student of today.

On 26th January an official report to the French Ministry of Health declared the anti-leukemia serum of **M. Gaston Naessens**, the Corsican self-taught biologist, to be "of no value." Five days later demonstrations in favour of M. Naessens took place in Paris as well as in Corsica. Despite this setback, offers of financial assistance poured in from Scotland and the United States.

From the beginning of February the authorities decreed that residents of College Hall should in future make their own beds. The decision was greeted with the scorn it deserved; so far the *status quo* has been restored on at least one floor. Just prior to this event was the arrival of the new housekeeper, **Mrs. Alexander**, who is vehement in claiming that the two are in no way connected. The rise of prices together with the decline of service are, no doubt, a sign of the times. Some attempt to reverse the fall of gracious living is gaining ground in Bart's: **R. L. Stevenson** spoke of *amateurs de vin*—a sense almost foreign to us now; a pity also that the word *dégustation* has no equivalent in our own language; however in Bart's we may soon have the answer to this.

In the world of international sport the gold medal victory of the British two man bobsleigh team of **A. Nash** and **R. Dixon** in the winter Olympics at Innsbruck was a morale booster. That they won using a piece of borrowed equipment gave the victory that delightful amateur touch so beloved of the British and yet so fatal in this increasingly professional world. On the same day, 1st February, **Mrs. L. Skoblikova** of Russia won her fourth gold medal.

Throughout the month a seemingly endless succession of scientists, among them **Professor Bush** of Birmingham, announced, amidst great publicity, that they were to take up positions

in the United States where apparently the scientific streets are paved with gold. Governmental reactions to the "brain drain" seems to be that although we can afford to train scientists we can not afford to allow them to work. Russia also faces this problem for on 10th February it was announced that Soviet disarmament expert **Mr. Yuri Nossenks** had defected; however the Russian government is at least trying to do something about it.

On 12th February **Sir Alec Douglas-Home** was warmly received in Washington, though not so warmly as the **Beatles**, who have turned out to be the biggest boost to Anglo-American relations since whisky.

On 14th February Bart's was featured in the B.B.C. television programme "Your Life in Their Hands" when **Professor Taylor** performed a thromboendarterectomy. The surgery was excellent, the acting less so.

On 17th February the task of choosing a jury to try **Jack Ruby** began in Dallas.

The Drama Society's main production of the year takes place on 21st and 22nd February. The play is **Jean Giraudoux's** "The Tiger at the Gates" produced by **Brian Lask**; the embryonic life of the play has had a stormy, not to say dramatic history. An exclusive report will appear in our next issue.

Bart's most successful sport's team must surely be the Cross-Country Club who followed up their victory in the Hyde Park Race by winning the Kent-Hughes Inter-Hospitals Cup for the fourth year in succession; first Bart's man home was **Terry Foxton** who came second.

The Rugby Club's interest in the 1964 Hospital Cup came to an untimely end on 4th February when Guy's, aided by good kicking, won 9-0 in the second round. Bart's began well but after Guy's had taken a fortunate lead we seemed to lose interest until late in the second half by which time it was too late. Despite this reverse the club gained two convincing victories over Old Merchant Taylor's and Old Paulines on successive Saturdays.

The Soccer Club won their replay Cup match against Westminster on 5th February after fog had providentially caused the abandonment of the first match while Bart's were losing badly.

(21st February).

THE MYSTERY OF THE PEPTIC ULCER

By B. N. Catchpole

AFTER doing my Physiology course as a medical student I thought that the mechanisms of gastric secretion were fairly simple. How horribly complicated they all seem now! We watched three-quarters of the stomach which appeared quite normal, being excised because there was an ulcer one centimetre in diameter in the duodenum. This appeared quite barbarous. But we have advanced: we now merely carry out vagotomy, which incidentally removes the whole parasympathetic nervous supply to the upper abdominal viscera and the gut as far as the mid transverse colon. And do a little additional operation to drain the stomach which has thereby become atonic! When shall we know better?

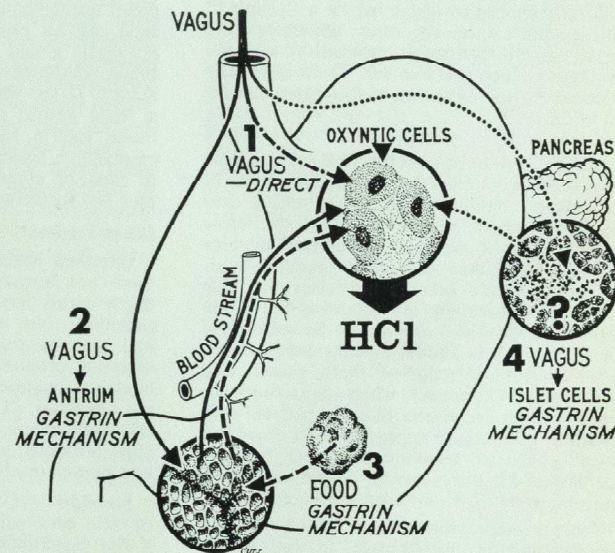
A peptic ulcer is one which develops in relationship to acid pepsin secretion. A multiplicity of factors governs this secretion and may go awry, but how and why can often only be surmised. There seems little doubt that many factors are important in any one patient and although we may discover one apparently dominant abnormality this may still not be the key derangement. We might look at some of the factors which are known to be important and try to decide if any of them bring us nearer to an understanding of the genesis of ulceration and its treatment.

Factors Increasing Gastric Secretion

The Vagus. It has long been known that psychic stimuli operating via the vagus nerve initiate a flow of gastric acid juice. That the vagus does more than this was suspected by Straaten in 1933 and it is now proved that vagal stimulation also causes liberation of gastrin which in turn stimulates acid secretion.

Does the vagus do anything else? In 1955 Zollinger and Ellison described the syndrome of massive gastric secretion associated with one or more pancreatic islet non- β -cell tumours; these are sometimes accompanied by hyperplasia of similar cells in the remaining islets. Such Zollinger-Elison tumours produce a substance with all the properties of gastrin. Now it seems very unlikely that these tumours and this hyperplasia developing precisely in islet tissue could develop from cells with other than a normal physiological role. Not only would such secreting tumours be virtually unique amongst endocrine glands if they did not have a physiological counterpart but the diffuse islet hyperplasia which sometimes occurs, seems to make remote the possibility of an origin from gastrin secreting cell rests.

At the time of the initial description of the syndrome, Dragstedt suggested that if there



The figure shows the principle pathways through which gastric secretion is stimulated. The hypothetical vagal-pancreatic mechanism is also included.

was a physiological counterpart to this syndrome it was probably under nervous control. I looked for this effect in the cat. The vagi were stimulated before and after pancreatectomy and the resulting gastric secretion collected and measured. However, in this animal no significant effect was demonstrated but it might have been overshadowed by the vagus-antral gastrin production, and the postulate of the existence of a pancreatic phase of normal gastric secretion stimulation is not disproved. We should probably repeat the experiment after excision of the antrum, since the effects of the vagally stimulated antral gastrin production may have swamped any pancreatic effect.

Several workers have now demonstrated that vagotomy reduces the gastric secretory response to histamine stimulation to approximately 60 per cent of the level before denervation. A parasympathomimetic drug given simultaneously with the histamine tends to restore the secretory level after vagotomy. We do not know if a direct or indirect parasympathetic influence on the oxyntic cell is necessary for a full response to histamine. Could, however, the necessary background for this full response to histamine be a "priming" with gastrin, since vagotomy denervates the antral gastrin production mechanism and the postulated pancreatic source? There is already evidence for the existence of this gastrin priming effect.

Gastrin. We have seen that the vagus begins the antral production of gastrin and food in the antrum continues to cause its release into the blood stream. Gastrin is said to "drive acid" because it produces a secretion containing little other than acid. How gastrin stimulates the oxyntic cells is not clear. It may be by the liberation of histamine but some other influence also seems to be necessary; for example, it is known that the acid outflow resulting from injection of both gastrin and histamine is increased when parasympathomimetic drugs are given. In some patients with duodenal ulcers there appears to be a dominant antral phase of secretion and this may be responsible for the recurrent ulceration rate of approximately five per cent after vagotomy.

Some extracts made from the body and antral region of the stomach as well as the upper intestine contain a substance, called Gastrozimin, which stimulates pepsin production. Although it has been suggested that this

is indeed a hormone, the fact has not been unequivocally proved, and its existence is in doubt.

The Stomach. The outpourings of acid in many patients with duodenal ulcer, whatever the mechanism, is potentially greater than in normal individuals because of the presence of a larger proportion of oxyntic cells in the body of the stomach. This state of affairs is not found in those with gastric ulcer. Hence Kay's histamine test which tests potential acid output from the stomach, leads to a high acid response in such patients with duodenal ulcer, and a response in those with gastric ulcer which is similar to that of normal individuals. If one gives the patient with duodenal ulcer a test meal, e.g., of oatmeal gruel, the acid output is very great; when given to the patient with a gastric ulcer it is not so high but still greater than normal. This "greater than normal" response as far as gastric ulcer is concerned seems likely to be an abnormal antral response but it is not necessarily entirely so. Gastric ulcer, however, seems to be a different disease from that of duodenal ulcer and its increased "acid" associations may be a side issue in its genesis. General gastritis is a frequent accompaniment of gastric ulcer; whether such gastritis precedes or follows ulceration is not clear. Could it lower gastric mucous membrane resistance and thus be a factor in ulceration? If so, why does it develop? Is there a basic gastric hypomotility with consequent raised gastrin stimulation and slowed gastric emptying, a basically abnormal gastrin response to food or simply an abnormality of gastric mucous membrane?

Other Factors

Intestinal hormones. There is no doubt that there are hormonal agents produced in the upper small intestine which stimulate gastric secretion: one may be identical with gastrin and appears to be liberated as a result of digestion products from the stomach acting on intestinal mucosa, but the precise mechanisms are unknown. Its role seems at present to be relatively minor. Concerning the other postulated hormone, gastrozimin, believed to stimulate pepsin production, doubt still exists.

Steroids. A.C.T.H. causes a raised output of acid and pepsin from the stomach, even if the vagal influence on the stomach, or the antrum has been removed. There is evidence that cortisone increases the number of oxyntic cells in the gastric mucosa as well as raising

the basal secretory level of acid. In some work with cortisone treatment there has been a reduction at the same time of the pepsin concentration in the juice secreted and an apparent reduction in the number of pepsin secreting cells. Mucus production seems to be lowered by steroids and perhaps—quite apart from any reduction in the intrinsic ability of the mucosa to resist acid-pepsin attack—these factors are adequate to explain the tendency for duodenal ulceration to develop or worsen during stress and steroid medication. Such ulceration rarely involves the stomach.

Blood Groups. For the past ten years it has been known that the relative incidence of Blood Group O is greater in those with duodenal ulcer than in normal individuals and greater still in those who develop stomal ulceration after operative treatment. There is also support for a similar but less marked association for gastric ulcer. However, the significance of these observations remains to be discovered.

Geographical and Other Factors. There has been a progressive rise in incidence of peptic ulcer in this country; symptoms and complications reached a peak during the early part of the last war. However, even in this country the incidence of the disease fluctuates from city to countryside, and elsewhere in the world amongst English-speaking peoples its incidence is different. In Australia for example duodenal ulcer is far less common than in Great Britain. Diet, climate, environment and race may all play a part, but they are intangible factors.

Having considered some of the mechanisms which seem to promote the development of peptic ulcer, it is important to examine some of those which seem to be controlling factors since if these break down the end result might be as unpleasant.

Factors Reducing Gastric Secretion

The Vagus and Antrum. When a normal person has finished eating and forgotten all about his meal the vagal "psychic" or cephalic stimulation of the stomach probably ceases, but in the patient with a tendency to duodenal ulcer there may be continued secretion of a highly acid juice even when he is asleep. Normally when the pH of the antral contents falls below about 2.5, gastrin stimulation of acid juice from the stomach ceases. How this is brought about is not clear. It has been

suggested that gastrin production ceases, that an antagonist to gastrin is produced and even that excessive gastrin production may inhibit the oxyntic cells' acid production. If this latter suggestion is correct, it is difficult to see why Zollinger-Ellison tumours should continue to stimulate the production of vast amounts of highly acid juice.

Another substance of interest is serotonin or 5-hydroxytryptamine. This substance is produced mainly by the alimentary tract and to a minor extent in the subcutaneous tissues, but of all the alimentary tract, the antral wall contains most. Serotonin reduces acid output from the stomach, increases mucosal mucus secretion and stimulates smooth muscle contraction. It is known that serotonin is liberated from the intestine when this is stretched and it is speculative if such liberation occurs when the human antrum is distended by food. Perhaps the gastric secretory function of serotonin is incidental and it is purely concerned with antral mobility and gastric emptying.

The Intestine. Several types of stimuli applied to the duodenum inhibit gastric secretion. They include hypertonic glucose and saline solutions, acid solution of pH 2.5 or less, peptone and fat. Experimentally the inhibition is greatest when there is normal innervation of the stomach. This inhibition is apparently caused by the liberation of a hormone enterogastron; this probably operates in conjunction with the effects of falling pH in the gastric antrum to control the antral mechanism of stimulation. Whether there is a nervous inhibiting mechanism in addition to the hormonal one is undecided.

The Pancreas. Glucagon, a hormone liberated from the α -cells of the pancreatic islets, raises blood sugar and has a marked effect on gastric secretion. It reduces the volume of gastric basal secretion, both the acid and pepsin production in man and also the acid secretory response to food and to insulin in the dog. Although the acid secretory response in the normal stomach can be completely suppressed, this is not possible in patients with duodenal ulcer. It is apparent that glucagon has a physiological role during starvation in elevating blood sugar and simultaneously reducing unwanted gastric secretion.

Other Factors. Adrenaline, nor-adrenaline and pituitrin have powerful inhibiting actions on the secretion of gastric juice, in part probably as a result of vasoconstriction in the gastric glands. The inhibiting effects of large

doses of parasympathomimetic agents have no importance physiologically, but we have noted that smaller doses actually potentiate secretion stimulated by histamine. Thyrotoxic patients who have been made euthyroid have been found to produce more acid juice in response to a fixed dose of histamine than they did when toxic, and the supposition has been made, therefore, that thyroxine reduces gastric secretion. Oestrogenic hormones have been shown in the cat to reduce the response of the stomach to histamine stimulation, and the observation that duodenal ulcers are relatively rare in women during menstrual life led to the trial of oestrogens in the treatment of this form of ulceration—not, however, with any marked success.

We have discussed some of the factors which modify the secretion of gastric juice and it is apparent that the control of secretion is indeed extremely complicated. It is also obvious that there are many stimulating mechanisms which may become over-active. Several of these have never been shown to become abnormal, for example, the intestinal phase of gastric secretion. Of the inhibiting mechanisms, not one has even been demonstrated to become abnormal, but it would be remarkable if they never became deranged.

There is little known about the resistance

of the mucous membrane of the stomach and duodenum to acid pepsin attack, and this aspect of the problem must be of considerable importance. How often the antral phase of secretion becomes excessive in man is unknown and is under study in the Professorial Surgical Unit. Is there a pancreatic phase of gastric secretion? How can we tell in man? We could collect autopsy specimens of pancreas and estimate the relative volume of islet cell tissue in various parts of the organ, comparing normal subjects with those having peptic ulcer; the method is simple but tedious. Many women are beginning to take progesterone contraceptive preparations: will this type of hormone therapy influence peptic ulcer symptoms? New drugs are being used today and the observation of side effects in modifying the symptoms of peptic ulcer or of any other disease, should be our constant object. Even if an unscientific method of discovery, chance correlations have played a large part in the progress of medical treatment in the past.

The mystery of peptic ulcer remains, and even deepens. It looks as though crude massive surgery for the one centimetre peptic ulcer is to remain with us for several decades to come.

I am much indebted to Mr. Peter Cull and the Photographic Department for the illustration.

AROUND AND ABOUT: I—ELY PLACE

By "Argus"

"When a man is tired of London, he is tired of life; for there is in London all that life can afford.—Dr. Johnson.

"I WORK in the City, you know." How often does one hear that remark, delivered with a look of surprise, whenever it is suggested that the average Londoner should take a little more interest in the great city that surrounds him. He passes up the same street for years, sees the same buildings, but he never observes them or muses upon their history, and yet there is a good deal of fascination about them if only he will give them his attention. Bart's men surely cannot offer such an excuse, for what is easier for them than to stroll out in the lunch hour or during the evening and wander where their fancy takes them. Wherever they go they will find something of interest, but particularly in the side streets for, as Dr. Johnson observed, "If you wish to have a just notion of the magni-

tude of this city, you must not be satisfied with seeing its great streets and squares, but must survey the innumerable little lanes and courts. It is not in the showy evolutions of buildings but in the multiplicity of human habitations that are crowded together, that the wonderful immensity of London consists."

Wandering in High Holborn many people pass Ely Place and hardly give it a second glance. But go there in the evening when the cars and office workers have left and you can imagine yourself in another age. On either side there is a terrace of unspoilt 18th century houses with their well-proportioned windows and doors whose regularity gives so much pleasure to the eye. Half hidden behind the western terrace is the church of St. Ethelreda whose history extends back to 1290.

It was originally the chapel of the London palace of the Bishops of Ely, and was constructed between 1290 and 1298 during the episcopate of the strangely named William de Luda. It became the final refuge of "time-honoured Lancaster", John of Gaunt, when his palace of Savoy was burnt down by Wat Tyler's rebels in 1381. The gardens of the palace sloped down to the River Fleet and were noted for their fruit, particularly strawberries; indeed Shakespeare mentions these in *Richard III* when the Duke of Gloucester, as he then was, remarks: "My Lord of Ely, when I was last in Holborn I saw good strawberries in your garden there, I do beseech you send for some of them." Plum Tree Court, Saffron Hill and Vine Street, all nearby, probably derive their names from these gardens. The palace remained in the hands of the Bishops until 1576 when part of the property was surrendered compulsorily to Sir Christopher Hatton, Elizabeth I's sycophantic Chancellor (He once wrote to her: "To serve you is Heaven, and to lack you is more than Hell's torments. Pain overcomes me, I can write you no more. Love me for I love you.")). Sir Christopher spent over £2,000 in improvements on the Palace, borrowing the money from the Queen. He is alleged to have died of a broken heart when the Queen tried to get her money back! The bishops attempted to reclaim their property but Elizabeth refused to surrender it until the money expended on the improvements had been paid. To one recalcitrant bishop she wrote: "I would have you know that I who made you what you are can unmake you and if you do not forthwith fulfil your engagements I will immediately unfrock you." The lawsuit dragged on for years before finally being settled. During one of the hearings it was stated that "Even half of the vault or burying place under the Chapel is made use of as a public cellar, to sell drink in, there having been frequently revelling heard during divine service." Between 1620 and 1624 the palace was occupied by the Spanish Ambassador and was the scene of the last recorded passion-play performed in England. During the Civil War much of the palace was destroyed, only the hall and Chapel remaining, these being used for a time as a prison and a hospital for wounded soldiers. In 1772 the whole of the property was transferred to the Crown, who sold the premises to a Mr. Cole. He demolished the remains of the Hall and built the terraces at



present standing. After many vicissitudes the chapel was purchased by the Catholics in 1874 and remains the only London pre-Reformation church in Catholic hands. It is one of the most beautiful examples of Geometrical decorated art extant and the south-west door is a particularly fine specimen of early Gothic architecture. The thickness of the walls in the crypt and its large size have suggested to scholars that the present church stands on the site of an earlier Romano-British one. Next door to the chapel stands St. Audrey's House. St. Audrey is another name for St. Ethelreda who allegedly died of a tumour in the throat caused by a youthful love of necklaces (hence the word "tawdry").

The gates of Ely Place are closed every night at 10 o'clock and opened again at 6 a.m. Until the Second World War one of the watchmen on duty used to go round calling the hour and "All's well" as long as the gates were shut. He used to call the state of the weather at one time, too. It is perhaps a pity that this delightful practice has not been continued. The sanctuary rights are still jealously preserved—no policeman ever setting foot inside the street, although of course they will come if summoned. The rights extend to the Mitre Tavern nearby and apparently you cannot be arrested or served with a writ there.

PATHOLOGY AND CLINICAL MEDICINE

By E. M. Darmady

This is the greater part of the Horder Memorial Lecture given by L. M. Darmady, the first Lord Horder Travelling Fellow, at St. Bartholomew's Hospital on the 21st March, 1963.

THE title of this lecture, "Pathology and Clinical Medicine", may perhaps seem to some to be out of place as a tribute to one of the outstanding physicians of this century, but I have chosen it for two reasons. First, because Horder himself was the first advocate of clinical pathology, and second because the pattern of pathology has changed so quickly since his day that there is a danger that it will become divorced from clinical medicine.

I would like first to sketch his career, second to suggest some proposals which may prevent such a divorce, and third to tell you some of my experiences as the Travelling Fellow.

To some of you here Horder is but a name, possibly a myth, for he retired from this hospital some 27 years ago, although he continued to live an active life until some eight years ago. It would be impertinent of me to try and give you a complete biographical picture as obviously I am not qualified to do so, and therefore I will content myself with a few impressions that he made on me while I was a clerk and later as his house physician. Those who have come here to gather material for the current Wix Prize may go away disappointed.

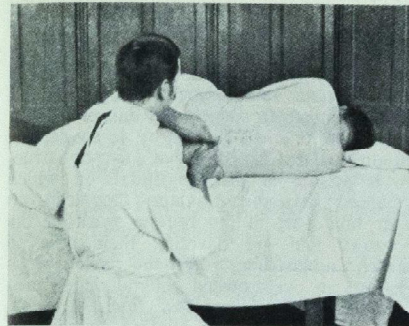
Nevertheless, a brief skeleton of his career may explain to some his success as the premier consulting physician and one of the outstanding personalities of his day. He was born in 1871 at Shaftesbury, Dorset, on 6th January, a day on which later his house physicians were to entertain him annually. From quite humble beginnings he was educated at Swindon High School and gained an entrance scholarship to Bart's in 1891 and he qualified in 1896, winning the Brackenbury and Wix Prize and obtaining a gold medal in medicine and forensic medicine. He became house physician to Dr. Samuel Gee to whom he was devoted and was later to dedicate his medical notes to "My teacher, Samuel Gee". Students may remember the linctus to which his name is now attached.

From a man of humble origin his life at that time was hard, for it must be remembered that there were no State scholarships and all the posts at the hospital were unpaid. The tradition has come down to us that during this time he helped to support himself by coaching



his fellow students, which laid the foundation of his great teaching abilities. Three years after qualifying he obtained his M.D. and M.R.C.P. in the same year, a feat which is not often paralleled today. During this period of his life, as a Demonstrator of Pathology, he devoted much of his time to applied Bacteriology. For, at this period of history, autopsies were still performed by clinicians and laboratories were primarily devoted to teaching or academic research; there was little application of laboratory methods, even to hospital patients. As Horder said himself of those days "a consultant physician often took with him only his stethoscope". But Horder was to change all this and was to make clinical pathology available in the home.

He established blood cultures as a diagnostic tool in infective endocarditis (Horder, 1912), and introduced lumbar punctures to Bart's. The picture taken from his book demonstrates



a lumbar puncture in the process of being undertaken. I think now in the day of Central Sterile Supply it would be criticised by the Nursing Procedures Committee. Sometimes, when my colleagues plead for caution in diagnostic procedures, I like to remember that Horder once told us that he received a post-card from one of the senior members of the staff forbidding him to do lumbar punctures on any of his patients.

It is perhaps interesting that his reputation was so firmly established that in 1906 he was elected to Fellowship of the Royal College of Physicians, although he was not yet on the staff of Bart's. For this he had to wait 16 years (1916). I hope this is a comfort to any senior registrars that may be present.

Curiously enough, although a great advocate of applying laboratory methods to medicine he was extremely critical of laboratory workers or clinical pathologists and in one of his articles in 1910 he complained bitterly that clinical pathologists had the audacity to call themselves "physicians" in the telephone book. There are, of course, many well known stories about him and I have chosen one of these which I think illustrates the exceptional powers of observation and dedication. It tells of the time Horder was called to King Edward VII who was found to be suffering from glycosuria. His keen sense of observation soon detected that the Royal bathroom was filled with tablets of all kinds and he successfully deduced that the reducing substance was not glucose but salicylates and although this may not seem remarkable to younger members of the audience, it must be remembered that diabetes mellitus at that time was invariably a fatal disease for as yet insulin had not been discovered.

This story is perhaps curious in that first there is no record of his attendance at the Palace at this time, and second he was not

yet on the staff of Bart's, nor was a Bart's man in attendance, third that it was one of the ladies in waiting who pleaded for Horder to be called in. Dr. Bourne in his obituary tribute says Horder himself said of this event that Bart's could hardly fail to take him now!

Horder was a small man with a confident self-possessed brisk walk, with inquisitive and piercing eyes. At first sight I found him a little disappointing as he did not quite live up to one's image of a successful physician, but once he was at a bedside things were different. His schedule at Bart's was always the same: first a visit to post-mortem and then to the wards. For those who were above average height it was always possible to see over his head. However, one house physician (now Professor Knox of Guy's), a cox to the Oxford boat, was just shorter than Horder, and Horder always insisted that Knox should stand in front of him at post-mortem. On arrival at the ward he would quizzically survey each patient in turn, observing their facies. He would then murmur under his breath his diagnosis to the house physician, and was overjoyed if he was right. His ward notes showed his brevity and capacity for detail (perhaps a trait which he had learned from Samuel Gee). All the relevant details of history, clinical signs, laboratory investigations were included on the front sheet, and those which were contributory to the diagnosis underlined. He scrutinised each laboratory report with care, saying that the value of the report lay in the

St. Bartholomew's Hospital			
RAHERE WARD.			
LORD HORDER OF ASHFORD.			
Admission	Name of Patient	History	Order No.
4. 4. 1913	Overton	...	11578
Discharged	Discharge	Letter Recd. 10/11/13	
181	Completion	(M. 111)	
Result	Specimen	Stethoscope in hand	
<p>Examination</p> <p>HT 5' 4" WT 120 lbs. Slight anaemia. Cap. 2000. 5-6-10-12-15-18-20-25-30-35-40-45-50-55-60-65-70-75-80-85-90-95-100-105-110-115-120-125-130-135-140-145-150-155-160-165-170-175-180-185-190-195-200-205-210-215-220-225-230-235-240-245-250-255-260-265-270-275-280-285-290-295-300-305-310-315-320-325-330-335-340-345-350-355-360-365-370-375-380-385-390-395-400-405-410-415-420-425-430-435-440-445-450-455-460-465-470-475-480-485-490-495-500-505-510-515-520-525-530-535-540-545-550-555-560-565-570-575-580-585-590-595-600-605-610-615-620-625-630-635-640-645-650-655-660-665-670-675-680-685-690-695-700-705-710-715-720-725-730-735-740-745-750-755-760-765-770-775-780-785-790-795-800-805-810-815-820-825-830-835-840-845-850-855-860-865-870-875-880-885-890-895-900-905-910-915-920-925-930-935-940-945-950-955-960-965-970-975-980-985-990-995-1000-1005-1010-1015-1020-1025-1030-1035-1040-1045-1050-1055-1060-1065-1070-1075-1080-1085-1090-1095-1100-1105-1110-1115-1120-1125-1130-1135-1140-1145-1150-1155-1160-1165-1170-1175-1180-1185-1190-1195-1200-1205-1210-1215-1220-1225-1230-1235-1240-1245-1250-1255-1260-1265-1270-1275-1280-1285-1290-1295-1300-1305-1310-1315-1320-1325-1330-1335-1340-1345-1350-1355-1360-1365-1370-1375-1380-1385-1390-1395-1400-1405-1410-1415-1420-1425-1430-1435-1440-1445-1450-1455-1460-1465-1470-1475-1480-1485-1490-1495-1500-1505-1510-1515-1520-1525-1530-1535-1540-1545-1550-1555-1560-1565-1570-1575-1580-1585-1590-1595-1600-1605-1610-1615-1620-1625-1630-1635-1640-1645-1650-1655-1660-1665-1670-1675-1680-1685-1690-1695-1700-1705-1710-1715-1720-1725-1730-1735-1740-1745-1750-1755-1760-1765-1770-1775-1780-1785-1790-1795-1800-1805-1810-1815-1820-1825-1830-1835-1840-1845-1850-1855-1860-1865-1870-1875-1880-1885-1890-1895-1900-1905-1910-1915-1920-1925-1930-1935-1940-1945-1950-1955-1960-1965-1970-1975-1980-1985-1990-1995-2000-2005-2010-2015-2020-2025-2030-2035-2040-2045-2050-2055-2060-2065-2070-2075-2080-2085-2090-2095-2100-2105-2110-2115-2120-2125-2130-2135-2140-2145-2150-2155-2160-2165-2170-2175-2180-2185-2190-2195-2200-2205-2210-2215-2220-2225-2230-2235-2240-2245-2250-2255-2260-2265-2270-2275-2280-2285-2290-2295-2300-2305-2310-2315-2320-2325-2330-2335-2340-2345-2350-2355-2360-2365-2370-2375-2380-2385-2390-2395-2400-2405-2410-2415-2420-2425-2430-2435-2440-2445-2450-2455-2460-2465-2470-2475-2480-2485-2490-2495-2500-2505-2510-2515-2520-2525-2530-2535-2540-2545-2550-2555-2560-2565-2570-2575-2580-2585-2590-2595-2600-2605-2610-2615-2620-2625-2630-2635-2640-2645-2650-2655-2660-2665-2670-2675-2680-2685-2690-2695-2700-2705-2710-2715-2720-2725-2730-2735-2740-2745-2750-2755-2760-2765-2770-2775-2780-2785-2790-2795-2800-2805-2810-2815-2820-2825-2830-2835-2840-2845-2850-2855-2860-2865-2870-2875-2880-2885-2890-2895-2900-2905-2910-2915-2920-2925-2930-2935-2940-2945-2950-2955-2960-2965-2970-2975-2980-2985-2990-2995-3000-3005-3010-3015-3020-3025-3030-3035-3040-3045-3050-3055-3060-3065-3070-3075-3080-3085-3090-3095-3100-3105-3110-3115-3120-3125-3130-3135-3140-3145-3150-3155-3160-3165-3170-3175-3180-3185-3190-3195-3200-3205-3210-3215-3220-3225-3230-3235-3240-3245-3250-3255-3260-3265-3270-3275-3280-3285-3290-3295-3300-3305-3310-3315-3320-3325-3330-3335-3340-3345-3350-3355-3360-3365-3370-3375-3380-3385-3390-3395-3400-3405-3410-3415-3420-3425-3430-3435-3440-3445-3450-3455-3460-3465-3470-3475-3480-3485-3490-3495-3500-3505-3510-3515-3520-3525-3530-3535-3540-3545-3550-3555-3560-3565-3570-3575-3580-3585-3590-3595-3600-3605-3610-3615-3620-3625-3630-3635-3640-3645-3650-3655-3660-3665-3670-3675-3680-3685-3690-3695-3700-3705-3710-3715-3720-3725-3730-3735-3740-3745-3750-3755-3760-3765-3770-3775-3780-3785-3790-3795-3800-3805-3810-3815-3820-3825-3830-3835-3840-3845-3850-3855-3860-3865-3870-3875-3880-3885-3890-3895-3900-3905-3910-3915-3920-3925-3930-3935-3940-3945-3950-3955-3960-3965-3970-3975-3980-3985-3990-3995-4000-4005-4010-4015-4020-4025-4030-4035-4040-4045-4050-4055-4060-4065-4070-4075-4080-4085-4090-4095-4100-4105-4110-4115-4120-4125-4130-4135-4140-4145-4150-4155-4160-4165-4170-4175-4180-4185-4190-4195-4200-4205-4210-4215-4220-4225-4230-4235-4240-4245-4250-4255-4260-4265-4270-4275-4280-4285-4290-4295-4300-4305-4310-4315-4320-4325-4330-4335-4340-4345-4350-4355-4360-4365-4370-4375-4380-4385-4390-4395-4400-4405-4410-4415-4420-4425-4430-4435-4440-4445-4450-4455-4460-4465-4470-4475-4480-4485-4490-4495-4500-4505-4510-4515-4520-4525-4530-4535-4540-4545-4550-4555-4560-4565-4570-4575-4580-4585-4590-4595-4600-4605-4610-4615-4620-4625-4630-4635-4640-4645-4650-4655-4660-4665-4670-4675-4680-4685-4690-4695-4700-4705-4710-4715-4720-4725-4730-4735-4740-4745-4750-4755-4760-4765-4770-4775-4780-4785-4790-4795-4800-4805-4810-4815-4820-4825-4830-4835-4840-4845-4850-4855-4860-4865-4870-4875-4880-4885-4890-4895-4900-4905-4910-4915-4920-4925-4930-4935-4940-4945-4950-4955-4960-4965-4970-4975-4980-4985-4990-4995-5000-5005-5010-5015-5020-5025-5030-5035-5040-5045-5050-5055-5060-5065-5070-5075-5080-5085-5090-5095-5100-5105-5110-5115-5120-5125-5130-5135-5140-5145-5150-5155-5160-5165-5170-5175-5180-5185-5190-5195-5200-5205-5210-5215-5220-5225-5230-5235-5240-5245-5250-5255-5260-5265-5270-5275-5280-5285-5290-5295-5300-5305-5310-5315-5320-5325-5330-5335-5340-5345-5350-5355-5360-5365-5370-5375-5380-5385-5390-5395-5400-5405-5410-5415-5420-5425-5430-5435-5440-5445-5450-5455-5460-5465-5470-5475-5480-5485-5490-5495-5500-5505-5510-5515-5520-5525-5530-5535-5540-5545-5550-5555-5560-5565-5570-5575-5580-5585-5590-5595-5600-5605-5610-5615-5620-5625-5630-5635-5640-5645-5650-5655-5660-5665-5670-5675-5680-5685-5690-5695-5700-5705-5710-5715-5720-5725-5730-5735-5740-5745-5750-5755-5760-5765-5770-5775-5780-5785-5790-5795-5800-5805-5810-5815-5820-5825-5830-5835-5840-5845-5850-5855-5860-5865-5870-5875-5880-5885-5890-5895-5900-5905-5910-5915-5920-5925-5930-5935-5940-5945-5950-5955-5960-5965-5970-5975-5980-5985-5990-5995-6000-6005-6010-6015-6020-6025-6030-6035-6040-6045-6050-6055-6060-6065-6070-6075-6080-6085-6090-6095-6100-6105-6110-6115-6120-6125-6130-6135-6140-6145-6150-6155-6160-6165-6170-6175-6180-6185-6190-6195-6200-6205-6210-6215-6220-6225-6230-6235-6240-6245-6250-6255-6260-6265-6270-6275-6280-6285-6290-6295-6300-6305-6310-6315-6320-6325-6330-6335-6340-6345-6350-6355-6360-6365-6370-6375-6380-6385-6390-6395-6400-6405-6410-6415-6420-6425-6430-6435-6440-6445-6450-6455-6460-6465-6470-6475-6480-6485-6490-6495-6500-6505-6510-6515-6520-6525-6530-6535-6540-6545-6550-6555-6560-6565-6570-6575-6580-6585-6590-6595-6600-6605-6610-6615-6620-6625-6630-6635-6640-6645-6650-6655-6660-6665-6670-6675-6680-6685-6690-6695-6700-6705-6710-6715-6720-6725-6730-6735-6740-6745-6750-6755-6760-6765-6770-6775-6780-6785-6790-6795-6800-6805-6810-6815-6820-6825-6830-6835-6840-6845-6850-6855-6860-6865-6870-6875-6880-6885-6890-6895-6900-6905-6910-6915-6920-6925-6930-6935-6940-6945-6950-6955-6960-6965-6970-6975-6980-6985-6990-6995-7000-7005-7010-7015-7020-7025-7030-7035-7040-7045-7050-7055-7060-7065-7070-7075-7080-7085-7090-7095-7100-7105-7110-7115-7120-7125-7130-7135-7140-7145-7150-7155-7160-7165-7170-7175-7180-7185-7190-7195-7200-7205-7210-7215-7220-7225-7230-7235-7240-7245-7250-7255-7260-7265-7270-7275-7280-7285-7290-7295-7300-7305-7310-7315-7320-7325-7330-7335-7340-7345-7350-7355-7360-7365-7370-7375-7380-7385-7390-7395-7400-7405-7410-7415-7420-7425-7430-7435-7440-7445-7450-7455-7460-7465-7470-7475-7480-7485-7490-7495-7500-7505-7510-7515-7520-7525-7530-7535-7540-7545-7550-7555-7560-7565-7570-7575-7580-7585-7590-7595-7600-7605-7610-7615-7620-7625-7630-7635-7640-7645-7650-7655-7660-7665-7670-7675-7680-7685-7690-7695-7700-7705-7710-7715-7720-7725-7730-7735-7740-7745-7750-7755-7760-7765-7770-7775-7780-7785-7790-7795-7800-7805-7810-7815-7820-7825-7830-7835-7840-7845-7850-7855-7860-7865-7870-7875-7880-7885-7890-7895-7900-7905-7910-7915-7920-7925-7930-7935-7940-7945-7950-7955-7960-7965-7970-7975-7980-7985-7990-7995-8000-8005-8010-8015-8020-8025-8030-8035-8040-8045-8050-8055-8060-8065-8070-8075-8080-8085-8090-8095-8100-8105-8110-8115-8120-8125-8130-8135-8140-8145-8150-8155-8160-8165-8170-8175-8180-8185-8190-8195-8200-8205-8210-8215-8220-8225-8230-8235-8240-8245-8250-8255-8260-8265-8270-8275-8280-8285-8290-8295-8300-8305-8310-8315-8320-8325-8330-8335-8340-8345-8350-8355-8360-8365-8370-8375-8380-8385-8390-8395-8400-8405-8410-8415-8420-8425-8430-8435-8440-8445-8450-8455-8460-8465-8470-8475-8480-8485-8490-8495-8500-8505-8510-8515-8520-8525-8530-8535-8540-8545-8550-8555-8560-8565-8570-8575-8580-8585-8590-8595-8600-8605-8610-8615-8620-8625-8630-8635-8640-8645-8650-8655-8660-8665-8670-8675-8680-8685-8690-8695-8700-8705-8710-8715-8720-8725-8730-8735-8740-8745-8750-8755-8760-8765-8770-8775-8780-8785-8790-8795-8800-8805-8810-8815-8820-8825-8830-8835-8840-8845-8850-8855-8860-8865-8870-8875-8880-8885-8890-8895-8900-8905-8910-8915-8920-8925-8930-8935-8940-8945-8950-8955-8960-8965-8970-8975-8980-8985-8990-8995-9000-9005-9010-9015-9020-9025-9030-9035-9040-9045-9050-9055-9060-9065-9070-9075-9080-9085-9090-9095-9100-9105-9110-9115-9120-9125-9130-9135-9140-9145-9150-9155-9160-9165-9170-9175-9180-9185-9190-9195-9200-9205-9210-9215-9220-9225-9230-9235-9240-9245-9250-9255-9260-9265-9270-9275-9280-9285-9290-9295-9300-9305-9310-9315-9320-9325-9330-9335-9340-9345-9350-9355-9360-9365-9370-9375-9380-9385-9390-9395-9400-9405-9410-9415-9420-9425-9430-9435-9440-9445-9450-9455-9460-9465-9470-9475-9480-9485-9490-9495-9500-9505-9510-9515-9520-9525-9530-9535-9540-9545-9550-9555-9560-9565-9570-9575-9580-9585-9590-9595-9600-9605-9610-9615-9620-9625-9630-9635-9640-9645-9650-9655-9660-9665-9670-9675-9680-9685-9690-9695-9700-9705-9710-9715-9720-9725-9730-9735-9740-9745-9750-9755-9760-9765-9770-9775-9780-9785-9790-9795-9800-9805-9810-9815-9820-9825-9830-9835-9840-9845-9850-9855-9860-9865-9870-9875-9880-9885-9890-9895-9900-9905-9910-9915-9920-9925-9930-9935-9940-9945</p>			

signature at the bottom. In Horder's day, laboratory investigations were carried out by the clinicians themselves and medical men devoting themselves to pathology were few and far between. The laboratory technicians were but glorified glass-washers and only at the end of his life were technicians allowed to count cells and undertake bacterial studies. It should be recalled that before the last war few hospitals outside teaching hospitals had laboratories and a clinical pathologist was usually a morbid anatomist, a Jack of all trades. Such investigations as there were were almost entirely devoted to confirming the diagnosis made on clinical grounds.

Since Horder's retirement and death, laboratory practice has taken a new trend and specialisation and division of laboratories has become commonplace even in provincial hospitals and the pathologist is no longer able to master all his subject. The general practitioner is now able to investigate his cases himself and a new type of request is emerging. The laboratory is now asked to exclude disease not to prove it and to provide tests which will control treatment. Recent assessment in G.P. investigations in the Portsmouth hæmatological and biochemistry departments show that only about 1 in 20 are abnormal, of which the great bulk are hæmatological.

It is inevitable that laboratory work will expand, both in quality and range. For example, in Portsmouth the number of requests in 1954 was 130,000 and in 1962, over 200,000. At the same time the actual number of investigations rose from $2\frac{1}{2}$ per request to 4. I am convinced, as Horder was, that the close integration of the pathologist on one side and the clinician on the other is essential if the standard of medicine is to be maintained and to be extended to the patient in the home. I am anxious that they shall not be divorced. I believe that this can be done in three ways:—

1. The modern student has a duty not only to be sure of his physical signs, but to evaluate his laboratory findings. No one will expect him to undertake his own laboratory tests, but he must be certain which tests are of value to him and in which disease. He must also know the technical errors of every investigation and to correlate the pattern of these tests with each disease.

Furthermore I would like to make a plea that, not only the clinician but also the pathologist should help the student to appreciate the value of such tests. It is the familiarity with these tests which will be of value to him in the future.

2. The division of the laboratory into constituent sections provides the specialisation

that is necessary to give the clinician that vast range of investigations that he now requires; but as Horder said in 1909, "the dissociation of pathology from clinical medicine tends to give a false aim to pathological progress," and I would venture to suggest the danger is even greater now that the laboratory is so departmentalized. I am disturbed that a two-tier structure is arising in many hospitals in which specialised departments claim they can no longer take part in the routine work of the laboratory and are devoting their time to research and teaching whilst the routine work is left to an overcrowded general department in the hands of technicians. Such a system cannot help the patient, student or clinician since all are being deprived of the value of specialisation; the remedy is to expand each specialist department so that its resources are available to all and that the clinician may become aware of the advantages and progress of each speciality.

4. The age of specialisation of both pathologists and clinicians tends to lead to lack of understanding one with another and above all with the general practitioner. In the past little attention has been paid to postgraduate training; I believe that each district hospital must establish a postgraduate centre where exchange of views can take place either by discussion or by formal conference.

In the third part of my lecture I would tell you briefly of my experience as the Travelling Fellow. The Trustees have laid no conditions to Fellowship but they have hoped the Fellow would visit the Commonwealth countries which were furthest from Great Britain, or those which were infrequently visited by British medical men.

My journey was divided into three parts and was almost entirely by air. First, a brief 10-day visit to the U.S.A. in order to discuss various current and proposed renal research projects and to give a series of lectures, the honorarium of which in part helped towards my wife's and my own travel expenses. The second, and perhaps most important part of my journey, was to New Zealand (2½ weeks) and to Australia (7 weeks). The third was to Singapore, Thailand, Burma, India and Kuwait, which countries were or had been in the Commonwealth or had received in the past postgraduate education facilities in the United Kingdom (2½ weeks).

As far as the first part is concerned, I will not say much except that it was always exhausting and stimulating. It led to one embarrassing moment when I was introduced to an audience in San Francisco as "The

Pathologist from the Isle of Wight, that well known bird sanctuary." In view of our labours we decided on a 36-hour rest in Honolulu which, although living up to its reputation, is now highly Americanised and commercialised.

Our next stop was New Zealand and I was impressed by three things:—

1. The New Zealand Health Service.
2. The keenness of doctors in post-graduate training.
3. The beautiful countryside.

The National Health Service of New Zealand has been established considerably longer than in Britain, and operates in a rather different manner. The hospital service is free, although the doctors are paid on a patient/attendance basis. This encourages the doctor to treat the patient himself. Many of the doctors in practice have higher qualifications and have received part of their training in this country.

This undoubtedly gives a higher standard of service, maintains the keenness of interest and reduces the hospital outpatient clinics.

The hospital laboratory service deals almost entirely with inpatients. The salary range of technicians is considerably higher than our own. Many of the private laboratories are highly organised and cover a wide variety of investigations, the cost of which are repaid on a fixed fee for each from the Government. Specimens are collected from patients throughout the town by part-time nurses equipped with two-way radio-controlled cars. In Auckland one private firm of pathologists employ eleven such nurses, unfortunately known as "Call Girls".

Australia is a vast country with tremendous potentialities, and I was tremendously impressed again with the keenness of all the doctors that I met. Of the excellent hospitals that I saw, at least two were brand new district hospitals and one was a private one.

Again, many of the doctors have received much of their training in this country and have higher degrees. I was told that less are turning to Britain than formerly, and more to the U.S.A. Nevertheless, it was clear that many wished to come to this country and in view of the better conditions in Australia it was difficult for me to understand this. After discussion with a large number of doctors, both junior and senior, I think there are three main reasons:—

1. The young man comes to Britain, firstly to obtain higher qualifications, although this

is not so important as formerly as Australian colleges are considered to equal our own; secondly, but more particularly, to obtain practical experience in surgery and medicine. This is difficult for him to do in Australia because once the young surgeon or physician has a higher degree and obtained proficiency in his subject it is not difficult for him to obtain affiliation to his local hospital. Since he will have to support himself in private practice, usually a group practice, it will be in his own interest to carry out his own emergencies or set operations. Thus it is difficult for the junior surgeon to obtain experience and he turns to a provincial hospital in the National Health Service to provide it. He knows that work in the N.H.S. is arduous and living conditions often poor, but he knows that it provides the experience which he requires. The Australian and New Zealander seem to have a greater thirst for knowledge than their British counterpart and many expressed the view that compared with hospitals in the U.S.A. there is a lack of instruction and supervision in N.H.S. provincial hospitals.

2. The financial security and thirst for knowledge and the encouragement given by hospitals and the State to take sabbatical leave every fifth year encourages an increasing number of doctors to travel. This takes two forms: either he wishes to visit a number of hospitals to seek general or more specified experience, for example in the U.S.A. and in London and Scotland (the biggest draw in London is without doubt the British Post-graduate Medical School at Hammersmith), or to undertake a period of intensive study on a specific subject, usually in a laboratory. This is a new departure and is due to the increasing interest in clinical research. The difficulty of investigators working in comparative isolation cannot be too highly stressed.

To the remainder of my tour I can only briefly refer. The underdeveloped countries need sympathy and help. Antibiotics are revolutionising many serious illnesses, but food and vitamin shortage still take their toll.

Finally, I hope that some of my remarks will not be taken amiss. I think that Horder himself would have preferred them to be provocative, and I hope these few remarks may help to improve the links between pathologists and clinicians.

In conclusion, may I express my thanks to the Trustees in the honour they have done me in appointing me their first Fellow, and for allowing me to undertake this unforgettable journey.

ELIZABETH BLACKWELL

By Rita M. Linggood

RECENTLY the Women Medical Students decided to name their palatial new quarters "The Elizabeth Blackwell Room". It therefore seems appropriate to know a little of the background of this pioneer woman doctor.

Elizabeth Blackwell was born on February 3rd, 1821, in Bristol, the third daughter of a family which ultimately numbered nine. When she was eleven years old, her father's sugar refinery was burned down during the anti-slavery riots and following this the Blackwell family set sail for America to make a new life. The next six years were spent in New York and during this time Elizabeth's character became clearly defined. Physically a small girl, she went to quite extraordinary lengths to demonstrate her strength, often going without sleep or food for example. In 1838 the family moved again, this time to Cincinnati to expand the family business. A few months later, however, Mr. Blackwell died after only a short illness. With capital of 25 dollars Elizabeth and her two elder sisters opened a day and boarding school to provide for the whole family. At this time Elizabeth was being wooed by several local gallants—quite unsuccessfully. She writes scathingly of dalliance down by the riverside, she went once only returning early through boredom, and, significantly, was not invited again.

In 1845 Elizabeth visited a dying friend in hospital who suggested that she should study medicine. She wrote: "The idea of winning a doctor's degree gradually assumed the aspect of a great moral struggle and the moral fight posed immense attraction for me." Such an idea was revolutionary, the term "female physician" being at that time synonymous with "abortionist". Accordingly she spent the next year as music teacher to a retired doctor who had a well stocked library, so that she might combine preliminary reading with saving the necessary money.

There was only one favourable reply to her application to twelve medical schools in New York and Philadelphia; this was from the Geneva Medical College which held a student

referendum on the matter. Three years later she qualified and overnight became a celebrity. Even so she was unable to obtain a medical post when she visited England later the same year. Undaunted, she proceeded to Paris where she took up an appointment at La Maternité; five months after her arrival she contracted a purulent ophthalmitis while attending a baby which resulted in the loss of the sight of her left eye, quashing for ever hopes of a surgical career.

Meanwhile, her cousin Kenyon Blackwell approached the large teaching hospitals in London on her behalf. Mr. James Paget, Dean of St. Bartholomew's Hospital, extended her a warm welcome together with an admission ticket entitling her to study in any ward and attend the rounds of any physician or surgeon providing that his permission had been obtained. Accordingly Elizabeth returned to London, taking rooms at 28, Thavies Inn, High Holborn, and began her studies at Bart's, which at that time had 550 beds and an annual turnover of 77,000 patients. Ironically, the only department to deny her entry was the Department of Female Diseases. The following comment appears in the diary of Lady Paget at this time: "Well, we have our Lady Doctor here at last and she has actually attended two of Sir James' lectures, taking her seat with perfect composure. The young men behaved extremely well and she really appears likely to go on her way quite unmolested . . . her manners are quiet and it is evident her motives for the pursuit of so strange a vocation are pure and good." Accepted professionally and socially, Elizabeth became acquainted with many of the leading figures of the day—not least of them being Florence Nightingale. In her diary she records: "Mr. Paget tells me that I shall have to encounter much more prejudice from ladies than from gentlemen in my course. I am prepared for this. Prejudice is more violent the blinder it is and I think that Englishwomen seem wonderfully shut up in their habitual views." This was borne out some time later by Fanny Kemble's response when asked to act in a charity performance in aid of Elizabeth's

hospital—"Trust a woman as a doctor—never."

In 1851 Elizabeth returned to New York and opened a pharmacy, weathering the storm of public opinion which was so much against her in her early days. She adopted an orphan, Kitty, who became very close to her, and amused her very much one day by saying, after the visit of a colleague, "Doctor—how very odd it is to hear a *man* called doctor!"

Six years later, together with her sister Emily, who was also by now medically qualified, Elizabeth opened the New York Infirmary for women and children. She also gave many public lectures on public health, both in America and England. Throughout the remainder of her life she contributed sound medical work and infinite help and encouragement to women intent on following her example. Her death on 31st May, 1910, marked the end of an era.

THE SURPRISE OF GENERAL PRACTICE

On December 10th, 1963, Dr. J. Michael Roberts came up from Twyford, near Winchester, to give a lecture to final-year students. This is a summary of that lecture.

ALTHOUGH Dr. Roberts had been qualified for eight-and-a-half years, most of which had been spent on Anatomy or Surgery, and was perfectly competent to perform a gastrectomy or, at a pinch, an exploratory craniotomy, he found on entering general practice that he was totally unprepared, and was soon in difficulties in prescribing for the common cold. But one must never think of general practice as all coughs and colds; it has an infinite variety which makes it so fascinating. Extraordinary rarities occur and he had himself seen patients with cowpox and with leprosy.

He thought it important to decide, early in one's career, whether to live in a town or in the country. Happiness is what really matters, and it is no good landing a first-class job somewhere, if one is going to be miserable in one's home and its surroundings.

"When you first go into practice you may seem to be rather popular; some of the patients hope you may have a wonderful new cure. Others are just curious and want to have a look at you; many of these you will never see again for they return to your more experienced partners. Remember that you are likely to live with your patients for the rest of your life. It doesn't pay to quarrel with them and one enemy in a country practice may do you a lot of harm." He went on to list some of the common conditions, so frequently seen in general practice—convulsions in children, skin complaints, herpes zoster and so on—and advised his audience to become familiar with them, if possible, before leaving hospital. "The

Rheumatics" covers a multitude of diseases such as osteoarthritis, rheumatoid arthritis, gout and even angina. It is well to know something about disc lesions and their manipulation—when to use it and when not to use it—for these troubles may incapacitate a man and keep him out of work for months. Other things to be learnt in hospital before leaving are the art of giving a good injection and something about dispensing.

"During the winter I see four or five new cases of otitis media a week and each presents a different problem. It is a help if you are able to do a myringotomy yourself while your partner gives an anaesthetic. You do no want to refer all your patients to hospital, any more than you want to call a consultant every time you have a really ill patient. It is bad for you if you can never treat an ill patient yourself, and patients soon get to know that you can't cope. On the other hand, don't be obstinate and refuse to call in superior aid when you are stuck. If you want to get patients into hospital, you must play fair with the housemen, and not land them with snags without warning. The houseman rarely knows the whole story; the patient's illness by itself may not justify admission, but if he lives alone he must go in." The treatment of vaginal discharge can often be conducted at the surgery without reference to hospital, except for the examination of swabs. Many women wear a pessary these days and will come up at regular intervals to have it changed. It is worth while to become proficient at this, for if it is done with the minimum of

discomfort it will be greatly appreciated and there will be no need for them to go to a stranger in hospital.

"I have learnt to treat the complaint as well as the disease. For example, if a patient has a burn you may well dress it with some wonderful tulle gras impregnated with the latest antibiotic and send him home. But remember that what will worry him most is PAIN. Give him something for that and something for a good night's sleep." Suspected neurotics are dangerous because so often it is not a neurosis, and there is after all a physical cause for the symptoms. "Give them the benefit of the doubt, in fact believe what they tell you, until you can prove that you are right. Try not to get cross or annoyed, because that distorts your judgment and may make you slipshod." Dr. Roberts went on to describe two men who complained of headache, which they had had for several days, and who both sent for him on Christmas Eve. He concealed his annoyance and saw them again two days later, when neither was better. One, aged 64, had a cerebral secondary from a carcinoma of the bronchus; the other, aged 30, had a sub-dural cyst following a fall from a motor-bike three months earlier. "Incidentally, headache is one of our commonest headaches, and it is well to have a line

of thought on headaches and their aetiology."

"If you have had a particularly hectic time, the last patient of the day is in grave peril. You should be especially careful if you are tired or in a hurry. One day in the summer, I saw 67 patients in the surgery, and the last came in at 8.15 p.m., a woman of 41, very apologetic, and complaining only of a little diarrhoea. Fortunately, I did not just give her a bottle of Kaolin, for rectal examination revealed a carcinoma. Then there are the patients with a muddled story, which doesn't make sense, and you cannot think why they have come. It pays to listen and it pays to examine them thoroughly. If you find nothing, they go away content and don't bother you again. If you don't listen and if you don't examine, they are always at the surgery. Sometimes they have found something, such as a lump in the breast, which they won't mention, and they wait to see if YOU find it. If you don't they go away happy with the false idea that it doesn't matter."

"Finally, look after yourselves. No one else will. Go to bed early—I think it's a good plan, for you never can tell when you will be called out. And don't rush your meals. Three-quarters of an hour for lunch will save you from the big business man's dyspepsia."



COLLEGE HALL ANNEX ?

(Photograph by courtesy of the Council of Industrial Design)

FURTHER NOTES ON THE TREATMENT OF THE RHEUMATIC DISEASES

by G. D. Kersley, O.B.E., M.D., F.R.C.P.

Having dealt with the main principles of treatment of the 'connective tissue diseases' (collagen and rheumatoid diseases) some brief notes on the treatment of degenerative rheumatic disease and gout might not be misplaced.

Osteoarthritis and spondylosis may be looked upon as a wear and tear condition, often accompanied by inflammatory episodes and pain of non-articular origin due to muscular spasm. The condition may be confined to a few joints, often due to trauma of injury, over use (occupational or excess weight bearing or in an effort to save another painful joint) or bad use (due to congenital malformation of the joint or abnormality elsewhere in the body upsetting the mechanics of the joint). In other cases the condition may be polyarticular due to heredity or other nutritional, metabolic and endocrine factors at present little understood. In these cases the spine is often involved (spondylosis, not the spondylitis previously considered*) and sometimes the terminal joints of the fingers (Heberdens nodes).

This conception of cause brings us to the principles of treatment:

- (1) an explanation to the patient, including a reassurance that he is not about to become crippled with rheumatoid arthritis.
- (2) removal or reduction of unnecessary further strain, stress and over-use of the affected joints.
- (3) non weight bearing exercises to maintain mobility.
- (4) muscle strengthening exercises.
- (5) treatment for non articular causes of pain with perhaps heat, massage and infiltration of tender areas with a local anaesthetic.
- (6) analgesics.

Only when these measures fail is surgery considered (minor soft tissue surgery (tenotomy, division of muscles etc.), joint stiffening (arthrodesis) and the manufacture of a new joint (arthroplasty). The decision as to whether to operate is usually governed by the degree of pain and especially by the presence of pain at rest. The choice of operation is often determined more by the age of the patient, his occupation and the state of his *other* joints, rather than by the condition of the joint on which the operation is to be performed. In some joints, however, the choice of type of

*See previous article—Bart's Journal, Jan. 1964.

surgery is limited by its anatomy and its use.

At present little is known of the internal factors causing osteoarthritis. Diet for weight reduction but with a high protein content may be beneficial. Correction of metabolic abnormality when possible, as in gout, may be of considerable importance.

Gout, accompanied by a deposit of monosodium urate monohydrate in the tissues, may be primary, associated with a familial tendency to increased production of uric acid and sometimes reduced excretion, or alternatively secondary to over production due to nuclear breakdown, blood diseases and radiotherapy, or to tubular suppression by disease or diuretic drugs. Acute attacks followed by complete remissions may be triggered off by stress of ingestion of a food or drink to which the patient may be allergic, by food containing a large quantity of purine, by worry, by trauma, or by exposure and fatigue.

Treatment can be subdivided into:

- (1) removal of stress trigger factors, and this necessitates careful history taking.
- (2) reduction of foods of high purine content.
- (3) the use of certain drugs to suppress attacks.
- (4) the regular exhibition of drugs to increase uric acid excretion.

Under (1) the part played by alcohol must be considered. 'One man's meat is another man's poison' is very true here. To some a wine glass of cider may be more dangerous than a half bottle of gin—provided he is not driving a car. In fact to most 'gouts' gin and whisky are often innocuous. Champagne is particularly dangerous, even if not coupled with rich food and the excitement of an evening on the tiles with an attractive partner!

(2) Foods containing much purine, such as sweetbreads, 'insides', fish roes and meat extracts should be taken with considerable caution if at all.

(3) The time tried drug to control attacks and the best for long term use is colchicine. For the first six weeks of uricosuric therapy and for the patient who gets frequent 'twinges', a dose of gr. 1/120th (0.5 mgms.) two or three times a day is required, but for the very acute attack the dose must be pushed to produce slight nausea or diarrhoea. Therefore, for the

(Continued on page 109)

PHAEOCHROMOCYTOMA—a case report

By R. E. Farrow

THIS case is presented to draw attention to the importance of accurate diagnosis in one of the rare causes of hypertension. It also illustrates the need for the most careful management, pre-, per- and post-operatively in cases of this kind.

History

F.S., a 53-year-old lady, was admitted on November 6th, 1963, complaining of increased sweating, pounding headaches and anxiety concerning her high blood pressure. She had been well until November, 1962, when she had noticed that she was sweating more—particularly her hands and feet. At about the same time she began to get pounding headaches. By April, 1963, the sweating and headaches were still bothering her and it was then that she learnt from her doctor that she had

high blood pressure. For a few weeks prior to admission she had been having occasional blurring of vision and difficulty in focussing.

Her past history revealed that she had been found to have diabetes in 1954 and had been on daily injections of insulin ever since. In 1960 she had had a transitory loss of sensation over the whole of the right side of her body from her neck downwards. She had recently begun to get swelling of the ankles and had also become somewhat short of breath.

Examination

On examination her fundi showed arterio-venous nicking corresponding to a Grade II retinopathy. Her blood pressure on admission was 230/160 mm. Hg. and thereafter it was recorded morning and afternoon, both in the

Fig. 1. Blood pressure chart for the first 17 days of admission.

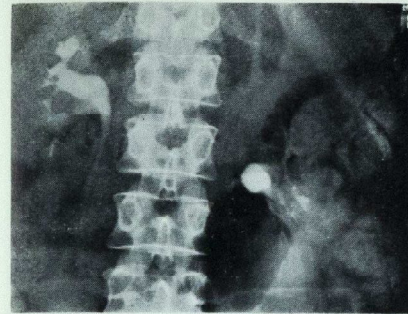
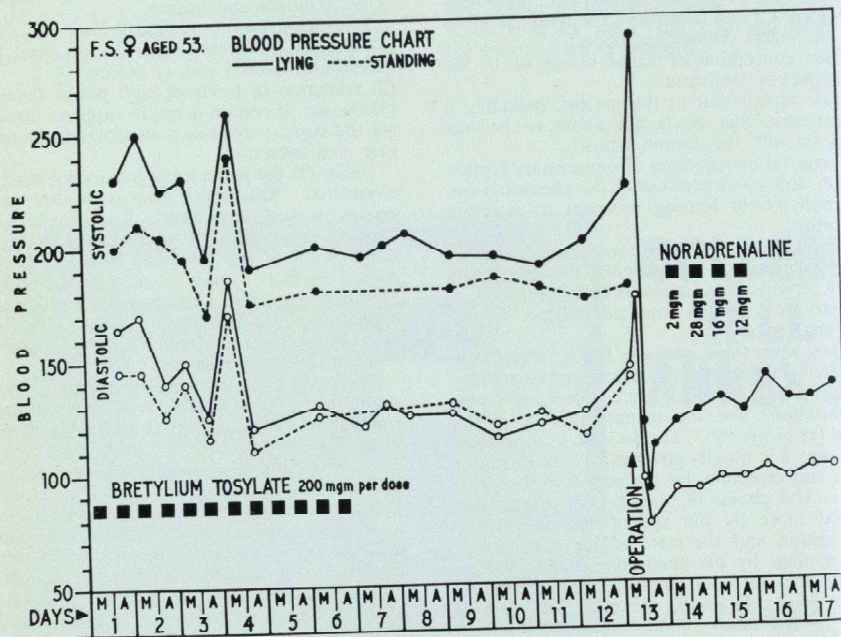
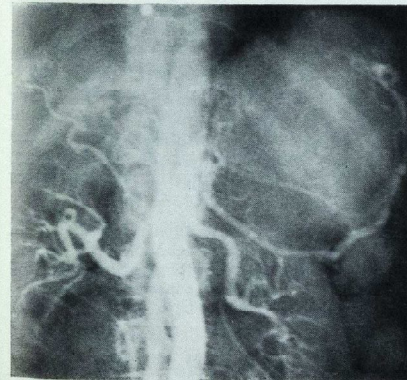


Fig. 2. Intravenous pyelogram showing left kidney pushed down.

lying down and standing positions (Figure 1). She was put on Darenthin (breythium tosylate)—200 mg twice daily and though her blood pressure had risen to 260/190 mm. Hg. by the fourth day, it soon settled to around 200/160 mm. Hg. and the Darenthin was discontinued. An intravenous pyelogram was done and showed the left kidney pushed down; kidney function, however, was normal (Figure 2). Later, an aortogram showed clearly an inferiorly displaced left kidney, and the splenic artery stretched around a large circular opacity situated beneath the diaphragm (Figure 3). A barium meal done at the same time demonstrated a mass displacing the stomach to the right (Figure 4). Analysis of a 24-hour urine specimen showed that her excretion of

Fig. 3. Aortogram showing left kidney pushed down and splenic artery stretched round a circular opacity.



VMA (vanillylmandelic acid or 3-methoxy, 4-hydroxymandelic acid)—derived from the breakdown of adrenaline and nor-adrenaline—was more than five times the normal value.

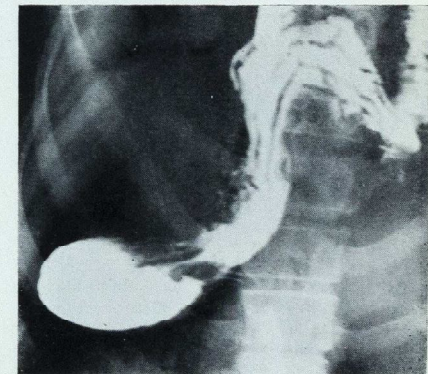
These findings, together with the history of high blood pressure and sweating, were convincing evidence of the presence of a phaeochromocytoma of the left adrenal gland. Accordingly, on the 13th day, Mr. Alan H. Hunt operated on her.

Operation

The porters were given instructions not to grip the patient around the left loin so as to avoid squeezing the contents of the tumour into the circulation and bringing about a dangerous rise in blood pressure. Precautions were also necessary during the induction of the anaesthetic, whilst the surgeon was handling the tumour, and after the removal of the tumour. Two drips were therefore set up: one of Rogitine (phentolamine) to lower the blood pressure if necessary, and the other of nor-adrenaline to raise the blood pressure, particularly after the removal of the tumour.

On opening the abdomen a well encapsulated tumour nearly four inches in diameter was found, displacing the left kidney inferiorly and with the spleen in a supero-lateral relationship to it. The splenic vessels were seen running along the inferior margin of the tumour (Figure 5). Removal of the tumour was complicated by the fact that palpation of it might seriously raise the blood pressure. The splenic vessels and spleen were so intimately bound to the tumour that it was thought better to

Fig. 4. Barium meal showing stomach displaced to the right.



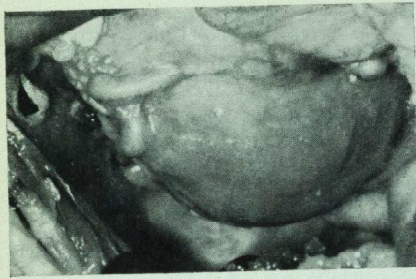


Fig. 5. The tumour at operation. The splenic artery is visible as a tortuous vessel below the mass.

remove them with the tumour rather than risk handling it. When the tumour was removed it was some minutes before the blood pressure began to fall. Then, from about 260/160 mm. Hg. it fell steadily until, by the time the patient had reached the ward, it had fallen to 90/70 mm. Hg. (Figure 1) Over the next 36 hours the blood pressure was maintained at around 115 mm. Hg. systolic by adjusting the nor-adrenaline drip. The drip rate over this period was gradually reduced until it could be stopped altogether.

Post-operatively it was found difficult to control her diabetes with insulin and the doses given would seldom have the expected result as regards her glycosuria. She still complained of slight difficulty in focussing objects at times, but the profuse sweating and headaches were no longer present. She maintained her blood pressure at around 140/95 mm. Hg. and on the 8th December (20th post-operative day) she was discharged.

Follow-up

At follow-up, a month later, she was found to be making good progress. Although having the occasional headache, she had had no recurrence of the profuse sweating. Her vision, though better, was not yet entirely recovered. Her blood pressure was 135/95 mm. Hg., compared with her pre-operative average figure of 200/120 mm. Hg.

It is fairly certain that, without prompt treatment, this lady's outlook would have been very grim indeed. Already she had had a transient stroke and judging from her shortness of breath and ankle oedema, was exhibiting the early signs of heart failure. Her eyesight was beginning to deteriorate, and it would not have been long before death would have ensued from pulmonary oedema, ventricular fibrillation or cerebral haemorrhage.

Discussion

The first published case of hypertension related to pheochromocytoma was reported in 1886 by Frankel. An almost uniformly fatal tumour prior to its first successful resection in 1927, it has attained greater importance than its relative rarity would appear to warrant. This is because of the comparative ease with which the hypertension associated with it can be cured or ameliorated in the majority of instances. By 1951 only two hundred, and by 1960 only seven hundred cases, had been reported in world literature. These tumours are found slightly more often in women than in men, and in the right adrenal gland almost twice as frequently as in the left. They are not confined exclusively to the adrenals—about 10 per cent being located in the urinary bladder, renal parenchyma, along the sympathetic chain in the chest or abdomen, or in the organs of Kohn and Zuckerkandl which lie along the abdominal aorta. About 10 per cent are malignant, although some authorities consider this figure too high. It has been estimated that 70 per cent of cases are only diagnosed post-mortem, and of the two million or more patients who receive an anaesthetic each year in this country, six to eight of them may have an unsuspected pheochromocytoma. Any or all of these patients might die as a result of their anaesthetic. The most important step to take to save these patients lives, and the most difficult one, is to suspect the diagnosis in the first place.

Since pheochromocytoma is present in approximately two per cent of all hypertensive patients it is not surprising that the clinical recognition of cases has increased each year for the past decade. However, it is a disturbing fact that in the unsuspected pheochromocytoma with an unrelated operation the mortality has remained rather constant. The principal causes of death of patients with or without pre-operative diagnosis of pheochromocytoma have been ventricular tachycardia with uncontrolled cardiac arrhythmia, hypotension, or post-operative haemorrhage.

The abnormalities presented by the patient with this tumour can be accounted for by the known physiological effects of adrenaline and nor-adrenaline. The most important of these is their pressor action. Very severe hypertensive cardio-vascular disease can be produced by these substances and they also have characteristic effects on the pulse: nor-adrenaline causing slowing, and adrenaline

acceleration. Many of the patients have a considerable tachycardia. A hypermetabolic state is produced by these substances, so that a mistaken diagnosis of thyrotoxicosis, or an anxiety state may be made. Adrenaline, and to a much lesser extent nor-adrenaline, causes glycogenolysis, hyperglycaemia and glycosuria resulting in a syndrome resembling diabetes mellitus. Excessive sweating is another characteristic feature which should alert the physician to the diagnosis.

As the finding of an elevated blood pressure is very common and the incidence of pheochromocytoma is low, it is not possible to carry out extensive studies in every hypertensive individual so as to rule out the possibility of a tumour. However, particular attention should be given to the following types of patient: those under the age of thirty with no previous family history of hypertension; those with malignant hypertension; those with hypermetabolism who are not hyperthyroid, those with spells of headache or sweating; those with severe hypertension and diabetes mellitus; those with severe hypertension of short duration plus a history of weight loss.

The recognition of pheochromocytoma demands uniformly accurate and reliable diagnostic techniques. Whilst the patient's history may be very suggestive and clear cut, nevertheless the diagnosis cannot properly be made without first carrying out some of the various clinical investigations which are available. Since the studies of Euler and Goldenberg in the late 1940's on the excretion of urinary catecholamines, the diagnosis of these tumours

has been made easier. Combined with radiological investigations (intravenous pyelography and aortography) sufficient data can now be obtained to make every surgeon confident that he will find the offending tumour.

Once the diagnosis has been confirmed and the side of the tumour defined its operative removal is usually not a matter of any great difficulty. Most surgeons would probably approach the adrenal concerned through a loin incision, but there is a strong argument in favour of laparotomy, which allows inspection of both adrenals, and also inspection of those other regions in which the tumour may occur.

It is hoped that increased clinical suspicion in conjunction with the newer diagnostic techniques may succeed in reducing the frequency with which this tumour is diagnosed only at autopsy.

Acknowledgements

I wish to express my thanks to Mr. A. H. Hunt, Dr. K. Carney and Mr. P. Cull for their help in the preparation of this article.

References

- GITLOW, S. E., and others. The diagnosis of pheochromocytoma. *J.Mt Sinai Hosp.*, 28, 1961, 157-179.
- The management of cases of Pheochromocytoma. *Proc.roy.Soc.Med.*, 55, 1962, 427-436.
- RIDDELL, D. H., and others. Experience with pheochromocytoma in 21 patients. *Ann.Surg.*, 157, 1963, 980-988.
- WOOD, K., and SUTHERLAND, J. W. M. Pheochromocytoma: a case report. *Brit.J.Urol.*, 34, 1962, 27-32.
- WRIGHT, J. T. Pheochromocytoma. *Postgrad. med.J.*, 36, 1960, 165-175.

SPECIAL DEPARTMENTS—VII:

THE EYE DEPARTMENT

by H. B. Stallard

BLINDNESS is the most tragic of all human afflictions, even for the intelligent. There is the loss of a large measure of independence, a limited sphere of work for most, the boredom of a pink-grey world for all, and often humiliations difficult to accept even by those with a philosophical sense of humour.

The purpose of the eye department is the conservation of sight and whenever possible its restoration when lost. Indeed, the cataract operation is probably the only example in surgery when from complete loss of function there is, after operation, complete gain, and this applies in a lesser degree to corneal graft-

ing and retinal detachment operations. Some of our work is the reassurance of patients that their particular disorder will not end in blindness.

What is the attraction for one trained in the wide field of medicine to focus his or her attention on so relatively small a part of the human body as the eye?

The eye, with its transparent media, affords the opportunity to study through the ophthalmoscope, the binocular microscope and the slit-lamp the course and changes in pathological processes in magnified detail in a manner which is not afforded by any other part of

the body. The appearances of physiological and indeed pathological processes through these precision instruments is exquisitely beautiful. Indeed, so exact are these means of examination that it is very rare for a diagnosis not to be made.

The surgery of the eye, like miniature art, is the keenest challenge to a surgeon in making minute, precise incisions and suturing to within 0.25 mm. accuracy, and is a test of nerve and control, for the slightest error may suddenly turn the potential of absolute success to the tragedy of complete disaster.

Medical Ophthalmology.—Eye diseases are commonly associated with disorders of the central nervous system, the heart, blood vessels, kidneys, endocrine and metabolic disturbances, diseases of the skin, and even with certain pathological states in gynaecology, obstetrics and orthopaedics.

It is thrilling to diagnose a leaking aortic valve from the water-hammer pulsation in the larger branches of the central retinal artery, almost before an added sound is audible at the base of the heart. There is no other part of the human body which allows a study of the arterioles and venules with 15 times magnification and more if necessary, nor which permits through the binocular microscope and slit-lamp a view of red blood corpuscles flowing in rouleaux through the capillaries. Such pathological changes in the eye may be photographed for follow-up comparison. Even the diagnosis of death may be made more certain by the ophthalmoscopic appearance of the 'cattle trucking' of the column of blood in the retinal vessels.

Surgery.—Eye surgery is as much a challenge to a surgeon as miniature painting and etching is to the artist. Each minute manoeuvre must be meticulously exact, minimal, finished and devoid of touching up. Moreover perfect timing is required for the cataract section, the most difficult incision in surgery. The surgeon at all times must be in absolute control of his feelings, balanced and disciplined to meet effectively the shock of sudden adversity. A number of the modern operations, particularly for retinal detachment, canaliculo-dacrocysto-rhinostomy, some orbital and plastic operations take 3 hours or more to do. The field of operative work has widened immensely during the last decade.

Because of the tension in this surgical work and the absence of any margin of error it is desirable to perform eye operations in a specially designed theatre, a quiet architectural

backwater remote from other theatres and from the extraneous added sounds of a hospital. Moreover it is essential to operate with a well disciplined team who make no distracting movements during an operation and who handle the exquisitely delicate instruments with great care.

After 16 years of cramped squalor at Hill End it is a joy to have, at last, appropriate conditions for eye surgery in the Queen Elizabeth II wing.

Refractions.—The objective estimation of the axial length and the curves of the cornea and lens in two meridians and the subsequent subjective testing for glasses is a small part of ophthalmology but a considerable part of routine practice outside hospital work. Refraction is of no teaching value for training undergraduate students in a general hospital. The work calls for infinite patience. The time and trouble spent in prescribing glasses, the most precise and effective of auxiliary medical aids, is rewarding in giving comfortable vision, relief from strain and headaches.

Teaching.—Knowing some of the tragedies that follow in the wake of serious organic eye disease which has been missed, it is difficult not to be irritated by the amused pride with which some doctors and nurses say either "I know nothing about eyes" or "It is only an eye case". An awareness of glaucoma, retinoblastoma and its dominant hereditary characteristic, and the difference between iritis and conjunctivitis might save some hundreds in this country from the tragedy of blindness.

In Scandinavia, the Low Countries and Germany the teaching of ophthalmology is whole time for two months, the students have 50-60 lecture demonstrations and a compulsory examination on 40 patients before they are signed up. Whilst this is more than a crowded curriculum merits, the other extreme is deplorable. In this hospital academic administration has allotted a maximum of 6 outpatient attendances and 4 voluntary lectures. Football matches, fevers, festivities and funerals commonly reduce this to 4 out-patient attendances, and for some students it is less. This is, I believe, the least training in diseases of the eye in the civilized world. Such a limited training is particularly serious in this country where 92 per cent of the people take their most precious organ of special sense to medically unqualified opticians in shops. During this meagre number of attendances the students are shown some of the grosser pathological disorders of the eye. It is difficult in the available time to do more than create an aware-

ness that something is wrong. Films have been made of the commoner operations to save the time expended in theatre attendance for it seems important that they should know what is done.

Original work.—The eye department of this hospital has made a number of original contributions to ophthalmic medicine and surgery. Henry Power, our first eye surgeon, was a pioneer in corneal grafting in the last century. Holmes Spicer made considerable contributions to diseases of the cornea, beautifully illustrated by his pencil drawings and water colour paintings. Foster Moore wrote an admirable book on Medical Ophthalmology, much of his material gathered from the medical wards. In 1929 he was the first to succeed in treating retinoblastoma with conservation of the eye. Since then the design of radio-active applicators and the technique of suturing these to the sclera over the marked site of a retinoblastoma has been elaborated with the help of the hospital physicists. This local application of Cobalt 60 has achieved remarkably good results when the neoplasm is under 10 mm. in diameter. Recently we have been indebted to the radio-therapists for much help in the treatment of neoplasms affecting more than one third of the retina by cobalt beam therapy and chemotherapy.

Infants and young children have been sent to the department from 23 countries, from Brazil in the West to Singapore and Hong Kong in the East and from Poland to South Africa from North to South.

To-date we are the only unit in the world which has attempted to conserve an eye with malignant melanoma by suturing a radio-active ⁶⁰Co applicator over the base of the neoplasm. Good results have occurred in 69 per cent of 100 cases. During the last 25 years the design for new operations for glaucoma, on the lacrimal passages, on the ciliary body, orbit, some plastic procedures and the modification of cataract and retinal detachment operations have

Rheumatic Disease
(Continued from page 103)

really acute attack butazolidin (phenyl butazone) 600-1,000 mgms. per day, is best used, for two or three days only.

(4) Uricosuria may be produced by the use of large doses of aspirin, benemid (probenecid) about 1.5 Gm. daily, or best and least toxic, anturan 400-800 mgms. daily. The main precaution to be taken during administration is to give plenty of fluids to avoid deposition of uric

acid from the eye department. Research is now being done on glaucoma, vascular hypertension and the treatment of virus diseases of the cornea.

Ophthalmology as a career. (1) **Academic.** It is desirable to attract men with first class minds to work on the problems which scourge humanity with blindness such as glaucoma, uveitis, the pathology of retinal detachment, virus diseases affecting the cornea, degenerations of the eye, and hereditary diseases. Such investigations require the combination of laboratory and clinical work. It is notable that the clinician through careful observation has discovered the cause of retro-lental fibroplasia, and of blindness affecting the infants of mothers who had rubella during pregnancy.

(ii) **Clinical.** In hospital practice most of the work concerns diseases of the eye. The investigation of glaucoma is time consuming and the follow-up exacting. It is a disorder which is increasing with the greater longevity of the population. In future, eye departments of most hospitals will require more beds to deal with the rising numbers awaiting admission and to reduce the misery of a delay of 1 to 2 years before sight is restored by surgery.

(iii) **In private practice** and in clinics outside hospital a large proportion of the work is refractions—regarded as either the bread and butter, or the drudgery, of ophthalmology or as a tranquil contrast to the exciting and concentrated demands of surgery. Operative work is a small part of practice outside hospitals and in private seldom comes to a surgeon till late in middle life.

A less happy feature of ophthalmology is its tendency to become isolated from general medicine and surgery unless constant efforts are made by the eye surgeon to keep contact.

All eye work is exacting in time (a glaucoma patient may require several hours of investigation) and in patience. It is rewarding in the comfort that it brings to patients and in the joy of restored sight after certain operations.

acid in the urinary tract. Treatment must be continued for years, if not for life, and should be started if there are frequent attacks, if tophi are present or if the blood uric acid is high (over 6 mgms.%). During the first 6 weeks of administration this group of drugs will not help the attacks and colchicine should be given at the same time during this period.

This combined approach to the treatment of gout has completely changed the prognosis of the disease.

BEHIND THE SCENES: VI

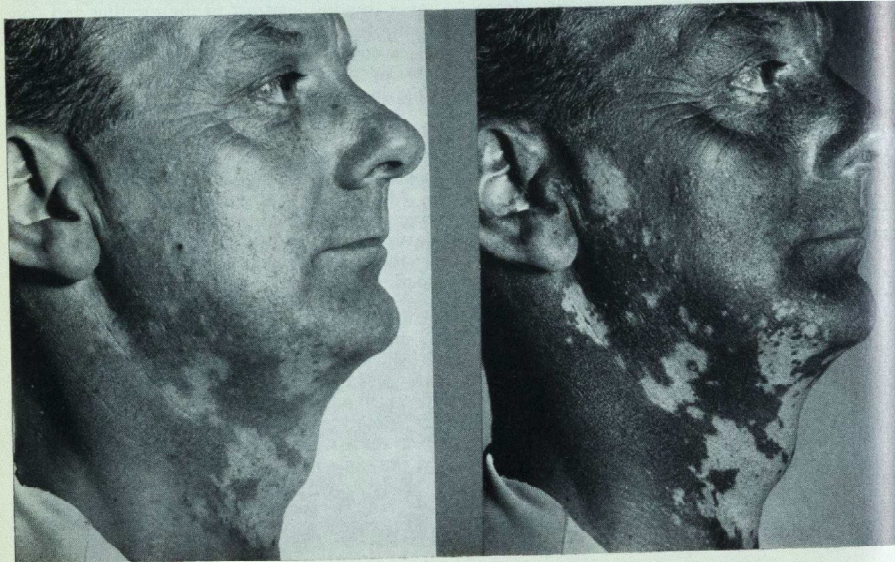
DEPARTMENT OF MEDICAL ILLUSTRATION

By P. G. Cull & W. D. Tredinnick

MEDICAL illustration as an aid to the practice and teaching of medicine has taken on an increasingly important role in the past decade. This has led to the creation of special illustration departments, not only in the majority of teaching hospitals, but also in the larger non-teaching hospitals. The department at St. Bartholomew's Hospital combines both art and photography and is administered by a committee drawn from the Medical College and the Hospital Governors and it is under the consultant supervision of Mr. D. F. Ellison Nash.

Medical Photography was established at St. Bartholomew's shortly after the war, at first in the College and later moving to the present premises between the Clinical Lecture Theatre and the Dispensary, premises now being enlarged and improved to accommodate the art section and to provide further studio space.

Ultra-violet light photography of vitiligo. Skin pigment absorbs ultra-violet rays strongly, but where pigment is lacking the rays are reflected after they have penetrated the surface of the skin.



Normal photograph.

Ultra-violet light photograph.

Photography

"What sort of photographs do you take?" is a question often asked. To quote the Ministry of Health, "Photography in Medicine is used as a means of permanently recording the condition of the patient at the time of examination, and as an objective check on subsequent progress and response to treatment. This method of recording is often more precise and valuable than a verbal description. It may be employed as an aid to diagnosis, for record purposes, for teaching and for research." At the moment the photographic staff of three photographers and a printer photograph over one thousand patients in the year, a figure which is steadily rising. Most of these are photographed in colour and an increasing use is being made of ultra-violet and infra-red radiations for demonstrating particular conditions which are not otherwise visible to the naked eye.

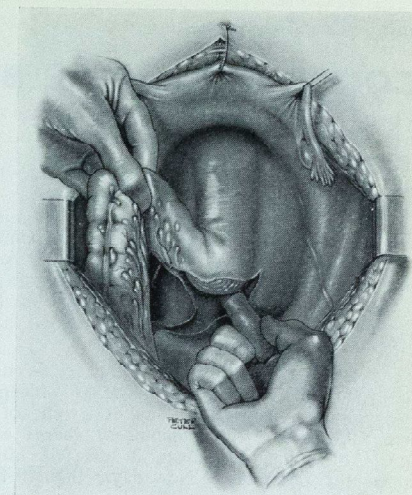
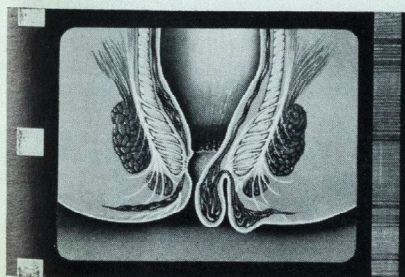
Pathological specimens, the reproduction of X-rays and a certain amount of document copying form the bulk of the rest of the work and make, in all, a total of over 20,000 pictures a year. All pictures of patients and specimens are carefully classified and filed to form a pictorial library from which lantern slides, book illustrations and other teaching aids may be drawn. A small section of this library is directed to cine films made by the department, some of which are purely records of patients and their progress while others are edited teaching films.

Art

The introduction of new and improved photographic materials, apparatus and techniques has resulted in radical changes taking place in Medical Art over the last 20 years. Pure recording of clinical conditions, gross pathological specimens, endoscopy and microscopy, which in the past formed a major part of the artist's work are now seldom required. The superiority in speed and accuracy of photography makes it the method of choice in these instances, although exceptions do occur when there is a need to idealise, interpret or reconstruct the subject. The fields of work which have remained relatively unaffected are anatomical illustration and the illustration of surgical technique, both of which require a selective and interpretive approach unobtainable by means other than drawing. As a result of these changes Medical Art has broadened its scope and has developed along the lines of illustrating and communicating information and ideas, rather than recording visible, tangible objects, using mediums varying from the simple graph or diagram, to the more complex animated film, model, surgical drawing or exhibition.

At St. Bartholomew's the work is divided fairly evenly between illustrations destined for

An animation drawing from a film on haemorrhoidectomy.



One of a series of drawings illustrating the "Ivalon Sponge" repair of rectal prolapse.

publications in medical and scientific journals, and that for use with more direct methods such as projection and display. The major part of the latter group being concerned with teaching in the Hospital and Medical College. It is impossible, within the allotted space, to give a complete survey of work undertaken since the service started in 1961; however, the list below will give some idea of its type and variety:

- Anatomical drawings—human and comparative.
- Illustrations of surgical anatomy and techniques.
- Instruction charts on ward procedure.
- Teaching exhibitions.
- Illustrations of laboratory apparatus and experimental techniques.
- Animation sequences for films and television.
- Simplified drawings of microscopic appearances.
- Statistical graphs and charts.
- Explanatory and instructional diagrams.

Although there are quite distinct areas in Medical Illustration in which either photography or art is the better or sole method employed, there is a steady growth in work of a combined nature. Two examples which stand out are teaching films and exhibitions. The integration of the two methods provide an ideal means of presenting and communicating information; with photography recording the facts and graphic art used as a medium for explanation. With the growing interest and use of visual aids in teaching at all levels, it is along these lines that we hope and expect the department to develop.

OTHER PROFESSIONS: 4

COULD YOU HAVE BEEN A CLERGYMAN?

BY CANON J. A. FISHER

The brief answer is "Yes, you probably could, provided you were strongly convinced that you ought to become one."

For a man who wishes to be ordained in the Church of England the obstacles to be overcome are three: (1) For those under 25 a University degree plus a specialised training at a theological college for two years or so; (2) Acceptance for ordination by a board of selectors; (3) Acceptance by a bishop and the offer of a post as curate in some parish (for a woman who wishes to be ordained, neither the Church of England nor the Roman Catholic Church offers any prospect at the moment, beyond her becoming a deaconess, a lay-worker or a nun. But that is another story).

The average young man who, at eighteen or nineteen, decides that he wishes to become a Clergyman and is offered a place at University, can, if he chooses, read for a degree in Theology, but he need not. This is a relic of the days when Oxford and Cambridge were Church Universities with compulsory chapel attendance, and the Deans were mostly of the Clergy. Any young gentleman, it was felt, after his University days, should be well enough equipped for ordination. Nowadays, though the authorities are encouraging young ordinands to read Theology, there is still a lot to be said for postponing theological studies till after his degree. A clergyman's duties can be very varied. An English degree might help him to preach and write well; Psychology and Sociology would help him in parochial work; History or Classics would be valuable in serving a Church with ancient traditions, and any form of Science degree might help him in the major problems of communicating religious truth in a scientific age.

Theological degrees and courses are much wider than they sound and, for many, are probably rather easier than a medical degree, as there is less need for sheer memorisation and accumulation of factual knowledge. The student who finds Church History unpalatable may find himself enjoying other sides of theology: the study of the Bible, or of Christian worship, or the Creeds. And there are other things to interest him as well: Pastoral Psychology, teaching techniques, and the application of Sociological studies to the life of the Church. His progress to ordination is unlikely to be smooth for his first experience of theological study will probably shake his faith to its foundations. If he comes through this experience and weathers the boredom associated with any serious learning he will find himself at his theological college in the midst of a confusing ferment of traditional approaches and new ideas. What should be the content of Christian teaching and preaching? "A Gospel stripped of its myths?" "Religionless Christianity?" "The Gospel restated for a scientific age?" Or is preaching dead anyway? Should he learn about film projectors and visual aids instead? Then what is the best kind of Christian worship?—Traditional mattins with anthem or a family Communion? Should he encourage A. & M* or modern jazz hymns? These and a mass of other questions will be around him as he trains.

Meanwhile the Board of Selectors who encourage him to go forward for ordination training will urge him, if he has not already done so, to spend a year working in industry or in some way widening his experience of the lay world. Towards the end of his training he will combine his final exams with interviews with the Bishop who is to ordain him and will be deciding in what parish he is to start work. (In the Church of England a man is only ordained when he has a place offered him).

What lies ahead? The average young clergyman may expect a period of three to six years working as a curate under a vicar, and then either a period as a priest in charge of a housing estate church still under some degree of supervision, or a vicarage of his own. His house may be a council house, a small villa with an extra room, as a study, or a large mansion with too

*Ancient & Modern Hymnal.

many rooms and an acre of garden. His stipend will start round £12 a week and rise to £20, but is not likely to rise further or to keep pace with rises in the cost of living. So with care and an economical wife he will have enough, but not more.

His conditions of work will be very free, so free that he will perpetually need a fair degree of self-discipline. After his first years no one will compel him to study, or to visit his parishioners, or to prepare his sermons. He will not have queues of people at his door, nor will his pay vary with the amount of work that he does. It is unlikely that he will have secretarial help with his letters and business. So he may slip in his middle years into an inefficient and ineffective way of life, or even to downright despair. Other men have an assured place in the community: on the whole people with toothache know they need a dentist, and men with complicated business to transact know they need a solicitor or accountant. But people with moral and spiritual worries don't recognise that they need their local clergyman. He is there, but few know quite what he is there for, except to sign passport forms or conduct services.

However, many clergy manage to use their freedom sensibly. Their parishioners gradually learn that they are to be trusted and the problem becomes one of finding time rather than of filling it. The clergyman may well find that his three main works of prayer and study, pastoral care and parish business give him a twelve-hour working day and days off are difficult to arrange.

You may yet become a clergyman. Nowadays a fair number of men, after 25 years of work in their profession, choose to be ordained at 50 and spend another twenty years or so in the work of a priest.

NEW PENGUIN BOOKS

Mesdames, Messieurs . . . ATV French series scripts in 2 vols. Penguin, 3s. 6d.

This is the script for a weekly series of television broadcasts in French for those wishing to learn the language in the comfort of their own homes.

The adventures of a young Englishman on a business-cum-pleasure sojourn in France may seem too like other attempts at livening up a method of teaching. But, in fact, this series is written with great imagination and humour and television is the ideal medium. Each programme contains a major theme: "The Office", "Letter Writing", "Drinks at a Café", with subsidiary themes which are introduced into the conversation and become major themes, more fully discussed, in a later programme. The subjects covered are more intelligent and useful than in most works of this kind, including the use of the telephone, the Métro and the buying of household articles. There is a glossary of technical, slang or difficult phrases at the end of each section.

The introduction claims that the text has "been designed for people who know a certain amount of French; who have learnt French at school; and for those who, having learnt French in England, have had little opportunity of practising it as a living language". The French used is modern, witty and idiomatic but presupposes a much higher level. I would venture to suggest, than the average English person could possibly have maintained from his schooldays. This is the only drawback in what is an otherwise very good attempt to bring France, her customs, way of life and people, to the English hearth.

Bruno Dubna-Kastelitz.

The Penguin Brockbank. Russell Brockbank, 4s. 6d.
The Penguin Hoffnung. Gerard Hoffnung, 4s. 6d.
The Penguin Thelwell. Norman Thelwell, 4s. 6d.

Good cartoons have a very ready appeal, more so than verbal humour, perhaps because of the speed with which the whole situation can be appraised without any preamble. To read through some five hundred anecdotes would be an ordeal, yet with the cartoon it is possible to do this and finish with humour intact.

Penguin have produced three new cartoon paperbacks containing selections from Thelwell, Hoffnung and Brockbank. That these artists have highly individual styles of presentation is very apparent. Mr. Thelwell's rotund, dished-faced ponies bounce their way over, through and under obstacles; mind over matter is an old theme, but here the matter has a definite mind of its own. The minute, globular riders in pigtailed endeavours to maintain some control are easily recognisable in Pony Clubs up and down the country and this volume should be compulsory reading for all horse-loving females over three.

"Musicians As Others See Us" might be an attractive title for the Penguin Hoffnung. The drawings in this collection are selected from six of his books including *The Maestro* and *The Hoffnung Symphony Orchestra and Music Festival*. To single out any particular drawings would be idle, as everyone has their own favourites, but perhaps the malevolent thoughts entertained by the more meek-looking musicians of their conductors will strike a ready chord.

The cover of the Penguin Brockbank tells us that the Punch pen of Mr. Brockbank is second

to none in the field of motors, and indeed every aspect, from the weekend motorist to the racing track, is covered. His humour appears to reside mainly in the situation and little in the drawing detail itself, which reduced its appeal to me.

Few people enjoy being kept waiting, and two provisions I would suggest to make it wholly bearable; a decanter of sherry and these three volumes. Gervase Kerrigan.

Casanova's Chinese Restaurant. Anthony Powell. 3s. 6d.

In the "Music of Time" saga, Anthony Powell has followed his previous successes with this, the fifth, Casanova's Chinese Restaurant. Despite the title it is in no sense a pornopocket biography of the great lover, being instead pre-war London when the left went to fight in Spain while the right stayed at home to play at decadence. The old characters are back again, bringing to life this next instalment; the dipso still in search of drink, musicians still manqués, writers always hoping—it has all the advantages of Mrs. Dale in Bohemia. Although the tone of the book is for the most part flippant and amusing, there are some intriguing views of bedrock wedlock. It would be fascinating to know what circle of friends the author kept; one feels that there is only the flimsiest of fictional veils round some of the characters. Perhaps there is a future for some aspiring editor who launches an annual directory on the style of "Who Might Have Been Who?" in high society.

The Loving Spirit. Daphne du Maurier, 4s.

"The Loving Spirit" was Daphne du Maurier's first novel after the "frank" reminiscences she wrote of her father Gerald. In an age when one would imagine that the brilliant cynicism of Huxley and Waugh reigned paramount, it is interesting to reflect that this writer followed her own genre in Romantic fiction. In "Rebecca" and "Rachel" particularly, and to some extent in "The Loving Spirit" Daphne du Maurier epitomises the Romantic World for the drawing room; heroines withhold the ultimate fiction. In "Rebecca" and "Rachel" particularly, conveniently for attitudes, villains are obvious—in fact all the trappings of this style in fiction are to be found. But however conventional this novel, it is none the less a consummate piece of craftsmanship, in which she creates around four generations a web of detail and circumstance that quite equals Sister Agatha in criminal fiction. One du Maurier is satisfaction, two are sufficiency, and three is an excess which provokes a reaction against the empathy that reading requires; it is in this mood that one can willingly take up the anti-hero, whose sentiment action and temperament are viewed as a spectator and not as a player. Temperance, as in most things, is the way to enjoy Miss du Maurier.

The Heart of London. Monica Dickens. 5s.

Monica Dickens fits too well in her later books, the tradition of the social novel which earmarks her great grandfather. Although the family feeling has an undoubted part in her work, it is facile to regard as applicable all that was said of Dickens in his time. Monica Dickens has no Mayhew from which to draw background; her characters as a result acquire more complexity and reality than

those contrived and tear-jerking scenes by which most people remember with pain the Victorian novelist. This book is set in some London suburb, which could alas be one of fifty, and filled with the brassy prosperity of universal affluence. How little the great architects of Socialism realised, that their dreams of material well being would bring social problems of equivalent seriousness in the form of such innocent objectives as leisure, education and money. Education has equipped the community with the ability to question why, that destructive but indestructible little word which has contributed more to the overthrow of authoritarian morality than practically anything else, and while money has come to represent success, leisure is now perhaps the greatest social problem of all. It is very easy to see a modern society in these terms, but they are problems that have no solution in nostalgia for the good old days. Perhaps the implications of the book leave one on an equivocal note, but as a portrait of our vast suburbia they seem depressingly accurate.

Patrick Smith.

The Profumo Affair—Aspects of Conservatism, by Wayland Young. 2s. 6d.

Those who were interested by the political peccadilloes of last summer will have gleaned all the facts from the excellent reports by Lord Denning and the author's "Scandal '63" and the fiction from the writings of Misses Keeler and Rice-Davies, and should omit the first five chapters of this book, being satisfied with the sixth and seventh (27 pp) as an instructive pamphlet about the affair.

The comments on Dr. Stephen Ward are sane: for fun or money? It was unfortunate that the right answer was not apparent to all Englishmen. His comments on the necessity of prostitution in civilised society are philosophical; he says that a labourer may buy a whore but a bishop may not. Quite literally the price and therefore the risk are higher. The argument goes on to suggest the advantages of a lay state with a dis-established church. It is difficult to see if such a suggestion would really lessen the "majesty" of British hypocrisy. The author becomes more ethereal still when discussing the business of security. Apparently good espionage and bad security are the necessary trappings of a nation-state and may or may not be to the advantage of the enemy, but in four or five decades he expects the nation-states to wither away. Anyway, what then—the world? Utopia!

Finally he writes about the famous lie of March 22nd. Should Profumo's colleagues have believed him—rather (although this point is not made) should they have risked believing him? The fault of Wayland Young's pamphlet is that of so much contemporary writing about the affair; he makes too much of it. "The name 'Conservatism' will survive; but it will not again mean the blatant purchase of that which should be built, enjoyed, loved and celebrated—and the words fit whether we speak of sexual relationships or of city centres—as it did in 1963". This is nonsense. As always it will be left to the textbooks of history to put the final banner headlines of the popular press into perspective. The Profumo affair? A footnote, not much more than that.

Tom Bottomley.

The Minister, by Maurice Edelman. Penguin Books 3s. 6d.

This book, published as it is after a surfeit of salacious political scandals of one sort and another, is particularly appropriate. It is about a senior Cabinet Minister's private thoughts and public actions.

If one accepts the reliability of Mr. Edelman's dialogue one is given a first-class insight into the machinations of political life and parliamentary procedure in this country. These are not particularly pleasant. The novel paints a distressing picture of some of the people caught up in politics, their relations with political journalists and their relations with each other. Really one should not be surprised by the implications of this novel: the members of any government are just like all of us, but they make a mistake if they appear to be just like all of us. That is, perhaps, one of the most important points that was stressed by the Profumo affair: a Minister's sexual activities, whether straight or devious are his own affair, just as they are with any man, but he must be doubly sure that if they are devious he should not be found out.

This book is particularly amusing for its continual atmosphere of double-think and double-talk. It may be that it is impossible for a politician to talk as he thinks in 1964, especially if he is a high Tory.

Tom Bottomley.

The Fall, by Alfred Camus. Penguin Books, 2s. 6d.

This is a very short book and a very readable one. It would be quite possible to review it in a greater space than the author took to write it.

It is sufficient to say that it is an essay in hypocrisy—an excellent one at that—every page full of excellent aphorisms, most of them profound, only a few superficial.

The story is about a Parisian barrister of some standing. He is liked both by his fellow men and himself until one day he is struck by the horror of the real motives of his and everyone else's everyday actions. After a fling at debauchery he settles in Amsterdam into a retirement of perspicacious and disturbing self-judgment. In fact, anybody who is not disturbed after reading this book must have something of a cow's complacency.

Tom Bottomley.

The Indiscretion of Archie. 3s. 6d.

The Heart of a Goof. 2s. 6d.

Hot Water. 3s. 6d.

Jeeves in the Offing. 2s. 6d. By P. G. Wodehouse.

Penguin Books Limited are on to a winner with Wodehouse. They have already published 27 of his books and doubtless they will publish many more. "The Indiscretions of Archie" was first published in 1921 and "Jeeves in the Offing" in 1960. Forty years has made no difference to Wodehouse's stories, the ingredients and the characters are the same and his situations just as ingenious and funny.

His period is set between the wars when the emphasis was on romance rather than sexuality and manners rather than morals, in an age when there was still some semblance of an ordered society. Only the most aggressive moderns can avoid feeling some nostalgia for those days, and in "The Indiscretions of Archie", Archie is an amiable and penniless young Englishman, who tries hard

to win the approval of his young American wife's rich but disapproving father. He gaffs consistently until finally he pleases the old man immensely by making him a grandfather.

"The Heart of a Goof" contains no less than nine excellent golfing anecdotes narrated most inappropriately by the club bore. The best is the "Magic Plus Fours" in which Wallace Chesney's miraculously improved golf and accompanying vanity and arrogance come within a short putt of ending a beautiful friendship between him and Charlotte Dix, his fiancée—"The afternoon I broke off the en-gug-gug-gagement he told me I ought to use an iron off the tee instead of a dud-dud-driver". Quite understandable!

The machinations in "Hot Water" merit the closest attention. There is action from beginning to end when a young millionaire finds himself in a French chateau with V.I.P.s from three countries and a variety of criminals. Half the house party are after the senator's compromising letter and the other half are after Mrs. Gedge's ice. Predictably the young millionaire begins the action affianced to the haughty, if beautiful, Lady Beatrice and ends it in the arms of Jane Opal, the senator's daughter; but predictability does not detract from Wodehouse's stories. If it did a reviewer would be bound to give "Jeeves in the Offing" the bird. Certainly it needs no introduction. Just pop round the corner and do the r.t. by buying it.

Tom Bottomley.

Lanterns and Lances. James Thurber. Penguin Books, 3s. 6d.

The White Deer. James Thurber. Penguin Books, 2s. 6d.

Lying awake at nights is a frequent trial to Mr. Thurber to judge from his book "Lanterns and Lances". In place of the standard remedies like sheep-counting, he combats sleeplessness by juggling words and letters and producing associative splashes of phrase and expression. Unfortunately, this written down tends to produce an equally soporific effect on the reader, but in a bedtime book such chapters are a virtue.

He chooses his subjects apparently at random—the problems of communicating with modern children, the decline of comedy, conversations with awful women at cocktail parties—but always the theme is but a vehicle for the words, their shape, sound, associations, use and abuse. "We can sleep twenty people in this house, but we can eat only twelve."

Frequent passing reference is made to Henry James and an entertaining piece is devoted to his play "The Wings of the Dove" of such chequered theatrical fame. He captures much of the spirit of James, and in a lighter and much briefer way than much of the current verbiage on Jacobitism.

"The White Deer" is a classical fairy story of a princess changed to a deer, to be disenchanting only when King Clode and his three sons bring her to bay, but even then unable to recall her name or kingdom. Only on the day when one of them should declare his love for her despite doubt, dread and gossip would the spell be broken. The story of the princes' adventures and the tasks set to them is told with charm and simplicity, yet with a wit and vigour that will appeal to all ages.

Gervase Kerrigan.

OTHER REVIEWS

The Making of Man. Kenneth Walker. Routledge & Kegan Paul, 21s.

This will not be Kenneth Walker's best seller, but no less than the others is it an intriguing book. During the 1920's the author, through his friendship with Maurice Nicol—another unusual Bart's man—first came into contact with Ouspensky in London, and later with the enigmatic philosopher Gurdjieff. The propositions of Gurdjieff's system were based on a series of philosophical, psychological and religious ideas, by which humanity might grow out of the "mechanical consciousness" which is its tragedy, to an "essence" or new spiritual awareness. Shades of many a philosophical corpse, noble savages, evolutionary ethics and theosophy, merge into this animate form of new consciousness.

Gurdjieff's way of life was more than a philosophy, since it also involved a series of difficult exercises and sacred dances, which the Master had brought with him from his sojourn in the wilds of Central Asia. It is in the sources of Gurdjieff's greatness that Kenneth Walker is at his best; he describes briefly Gurdjieff's growth to maturity in the Caucasus and the obvious influence of Hindu and Buddhist mysticism upon him, but it was a mysticism, though the word is not permissible, brought more by awareness of the body and senses than by meditation.

It is easy to draw the pedigree and to allocate the progeny of this rare man, but it is invidious to judge him. The search which he made is timeless, but perhaps posterity will come to value his contributions more than did his contemporaries.

P.S.

The Autonomic Nervous System, by J. H. Burn. Blackwell Scientific Publications, 18s. 6d.

The expanded title of this book claims that it is aimed at students of physiology and pharmacology, while the note on the dust cover states that it "deals with the autonomic nervous system particularly from the standpoint of chemical transmission." Having defined the scope of the work the author proceeds to cover the field thoroughly, and with the clarity of exposition which is characteristic of Professor Burn. He is one of the few scientific authors who writes in the same style as he speaks and who does so lucidly. In only one place—his discussion of skeletal neuromuscular transmission on page 47—did I feel that confusion might arise in the mind of the reader. In the early chapters there is presented an orderly account of transmission in the autonomic nervous system. This is largely historical, but with the history carefully selected to assist in illuminating the subject. This is also arranged so that the author can lead naturally into a fuller account of the sympathetic nervous system. Here he refers to the most recent work and presents each topic in detail. Although he lays careful foundations for it, Professor Burn does not refer to his own controversial theory concerning the release of nor-adrenaline until the last chapter. Therefore, whatever the fate of his theories, the majority of this book is admirably suited to the

needs of anyone who wants to read more deeply than the average textbook, or who wants to see some of the later work, but who does not want to read extensively in the scientific literature.

D.F.J.M.

Practical Therapeutics, by H. J. B. Galbraith, J. Q. Mathias, and R. C. King. Lloyd Luke (Medical Books) Ltd., London, 1962. 446 pages. £1 15s.

This volume bridges the gap between pharmacological theory and clinical practice and is intended for the use of medical students during their hospital training. It is about 300,000 words and gives a clear exposition of the principles of medical therapeutics. It is up-to-date without over-stressing modern trends and achieves simplicity without compromising truth. All doses are given in metric units which conforms with the recommendations and example of the 1963 British Pharmacopoeia. The fundamentals of therapeutics are well presented and a good index enhances the value of this book. It fulfils a need of every student and can be wholeheartedly recommended. It is a pity that more space is not devoted to drug-induced disease. Modern medicine is armed with so many potent and potentially dangerous drugs that every student, and indeed every doctor, needs reminding of the admonition of the Ancients "At least do no harm!"

Guide to Psychiatry, by M. Sim. E. & S. Livingstone Ltd., 868 pages. Price £2 15s.

The importance of psychiatry in undergraduate medical education has long been recognised in the U.S.A. and is gradually receiving recognition in the United Kingdom. The time given to psychiatry in Great Britain, however, remains extremely short compared with other countries such as Sweden and North America.

Psychiatry is a rapidly developing field of medicine and this book is intended as a guide for undergraduate and postgraduate students. The first four chapters are devoted to fundamental subjects, such as psychology, psychopathology, genetics and cybernetics. The chapter on psychology needs expansion, whereas the account of psychopathology is too elaborate for a guide of this kind. The chapters on systematic psychiatry are well written. Special chapters are devoted to Mental Subnormality, Psychosomatic Medicine and Social Psychiatry. Various therapeutic methods, including psychotherapy, physical methods and drug therapy are adequately dealt with.

The book is unusual in that the clinical examination and description of clinical features is given at the end as the final chapter. The book is indeed a useful guide for the student and practitioner and further reading is facilitated by ample references.

It can be recommended for undergraduate students and for qualified doctors who need to get up-to-date in their psychiatry.

W.L.R.

SPORTS NEWS

SPORTS DIARY

MARCH, 1964

Sunday, March 1st

Hockey 1st XI v The Bandits (H).

Wednesday, March 4th

Soccer 1st XI v London Hospital (A).

Hockey 1st XI v King's College Hospital (A).

Saturday, March 7th

Ruby 1st XV v Streatham (A).

Rugby A XI v H.A.C. (H).

Soccer 1st XI v Trinity Hall, Cambridge (H).

Sunday, March 8th

Hockey 1st XI v Past Bart's. (H).

Tuesday, March 10th

Squash Club v Escorts (H).

Wednesday, March 11th

Soccer Club 1st XI v St. Mary's Hospital (A)

Squash Club v Aspro II (H).

Saturday, March 14th

Rugby 1st XV v Aldershot Services (H).

Rugby A XV v City Police (H).

Tuesday, March 17th

Squash Club v Jesters (H).

Saturday, March 21st

Rugby 1st XV v Old Milhillians (A).

Friday, March 27th

Rugby 1st XV v Glynneath (A).

Saturday, March 28th

Rugby 1st XV v Treorchy (A).

Editorial

With some of the Hospitals' Cup matches already decided, and most well under way, it is interesting to review the progress made by Bart's. The Cross County Club, with the indomitable, and as it turned out, indispensable N. Pott, running, despite bronchitis and fever the previous day, excelled on Saturday, 1st February by defeating a strong St. Mary's team to win the Inter-Hospitals' Kent-Hughes Cup for the fourth year in succession.

The Rugby 1st XV however, although playing some good, fast, open football for most of the season, allowed themselves to become entangled in a somewhat scrappy game and suffer defeat in their second-round match against Guy's by nine points to nil.

The Soccer Club under the captaincy of H. Phillips, who has recently been selected to represent the United Hospitals against the University of Sussex, has done well to reach the semi-final of the Hospitals' Cup.

Although the Hockey 1st XI lost by a small margin in an early round Cup match the 2nd XI have reached the final of the Junior Cup for the second year in succession. On the 29th January they defeated a useful St. Mary's team by two goals to one, and, we have been assured, have a better chance than last year of winning the trophy for Bart's.

It is ironical that the Rugby XV have, as ever, been fortunate enough to attract many spectators to their Cup matches, whereas the more successful, if lesser known Bart's clubs, have again been ignored.

G.H.

RUGBY CLUB

Since the last report to the Journal the Rugby scene has been dominated in turn by the Christmas period, morning matches before home Internationals at Twickenham, a short spell of foggy weather and above all by the United Hospitals' Cup matches. While the 1st XV has been fortunate to remain stable during this period, the A XV have suffered many team changes and the junior teams are only just returning to their Michaelmas Term success, which was based on regular teamwork.

The foggy conditions, prevalent all over the country, prevented many first team members returning in time for the match against Old Rutlishians on December 28th, and the team that was fielded included six reserves and many players out of position. The outcome was a win for the Old Boys 6-16. Harris kicked two good penalties for the Hospital, while the opponents exploited our weakness in the centre

and lack of covering by our forwards to score some good tries by hard running.

Team: Davies, P.; Harris, S. G.; Letchworth, A. T.; Goodall, D.; Thomas, R. S. M.; Gateley, J. P.; Pope, D. C.; Gilmore, O. J. A.; O'Kane, A.; Knox, A. J. S.; Orr, M. M.; Stephens, K. M.; Ross, A. P.; Smart, C. S.; Jennings, M. C.

On January 4th, in contrast to the previous game, a full Bart's team met Nottingham at Chislehurst. Despite the early start, reactions were brisk and there was some fast, open play by both sides. Bart's opened the scoring when Pope used a quick heel from a loose ball to place a high cross-kick near the line for Griffiths to collect and score. Gibson converted. This type of kick, used from the touch-lines in the opponents' "25" was introduced to Bart's by the Penzance scrum-half, P. Mitchell. Since then, we ourselves have developed this kick and many points have been scored from the "Mitchell".

Throughout the first half, Bart's did most of the attacking, until a dropped pass, when our full-back was in the line, gave Notts a splendid opportunity to score a goal. This slip was to lose us the game, for with both sides making attempts at penalty goals, Notts converted to make the score 8-5. Although most members of this team went along to watch the All Blacks beat England with an impressive demonstration of the results of fierce forward play and fast covering, few of them appeared to appreciate this lesson, for on Thursday, 9th January, Bart's scraped through the first round of the Hospital's Cup by beating Charing Cross Hospital 6-3 at Richmond. The reason for the low score was simply that Bart's seldom raised their pace above a trot and this caused many an anxious moment for their spectators. Bart's did start well and soon had a three-point lead from a Gibson penalty, but, apart from a fierce period of attack just before half-time, they allowed Charing Cross to contain them in their own half. When one of Charing Cross's several attempts at penalty goals was successful, Bart's stormed back to score a fine try. Goodall charged down the fly-half's kick and he and Griffiths chased the ball on and tackled their full-back as he gathered it. The rest of the pack arrived very quickly at the loose scrum, heeled cleanly and Pope sent Savage away to crash over near the corner. However, after this Bart's attacks lacked the necessary vigour essential in Cup matches.

Team (v Notts and Charing Cross Hospital): Sidebottom, E.; Harris, S. G.; Griffiths, N. J.; Savage,

P. E.; Johnson, S. M.; Letchworth, A. T.; Pope, D. C.; Gilmore, O. J. A.; Revill, M. G.; Knox, A. J. S.; Bates, T.; Orr, M. M.; Gibson, J. A.; Smart, C. J.; Goodall, D.

On Saturday, January 11th, the 1st XV travelled down to Taunton. After lunch the traditional "pilgrimage" to the cattle market was made. Each year this market grows larger in size and importance, and is visited faithfully on the way to the ground. The only luck that this visit brought us was that the pitch was dry and not the usual quagmire! But whether from reactions of the Cup match or merely the train journey, Bart's got off to a very slow, lethargic start, and in the first half allowed Taunton to gain possession in every loose heel. With this possession, the home side scored three tries and a penalty. After the interval Bart's came to life and the pack, Gilmore in particular, played well in the loose and tight scrums. The three-quarters gained confidence as they started moving well, and, but for a lack of hard finishing after the opening had been made, the deficit in points could have been pulled back. The final result was 12-0 to Taunton.

There were several Bart's scarves in evidence in the crowd, and we were very pleased, after the match, to meet old Bart's men who were practising in the area.

Team: Davies, J. P.; Harris, S. G.; Griffiths, N. J.; Savage, P. E.; Johnson, S. M.; Letchworth, A. T.; Pope, D. C.; Gilmore, O. J. A.; O'Kane, A.; Knox, A. J. S.; Bates, T.; Orr, M. M.; Mumford, G.; Smart, C. J. S. (capt.); Goodall, D.

Despite an interval of a fortnight (frost cancelling the matches), on Saturday, 25th January, at Chislehurst, Bart's started the game against Old Whitgiftians in the same spirit as they had played the second half against Taunton. In doing so they inflicted the first defeat on the Old Boys' side since last October. But it was a hard-earned victory and the score of 22-17 suggests, rightly, that it was an open game.

Bart's took an early lead, but some bad tight scrum play and equally bad defensive positioning and tackling, allowed the visitors three tries, none of which was converted. This set-back did not discourage Bart's, and by good backing up in attack and determined loose scrum play, the backs were given plenty of good possession. Savage finally put this to effect and scrambled over for a very good try. A few minutes later Harris converted a superb fifty-five yard penalty kick to make the score

9-11. Just before half time a fifty-yard Bart's three-quarter movement was stopped, and Old Whitgiftians infringed. Gibson converted—the ball bouncing in off the upright.

After half-time the one-point lead was soon reduced as Old Whitgiftians kicked a long penalty. But as Bart's had now mastered the game, tried seemed inevitable. Firstly, Pope kicked a fine "Mitchell", and following up, scored under the posts. Gibson converted; then Johnson intercepted and ran strongly through a tackle and scored near the centre. Again Gibson converted.

A slight lapse in the defence allowed the Old Boys to score a try in the final minute of the game, but this made no difference to the result which was a fine win for the Hospital.

Team: Sidebottom, E.; Harris, S. G.; Griffiths, N. J.; Savage, P. E.; Johnson, S. M.; Letchworth, A. T.; Pope, D. C.; Gilmore, O. J. A.; Gurry, B. H.; Knox, A. J. S.; Bates, T.; Orr, M. M.; Gibson, J. A.; Smart, C. J.; Goodall, D.

On Wednesday, 15th January, the A XV beat Charing Cross in the Junior Cup. The score was 5-3, Bart's try coming from a fine move by J. P. Gateley. R. Bown, promoted from his Ex A XV, led the pack and the win compensated for the close defeats the A XV have been suffering this season in their other matches.

Team: Davies, J. P.; Powles, R. L. (capt.); Grafton, C. A.; Gateley, J. P.; Hopkins, G.; Niven, P. A. R.; Chesney, D.; Bown, R.; Gurry, B. H.; O'Kane, A.; Stephens, K. M.; Boston, R.; Mumford, G.; Bradley-Watson, P.

SOCCER REPORTS

Wednesday 11th December, v St. Thomas's Hospital. Won 5-3.

Bart's had most of the play early on in the match, but a defensive error allowed St. Thomas's to take a 1-0 lead after ten minutes. This encouraged them, and our defence was extended for a while. However, Bart's gradually fought back and contained the St. Thomas's forward line. Before half-time Bart's pressure was rewarded by two goals.

Bart's took things a little easy after the interval and St. Thomas's scored. Our lead was quickly restored by Dorritt with an excellent shot from the edge of the penalty area. Herbert then scored with a similar shot, making the score 4-2. The play then continued in our favour until a breakaway goal put St. Thomas's back in the fight. In the closing minutes Herbert clinched the game for Bart's with a fine curving shot.

Saturday, December 14th, v Guy's Hospital. Lost 4-1.

We met Guy's, who were unbeaten this season, having had no league goals scored against them, with a rather depleted side owing to the close of the pre-clinical term. The pace of the game was much faster than usual in the Hospitals' League. Guy's took the lead after ten minutes with a high lob. Bart's then did very well to fight back and equalise with a goal from Shorey. For ten minutes the Guy's defence looked panicky and Bart's just missed scoring several times.

Soon, however, Guy's increased the pressure and scored two quick goals to lead 3-1 at half-time. They again scored soon after the interval, eventually controlling the game through their midfield superiority without increasing their lead.

Saturday, January 4th, v London Hospital. Lost 5-3.

Bart's played the first half at a pace which displayed the effects which Christmas and the New Year had had on them. As a result, London were 3-0 in the lead by half-time.

Just before the interval, there were signs of life from the Bart's forwards which later developed into some spirited football. Bart's quickly scored two goals and the game was closely fought for 20 minutes. Then Bart's tired, allowing London to score twice, before themselves gaining a goal just at the whistle.

Saturday, 25th January, v Royal Free Hospital. Won 5-0.

Throughout this game Bart's played rather half-heartedly, but even so, spent most of the time in their opponents' half. Shorey opened the scoring with a headed goal from a corner kick, and followed this with two more goals. Thew and Phillips then added the remaining goals for Bart's.

HOCKEY REPORT

So far this season the club has a more satisfactory score card than it has had for many years, although there is considerable room for improvement. The results for this season's matches so far are:—

Wins 8 Losses 6 Draws 5
Goals for 47 Goals against 42

On November 30th, we won at home 1-0 against N.P. Bank. This was a hard game

against a good team. The match was very even all the way through, but we scored the winning goal just before half-time. Although the Bank side tried very hard to score, some excellent saves by H. daSilva undoubtedly helped us to win. The forwards were not on form, but managed to score the one vital goal.

On December 7th, we played away at Tonbridge Wells, and were beaten 1-4. The ground was very soft, and both sides found it difficult to stay on their feet. However, the opposition managed to find their's sooner than we did, and were soon two goals up, after some good forward movements. In the second half Bart's settled down a little, and scored a goal after a struggle in the goalmouth. But this did not deter the Tonbridge forwards, who scored two further goals. Once more H. daSilva saved us from a larger defeat.

On December 11th, we played away against Imperial College, and drew 1-1. From the beginning it seemed that the match would be very even, but we soon took the lead after a good centre from right-winger A. Bateman, from which I. Peek scored. We continued well, with more good crosses from both wings, but our inside-forwards seemed quite incapable of scoring any more goals. It was unfortunate when our opponents scored a goal from a scramble in our goalmouth, which we felt was quite undeserved.

On December 14th, we had an enjoyable game against Tulse Hill, which we won 4-1. In the first half we scored three goals, and were definitely the better team. At half-time there was talk of being able to reach double figures, but in the second half the forwards seemed to want to give the defence a little practice! The forwards, alas, only managed to score one more.

On January 11th, we beat Shell BP 4-0. The opposition was very much a scratch side, and we had little difficulty in beating them.

On January 18th, we drew 1-1 against Smith's of England. The match was keenly played by both sides, and towards the end there were some strained tempers, but fortunately no accidents. Again, the defence played very well indeed, and undoubtedly saved the day, particularly noticeable being our goalkeeper, daSilva. Our team was very much under strength, as we were missing I. Peek, W. Castleden, J. Harrison, A. Bateman and S. Thomas, but the forwards that we did play were very much off form, and so could not get going at any time of the match. From our

point of view it was a most unsatisfactory game.

On January 25th, we were beaten 0-4 by a strong side from Walton-on-Thames. Again we were four short of our best players. However, this is the first time we have been beaten since October. Unfortunately we deserved it. The forwards have much room for improvement. H. daSilva again played well, and two goals were scored when the opposition forwards were off-side, but there was only one rather bored umpire!

Wednesday, 29th January, 2nd XI Cup Match St. Mary's Hospital. Home. Result: Win 2-1.

From the result of this splendid match, it is evident that Bart's need have few fears about the 1st XI of the future. The play was very much in our favour throughout the whole game and was a delight to watch. As usual, the pitch was in perfect condition, thanks to Laurie White's constant tender care, and the whole team played extremely well. In the forward line S. Heyward was a veritable spear-head making most of the dangerous attacks, and being well rewarded with the first goal, which he made almost entirely on his own, having collected a good pass from right-inside A. Chant. Within a quarter of an hour Gordon had a long run on the left, and scored a good goal with the flick side of his stick, a difficult shot at which he is very adept.

In the second half, the play evened out a bit, with both teams playing well, but at all times there seemed to be two Bart's men wherever the ball went. A few close shots were unlucky not to enter the goal, and St. Mary's scored after the ball was hit towards S. Campbell-Smith, who could not see the ball for the bodies in front of him. Apart from those already mentioned, particular credit must go to M. Nightingale, an able captain, R. Browne and T. Billington.

Team: S. Campbell-Smith; C. Frears; R. Browne; M. Smith-Walker; M. Nightingale; T. Billington; T. Herbert; A. Chant; S. Heyward; M. Bructon; A. Gordon.

2nd XI Results, January/February

Saturday, 18th January v Smith's of England, lost 5-1.

Wednesday, 22nd January v Guy's 2nd XI. No result.

Wednesday, 29th January. Cup Match v St. Mary's Hospital. Won 2-1.

Saturday, 1st February v Imperial College 2nd XI. Lost 4-2.

Saturday, 18th January v Smith's (Clocks)

A very heavy frost made the pitch hard and rather dangerous. Smith's went into an early lead but then the play was very balanced and Bart's equalised before half-time. In the second half their experience and superior fitness added a further four goals. In spite of the result this match was very encouraging, as the forwards were working well together, with good passing between them.

Wednesday, 22nd January v Guy's Hospital

Because the coach failed to appear at the Hospital, Bart's arrived with only seven players. Guy's had trouble as well with ten men so we played a friendly game. Ten minutes from the start thick fog descended and visibility was cut to five yards. We continued to play and occasionally search parties were required to locate the ball or players lost on or off the pitch. After a short game we adjourned to play darts where the visibility was a little better!

SQUASH CLUB

1st Team

Since Christmas the team has played three matches, losing to Roehampton in a disappointing match, where the team were obviously suffering from the after-Christmas syndrome. Against Kensington Close we were without John Mitchell and David Latham and so were unable to repeat our victory of last October. The U.C.H. match turned out to be one of the best of the season. D. Delaney and C. Edwards both had very close matches, which could have decided the match either way. With Delaney winning 9-7 in the 5th game the match was ours.

With the loss of David Latham who has recently qualified, the team has weakened at 2nd and 3rd strings. However, David Delaney is able to play for the club again, and should well make up the loss of Latham.

With four more Cumberland Cup matches to play we still have a chance of maintaining second place in the division, and thus have a chance of promotion. The Hospitals' Cup will be played very shortly. We have only a fighting chance against the Middlesex Hospital, who have a strong side.

Results

v Roehampton. Lost 1-4.
v Kensington Close. Lost 1-4.
v U.C.H. Won 3-2.

Team: K. Bowles, A. Edelston, M. Downham, D. Latham, D. Delaney, C. Edwards.

2nd Team

The second team lost convincingly to a strong Jen de Paume team, 5-0. Mike Downham at No. 1, played an excellent game, and shows marked improvement over the last few months in his choice of shots. He was narrowly beaten in the 5th game.

Team: M. Downham, C. Edwards, D. Chesney, M. Graham, G. Gordon.

CROSS COUNTRY

Wednesday, November 27th. U.L. League Match (Div. D).

This, the third League match of the season, was organised by King's College on a flat six-mile course around the commons, canals, railways, streets and factories of Mitcham. Just before the first railway bridge R. Markham, R. Thompson and R. Sanders were running together when the latter fell over, causing the others, who were just behind, to suffer a similar fate. Meanwhile, T. Foxton was running very fast up in front and managed to finish ahead of Barton, of King's, to come in third behind Farrington and Yates, the two internationals from U.C. This was a very good result for T. Foxton. R. Sanders recovered from his fall to come in 26th with R. Thompson close behind. R. Markham, R. Phipps and F. Hardy, although further back, scored valuable points for us. T. Walsh and P. Brackenbury also ran. 68 runners finished the course. We thank King's College for providing an excellent tea and T. Walsh for driving.

		mins.	secs.
1	Farrington	32	15
2	Yates	32	15
3	Foxton	33	16
26	Sanders	36	4
31	Thompson	36	17
45	Markham	37	40
49	Phipps	38	56
50	Hardy	39	58

The team results of this race were as follows:

		points
1	University College	303
2	King's College	291
3	L.S.E.	280
4	St. Mary's College	266
5	Goldsmiths' College	226
6	Bart's	201

(Continued on page 123)

THE MEDICAL PROTECTION SOCIETY

ADVICE · DEFENCE & FULL INDEMNITY FOR DOCTORS & DENTISTS AT HOME & OVERSEAS *Founded 1892*

50 HALLAM STREET · LONDON · W.1

Secretary: Dr. H. A. Constable. Tel: LANGHAM 9241

Ref.....

BANKER'S ORDER

To..... **Bank Ltd.**

.....branch (address of your bankers)
Please pay to the National Provincial Bank Ltd., 59, West Smithfield, E.C.1 branch, for the credit of the St. Bartholomew's Hospital Journal Account the sum of £...../.....s./.....d.pounds
.....shillingspence (amount in words) on theday of.....
(month) of EACH YEAR, commencing 19..... until this order is cancelled by me. If the date of this first payment shown here is past, please make the first payment on receipt of this order.

This authority cancels all previous instructions.

..... (name and qualifications)
..... (BLOCK CAPITALS)
..... (Please sign over a 2d. Stamp)
..... (address for Journal)
..... (date)

PLEASE NOTE—The completed form should be returned to the Manager of the Journal.
WE WILL SEND IT TO YOUR BANKERS.

St. B.H.J., March, 1964

123

7	I.C. I	182
8	Guy's	128
9	Battersea	128
10	I.C. II	102

The positions in the League to date are:

		points
1	University College	928
2	L.S.E.	848
3	King's College	815
4	Goldsmiths' College	667
5	Bart's	637
6	St. Mary's College	623
7	I.C. I	622
8	Guy's	481
9	Battersea	426
10	I.C. II	355

Saturday, December 7th. University of London Championships.

The less said about this disastrous occasion the better in which we lost the Roehampton Cup for the smaller colleges of the University by not producing a team. Five runners were required to score but unfortunately only four arrived in time. The course was 4½ miles long around Wimbledon Common and was run on the same day as the Oxford v Cambridge match, whose runners were frequently to be seen, although on a different course, and there was some confusion as to which race started where. The race was won by J. Farrington, thus helping University College to win the event. T. Foxton ran well as usual to come 6th. The Roehampton Cup was won by St. Mary's Hospital who look like being our rivals in the Kent-Hughes Inter-Hospitals' Championship.

			mins.	secs.
1	J. Farrington	U.C.	20	21
2	N. Barton	King's	20	30
3	P. Yates	U.C.	20	47
6	T. Foxton	Bart's	21	43
21	N. Pott	Bart's	22	39
50	R. Sanders	Bart's	24	11
67	R. Thompson	Bart's	25	23

96 finished the course.

College positions:—

1	University College
2	Woolwich Polytechnic
3	King's College
4	St. Mary's Hospital

Wednesday, January 22nd. St. Mary's Hospital Hyde Park Race.

		points
1	St. Bartholomew's	20
2	St. Mary's	41
3	Guy's	70
4	London	112

This annual event, held for the London Hospitals, resulted in a convincing win for us, thus retaining the Porrit Cup. The race started near the Victoria Gate and by the time Marble Arch was reached it was obvious that the race was between Bart's and Mary's. Along Rotten Row Steiglitz (Mary's) and Foxton (Bart's) went into the lead with Pott, Tunstall-Pedoe, Thompson and Lightfoot behind. Further back Sanders dropped two Mary's runners by the end of the Flower Walk, and went on to overtake Lightfoot and Thompson. Meanwhile in front Steiglitz opened up a lead along the Broad Walk, and went on to win comfortably from Foxton. Tunstall-Pedoe, who is now running well again after his visit to India, and Pott, ran together to come in third equal. Thompson overtook Lightfoot along the south of the Serpentine and joined Sanders to come in 5th equal. Thus our scoring five finished in the first six, showing that our recent interval training on the road had its effect. St. Mary's were unlucky in that T. Bryan missed the start by a minute and that R. Walters was ill.

			mins.	secs.
1	L. Steiglitz	Mary's	27	19
2	T. Foxton	Bart's	27	38
3	N. Pott	Bart's	28	55
	D. Tunstall-Pedoe	Bart's	28	55
5	R. Thompson	Bart's	29	25
	R. Sanders	Bart's	29	25
7	N. Lightfoot	Mary's	30	2
22	R. Phipps	Bart's	32	36
25	R. Markham	Bart's	33	58

33 finished.

Saturday, January 25th. Queen Mary College 7½-mile race at Dytchleys.

This race normally provides the toughest course of the year but on this occasion the 7½-mile course was reduced to 4 miles due to the leaders going the wrong way. Conditions were very muddy, the ploughed fields being sticky, which suited Pott who ran very well against competition from the London Colleges and visiting teams from Cambridge and other universities, to come in 7th. Foxton also ran well to finish 10th. Thompson was well up in 26th position, Tunstall-Pedoe was 53rd and Sanders, who was suffering from shin soreness, came in last—about 100th. Heron of Cambridge, Moore of Leeds, and Yates of London, came in first, but no individual or team prizes could be awarded.

(Continued on page 124)

WHAT DOES



STAND FOR?

IT STANDS FOR security and peace of mind from the day you qualify—until the day you retire—and after.
IT STANDS FOR the provision of advice on all your professional problems . . . for legal assistance in any difficulty or proceedings of a professional nature . . . for unlimited indemnity in respect of damages and costs in the event of an adverse verdict or a settlement out of Court.

IT STANDS FOR THE MEDICAL DEFENCE UNION the oldest and largest organisation of its kind in the world. Further particulars can be obtained from

THE MEDICAL DEFENCE UNION

Tavistock House South, Tavistock Square, London, W.C.1

Secretary: Dr. Philip H. Addison, M.R.C.S., L.R.C.P. Dental Secretary: A. H. R. Rowe, B.D.S., F.D.S.

Saturday, February 1st. The Hospitals' (Kent-Hughes) Championships at Barnet.

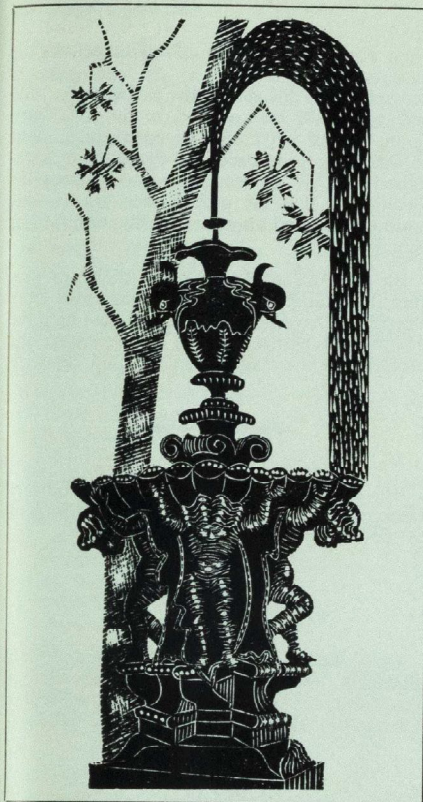
		points
1	St. Bartholomew's	30
2	St. Mary's	41
3	Guy's	62
4	London	147

In the days preceding this event there was much speculation as to whether Mary's or Bart's would be able to run their best teams due to illness and injury. On the day, however, we produced our full team to win the Kent-Hughes Cup for the 4th year in succession. Mary's were second but were unlucky in that R. Walters was unable to run. It was a fine sunny day, excellent for running, following a few days' rain which had made the U.H. course very muddy. The race was started by Mr. Stallard, the U.H. President. Steiglitz of Mary's soon went into the lead which he kept to win in 28 min. 38 secs., a very fast time considering the conditions on the 5½-mile course. Foxton, of Bart's, ran well to finish second as expected. Bryan and Thompson had a battle all the way which resulted in Bryan gaining a lead on the last hill to come

in third. Thompson, although beaten into fourth place, ran extremely well and in a time over a minute faster than he has ever recorded before over this course. Two more Bart's men, Pott and Tunstall-Pedoe, came in together in fifth position. This was a very noble effort by Pott who was ill with bronchitis and a fever the day before. Guy's packed in very well with 8th to 12th position. Sanders came in 13th to complete our scoring team. Markham, Phipps and Hale all ran well and although they did not score their efforts are much appreciated and promise well for future years. Thus the hard training we have been doing together as a team along the Embankment and over Hampstead Heath has been rewarded.

			mins.	secs.
1	I. Steiglitz	Mary's	28	30
2	T. Foxton	Bart's	30	38
3	T. Bryan	Mary's	31	25
4	R. Thompson	Bart's	31	34
5	N. Pott	Bart's	31	55
	D. Tunstall-Pedoe	Bart's	31	55
13	R. Sanders	Bart's	33	50
16	R. Markham	Bart's	34	45
17	R. Phipps	Bart's	35	4
19	R. Hale	Bart's	35	15
27	F. Hardy	Bart's	36	39

53 finished.



CONTENTS

Editorial	125
Dr. Hermann Lehmann—an appreciation	131
Up to the Minute in a Moment	132
Scandinavian Visit 1963—1. Travelogue by Norman G. Rothnie	134
A Look at General Practice by M. F. Hudson	140
East African Safari by J. D. Scobie	143
Boat Club Ball	146
Alteration in Casualty Department—II by James O. Robinson	149
Around & About by "Argus"—2 Medical Education and Practice in Australia by Kenneth Carroll	151
Tiger at the Gates	153
William Hogarth (1697-1764) by Roger Sanders	156
Other Hospitals: 5—Charing Cross Hospital by J. D. Robertson	157
	161

PUBLICATIONS COMMITTEE

Chairman: Dr. A. W. FRANKLIN.
Deputy Chairman: Dr. G. H. FAIRLEY.
Editor: TREVOR P. DUIT.
Review Sub-Editor: G. R. HAMILTON.
Social Sub-Editor: Miss J. BELL.
News Sub-Editor: C. J. KELLY.
Sports Sub-Editor: G. HAIG.
Photographic Sub-Editor: B. C. P. LEE.
Manager: G. O. GEY, Jnr.
Assistant Manager: J. R. SWAIN.
Nurses' Representative: Miss M. IRONSIDE.
Charterhouse Representative: G. W. IBBY.

EDITORIAL

TELLING THE RELATIVES

"Here an idea recurs often met with in affairs of this kind; that of the "patient condemned by the doctors". The obvious good faith of those connected with the patients is shocked, either by words or letters wrongly interpreted, or by the obviously bad condition of the patient. But to tell a family that a patient cannot be cured is not the same as saying that things will soon go badly. To consider that a patient, obviously in bad condition at the end of a treatment, is speedily condemned, even if his chances of a final cure are very small, does not correspond with what is usually found."

This quotation is from Sir George Godber's translation of Professor Pierre Denoix's report on the treatment of leukaemia and cancer by M. Gaston Naessens, published in the British Medical Journal on the 7th March*. We are not qualified to enter into any discussion on the merits or otherwise of this much publicised treatment but we do suggest that the passage quoted above constitutes an admission to a remarkable lack of proper communication between the doctor and his patient.

Opinions differ widely as to whether or not the doctor should tell the patient that he has an incurable and fatal disease but most doctors today would agree that the close relatives should know of the situation in such cases and that parents in particular should be well informed if the patient concerned is a child. How then does it come about that the doctor's explanations are misunderstood?

There are two reasons for this unfortunate state of affairs, the lack of time on the part of

*Brit. Med. J. March 7, 1964, p. 625.

the doctor and, much more important, the fact that many doctors, even today, while accepting that the relatives should be told of the condition and prognosis, still feel that a full description of the course of the disease is unnecessary.

The time factor is one which is continually recurring whenever the doctor-patient relationship is considered. The consultant in the hospital may have a busy out-patient session and may in any case feel that any explanation would come better from the family doctor. The family doctor, on the other hand, with a full surgery and a long list of visits often finds it almost impossible to spend a really adequate amount of time with the relatives.

There can be little doubt that it is the responsibility of the general practitioner to explain the position fully to one or more of the relatives, for it is he alone that is in a position to decide which of the relatives will best appreciate the problems, be most understanding and capable of dealing with them and be most likely to maintain a genuine spirit of optimism even in the knowledge of the inevitability of the final outcome. It is unjustifiable for the family doctor to plead a lack of time for giving such explanations, for the whole tenor of the patient's remaining life, be it measured in days or years, may depend on the attitude adopted by his relatives and friends, and this in turn will depend largely on the information which they have received from the doctor.

How much should the doctor tell? This, and the way in which he tells it, will of course depend on his assessment of the person to whom his words are addressed but, in general, those people who are to care for the patient should be told an outline of the whole course of the disease as it is likely to affect that patient.

It is also essential that the doctor should encourage both the patient and the relatives to come to him should they have any worries or problems, however trivial they may seem. If such a relationship is not established either the patient or the relatives may worry over some matter which may or may not be important but which disturbs them. Should this occur the well being of the patient is almost certain to suffer. It may be difficult for the harassed G.P. to encourage a relationship of this nature as it amounts to asking for extra work, but this is a sacrifice which he will have to make.

Although, ideally, the family doctor should be the person to talk to the relatives, it may

often happen that force of circumstances or questions from a husband or wife make it necessary for the consultant to play this role and he should be prepared to do so. Once again, a brief but clear and complete account of the likely progression of the disease is required and it is usually a good policy to recommend that the patient then goes to his family doctor and discusses the situation further with him.

By adequate explanation we shall not prevent the relatives of some hopeless cases from clutching at straws but we can at least help the majority to appreciate and to overcome the problems in the management of such cases.

We would like to congratulate Mr. Edward George Tuckwell on his appointment as Surgeon to the Royal Household.

On Tuesday, 28th April, Her Majesty Queen Elizabeth, the Queen Mother, Chancellor of the University of London, will visit the Medical College to inaugurate the new science buildings.

Erratum

We regret that figures 4 & 5 of *Phaeochromocytoma—a case report* by R. E. Farrow (page 104) were printed upside down in the March issue of the *Journal* (Vol. LXVIII, No. 3).

Binding the Journal

In response to a number of requests we can now arrange for the binding of copies of the *Journal*. Anyone wishing to take advantage of this service should send their copies to the Editor, enclosing the full name and address to which the bound volumes are to be sent.

In certain cases it may also be possible to supply missing copies of past issues.

The cost for the binding service will be 30s per volume (post free) with an additional charge of 1s. 6d. for any back numbers supplied.

Correspondence

THE RUGGER MYTH?

Sir,—I quote from the Sport's Editorial of your March issue:—

"It is ironical that the Rugby XV have, as ever, been fortunate enough to attract many spectators to their cup matches, whereas the more successful, if lesser known Bart's clubs have again been ignored". The Sport's Editor should have been less polite, and, once and for all, exploded the Rugger Myth. Year after year, work grinds to a halt, one cold wet January afternoon to enable the XV's faithful followers to cheer on their side during yet another defeat. An honest comparison of the various Sports club's records will reveal that of them all, Bart's own Sacred Cow is the least successful.

This insular attitude is typical of medical students in general, and Bart's students in particular. Their parochialism consists of their one sport, girl (or boy) -friend, the Hand and Shears, the car and just manages to squeeze in Medicine, though some worthies manage the latter and precious little else. The sceptic should here ask himself what he and his friends discuss over tea every afternoon in the refectory.

The whole topic is, of course, an individual matter, but can the authorities not help to a certain extent? If annually they can lend the full weight of their support to the Rugger Club then perhaps they could consider some of the other far more deserving clubs and societies in an equally forceful and appropriate manner, thus indirectly enhancing the Hospital's so-called good name. To mention but a few of the successful clubs that receive virtually no recognition: the Ladies' Hockey Club with its almost unbroken run of success since its formation; a year never passes without the Cross-Country Club bringing back several trophies; the achievements of the Tennis and Swimming Clubs pass unheralded; but everyone knows that Guys again knocked the 1st XV out of the Cup (and once more the VIII didn't quite manage to survive the first round at Henley).

Needless to say the 'fringe-of-sport' clubs or frankly non-sporting societies gain even less support. "Which hospital each year has the least number of entrants for the Brighton Stroll?" is a rhetorical question—this despite our relatively high student population. How many of us even thought of writing for Broad-sheet during its sadly ephemeral existence, let

alone actually put pen to paper? It's almost incredible but nevertheless true, that on both nights of the Drama Society's Main Production last month, there were more students in the cast than in the audience! And exactly how many will make the 6d. tube-ride away from the domesticity of West Smithfield to encourage Bart's in their first appearance at a Drama Festival next May?

I appeal to the Medical College Authorities, the hierarchy of the Student's Union, and above all, to the Individual, none of which is beyond reproach. Can we make no attempt to rid ourselves of this malignant selfishness, this idiotic attitude of apathy and phlegmatism? Let's get up off our proverbial backsides and regain our sense of proportion, and our sense of awareness.

Your faithfully,

BRYAN LASK,

28th February. The Abernethian Room.

BLUE STOCKINGS?

Sir,—It would be thought that the presence of women in an academic community would cause the men to be more conscious and more careful of their appearance. But during this present winter, the women students of this hospital have led the men down a slippery slope of increasingly casual, if not downright careless, dress.

Have women become more sensitive to cold during the past year, or has winter become more severe, so that they must offend the eye with patterned, coloured or (horror of horrors!) even many-coloured hose? These garments, though "mod" or "with it", or whatever may be the current catchphrase, may be suitable for typists and shop girls of tender years, but they do not accord well with the white coat and stethoscope of the aspiring doctor. They must surely offend against the patient's image of a sagacious physician, especially one at the august hospital of St. Bartholomew; in the patient's eyes, all who wear a white coat and wield a stethoscope are both equal and qualified.

Before the men who read this raise their voices in assent or dissent, let them consider well when they last cleaned their shoes or visited a barber; let them then ask themselves when the shirts they are wearing last visited the laundry, or their suits the dry cleaner? How many of them are wearing those abominations, which should be reserved for a ramble in the country, shirts with collars both attached thereto and sadly lacking the warm embrace

of a smoothing iron? Further, do they wear a suit always, or usually, or are they frequently seen wearing an exotic combination, as of Harris tweed above and corduroy below?

We are proud of our association with a hospital which claims to be the oldest and the best in the world, and one which has been described as "the sheet-anchor of the medical profession". It the standard of our dress reflects the future standard of the medicine to be taught and practiced here, one shudders to think how our revered predecessors must turn in their graves, and one can only pray for the patients of other, more "progressive", hospitals.

Your obedient servant,
ALAN J. LYONS.

The Abernethian Room.

4th March.

POT-POURRI, 1963

Sir,—May I join forces with Messrs. Chapman, Matheson and Bottomley, who so deplored your Special Correspondent's churlish jottings about the 1963 Pot-Pourri and use more of your valuable space to censure further his contrived comments which were surely designed to be controversial? Certainly no other motive could excuse a pen as sharp and writing as tart about a show that was generally well received.

Every Christmas there is misguided talk about ward show audiences, ward show material and the Pot-Pourri itself. Invariably the perennial discussion forgets three things: our patients form less than a fifth of the ward audiences. These patients if well enough are out, even determined, to enjoy Christmas in Bart's and will laugh equally at the alleged satire of Chapman and the outright slapstick of Wilson and Wise. Within twenty-four hours the Pot-Pourri producer attempts to do no more than reproduce the best of those ward shows at the Cripplegate as the Pot-Pourri. Both the ward shows and the Pot-Pourri are conceived, produced, acted and watched strictly in the Christmas spirit. Special correspondents are not privileged and should be no exception to this dictum.

In a parochial institution such as Bart's the reviewer or critic is in an invidious position and no one should grudge him a degree of anonymity, more especially if his remarks are censorious. However, every amateur critic here should consider carefully what he is about. Because he is not in the position of advising the populace at large about the merits of a show which may run for some months, he is tempted

to amuse himself by writing review for review's sake. In fact in such circumstances the only justification for his comments are their news value, their topicality; in other words to be acceptable and readable they must be a report. In reporting the cardinal aim is accuracy which should never be distorted to gain cheap and fast interest. The report of your Special Correspondent was so out of touch with popular impressions that I thought he must be as ignorant of the inmates of this ancient Hospital as he appeared to be of the accepted and acceptable bonhomie about Bart's at Christmas.

In these days although *A CHRISTMAS CAROL* is no longer considered compulsory yuletide reading I think we should be mindful of old Scrooge. You see Sir, your Special Correspondent's remarks were mean.

Yours faithfully,

SIMON CAMPBELL-SMITH.

9th March.

Abernethian Room.

[We quote from the (anonymous) review of the 1962 Pot Pourri entitled "Hash" which was published in Broadsheet (No. 3, Jan. 16th, 1963) of which Mr. Campbell-Smith is a co-editor.]

"The annual Pot-Pourri needs a face-lift. Of late it has rather run to seed; it has swapped happiness for noisiness, subtlety for easy smut and talents for traditions".

and later:—

"This is an annual event that one of the most respected Chiefs has dropped from his Christmas engagements for nine years because, he says, as it's lavatorial content increases, it's standards decrease, and therefore he no longer wishes his family or himself to see it. This is very sad".

We agree, and so, we believe, does Mr. Campbell-Smith.—Ed.]

THE PRACTITIONER'S POSITION

Sir,—Many people will agree with your Editorial that the demonstration of complicated surgical operations on television are of little value, but they certainly do no harm. The time would, however, be better employed by discussions on general health and symptomatology. In the case of malignant disease the latter is very essential.

In 1957 the Registrar General reported the following figures. In Cancer of the Breast the median delay between noticing symptoms a start of treatment was 6.2 months but 17.3% of cases waited over two years. There is little doubt that this delay is due to ignorance of the Public concerning painless lumps in the breast. If television could inform women, and persuade them of the importance of three monthly 'Self Examination' of the breasts, as is done in other countries, hundreds of lives

would be saved each year. Nearly all cancers of the breast are discovered by the patients, who ignore the condition because there is no pain.

The figures quoted for delay before treatment in Carcinoma of Cervix is 5.7 months but 8.4 waited over two years. Much of this delay is due no doubt to the bleeding being considered "Only the Change of Life".

In Cancer of the Rectum 25% wait over a year, which no doubt is due to the patient considering it to be "Only an attack of Piles".

After years of experience and delivering hundreds of lectures to the lay Public, I am convinced that the giving of such information *does not* produce neurosis, but on the contrary diminishes Fear and leads to many more "Early Stage" diagnoses and saves hundreds of lives.

Yours faithfully,

MALCOLM DONALDSON.

9th March. Cancer Information Association.

PATHOLOGY & CLINICAL MEDICINE

Sir,—I was very interested in the article Pathology and Clinical Medicine by E. M. Darmady in the March Journal.

I am afraid there is one serious error with reference to Lord Horder. I qualified in 1908, he was then an Assistant Physician at the Hospital and I attended his Medical Out-patients on a number of occasions. I think it was 1906 when he became an Assistant Physician. Previously he was Medical Registrar, which was considered the next step to being appointed Assistant Physician. Dr. Norman Moore used frequently at medical consultations to state that he was Medical Registrar for 16 years at that time he was Senior Physician.

I well remember one occasion when Dr. Horder was demonstrating morbid anatomy, the small white kidney thickened arteries, etc.

Yours sincerely,

E. R. JONES.

The Cottage,
Staines Road,
Wraysbury,
Staines.

11th March.

Calendar

APRIL

Sat. & Sun., 4th & 5th:

Dr. Dudley Scott
Mr. Alan Hunt
Mr. J. N. Aston
Mr. G. Ellis
Mr. A. P. Fuller

6th April: Copy date for May Journal.

Sat. & Sun., 11th & 12th:

Dr. E. R. Cullinan
Mr. C. Naunton Morgan
Mr. H. J. Burrows
Dr. K. W. Ballantine
Mr. J. W. Cope

Sat. & Sun., 18th & 19th:

Dr. G. Hayward
Mr. A. W. Badenoch
Mr. J. N. Aston
Dr. Ian Jackson
Mr. R. F. McNab Jones

Sat. & Sun., 25th & 26th:

Dr. A. W. Spence
Mr. E. G. Tuckwell
Mr. H. J. Burrows
Dr. T. B. Boulton
Mr. J. C. Hogg

Monday, 27th April: Her Majesty the Queen Mother visits the Medical College.

The Physician Accoucheur on Duty for the month of April is Mr. G. Bourne.

Sports Day this year will take place on Wednesday, 27th May.

PHOTOGRAPHIC SOCIETY

The View Day Exhibition will be held in the Hospital Library on View Day, Wednesday, 13th May.

The Exhibition will be divided into the following groups:

Black & white: Portrait
Pictorial
Record
Action

Colour: Transparencies
Prints

Black & white entries must be at least whole plate size (6½ x 8½ inches), mounted and must be the entrants own work (this includes mounting). Colour entries may be of any size and may be commercially processed.

All entries must be handed in to the Library by Friday, 8th May and must be clearly labelled with the entrant's name, the group for which they are intended and their title.

NURSES' FINAL HOSPITAL EXAMINATION—FEBRUARY, 1964

Engagements

COLLETT—PLUMMER—The engagement is announced between Robert William Cecil Collett and Jennifer Anne Plummer.

ORRELL BARKER—The engagement is announced between David Howard Orrell and Patricia Mary Barker.

STAINTON-ELLIS—RONSON—The engagement is announced between David Stainton-Ellis and Ruth Ronson.

WHYATT—LAWSON—The engagement is announced between Nicholas David Whyatt and Anne Lawson.

Marriages

SCOTT-BROWN—HAWKES—On 26th January in Nepal, Mr. George Graham Scott-Brown to Margaret Hawkes.

Births

BODLEY SCOTT—On 15th February, to Mary (née Richards) and David Bodley Scott, a son (Richard).

HOWES—On 8th February, to Gill and Alan Howes, a son (Mathew Toby Charles).

R. L. Bailey
A. Bannister
J. M. Blunt
J. Bond
J. A. Booth
R. M. Burn
A. P. Butler
D. B. Cole
E. M. Coles
J. J. Coles
R. A. Coulter
Y. M. Cunliffe
W. A. Darracott
G. A. Draper
J. E. Elkington
S. A. Finnigan
J. R. Gillett
M. E. Green
D. E. Hammonds
W. V. Hart
M. A. Hill
*D. P. Hogan
C. J. Howard
O. M. E. Kesby
J. M. Kingdon

B. E. Knight
E. J. Knights
G. Knudsen
P. A. Ladd
J. M. Lainé
M. Layton
D. Luza
P. A. Macdonald
S. P. Macklin
S. B. Mears
B. L. Methven
A. C. Milne
E. Morley
E. A. Napper
C. P. Newbigging
G. M. Noyce
C. M. Pearson
S. M. Pedley
J. A. Plummer
J. E. Porter
J. Prior
J. M. Rose
A. Sadler
R. J. Sale
I. D. Sansom

F. H. Scott
D. J. Seabright
C. G. Sharpe
J. F. Simpson
J. F. Simpson
J. Sirrell
V. E. Skala
S. Smale
A. S. Smith, née Willis
S. Smith
R. A. J. Sparrow
F. Stack
P. A. Stokell
H. B. D. Stainton
J. Streat
S. Sydes
C. M. Turner
J. Topping
M. N. Towers
L. M. Turpin
H. M. Turton
B. I. Tyler
*Y. M. Wall
C. J. Whiteside
E. A. Whiting.

* Gold Medal and First Class Honours.

MUIR—On 24th February, to Patricia (née Sketchley) and Dr. Grainger Muir, a daughter.

WYATT—On 15th February, to Margaret and Arthur Wyatt, a son, David William Thomas, a brother for John and Robert.

Deaths

POTTS—On 12th February, John Leonard Potts, B.A., M.B., B.Ch. Qualified 1921.

SEWELL—In February, Lieut.-Col. R. B. S. Sewell, M.R.C.S., L.R.C.P., aged 83. Qualified 1907.

URWICK—On 25th February, Reginald Henry Urwick, M.A., M.D., aged 88. Qualified 1901.

WELLS—On 3rd February, Gordon Wells, F.R.I.C., B.Sc., M.R.C.S., L.R.C.P., Qualified 1931.

Appointment

Orthopaedic Department.
Mr. C. W. S. F. Manning, F.R.C.S., has been appointed Consultant Orthopaedic Surgeon in place of the late Mr. Coltart.

DR. HERMANN LEHMANN

It is sad to think that there will soon be a generation of clinical students at Bart's who will not have had the pleasure of knowing Dr. Hermann Lehmann, who left us at the beginning of this year to take up a research post at Cambridge. Those of us who knew him and were taught by him will miss his cheerfulness, wit and generosity. We will remember the tremendous enthusiasm with which he approached everything he did, whether it was imparting the excitement of Chemical Pathology to a not always wide-awake class or helping the Students' Union clubs and societies with which he was associated. It is with this in mind that I feel that a brief review of his activities involving the students would be appropriate now.

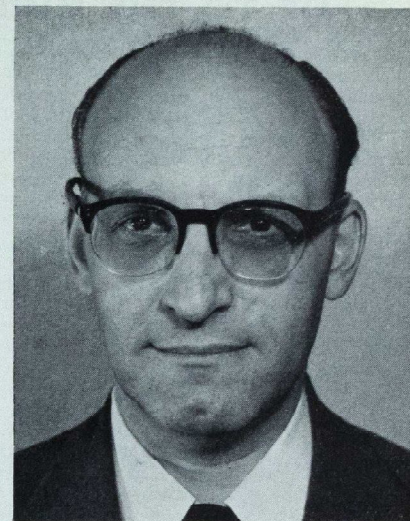
Perhaps his main interest was the Drama Society, of which he was a Vice-President. Nobody who was associated with the Society or went to the plays will forget his smiling figure at every performance, or his gifts of flowers for the cast. He was always available for advice and information and was a constant source of encouragement and strength to the Society.

Dr. Lehmann was also associated with the Ladies' Tennis and Ladies' Hockey Clubs, and is remembered by the members as providing tea, and at times sympathy, after matches and at their Annual General Meetings. One promise he made to the Ladies' Tennis Club was never carried out. The players were to have a strawberry and cream tea if they got into the final of the United Hospitals' Cup. It is hoped that the offer still stands and that strawberries will be eaten this year.

He did keep a similar promise, and the story illustrates his generosity. In 1962, Part I Finals Class were promised dinner at his club if they all passed. Miraculously, they all did pass and forty people had one of the best dinners of their career.

In recognition of his services to the Students' Union, Dr. Lehmann was elected an Honorary member in September, 1963, and presented with the Union tie. He has promised to wear this proudly and to spread Bart's propaganda whenever he can. He has also said he will keep an eye open for hockey players (the pretty ones only) and see that they are directed to us.

In October, Dr. Lehmann presented the Students' Union with a clock which is to be put in the reading room of the new students' lounge at the hospital and the Union are glad to take this opportunity of thanking him for this, and for all his other kindnesses to us in the past.



When we look at the clock we will think of Dr. Lehmann with gratitude; some of us may even remember with nostalgia what he called "the thrill of milliequivalents on a summer's afternoon."

T. J. McE.

A.W.F. writes:

You cannot catch a comet—even at Bart's. One that swims into the visible sky illuminates, and by its light we learn. When on its predestined course the comet drops out of sight we know that it excites observers in some other sky, but ours is dim and looks a little darker than it was before the comet came. Those whose eyes keep steadfast on the ground are undismayed, but those who sometimes look upwards to the stars are diminished and by this diminution saddened.

By Hermann Lehmann's translation to Cambridge Bart's has lost an international figure. His work in elucidating the mysteries of the haemoglobinopathies has helped to add another storey to the building whose foundations were laid here more than fifty years ago by Sir Archibald Garrod when he developed his ideas of inborn errors of metabolism. At least Lehmann has left us Haemoglobin Bart's. This is good enough for the historians, but we who knew him at the hospital will remember his immediate readiness to help with any of our clinical problems, his intelligent enthusiasm and how much he taught us all about the excitement and the enlightenment that biochemistry holds for medicine today.

UP TO THE MINUTE IN A MOMENT

February saw more coals heaped on the educational fire when, in a supplement to the magazine "Where", the Advisory Centre for Education examined the academic results of the Public Schools. Some of these schools, according to the report, compare unfavourably with maintained grammar schools. The report achieved little besides provide ammunition for those ardent souls who would have us abolish our historical schools, forgetting that they do more than push people through examinations.

On 18th February **Sir Patrick Dean**, British Ambassador to the United Nations, called for immediate U.N. help in maintaining peace in Cyprus. Such is the manoeuvrability of the U.N. that it was twenty six days later, on the Ides of March, the first U.N. troops landed on the island.

The same day, because of continuing British trade with Cuba, the U.S. State Department cut off foreign aid to this country. Meanwhile, American wheat sales to Russia continue.

Evening newspaper placards on 28th February carried the slogan "Man to Marry Princess". It it had been "Woman to Marry Princess"—well that would have been news. The story, it turned out, referred to the engagement of **Princess Margaretha** of Sweden to **Mr. John Ambler**, a London businessman.

Mr. Edward Anderson, the owner of the missing yacht "Christine", stated on 1st March that, before the vessel sailed on what was presumably its final voyage, £1 million from the Great Train Robbery was put on board. It would be a great pity if the truth about this fascinating episode were never to be revealed. So far the story has been pure **Ian Flemming** minus **Bond** and **Birds**.

Also on the 1st March, **Professor Blackett**, Professor of Physics at Imperial College, speaking at a conference convened to work out the scientific policy of the Labour Party said that grants for scientific development in industry might be increased by £50m. under a Labour government. And there again, presumably, they might not.

On 3rd March a Press Agency reported that a **Mr. Harold Wilson**, claiming to be leader of the British Socialist Party, had stated, in Washington, that in the event of his coming to power he would hand over the Royal Navy to the United Nations. Denials and recriminations followed, leading to a stormy scene in the House of Commons between **Sir Alec Douglas Home** and the Leader of the Opposi-

tion. By 12th March the National Opinion Poll reported that the Labour lead had dropped to only 7%.

On 8th March the Kenya Broadcasting Company saw fit to apologise for the playing of "Rule Britannia". The tune is apparently offensive to the democratically elected government of Kenya.

Her Majesty The Queen, on 10th March, gave birth to a son. Her Majesty was attended by five doctors including **Dr. Ronald Bodley Scott**.

10th March was perhaps the most politically significant day of the month. In Westminster on that day twenty-one Tory back benchers voted against the Government's bill to end re-sale price maintenance, while many more abstained. Six thousand miles away, in snowy New England, the New Hampshire Republican primary was won by a write-in candidate **Mr. Henry Cabot Lodge**.

In Dallas, Texas, on 14th March, **Jack Ruby** was convicted of the murder of **Lee Harvey Oswald**, the alleged assassin of **President Kennedy**. In Montreal on the same day **Richard Burton** married the much-wed **Elizabeth Taylor**; it is believed to be Miss Taylor's first Leap Year wedding.

An important change in the Bart's calendar this year is that the View Day Ball is to be held on View Day itself—13th May—in the Café Royal.

Bart's sports clubs have been extremely busy of late. The Rugger Club, ably led this season by **C. J. Smart**, have had more wins than in any season since the war: the club recorded two large victories over the Welsh Guards and Middlesex Industries, as well as beating Streatham for the first time for many years.

The Cross Country team enhanced their reputation by winning the Orion 15 mile race; **N. Pott** and **T. Foxton** were joint third in the individual placings.

The Soccer Club have had a successful season especially in their leading goal scorers **P. Herbert** and **C. Sutton** but they were beaten in the semi-final of the Hospital Cup by the London Hospital.

In the world of hockey Bart's appeared in two Hospital Finals. The men's 2nd XI lost 2-1 to Guy's having led 1-0 at half-time. The Ladies' team, without their captain for most of the season, were ably led into the final by their vice-captain **Miss J. Young** only to be well beaten by St. Mary's. (17th March).



Dr. R. Bodley Scott

SCANDINAVIAN VISIT 1963

I. TRAVELOGUE

By Norman G. Rothnie

It is unusual for the surgical traveller or the holidaymaker from this country to direct his attention north-east to the Scandinavian peninsula. The surgeon tends to journey westwards to the attractions of the New World and the tourist heads southwards to warm Mediterranean climes. To the traveller whose time is limited, Scandinavia seems a far cry across the North Sea and does not offer him or her the certainty of a prized suntan. After all, Scandinavia lies in more northern latitudes than this country and one imagines it to have a hardy climate fit only for the Laplander and his reindeer. This we did not find to be so and enjoyed many weeks of clear blue skies and hot sunshine with long hours of daylight. Perhaps we were fortunate for we were told that at times the summer weather can be like our own—uncertain and unpredictable.

Despite our Viking forbears, most of us have scant knowledge—apart from Danish bacon, Swedish steelware and Norwegian sweaters—of the Scandinavian countries and have had little opportunity of exploring them. It was therefore with much enthusiasm that I planned a three month visit to Scandinavian surgical centres in the spring and early summer of 1963. This period was to include our annual family holiday and raised the big problem of how a family of six was going to travel and live economically for nearly twelve weeks. After much thought and discussion, we decided to adopt a gipsy way of life and use a trailer caravan; after all, the British invented and pioneered camping. But we soon found out that the Scandinavians and Continentals have expanded and exploited it to the full. Nobody need have any doubts or fears about camping abroad; it is far better organised than in this country.

Outward Bound

So, after much discussion, documentation, gathering of information, and finally the packing of the most varied gear, we set forth with fully-loaded car and caravan on our 4,000-mile round trip. It was just as well that our many ferry crossings were charged according to the length of our vehicles and not their weight!

We chose the Dover-Ostend crossing in prefer-

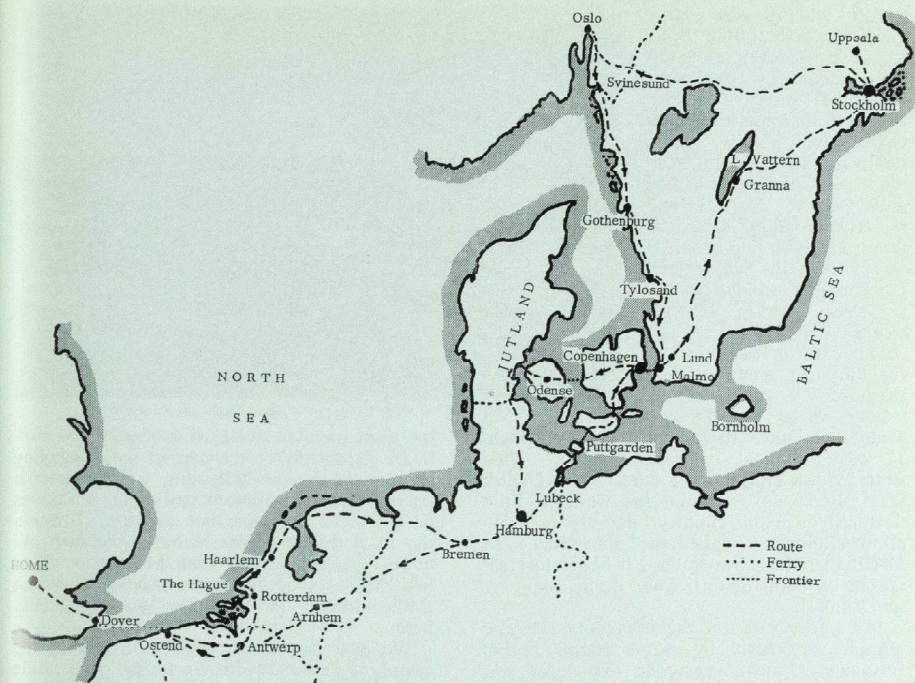
ence to the longer but more direct North Sea passage. It was more economical and gave us an opportunity to see Holland at tulip time. (It also reduced the risk of any retrograde peristalsis at sea!).

We drove gingerly along the Belgian roads gradually becoming accustomed to driving on the "wrong" side. In fact, I found it an advantage to be hugging the edge of the road while towing our 14-foot long mobile home. Another reason for our cautious progress was the frequent vicious cobbled surfaces through the towns, which slowed our average speed by 10 m.p.h. It was on the jarring cobbles that we first experienced the see-sawing effect on the car of a heavy trailer—how those creaking and groaning car springs suffered, but they held out. Another rather terrifying abnormal motion was a whipping effect of the caravan on the tail of the car if we ventured too fast. It was particularly marked when the van was weighted at the rear, and a redistribution of the load to the front gave us a smoother ride.

The highways of the Low Countries are mostly flat, smooth and straight, and therefore ideal for towing. We were soon through Antwerp and on to Rotterdam unharmed by the mad Continental drivers—perhaps we looked too formidable a combination to challenge! We looked in on the quaint old Dutch town of Delft, with its busy narrow streets, sharp corners, and numerous hump-backed bridges over equally numerous canals. Now, anybody who knows Delft would not dream of towing a caravan around it. Well, we did—fortunately a G.B. plate is a good excuse for such mad impulses!

At The Hague we had to view a big attraction, the miniature city of Madurodam, which is an extensive working-model layout and a great hit with the children. North from The Hague to Haarlem stretch the famous bulb-fields and we visited the very colourful tulip gardens of Keukenhof—a 'must' for any tourist in Holland.

Kilometre after kilometre of flat, straight Dutch highway was rapidly caten up and then we crossed that marvel of Dutch engineering, the enclosing dyke of the old Zuider Zee. It stretches for 20 miles with the North Sea on one side and a large inland lake at a lower



level on the other. It forms an essential part of the land reclamation schemes and carries the roadway over to Friesland in North Holland.

Our route then passed across the North German plains to Bremen and Hamburg, progress now being faster on the 'autobahns'. Fortunately, these motorways, as those in Scandinavia, are well provided with resting and parking places suitable for picnicking and watering purposes—most essential requirements for us!

From our well-equipped camp-site south of Hamburg (which still appears to be rather battered), we struck north to Lübeck on the fringe of the Iron Curtain, and on to the brand-new, Danish, ferry terminal at Puttgarden. This ferry service had just been inaugurated and is shorter and faster than the old ferry route between Germany and Denmark. For a modest sum (it was one-fifth of the Channel crossing) we were transported to Southern Denmark in 50 minutes by a large and most up-to-date ship. Rapid and interesting though

the crossing was, we were still able to stock up with suitable duty-free goods.

Denmark

The oldest kingdom in Europe is a small low-lying country comprising the peninsula of Jutland to the west and four main islands to the east. We landed on the southernmost of these islands and headed north through gently rolling agricultural land to the island of Zealand. On its eastern shore and facing Sweden across the narrow waters of the Baltic gateway lies Copenhagen. This was our first port of call after one week on the move.

A quarter of the Danish population of 4½ million live and work in this busy commercial, industrial and cultural centre and its surrounds. This maritime city is a communications link and a warehouse for transit trade to the north. A plan of Copenhagen is characterised by the remains of old city fortifications, the ramparts and moats of which form a green belt with canals and lakes around the city and its central harbour.

The Danes have always been seafaring

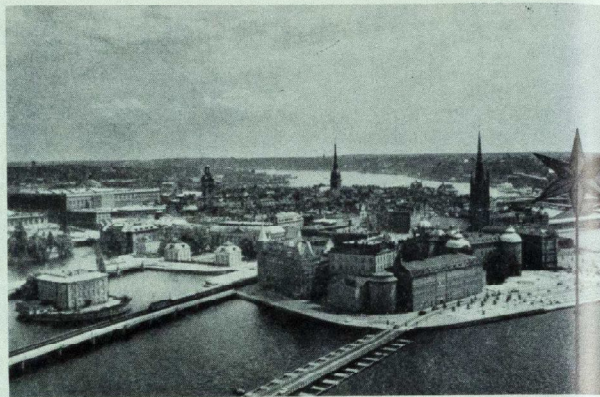
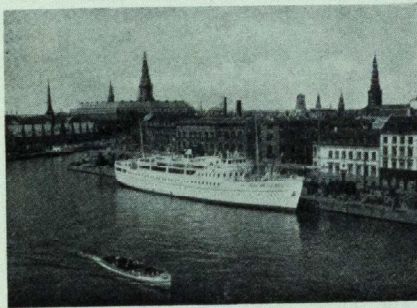
nation and possess large merchant and fishing fleets which are so important to their country's economy. Ships of many countries line the mile of quays in Copenhagen and white steamers play to and from other parts of Denmark, and also Sweden, Norway and the Russian Baltic States. It was with blaring martial music from the ship's loud speakers that one day we saw a sleek white Russian steamer depart for Estonia.

Our caravan came to rest for the next month on the seashore by the attractive fishing village of Dragor, some 20 minutes' drive south of Copenhagen. It was an ideal camp-site and we soon settled down and adapted ourselves to Danish fare. Foodstuffs were on the whole a little dearer than in this country but were certainly cheaper and more varied than in Sweden. In fact the southern Swede finds it better to cross on one of the many ferries and do his shopping in Denmark.

My working day at the University Hospital started very early by Bart's standards but fortunately finished early so that there was still a good part of the day left to enjoy sight-seeing and outdoor activities. This daily routine suited me in my dual role of visiting surgeon and tourist.

We explored Copenhagen, a city of lime-green spires and domes, by car, tram, bus and canal boat, and always found something to interest us. The bicycle and scooter are

Copenhagen—the quay.



Stockholm—The Old City from the Town Hall Tower.

the most popular means of transport. At rush hours the streets of the capital are a jangling chorus of bicycle bells and noisy scooters. After having experienced rush-hour conditions in the three Scandinavian capitals, I found the local drivers to be better disciplined and more "lane conscious" than Londoners. Woe betide you if you changed or chose the wrong traffic stream! A G.B. plate was no excuse here.

We also meandered round the rest of the island of Zealand with its fertile countryside dotted with small, thatched farmsteads glistening white in the sunshine. Wide panoramic views were easily seen from the roadside since there are no hedgerows or fences to obstruct the eye. The land is very precious to the Danes and is their only natural resource. Its prime quality dairy and livestock products are the chief mainstay of the country's economy. Efficient farm management and co-operative measures, backed by successive liberal-minded Socialist governments have made it so.

Denmark has a long, low coastline, fringed with mile upon mile of golden sands which are safe and ideal for all ages. Any part of Denmark is within easy reach of the sea and ideal for the family holiday.

We found the Danes friendly, hospitable and very pro-British. Although a large part of their trade, including tourism, is with Germany, they have no great love for their neighbours and former occupiers. The average Dane does not relish the moves toward the Common Market and fears another invasion, this time industrial, which might again exploit and weaken the country.



Gränna camp-site (centre) on the shore of Lake Vättern.

The Danes are rather jealous of their rich Swedish neighbours with their many natural resources and impregnable neutrality. One Danish cynic remarked to me that Asia began across the narrow Baltic entrance!

Denmark has a mainly classless society in which there is an even distribution of incomes—few have too much and fewer too little. However, there is one thing of which they have an excess and that is beer! It is quite common to see a group of workmen with a crate of beer bottles beside them drinking frequently as they go about their tasks. This has created many social and medical problems and contrasts markedly with the rigorous control of alcohol in Sweden.

Our time in sunny Denmark passed all too quickly. In mid-June we struck camp, hitched caravan to car, and crossed the quiet waters to Sweden.

Sweden

We landed at Malmö and drove a short way inland to the old town of Lund. Once it was the commercial centre of southern Sweden but now it is overshadowed by its neighbour—the busy seaport of Malmö, Sweden's third largest city. Nowadays, the cathedral town of Lund exists mainly for its old-established University with its large and modern teaching hospital.

This part of Sweden is mainly flat and arable and is the "food basket" of the country. Only about one-tenth of Sweden's surface, compared with three-quarters of Denmark's, can be cultivated. Swedish agriculture is geared to self-

sufficiency because of the threat of isolation in times of war. Food, especially bread and meat products, is therefore expensive and of limited variety, especially away from the south.

The southern part of Sweden has for long periods in the past been under Danish influence and rule. It is not surprising, therefore, to find the language and habits of this area to be closer to Denmark than to their kinsmen in the north. Their guttural speech is similar and contrasts with the lilting, almost "sing-song" dialect of the Stockholmer—

rather like the difference between a Lowlander and a Highlander.

From Lund our route passed 400 miles north-east along the "Laga Trail", the ancient highway to Stockholm. The open cultivated land of the south was gradually replaced by pine-covered hills and valleys. Between the forests were scattered innumerable lakes and small farmsteads. The wooden walls of these were painted a characteristic brick-red colour edged with white, and contrasted sharply with the surrounding shades of green.

We rested for a few days beside Lake Vättern, one of Sweden's largest and most picturesque inland lakes lying halfway between Malmö and Stockholm. It certainly had the coldest water I have ever splashed in! Our stay here at the village of Gränna coincided with the midsummer celebrations round the maypole and little sleep was had during that brief night! At this time of the year the small silver birch is placed outside houses as a sym-

Stockholm—the Town Hall



bol of midsummer. It was here, after experiencing a local haircut for 7s. 6d., that I became a true barber-surgeon and dealt with the boys' hair myself!

The Swedish highways are wide, smooth and well maintained, making it easy for towing. We were, of course, back on the British side of the road and feeling more at home. The extraordinary thing is that Swedish cars are all built with a left-hand drive! However, this may be wise in the long run as they are planning to switch to the right side of the road. The secondary roads are mainly firm dirt tracks but are often rough and are to be avoided if you wish your car to bring you home again.

The eastern coastline of Sweden is broken up by extensive archipelagoes extending many miles out to sea and comprising a maze of channels between pine-trimmed rocky islands. The archipelago between Stockholm, our next port of call, and the open Baltic stretches for about 30 miles.

The capital is built on and around a number of these islands joined together by slender, graceful bridges. It is a beautiful, natural setting and a photographer's paradise—a city on the water. In the centre is the old city and harbour with its large royal palace, old churches and dominant Town Hall. Around this lie parts of the city of the nineteenth and early twentieth centuries, and on the fringe of the capital are the sprouting modern suburbs. Tall blocks of flats of typical Scandinavian design climb high above the surrounding pines. In their midst nestle the car-free shopping centre and railway station. Like the Danes, the Swedes in the towns are mainly flat dwellers but many in Stockholm have a summer log cabin somewhere on the islands along the coast. We found Stockholm a fascinating city with many and varied attractions (especially the open-air folk museum and zoo at Skansen), and we received most generous hospitality.

Sweden is a highly-developed industrial nation, rich in natural resources of wood, hydro-electric power and mineral ores. Its steel industry and products are world-famous and its chemical and pharmaceutical industries are equally well known. The invention of dynamite and the Swedish arms industry are linked with the name of Alfred Nobel, whose name is perpetuated in the various prizes awarded every year—about £18,000 each.

The standard of living, work conditions and

wages are high due to full employment and a highly-organised and peaceful labour-management relationship. High wages result in high prices for manufactured goods and it would be difficult for some industries to hold their own in world markets were it not for the high quality and design of their products.

Their prosperity is also due to the fact that they have not been at war for a century and a half. They have pursued a foreign policy of neutrality in war and non-alignment in peace. Successive Socialist governments have avoided entanglement in big power politics and have maintained strong and mobile defensive forces for a small nation of 7½-million people—neutrality through strength.

Fifty miles to the north of Stockholm lies another famous old university town—Uppsala. Here there is a beautifully preserved anatomical theatre, which was built in the 1660's by Claus Rudbeck, the discoverer of the lymphatic vessels. It was at Uppsala that Linnaeus, the founder of modern botany, lived and worked in the 1700's. His botanical garden is preserved to this day.

On the move again we turned westwards from Stockholm through the industrial areas of central Sweden toward Oslo, 400 miles away. As we approached the frontier the terrain became more mountainous and the road surface rougher, considerably slowing progress.

Obviously the Swedes thought that maintenance of this tourist highway was not economically important. It was here that we suffered a slow puncture from a nail in a caravan tyre but were fortunately able to limp to one of the rather infrequent garages. I can assure you that it is quite impossible to blow up a loaded caravan tyre with a hand pump! No English was spoken at this garage but the international sign language achieved what we wanted and on we went into Norway.

Norway

The roads here are hilly and poorly surfaced outside the towns and it is inadvisable to take a caravan far afield from Oslo. The greater part of Norway is made up of high, rugged plateaux falling abruptly to an extensive coastline broken by fjords and fringed with countless islands. It is in the main a barren country with only 3 per cent of its surface arable land. She is dependent on her lumbering products, hydro-electric power and the surrounding seas for her hard existence.

The oceans have been the mainstay of her life for centuries. Norwegian ships range far

and wide as their Viking forbears did in the past when they discovered Greenland and North America 500 years before Columbus! They have a reputation as explorers—Amundsen and Nansen of the polar caps and the men of the famous Kon-tiki expedition. Relics of those achievements are to be seen in Oslo, where we set up camp in its well-known and very busy Bogstad campsite on the hills at the back of the city.

Oslo is a compact city built at the head of a wide fjord and enclosed by mountains. Magnificent views over the capital and hinterland are to be obtained from numerous vantage points. It also has plenty of interest for the tourist and surgical visitor. There is a strong bond of friendship for Britain and tourists from this country are more frequent here than in other parts of Scandinavia. The Germans predominate elsewhere.

Norway is a small nation of 3½ million people and with few natural resources. They are less wealthy than their neighbours but, despite their harder life and climate, they have full employment and a high standard of living. The design and manufacturing industries have made great strides since the war.

The Norwegians have a great love of outdoor activities, hiking, fishing and ski-ing being their favourite pastimes. Norway is considered to be the cradle of ski sports, especially jumping.

English is freely and fluently spoken in Oslo, more so than in other parts of Scandinavia. In the short time we had in Oslo we were able to see most of its sights because of the city's small size.

The day had come, however, to start the long trek home and we aimed as we had done before while on the move, to alternate, as far as possible, days of hard driving with days of rest. We found this method most suitable for the family.

Homeward Bound

We headed south from Oslo to the Swedish border at Svinesund where a magnificent high bridge crosses the fjord which forms the boundary. A change from the right to the left of the road brought us back on the fast Swedish highways which took us down the picturesque west coast of Sweden. The rocky islands here lack the pine cover of those on the east coast.

After a quick tour of the bustling city and

harbour of Gothenburg by car and canal boat we went further south to the holiday resort of Tylösand. The extensive beaches and rolling sand dunes were ideal for a short rest by the sea. From here we drove back to Malmö and finished our Swedish shopping before crossing to Copenhagen.

For our route home we chose to cross the Danish islands to Jutland and so down through Schleswig-Holstein to Germany. This entailed another ferry across the Great Belt between Zealand and the central island of Funen, but this time no duty-free goods on board! In the centre of Funen is Odense, the birthplace of Hans Christian Andersen. His house is a museum and the surrounding old-fashioned houses and streets are particularly well preserved.

From Funen we crossed the long Little Belt bridge to Jutland and sampled its beaches on the east coast. We made sure our petrol tank was full before entering Germany where petrol is more expensive. It was only at the German frontier, both going out and coming home, that much fuss was made about passports and vehicle documents. All we had to declare were four children and a load of rubbish in the caravan!

We went back across Germany, using a route further south than our outward journey and passed into south Holland and over the famous war-time Rhine bridges at Arnhem and Nijmegen. We were soon back on the trying cobbled surfaces of Belgium but reached the Ostend coast safely with a day to spare before our scheduled Channel crossing. This gave us time to explore and enjoy the Belgian holiday coast before returning to Dover. On landing I think the Customs took pity on us for they passed us through without turning out our caravan!

We were in no great hurry to be home again; all of us were completely converted to our gipsy way of life and had no wish to relinquish our freedom. But back to "civilisation" we had to come and we slowly settled down to our old ways.

We are very grateful for the opportunity given to us to carry out this journey of exploration. We found our adventure most rewarding and all gained a considerable amount of varied knowledge about Scandinavia, its people and its modes of life. In my next article I will say something of the medical aspects of my tour just in case, from reading this, you may think my visit was all play and no work!

"THE OTHER SIDE OF THE FENCE" — A LOOK AT GENERAL PRACTICE

By M. F. Hudson

The formation of the General Practitioner's Association in October, and the dissatisfaction which is being expressed by many G.P.'s, makes it seem particularly relevant at this time to take a closer look at general practice and to see for oneself whether the picture painted both for us and by us is really so black. It is easy to criticise, especially when one's criticisms are based on preconceived ideas obtained through hearsay, and to which little or no thought has been given.

There is little doubt that General Practitioners on the whole are not satisfied, and the recent petition by 6,000 of them to the Minister of Health is ample proof of this. As the G.P.A. says "the family doctor in the N.H.S. had terms of service which in general were of an inequitable and oppressive nature". It is not the basic ideal of the N.H.S. which is being questioned but the way it is being organised, so that most attention is being paid to the hospitals rather than to the G.P.'s. This dissatisfaction should not cloud one's approach to general practice, but it unfortunately does so and to this is added a battery of anti-G.P. attitudes which are presented whilst an undergraduate. This leads many, if not all, to regard the family doctor, once the cream of our profession, as now rather sour.

One of the great defects of the medical curriculum is the weight of emphasis placed upon hospital type of medicine, and the almost total lack of attention paid to the medicine which is being practiced outside the "academic institutions". Throughout one's clinical career, the hospital is presented as infallible and the G.P. as completely fallible. This may not be a conscious presentation, but it leads to a warping of the student's mind, and it is not long before most G.P.'s are classed as the "left-overs" and "failures" from the so-called "higher spheres" of medicine. The criticisms levied against them are often ill-informed, ill-advised, and in the majority of cases wholly unjustified. The student has little idea of how a G.P. works and what that work entails. Often his only contact is through the occasional letter he may read when clerking a patient. The badly written and scruffy letter, the lack of careful examination, and the mistaken or vague diagnosis of a few, are seized and used as further evidence of the inadequacy and in-

efficiency of General Practice as a whole. One forgets the many good letters and accurate diagnoses made, and never considers the amount of medicine a G.P. can, and does, do without any help from the hospital.

Perhaps this is not entirely the fault of the student, for the only knowledge of general practice which we can gain is from a few lectures on the subject, a week at Bethnal Green (which I might add, is one of the most illuminating and interesting weeks in the whole curriculum), and perhaps, if we make a special effort, a visit or two to a G.P. To say there is no time for more teaching of this type is untrue, and is only a weak excuse to avoid the problem. During Specials, there is ample opportunity for study in General Practice. A great many of us will eventually become G.P.'s and it is ironical that we should spend so little time learning and experiencing some of the special problems and techniques involved.

This article is the result of visiting a London G.P. twice a week for three months and it is not intended to be a comprehensive survey of General Practice. It is an attempt to show the G.P. in a better light, to discourage much of the abuse and apathy which clouds our ideas of how he works, and to suggest some means of encouraging a closer co-operation and understanding between the student, hospital and G.P. Under a dark exterior there is much to enthuse about and much to praise.

I was very impressed with the General Practice which I saw during the three months. It is obvious that G.P.'s are unhappy with conditions and that they are united in their efforts to improve them. I was struck by the enthusiasm, knowledge and skill with which the doctors work under these conditions. Far from running away from them and being completely disillusioned and depressed, they are fighting the conditions, and at the same time succeeding in making their work a source of inspiration to those with whom they come into contact.

The practice which I was visiting is situated in South London across the River from Westminster. The list is some three thousand five hundred strong and the patients are almost entirely working class, who live either in the old terraced-type of house or in the large blocks of pre- and post-war flats. Money is not really scarce, the people are a very material-conscious

community, highly productive, and in the majority of cases both mother and father are working.

The doctor himself lives some distance from his surgery which is of the lock-up leasehold type. It is small and inadequate, and apart from essential equipment there is little in the way of "extras". The lease runs out soon and the L.C.C. are being very unhelpful in attempting to re-house the surgery, in spite of a vast new building programme for the area. All this is of little importance in comparison with the two most important factors: the patient and his doctor. The trust and devotion of the patient to the G.P. is far greater than I expected and so is the friendship, interest and understanding of the G.P. to his patient. Both have, in most cases, the advantage of knowing each other through past encounters. This helps the patient to have confidence in his doctor, and assists the doctor to understand why this particular patient has come to consult him. One of the great arts in General Practice is recognising the really sick patient, in the "clinical" sense, and recognising the "socially" sick with apparently physical symptoms, whether true or imaginary. This sense of *rapproch*, though by no means always engendered, is the basis of good medicine, and in General Practice this is perhaps one of the most difficult states to attain, yet one of the most satisfying when reached. The previous experience the doctor has of that particular patient, his home and family background, his work and the way that particular individual reacts to his environment, is the foundation on which the G.P. must base his diagnosis and treatment. For the facts which a patient may present in his History and the examination, are of little value without an assessment of the patient, and his relationship to the environment in which he finds himself.

In the light of this, it would seem best to discuss some of the aspects of General Practice which impressed me from two angles. Firstly, that of "Clinical Pathology" and secondly that of "Social Pathology" with which one is confronted. Often, these two are interacting and in each case they represent the reaction of the patient to the environment in which he lives. It is a fallacy that classical "Clinical Pathology" is only seen and treated in hospitals. During my visits I saw patients with heart disease of all types, including mitral stenosis, aortic incompetence and neurological conditions of many types including subacute combined degeneration, aphasia, etc. These cases are, at

this moment, not lying in a hospital bed, but are still living and working in their environment. This leads to problems of care of these patients and to the prevention, as far as possible, of the complications of their disease to enable them to continue to function effectively. These problems are not seen in hospital, but they cannot be neglected, and sooner or later will face many of us.

Two patients who particularly remain in my memory are of special interest. Both are old people; both are over 80. One is a lady who some years ago was considered beyond help and was expected to die within a few months. She is a woman of great courage who was not prepared to die, and now, ten years later, is well. With special care and attention from the G.P. she has managed to survive, when all hope had been lost. The other is an elderly man who had carcinoma of the prostate, which a few years ago was considered inoperable. He is being maintained well and active outside the hospital. These examples are not intended to criticise the hospitals but rather to show that in General Practice there is much more than just form filling and frustration.

Geriatrics is becoming an increasingly important subject in General Practice; old people live longer and are not left to fade away. Much is being done by this G.P. to help the old people, and I realised for the first time that there is much interest and fascination in this neglected branch of medicine. This G.P. is Medical Officer to a new L.C.C. old folk's home, which is of contemporary design and has modern equipment and facilities. One old man there has worn a truss for 30 years and is soon to have an operation to repair his hernia. Geriatrics is no longer a bore but a vital and interesting aspect of General Practice. Today the old people represent an important part of the community and it is up to us, as doctors, to give them, in their old age, all the benefits we can bestow.

At the other end of the scale, Paediatrics takes up more of a doctor's time. It is estimated that 75% of children in a practice will be seen at least once a year by the doctor. From the clinical point of view acute upper respiratory tract infection, bronchitis, pneumonia, otitis media, urinary tract infection, etc., are problems facing the G.P. every day, which must be diagnosed promptly and treated adequately and effectively. The asthmatic child and the enuretic child are common visitors to the doctor. They should rarely need to be sent to hospital except to exclude any underlying

pathology (seldom present). The G.P. is in a unique position to treat these patients himself, and often does. The problem is not so much the child but its environment to which it is reacting.

There is little point in continuing this list of diseases one sees in General Practice, for it is as long as any list of diseases can be, but some idea has been given that not all the clinical medicine is managed in the hospitals, the majority is seen and treated by the G.P. himself.

The "Social Pathology" aspect presents a similar picture of variety in which the knowledge, skill, and understanding of the G.P. is of paramount importance. This was one of the aspects of medicine of which I had seen and of which I knew very little before my contact with General Practice; it is often overlooked and dismissed. In spite of the vast improvement in medical diagnosis and treatment, raised standards of living and more health and welfare legislation, an apparently irreducible mass of social disease remains, which is being developed and nurtured by the type of society in which we live. This great mass of human suffering shows no sign of decreasing, and if anything is increasing. The G.P. is at the forefront of this problem, and indeed is tackling it to the best of his ability, but he is virtually alone and is merely scratching the surface. Social disease is rapidly becoming one of the branches of medicine which is going to concern us all. It is time we realised that it is desirable to change our attitude about sickness and disease, towards its causation and effects which are not always reflected in distinct pathological and biochemical patterns. The broken home, the acute boredom of leisure time, the depressive illnesses, the unwanted children, the child behaviour problem, delinquency, frustration of work and the vast field of mental disorders are all problems created by the type of society in which we live. Some of these are new, but many are not and the rapid rate at which this "Social Pathology" is catching up, and in some aspects is even level with the "Clinical Pathology" already mentioned is alarming. The G.P. must not only have the mind and knowledge of a "clinical physician" but also the skill and understanding of a "social physician". His task is very difficult, as the challenge is exciting, the variety wide, and the interest sustained, for one problem solved is another created. This concept is a very different one from the form-filling, drug-peddling intermediary which is the picture

many of us have.

How is it possible to present such a concept to the medical student and yet not deprive him of the time and interest to sustain and fulfil the requirements of the recognised curriculum? To quote this G.P.:—

"The General Practitioner has been called the "King-Pin" of the Health Service. That this is the true position for him is borne out by the fact that 90% of all "diseases" are treated at home in their entirety, and never pass through consultant hands. How long, therefore, can it be before General Practice is afforded its proper place in the curriculum of student teaching? I feel strongly that General Practice must be afforded a place in teaching, equal in importance to the more specialised fields. Every student, before reaching Finals, should have had a course of lectures given by a General Practitioner and should be given the opportunity to be attached to a Practice for a period of 1-3 months. This would be of immense value to the student, whether he eventually goes into General Practice or specialises. It is surely wrong that the Practitioner knows much of hospital practice, yet the consultant knows little of the work done by his colleagues on the other side of the fence."

I agree fully with this and add that it would be better to create more liaison between hospitals and G.P.'s with better letters not only from the G.P.'s but also from the hospitals. The recent move by one Medical School to create a "chair" in General Practice is a step in the right direction. Perhaps students should consider being attached in groups to the regional College of General Practitioners, to attend clinical and social lectures given by G.P.'s. Yet it is hardly my prerogative to suggest what should be done with my time as a medical student, and what type of training I should have. However, I feel most strongly that we are trained too much as hospital doctors, and not nearly enough as General Practitioners. Of course, the former is the basis on which our medical life is to be founded, and experience and practice are of greater value than a few years as a student. But I am certain that it is because of this lack of general-practice teaching, and co-operation, in an age when this type of medicine is becoming increasingly important, that we are being presented with a false picture of General Practice, which is a concept we can ill afford if we intend to cope with the problems which modern society is creating, and will create in the future.

EAST AFRICAN SAFARI

By J. D. SCOBIE

Eight o'clock as we bounce jauntily down through the town, late as usual, in the Land Rover. It never seems possible to get away early, with all the packing for four people for four days, and something is always left behind, usually our pullovers, for it is difficult to remember that in the hilly north it is cooler in the evenings. However, this time with Sara and I and the baby in the front and the houseboy and all the equipment in the back, we think we have everything and rattle confidently along the dusty road into the plain in the still fresh morning.

I am going on a "dispensary safari". There are three dispensaries on this route at about 50-mile intervals. They are small huts subdivided into rooms for examination and treatment of patients, and are run by a male nurse and an unqualified assistant. Each provides the only medical service for an area of about twenty miles in radius, containing some twenty thousand semi-nomadic, semi-naked and completely primitive tribesmen. My job is to ensure that this service is as efficient as possible, and a monthly visit is made with this end in view.

Eight miles out of town we turn right down an unsignposted, bumpy and rutted track; this is the main road to the north. On the horizon is the blue, jagged, hazy outline of Tolot, a 7,000-ft. mountain beyond which lies our first destination, Nalakath. To our right now is Alerek, the 10,000-footer, from whose base we have just come. Between these mountains and stretching away in every direction lies the flat scrub-covered plain populated only by scattered herdsman and their skinny cattle, and wild animals. Our speed comes down to 20 miles an hour as we steer round the pot-holes or, with brakes on, descend into them when they are unavoidable. Sometimes, in a moment of wild devilry on an open stretch, we get up to 30 or even 40 miles an hour, but this inevitably ends in disaster as we hit a concealed rut with a tremendous bang and tents and rucksacks slide into our necks and the houseboy gives a deep sigh.

However, at the beginning of the first day's safari one's backside is resilient and we can afford to take our eyes off the road and concentrate on the main business of looking out

for game, with camera, binoculars and books of reference at the ready. Ground squirrels scutter away from the approaching vehicle in a small cloud of red dust and an occasional snake slithers rapidly into the protective bush. Many different species of weaver bird and shrike dart, whirr and chatter in the thorns on either side of us, and we pass a crested eagle perched on a tree, its black body impassive, its head, with glaring yellow eyes, jerking round in the search for the movement of some small animal on the ground below. A mile to the left in the clear, blue, hot sky, vultures circle over an unknown body, dead or dying in the bush.

An hour and a half later Tolot is closer, the angular outcrops of volcanic rock clearly visible. Now there is a secretary bird just ahead of us. It runs away on long legs, its vicious head, for it is a bird of prey feeding on snakes and lizards, outstretched and the feathers which give it its name sticking out behind its ears like quill pens. At length it gets up enough speed and flaps strongly to one side, and almost immediately comes down with a long ungainly run like a man who has jumped off a bus which was going faster than he thought. We press on, now hot and parched. We pass through the foothills to the right of Tolot and look back at Alerek in the hazy distance. Soon we are coming down on the other side of Nalakath, which we enter in a cloud of dust.

Nalakath has the plan of many an English village, as a triangle of buildings round a broad village green with a duckpond. There the resemblance ends. Here the green is bare earth, baked and cracked by the sun. The duckpond is dry. On one side is a row of corrugated iron huts which are shops. In the shade of the broad eaves a handful of natives stand or squat. The women are more active, with a petrol can of water on their heads, or a baby, under a black cloth, on their backs. The young men stand around as though they were on a street corner of the Elephant and Castle, with elaborate coiffures and effeminate posture, but completely naked. The other two sides of the triangle are made up of the houses and office of the local Government officers, for this is a

County Headquarters. Among these buildings the County Court stands out, an open building with an asbestos roof raised on metal poles. There is a case going on, and a policeman hurrying about with papers in his hand adds some vitality to the torpid scene.

We drove up at the dispensary which lies at the furthest apex of the triangle and I try to look efficient and energetic by leaping down, although I am tired, hot, and covered with dust after the three-hour drive. The male nurse (his Swahili title of *doktari* is much more suited to his function) comes out to greet me, also trying to look efficient and energetic although he has seen 85 patients already this morning in his dark little room, all of them smelly, and most of them with pus pouring from their eyes, or from sores on their legs. I have a quick look round. The township lies on a completely bare, low ridge and the hot, dry season wind blows over it all day. I note that Mr. Onyango, the *doktari*, is sober, and his uniform of white jacket, white shirt and striped tie, and long *kiaki* trousers, neat and clean. This is a good start. Like all the medical staff working with this tribe he is a "foreigner", coming from a land of lush banana plantations, rich fields of cotton, sim-sim, groundnuts and maize. He does not like this wide, dry country, nor the tall, fierce men, who stare him in the eye, stroke the tattoo marks on their shoulders which mean that they have killed a man, and spit into the dust. He wants to go home, but he has not gone to pieces, as so many of his fellows do, and as the European road engineer has done sitting outside his caravan on the other side of the road. Well into his first bottle of gin at half-past eleven in the morning, looking into the distance with red-rimmed, bleary eyes, thinking of . . . gin?

Next I look round the compound. The bare earth has been swept, the brown grass has been cut, a few seedling trees, protected from the sun and wandering cattle by little thorn houses, have been watered, a little flower bed has been carefully nurtured. Further off, Onyango's house, of polished aluminium, garishly ugly but cool and cheap, and the round out-buildings, kitchen and latrine, both of mud and wattle construction with thatched roofs, seem to be in good repair. All is well here. I turn back to the dispensary. Twenty or thirty tribesmen are gathered on the verandah, others are sitting or standing about outside. A young man with a clean new dressing on his leg ulcer is unwinding the bandage and

fingering the sore to see what the strange medicine is that has been put on. I tell him not to be such an idiot, in English, and he smiles genially. He also has trachoma, a visibly enlarged spleen, and looks half-starved. Onyango hurls abuse at him in his own language and he sheepishly winds the bandage up and walks off, limping.

"Have you any patients you want me to see, Mr. Onyango?" I say as we go into the dark inner room. The windows are not glazed so the shutters are closed to keep the dust out.

"Yes, three, one of them, a burns case, has just come this morning."

"What are the other two?"

"One is a man who was gored by a cow, and the other is a query T.B." Onyango was taught by English nursing sisters.

We go into the inner room, like a prison cell, where there are three low iron bedsteads with dirty mattresses and sheets. On one is lying a woman cradling her whimpering child, burnt on the face, chest and hands by an accident with paraffin a few days before. Treatment at home by smearing the burns with the intestinal contents of a ritually slaughtered white goat had been unsuccessful, and the parents had walked the 15 miles to the "hospital".

The two other patients were out at the shops, so having decided that, though my hospital is no East Grinstead, the child should be transferred there for probable skin grafting of one area, we sat down to discuss how things were going. Onyango has started a Child Welfare Clinic on Thursday afternoons, and the County Chief was encouraging people to come. Initially the attendance was good as a rumour had gone round that the children were to get injections which would make them strong like soldiers. Later it was said that they only received advice which, if carried out, would make them blind and sterile, and numbers had fallen off. However, some still came, mainly from the more advanced section of the community, and as it was obvious that their children were more healthy perhaps the penny would drop with the others one day.

I told Onyango that the outbreak of small-pox a hundred miles to the south had died out after our vaccination campaign and that there was a meningitis epidemic 60 miles to the west, but he had seen no cases in his area. At this point the two other in-patients

returned. The old woman probably had tuberculosis all right and was happy to go to hospital. The young man had been gored right through the thigh and the wounds were heavily infected. However, this would heal just as quickly with penicillin and dressings here as it would at the hospital, especially if he spent most of the day at the shops.

I go over some things with Onyango, look at his stocks of drugs, check his books, see that he is treating his patients correctly. Remind him yet again that it is all right to treat gonorrhoea with penicillin, but for backache it is a little arbitrary. He starts on a long excuse. I cut him short and we go out to inspect his latrine, which is clean and tidy and has a cover over the hole. Nevertheless it is full of flies. We then go and look at some of his out-patients, and finally I give him his pay, three weeks late as usual, and ask him if he has any other problems, which he has. Some trouble between his wife and another woman, shouting, fighting. I try and make some conciliatory judgment on what he should do. A few last questions from me on whether the peoples' grain stores are lasting out, if not famine relief may be necessary. Are the

FIFTY YEARS AGO

From the *Bart's Journal* of March, 1914

THE NEW COVER

To the Editor of the 'St. Bartholomew's Hospital Journal.'

Dear Sir,—It is always a somewhat distressing sight to meet an elderly and valued friend tricked out in the extravagant fashions of the day, and when the *Journal* appeared some months ago with a very inadequate photograph of the New Pathological Buildings on the cover I am convinced that most of your readers, with myself, looked upon it merely as a temporary concession to the claims of modern journalism, and hoped for the time when the old block should be again taken into use.

The continued appearance of the *Journal* in its new guise has prompted me to suggest that

people selling their cattle? No, they are not, therefore they are not hungry. Any political trouble? No. And so on.

We bumped away in the Land Rover, having paid our respects to the A.D.C. (Assistant District Commissioner) who administers this area, and had a cold Pepsi-Cola. We had to hurry on or I would not be back by Thursday when I had to give a ten-minute talk on Medical Problems in the District to a visiting United Nations expert. I was as usual a bit depressed leaving the dispensary. So little done. Twelve thousand square miles, a hundred and eighty thousand people, two doctors, total annual expenditure on drugs, stores, and equipment from tetracycline and artery forceps to coverslips for microscopic slides—£5,000. An ignorant, diseased and poverty-stricken population. It is easy to see the problems, even talk about them, but. . . .

We round a corner and I stop the Land Rover. "Look, Grant's Gazelle!" A small herd of about fifteen. Beautiful animals, a clean shining brown back with a white belly and a black stripe along their sides. One of them has a red-billed Oxpecker perched on its back. Most unusual.

you should revert to the old cover, which has for twenty-one years been familiar to St. Bartholomew's men in all parts of the world. The picture of the various candidates for the Orthopaedic Department painfully making their way to the Henry VIII Gate never gave one the impression conveyed by the modern cover that one was about to open a book of views or a prospectus of the Hospital.

Finally, Sir, if a change of cover is considered necessary, in view of the prominence now given to things anatomical (which must be relatively uninteresting to a large proportion of your great number of subscribers), may I suggest a photograph of the Anatomical Department or a panoramic view of Basle as a suitable indication of the contents one may expect to find in the *Hospital Journal*.

I am, Sir, yours, etc.,

R. E. BARNESLEY.

March 24th, 1914.



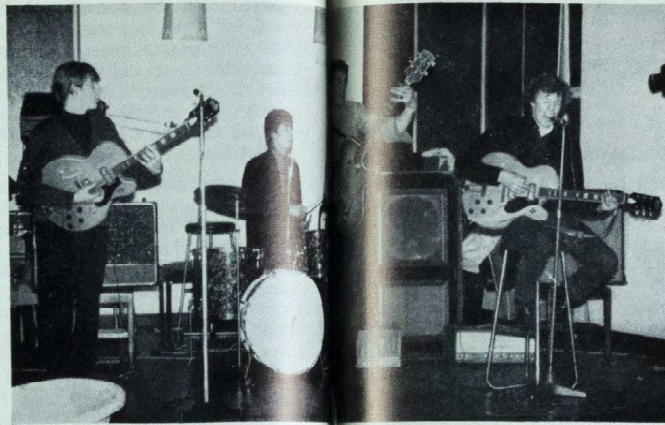
Mr. Christopher Smart, Miss Janet Elkington and an iris.

The more formal occasions in Bart's social life have been looking up recently and it was therefore with great expectation that we awaited the re-introduction of the Boat Club's Annual Ball. We were not disappointed, in fact we were most impressed.

The Spring-like weather of that week had reminded everyone of long days spent on the river; of regattas, *cetera populea velatur fronde iuvenes nudatosque umeros oleo perfusa nitescit*, and the modern touch of fantastic blazers and boaters. This feeling was immediately captured in the decorations; lights, fountain, waterfalls and newly painted blades—the atmosphere was definitely Boat Club.

A good innovation was the additional bar in the annexe of the refectory—how many times has one lost a partner for hours when he departs on the pretext of buying a bitter lemon! Here we enjoyed the more orthodox candles and dancing with some competition from the Alpha-Beats. Many of the more osteo-arthritis of us (it was a great pleasure to see so many of the House there) couldn't keep up the pace and it was a relief to mingle the Twist with longer spells of the more civilised "social step".

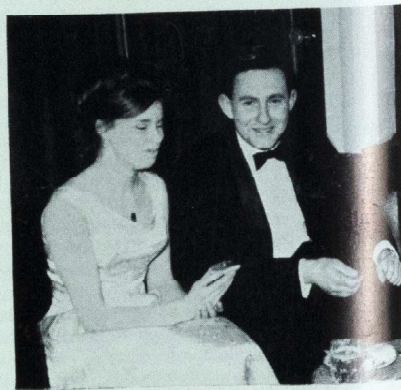
An absolute feast was waiting at 10.00 enough to satisfy even rowing men. Long tables in the Abernethian Room were absolutely groaning with turkey, meringues and trifles.



The Alpha warming up.

BOAT CLUB BALL

Mr. William Garson (Captain of Boats) and Miss Pamela Millage.



Mr. Robin Anderson (Treasurer of Boats) and Miss Barbara Alexander.

Graham Chapman et al.



An element of "bready bottom" was washed down with ample supplies of free punch.

Looking back over the year it seems significant that the tremendous rise not only in the standard, but in the actual enjoyment of social functions is co-incidental with the formation of the Wine Committee. Cynics may say that if spirits are 1/9d. a nip, naturally proceedings take on a rosy glow, but it is more than that. There seems to be a new atmosphere abroad; it may be better organisation, new ideas of entertainment, the Alpha-Beats, ample supplies of liquor, or all these qualities. This new feeling is however a definite entity and has produced a great number of first class social occasions.

Cabaret time and the antics of Tony Hendra and Nick Ullett. I agree that we've seen plenty of these men but the mixture was new (I hadn't seen it!) and as always excellently put over. These people never fail for though they are thoroughly professional their performance is angled for (at?) undergraduate audiences. They also seem to have an uncanny knack of judging the optimum length of time for cabaret.

Back to the dancing and then it was finally time. Couples drifted home and cars bounced precariously along the cobbles of Charterhouse Square. The Ball was over.

VIEW DAY BALL

Wednesday, 13th May, 1964

This year the View Day Ball will be on View Day. It will be run from 9 p.m. to 3.30 a.m. at the Café Royal and will be in aid of the Royal College of Nursing. It is hoped that the Ball will raise the sum of £400 for this excellent cause.

The Ball will take place on the 4th, 5th and 6th floors of the Café Royal. There will be three bands and dancing throughout the evening in the Napoleon and Dubarry rooms. Dinner will be served at 10.30 p.m. and the cabaret will take place at 1 a.m. in the Dubarry room. Gaming will be possible for most of the evening in the Marquise room on the 5th floor and the Tombola will run continuously on the 6th floor. There will be bars on all floors with an extension until 3.30 in the morning.

The View Day Ball Committee hope that as many past and present Bart's men as possible will be able to make the Ball a fitting end to View Day, 1964.

THE ROYAL AND ANCIENT HOSPITAL OF ST. BARTHOLOMEW

VIEW DAY BALL

THE CAFE ROYAL · WEDNESDAY, 13th MAY, 1964

9 p.m. - 3.30 a.m.

DINNER TOMBOLA BILL SAVILL ROULETTE CABARET

DOUBLE TICKET : 90/-

CUT HERE

Send this to:

Secretary, View Day Ball Committee, Abernethian Room,
St. Bartholomew's Hospital, London, E.C.1.

I, (Name in block caps.)

wish to apply for Double Tickets and enclose cheque/

cash for the sum of £ : s. d.

Address

I understand the Committee cannot guarantee to refund
money for returned tickets.

Date Signed

N.B.—Cheques payable to St. Bartholomew's Hospital Students'
Union, crossed "Ball a/c".

Receipts will only be sent if requested. No tickets will be sent out
before April 26th.

TABLE RESERVATIONS

Tables will be for parties of ten. It will greatly assist the Committee in arranging the seating plan if the organisers of individual parties would fill in this form:

I wish to reserve a table for ten in the name of

.....
and the male members* of the party will be

* (This information will prevent double bookings).

St. B.H.J., April, 1964

ALTERATIONS IN CASUALTY DEPARTMENT, II

By James O. Robinson, Chairman of the Casualty Project Team

Nearly two years ago, an article entitled "Alterations in the Casualty Department" appeared in this Journal.* The new Department has now been planned by the Project Team and approved by the Ministry, and it is hoped that the work will begin some time this Summer.

In the early stages of planning, it became apparent that a self-contained Casualty Department could not be developed unless the Abernethian Room was incorporated. The Medical College was approached and kindly agreed to relinquish this Room if other accommodation could be found, which although temporary, would be suitable for the students. The new Abernethian Room is now complete and its occupation has allowed Phase I of the alterations to be started.

The object of this article is to let people know what is going on, for there is nothing more irritating and frustrating than to be kept in the dark about something which must be of variable concern to everyone in the Hospital. Nothing is more likely to arouse criticism and even opposition than secrecy cloaked in pomposity, and this must be avoided for the highest degree of co-operation will be required from every single individual within the Hospital while the alterations are being made. Considerable sacrifices will be necessary due to unavoidable difficulties and frustrations, and these cannot be made willingly unless their object is apparent.

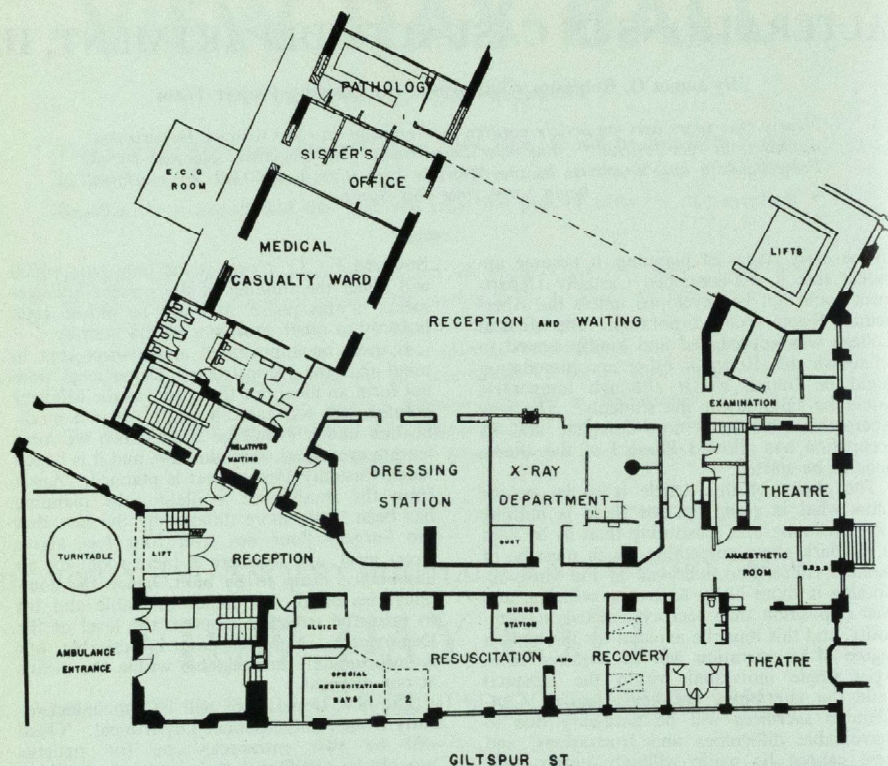
The plan shows the broad outline of the alterations. The whole of this area cannot be closed at once so that the work must be carried out in phases. At the moment it is envisaged that three phases will be necessary, so that various clinics occupying the rooms which are required for alterations may be decanted phase by phase. Phase I will start with the alterations to Windmill Court which is to be the new ambulance entrance. At the same time alterations will be made to the old Abernethian Room as far as the partition leading into the two-bedded Recovery Ward. The new staircase down to the Refectory and up to the Resident Staff quarters, the adjacent lavatories and the new E.C.G. room will also be built and altered in this phase. Room 19, which is now occupied by the Resuscitation

Bay and E.C.G. room, is the only part which will affect the running of the present arrangements in this phase, and will be moved temporarily to other situations within Surgery.

It must be appreciated and always kept in mind that the reconstructed Department does not form an ideal, for the space, as the Ministry pointed out, was far too small. It is a modification and a prototype from which we must learn a great deal when the new, and it is hoped ideal, Casualty Department is planned. Apart from the small area available, the planning has been made more difficult by the fact that the Surgery floor lies over four feet above street level, and nowhere is there room for an ambulance ramp to be built, hence the complications of an ambulance turntable and lift to raise the stretcher cases to the level of the Department. None of these is desirable, but is unfortunately unavoidable within the means at our disposal.

The new Department will be run independently from the Outpatient Department. There will be two entrances, one for patients brought by ambulance and another for walking patients. A porter will be permanently stationed at the ambulance entrance, and will notify by a calling system the medical and nursing staff of the arrival of a patient brought by ambulance. The patient will be lifted off the ambulance, passed through a heat curtain and placed on a bed trolley which will always be situated on the lift. At the top of this lift the patient will be met in the Reception Area by a doctor, nurse and clerk, and if the diagnosis is immediately apparent, will be directed to the appropriate ward. Patients requiring immediate resuscitation will be taken to the special resuscitation bay where all necessary equipment is permanently situated. If there is any doubt about a diagnosis, the patient will be placed in the main resuscitation room. Those patients who walk into the Hospital with minor injuries or as casualties will enter by the

*St. Bartholomew's Hospital Journal, Vol. LXVI, No. 6, Page 127.



main Outpatient Department entrance, and be directed to the Casualty Reception and waiting area, where they will be seen by the doctor, who will examine them in one of the special cubicles, or direct them to the Dressing Station according to their complaint.

The x-ray unit is situated in the middle of the area, and is capable of dealing with all types of radiology required by a casualty department. It will be in direct communication by television with the main Radiology Department, so that a diagnosis may be made without the films being taken up to the Department on the Fourth Floor.

The Theatre Suite comprises two main theatres separated by an anaesthetic and store for the Central Sterile Supply Department. There are also two small changing rooms for male and female staff, including

students. Between the main resuscitation room and the theatres is an area of recovery. This is divided into a two-bedded room for post-anaesthetic patients who will be within vision of the nurses' station, and a cubicled area where patients only requiring local anaesthesia may change and leave their clothes.

A Pathology Room has been planned which will serve the Outpatient and Casualty Departments.

Plans are being made to make better use of all the available rooms and to condense the space utilised by the Surgical Firm Boxes. This has a two-fold object, firstly to ensure that the work carried out in all the Firm Boxes could be undertaken within the size of the two Boxes which are labelled in Figure 1 as Dressing Station, and secondly to liberate more rooms for decanting clinics during the recon-

struction. This has gradually come into operation by treating men and women in the same Box, and by allocating times to the Firms so that two Firms may use one Box throughout the morning and by preventing "casuals" being investigated and treated in the accident Department, when they should rightly be referred to the appropriate Outpatient Clinic after their first attendance.

Phase II will probably be directed to work on the Medical Casualty Ward, Sister's Office, Pathology Room, Dressing Station, X-ray

Department, and part of the Reception and Waiting area. It is at this stage that the major decanting of clinics will take place, and when there will be difficulties in connection with space, noise and times of clinics. Details of the arrangements will be drawn up after consultation with people affected and posted in the Surgery. There must be criticism, but if anyone has any queries or useful comments or suggestions to make I should be pleased to try and answer or receive them.

AROUND AND ABOUT:

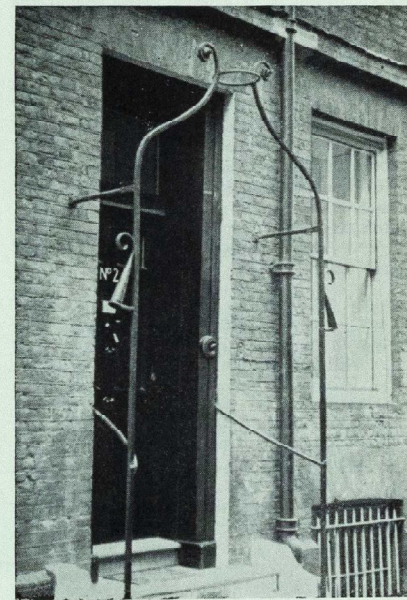
2—Precincts of Saint Paul's Cathedral

By "Argus"

"What London hath been of ancient time men may here see, as what it is now every man doth behold".—John Stow.

"NO one will ever forget their emotions on the night when London was burning and the dome of the Cathedral seemed to ride the sea of fire like a great ship, lifting above the smoke and flame the enviolate ensign of the golden cross." So *The Times* described the memorable Sunday of the 29th of December 1940, when the whole character of the area round Saint Paul's was altered overnight. Most of the little courts and alleys off Paternoster Row and Bread Street were destroyed and have now disappeared for ever beneath the towering offices of publishers and financiers. Yet hidden in the shadow of these concrete and glass colossi are secluded little areas that are the essence of the real London.

Walking up Ludgate Hill and turning into Ave Maria Lane off which runs Paternoster Row, you will see, on the left, a gateway at the entrance to Amen Court. The Latin names of these streets mark the halting places of the religious processions that were held before the Reformation. Amen Court, where the minor canons of the Cathedral live, is one of the most delightful retreats in the City; one might be miles away from Fleet Street. There is a row of late 17th century houses with link extinguishers outside the front doors and at the far end a little garden tucked away. A few courses of the Roman wall which surrounded the City



A doorway in Amen Court

may be seen here, embedded in a section of Medieval masonry and topped by a wall of modern brick.

Returning to Saint Paul's a number of narrow courts running off the churchyard will be seen. These were originally gates or posterns, kept closed at night, in a wall erected by order of King Edward I, "in consequence of thieves and other bad people in the nighttime within the precincts of the churchyard, divers adulteries, homicides, and fornications having been committed therein."

At the north-eastern corner of Saint Paul's is an open air pulpit called Saint Paul's cross. It was erected in 1910 on the site of a much older cross first used for sermons in the twelfth century, and referred to by Carlyle as "the Times newspaper of the Middle Ages." Papal Bulls were read from the cross including one of Paul II of 1469 cursing all shoemakers who made peaks to shoes more than two inches in length. These shoes made kneeling at Mass difficult and the devil is illustrated in the art of the time wearing them. In 1530 John Fisher, Bishop of Rochester, preached at the Cross against Luther before Cardinal Wolsey. By 1534 however, Henry VIII was commanding all who preached there to deny the supremacy of the Pope. In 1603 the Puritan element gained the upper hand and we find that a Mr. Hemmings of Trinity college was "very severe on women"—a sermon perhaps justified for in 1617 Lady Markham was ordered to, "stand at the cross in a white sheet and be fined £1,000 for marrying one of her servants, her husband still being alive". The old cross was demolished in 1642 by command of parliament.

To the south of the Cathedral and Ludgate Hill lies an area of closely packed streets and courts with such curious names as Creed Lane, Addle Hill, Wardrobe Place and Playhouse Yard. From Godliman Street the South side of the Cathedral is well seen, its sooty walls contrasting with the newly cleaned East front. When Christopher Wren had decided on the dimensions of the dome a labourer was sent

to fetch a flat stone from a nearby rubbish heap as a direction for the masons. He returned with part of an old gravestone with the word "Resurgam" (I shall rise again) enscribed on it. This was carved over the typanum and can be seen to this day. Near the South entrance are some fragments of the pre-Great Fire cloister of the Cathedral which were found in 1878—all that is left of the original building.

Wandering down Carter Lane there is a small entry just past Addle Hill. This opens into a delightful tree shaded close, remote but intimate. Here originally stood a house called the Wardrobe where were kept "the ancient clothes of our English Kings, which they wore on great festivals; so that this Wardrobe was in effect a Library for Antiquaries, therein to read the mode and fashions of garments in all ages". William Shakespeare was given four and a half yards of scarlet material from this Wardrobe for the state entry of James I into London in 1604. The house was burnt down in the Great Fire and on the death of the last Wardrobe Master in 1709 the Gardens of the house were converted into the houses which still stand.

At the end of Carter Lane runs Blackfriars Lane. A few doors down on the left is Apothecaries Hall originally built in 1664 and altered in 1779. The main buildings are arranged around an inner courtyard—a charming, secluded little area. The brickwork of the eastern wing rests partly on the medieval stone walls of the monastery of the Black Friars (the Dominicans), demolished after the Reformation. Part of the site was used by Thomas Burbage to establish a playhouse (hence Playhouse Yard) until he was compelled by the objections of the aristocrats and puritans in the neighbourhood to remove to Southwark where he built the Globe theatre.

Even outside the historical interest of the buildings the group of narrow streets in this area have a fascination of their own. One can spend an hour just rambling around ending by admiring the elegant Georgian houses set at an angle near the bottom of Saint Andrew's Lane.

MEDICAL EDUCATION AND PRACTICE IN AUSTRALIA

By Kenneth Carroll

Of late there has been much to and fro correspondence in both the Medical and Lay press on the unilateral migration of trained doctors and scientists abroad, mostly to the United States, but some to Australia. Most of the Chairs at Universities throughout Australia and many of the senior academic appointments are filled by graduates from the United Kingdom. There are also well over 100 doctors migrating to Australia each year. What are their reasons for changing and what sort of life have these people found in Australia? In this article I propose to view the educational system as a whole so as to obtain a balanced picture of medical discipline.

Pre-University Education. The whole of the Primary, Secondary and Tertiary education is basically the same as pertains in this country. Primary and Secondary education is the responsibility of the separate State Governments, and, although there are minor differences, each system prepares students to the standard necessary for matriculation to the universities established in the respective states. The states mutually recognise each others matriculation standards, and as far as students from the United Kingdom are concerned, they will find that provided they have already matriculated or qualified to matriculate from a recognised University they will be admitted *ad eundem statum* to any Australian University. However, the decision to admit a student to a particular University in the light of his qualifications can only be given by the authorities of the University concerned.

A student commences Primary education at the age of 5 to 6 years and pursues a general course of instruction until 13 to 14 years when an examination (called, in Queensland, the Scholarship Examination) is taken. If he passes this test the student proceeds automatically to Secondary school without the payment of fees, providing he is attending a State School. If he fails, the payment of fees

becomes necessary. About 80% to 85% of students pass this examination. State schools are maintained and administered by the State Government, and provide free education to University entrance level. The great majority of students in Australia attend these schools, which maintain a very high standard. The State Schools are to be found in every part of the country, whereas only the larger cities have Private Schools where students pay for their tuition and accommodation. Their academic standards are on a par with the State Schools.

Secondary Education proceeds for 2 years, when an examination is held (which corresponds to the 'O' level here), from which students either leave school and enter the commercial world, or proceed to another 2 years at High School. To proceed to this second stage a student must pass in at least 5 chosen subjects, which must include English, Mathematics and another language. It is during this final 2 years at High School that the potential medical student is channelled along the rails of matriculation, finally taking his Senior or Leaving examination at the age of 17 to 18 years.

University Education. So far then, we see that most students proceed to University level at a State school, easily accessible to them geographically, and with little financial burden provided they maintain the required standards. There is no limit to the numbers that can be accommodated.

A medical course may be taken at any of the 10 Universities in Australia except the National University at Canberra. At the present time, provided the student passes the matriculation examination from Secondary school, there is no selection on the numbers entering the course. Let us examine these requirements more closely. In Queensland a candidate is required to pass in 5 Senior ('A' level) subjects including English, Mathematics, Chemistry and Physics; German, French or Latin must be passed or have been passed at

not less than Junior ('O' level) standard. There is no special pre-entrance examination or interview. In New South Wales, University entrance in Medicine at Sydney University is open to all who graduate from Secondary school in appropriate subjects at a level of 5 "B's" or 3 "A's" and one "B". The subjects are the same as for Queensland. If a matriculation pass in the Leaving Certificate is not obtained then the University has its own matriculation examination which may be entered for. There is no restriction on the number who enter Medicine if they have gained matriculation.

In Melbourne, to matriculate a student must firstly obtain the Leaving Certificate in 5 selected subjects, and secondly, pass a matriculation examination in 4 selected subjects at not more than two attempts.

Almost half of all students have financial assistance in the form of Bursaries and Scholarships. Four thousand Commonwealth Scholarships are awarded annually on merit in all subjects, and they cover tuition fees and living costs. Taking account of University and other fees, College students would need £A600* to carry them through a full calendar year. The average cost of lodgings is £A5-7 per week.

The Medical curriculum covers 6 years, of which about half are preclinical studying the basic sciences, and half are clinical. In Queensland and New South Wales at least, there is a restriction on those who fail examinations. Students who spend more than 3 years in any 2 academic years must leave. Recurrent failure is not allowed, unless there are extenuating circumstances. The preclinical years, especially the first year, have high failure rates. The Academic year commences in March and annual examinations are held in November during the course. Failure to pass in any one subject means that the student must repeat the year and sit for all the subjects again the following year, unless he is granted a supplementary examination in the failed subject. If he passes this, he may then proceed to the next year's studies without repeating the year. Also if he fails a year any Government financial assistance he is receiving lapses until the examinations are passed.

Students are given wide training in preparation for the general practice which most will pursue. This includes 4 to 6 weeks residency in obstetrics during which time each student must confine a certain number of patients, perform forceps deliveries, and assist at Caesarean

*£A1 is worth about 15s. sterling.

operations. During one of the clinical years lectures are given on Social and Tropical Medicine, and weekend visits are organised to various industrial and social centres. During University vacation each year selected students are sent to work in the Native Hospitals in New Guinea where a very good experience of tropical medicine is obtained.

In Queensland facilities exist whereby medical students, at the end of their fifth year, can spend 2 weeks of their vacation assisting a General Practitioner with his work. This is a splendid way of bringing a student into contact with the problems of general practice.

On the whole students seem to spend less time doing ward dressings, attending at operations and working in casualty and outpatients than their counterparts do here. Clinical teaching is done by Consultants to a greater extent than here, probably because we have no corresponding Senior Registrar positions. In Queensland, during one of their clinical years, all students must carry out some original work on Social or Tropical medicine, and compile a report or project which must be passed as satisfactory. For example, a student may go from door to door enquiring about domestic accidents, and write a paper on their prevention. This again brings all students into contact with the various problems encountered by general practitioners.

Having passed his final examinations a student will graduate M.B. B.S. from any Australian University, and must then do 12 months residency before he can become fully registered. In most States, this must include appointments in Medicine, Surgery, and Casualty. Most Doctors then go on and do a second year, concentrating on those facets of medicine that will assist them in their future career. For example, a prospective G.P. will do obstetrics, anaesthetics and perhaps more medicine or surgery. In other words, the time spent in each subject is usually 2 to 3 months, instead of the 6 to 12 months spent here. The salary of a first year R.M.O. varies between £A1,000 and £A2,000 depending on the State and the geographical situation within that State. Accommodation is usually provided free of charge for single persons, and a small allowance given if married and living out. The less densely populated areas of Australia are short of hospital doctors and graduates willing to go to such places receive incentive payments and in most cases a taxation allowance. Practically all peripheral hospitals provide married

accommodation at a nominal rental (about 25/- weekly).

Post-Graduate Education. There is a tremendous swing towards higher degrees and post-graduate education in general in Australia at the present time. Full time courses are now being held in medicine, surgery and anaesthetics, for the corresponding diplomas F.R.A.C.S., M.R.A.C.P., and F.F.A.R.A.C.S. There are also courses and diplomas in pathology, radiology, radiotherapy and psychiatry. There is no doubt that fewer graduates are coming abroad now that these courses are well organised and adequate training facilities are being provided. For example, to obtain a surgical appointment in Australia, a candidate must hold the Australian Fellowship, even though he may have qualifications and training abroad.

The G.P. is encouraged to do refresher courses. During these courses he returns to a teaching hospital or base hospital for 6 to 8 weeks for general instruction, and during this time his practice is run by a hospital R.M.O., usually in his second or third year. Also weekend refresher courses are held by the Association of General Practitioners and these are very popular academic and social events. Selected consultants also go on country visits, giving a series of lectures at country centres on topics selected previously by the G.P.'s in the area. These are conducted on an informal basis and are very popular with the G.P.'s.

Medical Practice In Australia. A pattern has developed owing to tradition and local circumstances. There are great distances and the population is concentrated around the coastline. Here are situated the larger teaching hospitals in the capital cities, and the large base hospitals. Here also most G.P.'s practice. The rest of the community is cared for by G.P.'s, many of whom now have specialist qualifications. Superintendents at the small local hospitals are often practising in private as well.

One should note the extent to which the G.P.'s carry out medical and surgical procedures which elsewhere would be carried out by specialists. In 1960 in N.S.W., 70% of appendicectomies and 40% of hysterectomies

were carried out by G.P.'s. In country areas they tend to do more surgery than their urban colleagues. Here there are any number of young specialists without a hospital appointment only too willing to do the surgery for the G.P. and gather the small fee he gives them. G.P.'s also do their own confinements (with few exceptions all babies are born in hospital in Australia), and give each other's anaesthetics. Remuneration is by the fee for service system, and at the present time in Q.L.D. a visit to the surgery costs the patient one guinea. 80% of the population belong to Government assisted Insurance schemes, which cover most of the cost of medical and hospital treatment, including confinements. A pharmaceutical benefits scheme is also in operation.

The prospects for the young specialist who wishes to pursue his speciality and not enter general practice are rather limited. There are many more candidates than positions becoming vacant or likely to become vacant in the foreseeable future, with the result that many are being forced, in order to exist, to enter group general practice. More fortunate ones enter group specialist practice, but these opportunities are limited. Some take academic appointments in the rapidly expanding units being opened in the teaching hospitals. Most of these are now headed by U.K. graduates who are gathering around them a large number of workers.

Conclusion. The whole structure of medicine would be altered by the introduction of a National Health Scheme based on that which exists in this country. This would depend on political issues but would be actively resisted by the profession as a whole (as it is at the present time). Most people think that a system will eventually come, but not in the near future. More doctors are still required to staff the more peripheral hospitals and to become G.P.'s in more distant areas. A restriction on the numbers of students entering the medical curriculum at some of the Universities will almost certainly be made in the future, owing to lack of accommodation and facilities for the increasing numbers of students.

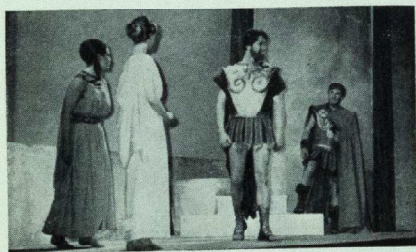
Reference. "The Commonwealth Universities Year Book," 1963.

TIGER AT THE GATES

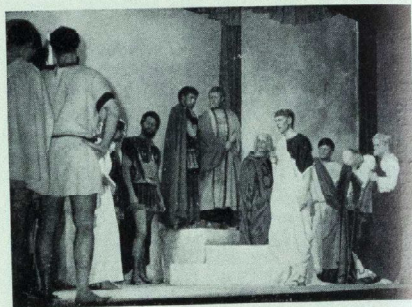
The production of 'Tiger at the Gates' by Jean Giraudoux continues the laudable trend of the Drama Society in performing some of the more interesting and rewarding plays of modern European dramatists. The play's original title was "La guerre de Troie n'aura pas lieu" and this is a rough summary of what the play is about—an anti-war play in Greek costume. Hector is an accomplished head soldier who knows only too well the horrors and degradation of war, and tries to preserve peace in the face of the unthinking, unconcerned Trojans. The play has a delicacy of wit, alternating with a poetic intensity of feeling, which has been superbly translated by Christopher Fry.

Bryan Lask's production was the best Drama Society work that I have seen. He showed an overall control and grasp of the play which was admirable if one considers his difficulties in producing a play of this sort on the Gloucester House stage with the limited number of medical students at his disposal for casting. My criticisms are not intended as studied insults, but as personal preferences and suggestions.

The play's mood swings between the wit of the dialogue between Hector and Paris and the lyrical intensity of that between Hector and Andromache. Possibly these mood swings could have been developed and the emotional flatness which was occasionally noticeable relieved. I also felt that the alternative ending to Act 1 which was used when the play was first performed in England would have been much easier to bring off. In spite of these criticisms I feel sure that the fact that the



Ajax to Hector: "What's your name? It ought to be pimp!"



Ulysses to Helen and Paris: "He kissed your hand! I see an outbreak of the animal in him."

Drama Society has a producer who believes in the play he is producing and has the ability to direct the performances of his actors is going to be a help to the Society in the future.

The central role of Hector was played with convincing sincerity by John Graham Pole, a long and difficult task which he never made boring. Of the other performances, Benita Wylie's Hecuba and Nicholas Wagner's Ulysses struck me as especially good. Most of the other roles were very competently performed though I felt that, in one or two cases, the individual personalities had been allowed to take over the characters rather than the other way around. The remark "Of course, he's just like that off-stage" is no compliment.

The stage in Gloucester House is more suited to an Annual General Meeting than a dramatic performance. The shallow stage is out of proportion to the rest of the hall and presents almost insuperable difficulties of lighting and staging. In spite of this the stage was always well lit and the two sets were thoughtfully designed and executed showing off the actors and adding a great deal to their credibility.

It is adventurous of the Drama Society to stage some of the more modern plays which are less certain of "box-office" appeal. I hope that they will not be discouraged by the less than full houses to which they played nor by the adverse criticism which they sometimes receive. Their improving standards of play and production deserve much more support.

J.R.S.

WILLIAM HOGARTH (1697-1764)

by Roger Sanders

Photographs by courtesy of the Photographic Department

William Hogarth was born on November 10th, 1697, in Bartholomew Close, "next Mr. Downing's the printers", and baptised in the Church of St. Bartholomew the Great on November 28th of the same year. He was not clever at school, but showed great aptitude as a draughtsman and worked as an apprentice silver engraver at Leicester Fields until 1720, when he set up as an engraver near the Black Bull in Long Lane, adjoining Smithfield. He studied painting under Sir James Thornhill, whom he greatly admired, and Hogarth records that Thornhill's frescoes in St. Paul's Cathedral and Greenwich Hospital which were at that time going on, "ran in my head, and I determined that silver-engraving should be followed no longer than necessity obliged me to it." In 1729 Hogarth eloped with Thornhill's daughter. All his early paintings depict accurately the environment in which he lived and many of the characters depicted he he observed in and around Bartholomew Fair, the shows of Smithfield, and Newgate Prison. He was a moralist as seen in "Beer Street", "Gin Lane", and "The Four Stages of Cruelty", and a satirist in "Calais Gate".

Although Hogarth enjoyed great success in this "low" style of painting with the "Harlot's Progress" (1731) and the "Rake's Progress" (1735), he wished to revive English painting, thinking this could be done by painting in the "higher style of History painting". English painting did indeed need a stimulus, since the market at the time was flooded by imitations and alleged Italian "Old Masters", often badly painted and in poor condition, which were collected by the connoisseurs. He was further encouraged, not only by Thornhill's achievements in a heavy baroque style, but by the essays of Jonathan Richardson, a competent artist himself, in which he declared that English painters should form a new school in the grand manner after French and Italian art. Hogarth was therefore very pleased when he was asked by Gibbs, who was rebuilding the Hospital at the time, to decorate the staircase to the Great Hall. "Thus," he says, "I quitted small portraits and family conversation pieces, and with a smile at my own temerity commenced History Painting."

Hogarth showed a great interest in the work of hospitals for he greatly wished to abolish the cruelty, poverty, sickness and immorality which existed, as we see in his paintings, at that time. In 1734 he became a Governor of the Hospital and on July 21st, 1737, it was "resolved that the thanks of this court be given to William Hogarth Esquire, one of the Governors of this House, for his generous and free gift of the painting of the great staircase, performed by his own skilful hand in characters (taken from Sacred History) which illustrate the charity extended to the poor, sick, and lame of this hospital". Contemporary writers suggest Hogarth had these works in mind in becoming a Governor, and that instead of paying the £100 usual for this honour, he offered to paint the staircase free of charge. On December 14th of the same year it is recorded that a copy of Holbein's full-length portrait of Henry VIII, which was given by Mr. Stweete, a Governor, was fixed "with decent and respectful ornaments" under the supervision of Gibbs and Hogarth in the Great Hall. In 1739 he helped found the Foundling Hospital.

Thus Hogarth came to paint the "Good Samaritan" and the "Pool of Bethesda". There is no doubt that Hogarth was able to study the symptoms of the sick through his friend John Freke, who was a surgeon in the Hospital at the time, and whose gift of a wooden chandelier can be seen above the staircase. This is probably also the source of Hogarth's sketch of an operation scene, and his painting "The Consultation of Physicians". The subject in this latter painting is not clear, and it has been called "A debate in palmistry", but he is probably using this medium to attack the staff at the Hospital who are debating suitable methods for obtaining their fees, for Hogarth probably shared the belief, general in England at the time, that doctors were disreputable and insensitive to human suffering; and for this reason, like butchers, they were excluded from juries. He attacked and satirised the medical profession in the print "The Undertaker's Arms" in which Dr. Pierce Dodd, a pompous physician of the Hospital, is caricatured



The Good Samaritan

together with other contemporary doctors and quacks.

In the painting depicting the parable of the "Good Samaritan", the Samaritan, as recorded in St. Luke's Gospel, is pouring oil and wine into the wound of the robbed man who also has an injured arm. In the background the priest and the Levite are seen passing the wounded man, while in the foreground a typical Hogarthian dog is licking a wound in its leg presumably received in defending its master.

The practice of pouring oil and wine into

wounds was common until Ambrois Paré, one of the greatest surgeons of the Renaissance, gave it up. While working in Turin he ran out of oil and "was forced with much trepidation to use a digestive of eggs, oil of roses and turpentine" as an alternative and found to his surprise that these patients had little pain and that their wounds were not inflamed, whereas those who had been treated with boiling oil were feverish with great pain and swelling of their wounds.

The subject is traditional and a similar picture, painted by Van Cortemde in 1647 hangs



The Pool of Bethesda

in the Surgeons' Hall at Antwerp. The position of the wounded man is somewhat different in Hogarth's picture and is probably taken from "St. Sebastian cured by angels" by Van Dyck, the position of Van Dyck's angel being very like that of Hogarth's Samaritan. Neither of the figures are typical of Hogarth's earlier work.

In the "Pool of Bethesda", the first picture to be painted, Christ is seen addressing the lame man who, according to St. John, had been ill for 38 years, and surrounded by a "multitude of invalids, blind, lame and paralysed". The painting is in the style of Dutch Protestant Biblical illustration and evokes pity for the poor in their struggle against the rich. The rich woman at the pool is seen ordering her coloured servant to push aside the poor mother who is seeking to cure her child in the water.

The nature of the sufferers' symptoms has been studied by Norman Moore. On the extreme right a man with a thin, pale face and painful expression is seen with his right hand on a swollen abdomen, and is suggestive of suffering from cancer of the liver. The rich woman turning her face away from Christ is said to be a portrait of Mistress Wood, a well-known courtesan who lived in the City at the time. She shows a patch of psoriasis on both

knees and on her right elbow. The figure at her side is her maid. The poor woman's child is suffering from rickets and shows a typical facial expression. The prominent forehead, curved spine and enlarged joints are characteristics pointed out by Dr. Francis Gibson who succeeded Harvey as Lumleian Lecturer and first described the disease. Freke also described rickets. The man in the foreground who has waited so long to reach the pool is depicted unwinding a bandage from a chronic leg ulcer, but he doesn't appear particularly wasted, and one cannot imagine Hogarth thinking that this alone kept him from the pool. Perhaps it is just symbolic or one is supposed to imagine some other ailment since he does have a bandage around his head. The woman with the painful expression on her face is raising her arm to her head to expose an abscess on her breast. The pale face contrasts with the red inflammatory area. The man with the bandaged head has the face of a hard drinker and his gouty hand appears to have been knocked by the man with the staff who is probably blind. The woman in the background must have acute melancholia, and the young figure in the foreground has a bandaged arm. On the extreme left is an unhealthily fat girl with red cheeks, thick lips and a short nose,

and an emaciated crone. These two figures represent the two forms of consumption which used to be talked of at the time. The former represents the strumous or scrofulous type, the latter is a clear case of advanced phthisis.

The subject was a very popular one in Hogarth's day and the influences in this painting are many. However the painting is original in that, for this type of subject, the result lacks dignity but is very realistic and human. This interpretation is in line with the European tendency to humanise the Bible, and to produce a practical rather than a dogmatic approach to Christianity, as seen in the protestant Bible illustrators since the end of the sixteenth century. The figures are not typical of Hogarth, except for the two women on the left suffering from consumption, which do not appear in the original sketch, and are therefore painted with more boldness and vitality. On looking at the picture the groups of figures, whilst well painted in themselves, seem apart and unrelated, giving the impression of small drawings enlarged to fill the space. Hogarth recalls with great pleasure that the figures are seven feet high, but he is not at home painting in this alien style of portraying heroic scenes on such a scale and has not made the best use of the available space. He is however on more familiar ground in portraying the sick which he does with great accuracy and originality. The source of the painting can be seen in Rembrandt's Hundred Guilder Print of "Christ healing the sick", and Raphael's cartoon of "St. Peter and St. John healing the lame". The main group of figures with Christ appears to be taken from Callot's "The raising of Lazarus", the gestures and relations of the figures being very similar, and Rembrandt's print of the same subject. The two pharisees seen reading from a large book in the background of the sketch are taken from Rembrandt. This is a serious subject for Hogarth, and the recognised tradition was to depict Christ larger than the surrounding figures to add to his importance in the scene, but this is not adhered to here and the figure lacks dignity. There is a stylish resemblance to Amiconi's picture "The return of the Prodigal" which was painted shortly before the "Pool of Bethesda", for Emmanuel College, Cambridge, and indeed this painter was seriously considered for the decorations at Bart's. In style the handling of the subject is also akin to the work of Ricci and Paninni and is close to Thornhill's heavy baroque style. The architecture, distant land-

scape, and flying angel, are reminiscent of Italian art, the architecture of Veronese in particular. In the engraving of the painting by Hogarth, which he invariably executed to make money, and to bring his work before a wider public, he inserted a contemporary portrait of Nell Robinson, a celebrated courtesan, with whom Hogarth had been intimately connected in early life.

The landscape in the Good Samaritan and the ornamental work is not by Hogarth. The landscape is by George Lambert who was scenery painter at Covent Garden, and it is possible that the pictures were painted in Lambert's large studio and later transported and erected at Bart's. The intricate ornamentation was painted by Richards at Hogarth's expense, and includes baskets of medicinal plants, medallions of Galen and Hippocrates, and frames in Georgian style. The dog in the "Pool of Bethesda" gives the impression of standing on the frame and being about to jump out. Below the paintings the frame encloses the relevant passage from the Bible, and in addition, below the "Good Samaritan", sketches connected with the life of the Hospital. In the first Rahere is sleeping, and presumably having his famous dream. The second shows the reception of gifts and the beginning of the building. The third shows a patient on a stretcher being received in the Norman cloister by two brethren of St. Bartholomew. The inscription above the entrance to the Great Hall was added later in 1754 by order of the Governors. Hogarth requested that the pictures, which are painted on canvas, and are not frescoes, should never be varnished but this was later found necessary in view of the London atmosphere, although with some detriment to the paintings. The pictures were first cleaned as early as 1751 by John Williams, at Hogarth's expense. The Pool of Bethesda is recorded as having suffered as a result of the sun, and several creases appeared in the "Good Samaritan" when it was cleaned in 1780. Many coats of varnish were removed when the paintings were cleaned four years ago.

While the paintings are successful in portraying the sick and their symptoms, very accurately observed by Hogarth, they were a failure from an artistic point of view. Hogarth was right that English painting needed a stimulus, but he was wrong in thinking that he could provide it by painting in a grand manner. The Grub Street Journal esteemed it "a very curious piece" and Horace Walpole observes that "the

burlesque turn of our artists mind mixed itself with his most serious compositions." Hogarth was disappointed for he hoped this might lead to further pictures of a similar kind, but the paintings lacked dignity, in spite of the borrowings from Raphael, and as Hogarth says "religion, the great promoter of this style in other countries, rejected it in England." He therefore "dropped all expectation of advantage from that source" and returned to a lower style of painting, moralising and satirising London life, in which he was more successful. Later on he tried again to paint in a grand manner, but he was never to enjoy success in this style.

References

1. History of St. Bartholomew Hospital by Norman Moore.

2. A brief history of the Hospital of St. Bartholomew by G. Whitteridge and V. Stokes.
3. A History of Medicine by D. Guthrie.
4. Hogarth's Progress by P. Quenell.
5. Art & Medicine by L. P. Mark.
6. Hogarth and his place in European art by F. Antal.
7. The works of William Hogarth with descriptions and explanations by Rev. J. Trusler, J. Nichols and J. Ireland.
8. Hogarth by R. B. Beckett.
9. William Hogarth by Austin Dobson.
10. Biographical anecdotes of William Hogarth by J. B. Nichols.
11. Hogarth's staircase at Bart's by E. Croft-Murray.

OTHER HOSPITALS: 5

CHARING CROSS HOSPITAL

By J. D. Robertson



Dr. Johnson said that "the full tide of human existence is at Charing Cross", and in 1815 Dr. Benjamin Golding found that this densely populated area was gravely lacking in medical amenities. Golding qualified at St.

Thomas's at the age of 22 and went into practice near Leicester Square. Because of the lack of hospitals he tended gratuitously many patients at his house and persuaded two colleagues to do

likewise and within three years they had seen 20,000 patients. He decided to form a charitable institution and in 1823 enough funds had been raised to purchase and convert a house in Villiers

Street opposite the old market of Hungerford, on the site now occupied by Charing Cross station. The building was named the West London Infirmary and Lying-in Institute, and was a general hospital receiving accidents and the sick. There were then twelve beds and a few students, and it was the first London hospital to open with a teaching department. The staff consisted, besides Golding, of two physicians, a dentist and a "cupper", who endeavoured to reduce inflammation by applying suction to the affected part.

In 1823 the Managing Committee of the Charity had £7,000, and Golding set out to acquire a suitable site for a new and far larger hospital. At that time the area of Trafalgar Square, then known as Union Square, was being developed by the Crown Commissioners as a War Memorial. A derelict site was eventually obtained just east of St. Martin's church. The Commissioners wanted the hospital to be erected in a back street in the centre of the dreadful slum area to the east of St. Martin's Lane. Westminster Hospital were also trying to obtain a site for new premises in the Charing Cross area and were backed by a well advertised appeal for funds; moreover, the Ophthalmic Hospital, now our annexe, had acquired some land adjoining and immediately to the west of Golding's site and nearer to St. Martin's Church.

The architect chosen to design the new hospital was Decimus Burton, who planned many well-known buildings in London, including the Athenaeum and the Triumphal Arch at Hyde Park. The cost was estimated at £14,000 but half of the building was erected for £8,000 and the remaining money was found in time to complete the entire structure without interruption. The foundation stone was laid on 15th September, 1831, by H.R.H. the Duke of Sussex, fifth son of George III. This foundation stone cannot be seen today and is probably hidden by the porch of the main entrance in Agar Street added when the building was extended in 1862.

The early history and advancement of Charing Cross Hospital owed much to the resourcefulness and perseverance of the founder, Dr. Golding. He was a physician at the hospital until a year before his death, at the age of 62 in 1863, and was the director of the charity for 3 years. At the outset of his career he showed his interest in hospitals and their organisation by publishing (1819) a very full and accurate account of St. Thomas's

Hospital. During his term of office the hospital was never in debt, and it was in fact the only hospital paying its way when the National Health Service took over the hospitals in 1948. He increased the number of students from 22 in 1834 to nearly 100 in 1842 and provided them with a very complete curriculum. The early teachers were some of the best physicians and surgeons in the country. Among those on the medical side was James Risdon Bennett, who was later knighted and became President of the Royal College of Physicians. One of the first surgeons was John Avery who applied his flair for mechanics by inventing lamps, tubes and reflectors by which means he was able to examine the ear, bladder, oesophagus and larynx as probably no surgeon had ever examined them before.

Charing Cross has had its share of famous men. David Livingstone, the African explorer, came in 1839 to take his clinical subjects before returning to Glasgow for his final examinations. Thomas Henry Huxley won a Free Scholarship in 1842 and spent five years at Charing Cross. His own writings tell of how he came under the influence of a really great teacher for the first time and how he "never forgot his debt to Wharton Jones and never felt so much respect for anybody as a teacher before or since."

The hospital progressed and in 1877 was enlarged and its accommodation increased to 236 beds and the new wards were formally opened by H.R.H. the Prince and Princess of Wales, afterwards King Edward VII and Queen Alexandra. In 1881 the present school premises were opened in Chandos Place, opposite the north side of the Hospital. The opening was performed by H.R.H. the Duke of Edinburgh, President of the Hospital. The results of the change were immediate and most satisfactory since the number of students doubled and for the first time dental students were catered for. The increase in students meant a great deal to the hospital since one-fifth of the students' fees went to the hospital. The Dean of the Medical School at this time was Dr. Mitchell Bruce, who was said to be such an instructive lecturer and clinician that students came from many other hospitals to hear him.

In 1894 Charing Cross found, in common with the other London Medical Schools, that changes in the conditions of medical education throughout the country had drastically altered the secure footing built up in preceding years.

The need for new laboratories for Pathology, Physiology, Bacteriology, etc., had increased costs, and the popularity of the provincial universities, together with an increase in the curriculum from four to five years, had reduced the number of students. The net result was that development and research were curtailed and the growth of the school retarded until 1911, when a successful reorganisation was put into effect.

During this time there is perhaps one name which stands out—that of Christopher Addison, whose anatomical researches are remembered in Addison's transpyloric plane. He came to Charing Cross from Sheffield where he had been Professor in Anatomy, and was appointed Special Lecturer in Anatomy. Before he left in 1907 he had risen to Professor of Anatomy and Dean of the Medical School*. Although an outstanding anatomist he will be remembered best as a politician. He was the first Minister of Health, and later became Viscount Addison.

In 1901 the hospital was reconstructed and a new surgical block, with wards and outpatient departments and a nurses' home was added.

During the Great War all the residents joined the forces and for the first time Charing

*Christopher Addison was Lecturer in Anatomy at Bart's from 1907 until 1913.

BOOK REVIEWS

Blood Pressure Sounds and their Meanings. Part 3.
By J. F. Malcolm. Published by Heinemann at 30s.

Group Captain Malcolm has made a new approach to cardiovascular physiology, based on analogies with electronic and hydraulic models. These studies have led him to discard the theory of the heart as a simple pump in favour of the system which he develops in the first four chapters of the book.

According to his theory the pulse wave is generated by hydraulic resonance in the chambers of the heart, with the coronary tree and heart muscle forming an oscillator, the peripheral pulse being synchronised by conduction through the skeleton.

A theory which explains the observed facts may be valid, and these models have been built up to imitate more and more closely the known actions of the heart. A model does not become useful, however, until predictions made from it can be applied back to the biological system which it

Cross had three lady doctors from the Royal Free. They proved so popular that the University proposed that Charing Cross should accept an unlimited number of women students. This was refused and the West London Hospital stepped into the breach and accepted them.

When the Second World War broke out it was decided that Charing Cross was too vulnerable and the staff and equipment were moved 35 miles out of London to Bonar Law College at Ashridge which was converted to a 1,200-bed hospital. Casualty work continued at the Cross amidst sand bags, and the outpatients' department opened again after six months. The Medical School soon followed the hospital into the country after being hit by a shell and the school occupied a large house at Boxmoor, quite close to the temporary hospital.

Several attempts have been made this century to obtain a suitable site for a larger and more modern hospital. Negotiations reached advanced stages and were then foiled first at Holborn and later at Harrow. Fourteen years after the last war the Ministry of Health requested Charing Cross to build a new 800-bed hospital at Fulham to combine the present Charing Cross, Fulham Maternity and West London Hospitals. Work has now started on the scheme and when completed the new hospital will be one of the most advanced in Great Britain.

represents. To dogmatise from it at this stage can be most misleading.

The later chapters, which are rather more obscure, deal with analogies between the cellular structure of tissues and the crystalline structure of minerals. This book can only be recommended to biologists with an advanced knowledge of physics.

A Summary of Medicine for Nurses, by R. Gordon Cooke, M.D., M.R.C.S., L.R.C.P. Published by Faber. Price 9s. 6d.

A pocket-sized book of 154 pages which is a summary of the whole field of Medicine cannot be criticised for its omissions, since obviously it must leave out so much. It is a little difficult to think of any use for such a presentation, apart from imparting facts to a nervous examination candidate, but since there are many of these about Dr. R. Gordon Cooke's book may well be valued as an aid to revising.

W.E.H.

Basics of Clinical Neurology. Samuel Brock, M.D. and Howard P. Kreiger, B.S., M.D. 4th Edition. pp. VIII + 616. Ballière, Tindall & Cox Ltd. Price £5 12s. 0d.

When the first edition of this book by Professor Brock of the College of Medicine, New York University, appeared in 1937 it was recognised as an outstanding contribution to the integration of academic neurophysiology and the practice of clinical neurology. In this fourth edition Dr. Kreiger has collaborated with the original author, and others have contributed chapters on subjects of special interest to them. The main purpose of the book is to relate the disturbance of function occurring in neurological disease to what is known of normal function of the nervous system and the authors have been unusually successful and up-to-date in this aim. In places the book is concentrated and perhaps difficult reading. It is possibly too detailed for some students but can be confidently recommended for those reading for honours degrees in physiology and for post-graduates taking the primary F.R.C.S. or the M.R.C.P. It will, however, be most enjoyed by anyone who is interested in the physiology of the nervous system.

J.W.A.T.

Hale-White's Materia Medica; Pharmacology and Therapeutics, by A. H. Douthwaite, M.D., F.R.C.P. Thirty-second edition (pp.519 + VII) 27s. 6d. J. & A. Churchill Ltd. 1963.

This is a further continuation of a book which has been very popular and useful in the past to medical students and general practitioners.

The book gives a summary of the pharmacology and therapeutics of drugs in common use. The drugs are grouped according to their action which assists the reader in finding drugs of common action should he or she be looking for a substitute. Trade names are given under the official names, as are the chemical properties and the empirical chemical formula, which should be of considerable help to the pharmacist. All the doses are given in the metric system, a virtue which cannot be surpassed by many other books on this subject.

The important side effects of the drugs are brought out in the short, easily readable text and all the important actions and effects are in bold-face type to catch the reader's eye. When more than one system of the body is affected by the drug, the actions are listed under system headings. This makes the book very useful for review purposes and a true handbook. There are also chapters on prescribing, preparations and the dangerous drugs acts.

In short, it is an incredible book for information. For example, there is a short, concise summary on radioactive drugs with their actions and information about their use. It also gives the history of some of the drugs. Did you know that tubocurare is called tubocurare because it was supplied in bamboo tubes from French Guiana?

G.G.

General Pathology, by J. B. Walter and M. S. Israel. pp. 937. London. J. & A. Churchill Ltd. Price 100s.

The publication of yet another textbook on pathology might be thought to require some special

justification and the authors open their preface with an apology. "This book is designed," they state, "for students embarking on a specialist career in medicine, surgery or anaesthesiology," and the authors' experience of postgraduate teaching at the Institute of Basic Medical Sciences of the Royal College of Surgeons has convinced them of the "need for a comprehensive book on general pathology that should embrace the disciplines of morbid anatomy, microbiology, biochemistry and haematology." Has this somewhat ambitious intention been realised in the present work? Yes, in your reviewer's opinion it has, and to a highly successful degree.

It is taken for granted that the reader is already conversant with the terminology and the book is therefore not suitable for the undergraduate student encountering pathology for the first time. Nevertheless, the treatment of each topic is thorough, starting with the basic essentials and giving a fair and balanced picture without attempting to conceal the difficulties or to cover up ignorance. The arrangement of the subject matter is somewhat unorthodox in that the chapters on thrombosis, embolism and infarction appear in the latter half of the book, but it may be argued that they follow logically upon the discussion of "reaction to trauma", "fever" and "disturbances in body fluids and electrolyte balance" which occupy the three preceding chapters. The broad basis of the work may be judged from the inclusion of chapters dealing with "the graft reaction", "antibacterial chemotherapy", "the chemotherapy of cancer" and "some abnormalities of protein metabolism", as well as the more orthodox content of general pathology. Useful chapters are also included on failure of the heart, kidneys and liver, and there are appendices which deal with the principles of disinfection and of bacteriological diagnosis and the physics of ionising radiation.

Although there is some redundancy in certain chapters, all the 890 pages of text are packed with information and there are few errors, either of fact or typography. No fault has been found with the index; the print and paper are good; the illustrations are for the most part clear and well chosen, but some of the line drawings are poor. Perhaps the most serious criticism that can be made concerns the system of references. There are no references in the text, but at the end of the book the authors give a "guide to further reading" under each chapter number. Many of the references here given are to other textbooks or to annotations or leading articles from the *BMJ* or *Lancet*. Useful as the "guide" may be in revealing the sources of information drawn upon by the authors, this is an inadequate substitute for a proper bibliography giving the original source or authority for many of the statements made. No doubt the compilation of such a list would have added considerably to the authors' labours, but it would have increased enormously the value of this admittedly valuable book.

The authors and publishers are to be congratulated on the production of a new book which supplies a genuine need and for which a successful future seems assured.

A.G.S.

Outline of Histology, by Gerrit Bevelander. Henry Kimpton. 44s.

This work is slightly unusual in style and presentation. It has neither preface nor introduction, and though it has the now familiar double-column format, the lines are unjustified. The paper used is too coarse in texture for the successful reproduction of fine detail in illustrations.

The book is arranged in two parts. Part one deals with general histology, firstly with tissues, and then with the various systems of the body. The whole of this part is illustrated with drawings. Two of the customary coloured plates, showing the cells of the circulating blood, and the structure of bone marrow, appear in this section. These are printed on art paper, but in the first-named plate the registration of the three-coloured blocks is so bad as to ruin the effect. The bone marrow is good.

Part two deals with the embryological development of the face and jaws and with the special histology of teeth. The embryological chapters are illustrated exclusively with drawings, but some photomicrographs are included in the chapters on special histology; these are spoiled by the poor grade of paper on which they have been printed.

The text is just adequate, but contains some errors, the most obvious being the perpetuation of the myth of the liver cord. As is usual with this blunder, the illustrations give the lie to the text. The drawings of the striated muscle is useless.

The author's intention has been to produce a book for the use of dental students which shall incorporate both the outline of general histology, the special embryology and a detailed account of

the microscopic structure of teeth. At the same time an attempt has been made to keep the price low. Unfortunately a very laudable attempt has been spoiled by the poor paper and faulty printing. F.J.A.

Venereology for Nurses. By R. D. Catterall. Publishers: English Universities' Press. Price 8s. 6d.

This is a subject that concerns nurses not only professionally but also socially. All responsible members of society see with concern the rising incidence of venereal disease in most countries of the world. A new textbook on this subject was much needed by nurses, and this one will be popular.

The price is reasonable, the print businesslike and well varied, with bold type for important terms and headings. Dr Catterall writes a clear, accurate and up-to-date account of all aspects of his subject, of which he takes a view broad enough to include many fringe-conditions.

The most striking feature of the book is the illustrations. Drawings tend towards a marked family likeness in many nursing books, but these are treated with great originality. Perhaps one should not call such presentation of the subject "attractive", but they are outstanding for originality of treatment and fidelity of line.

The social aspects of venereology are not very fully treated; perhaps this is because the causes of the increasing number of infected people are very ill-understood, and speculation about them is more common than firm information. We wish Dr. Catterall real success with his book.

W.E.H.

SPORTS NEWS

RUGBY CLUB REPORTS

Saturday, 8th February, v O. Paulines, away. Won 11-3.

Saturday, 1st February, 1st XV v O.M.T's. away. Won 10-3.

In a game of mediocre pace Bart's showed themselves to be the better side. The forwards played well in the fight and gained possession in the loose scrums to give the three-quarters a chance to show their capabilities. After twenty minutes this paid off and S. G. Harris ran over the line from the blind side of the scrum. The pace became slower and one must criticise all the Bart's team for not pouncing on their opponent's mistakes. An unfortunate incident ten minutes from the end of the game, when D. C. Pope was kicked in the stomach, gave O.M.T's a penalty, which they converted.

Team: Sidebottom, Harris, Griffiths, Savage, Johnson, Letchworth, Pope, Gilmore, Gurry, Knox, Bates, Orr, Gibson, Smart, Goodall.

On a frosty, foggy morning Bart's kicked off against O. Paulines. The ground was very hard, making tackles very half-hearted with a slippery surface making running difficult. Bart's soon realised that they would have to take advantage of their opponent's faults and kick on till near the line. Using these tactics, Bart's scored twice with Pope going round the blind side of the scrum. More tries should have been scored but the hard ground deterred people from diving over. Eventually, backing up a break by Savage, Goodall collected the kick ahead and scored. Gibson converted. In the last minute Old Paulines launched an attack which caught the Bart's defence off-guard and scored.

Team: Davies, Harris, Griffiths, Savage, Johnson, Letchworth, Pope, Gilmore, O'Kane, Knox, Orr, Bates, Gibson, Smart, Goodall.

Saturday, 15th February, 1st XV v Met. Police.
Lost 3-27, away.

This was a Black Saturday for the Rugby Club. All four teams lost and 136 points were scored against them. The first team were beaten by a fine Police side which had already disposed of St. Mary's (24-0) and St. Thomas's (27-0). They had a very heavy but mobile pack which effectively linked up with their hard-running three-quarters. The Hospital forwards failed to contain their opponents and the Bart's backs time and again found themselves faced with three or four men each. In comparison, Bart's launched few attacks, but in the final minutes, Pope kicked ahead from a short penalty, Goodall gathered and Pope, backing up, sent Orr away for a try in the corner.

Team: E. Sidebottom, D. Goodall, N. J. Griffiths, P. E. Savage, S. M. Johnson, A. T. Letchworth, D. C. Pope, O. J. A. Gilmore, B. H. Gurry, A. J. S. Knox, T. Bates, M. M. Orr, J. A. Gibson, C. J. Smart, P. Bradley-Watson.

Saturday, 22nd February, 1st XV v Harlequin Wanderers. Won 29-0. Home.

This was a welcome contrast to the previous Saturday. Bart's threw the ball around liberally and beat the Harlequins at their own game. Three-quarter movements were prolific and the scorers were Savage, Bates (in a push-over try), Goodall, Gibson and Griffiths. Gibson converted all but two and in addition scored two penalty goals.

Team: E. D. Dorrell, G. Hopkins, N. J. Griffiths, P. E. Savage, J. M. Johnson, A. T. Letchworth, D. C. Pope, O. J. A. Gilmore, B. H. Gurry, A. J. S. Knox, T. Bates, M. M. Orr, J. A. Gibson, C. J. Smart, D. Goodall.

Saturday, 29th February, 1st XV v Rugby.
Drawn 11-11. Away.

Bart's, playing down a slight slope, were soon ahead with an easy penalty. They continued to press with some good running from the backs and increased their lead with another try and a converted try, in which Orr broke from a loose maul in the Rugby 25-line to put Goodall over near the posts.

Playing with the slope in the second half, Rugby found their feet and attacked the Bart's line hard, but firm tackling and marking held them. Play then swung from end to end of the field until the last fifteen minutes in which Bart's lapsed fatally, allowing the Rugby backs that extra yard to move in. Three tries resulted, only one of which was converted. The final whistle went as the ball, in the last conversion attempt, bounced back from the upright.

Team: E. D. Dorrell, S. Harris, N. J. Griffiths, P. E. Savage, S. M. Johnson, A. T. Letchworth, D. C. Pope, O. J. A. Gilmore, A. O'Kane, A. J. S. Knox, T. Bates, J. A. Gibson, C. J. Smart, D. Goodall.

SOCCER CLUB

Saturday, 1st February, 1st XI v West Ham College. Draw 3-3.

Bart's had the support of a strong wind during the first half, which was soon used to our advantage. Ten minutes after the start a long ball through the middle of the field found Shorey. He quickly controlled the pass and lobbed the ball accurately into the top right hand corner of the goal. Soon afterwards Sutton fired home one of the numerous centres from Phillips who was playing at outside right. Both teams scored just before half time reducing Bart's lead to 3-1.

During the second half play was more equal. Bart's had countless chances to score, but all were squandered. Meanwhile, West Ham were less careless and managed to score twice to draw the game.

Team: A. Layton-Smith, P. Turner, D. McGeachie, N. Offen, R. Thew, S. Dorritt, H. Phillips, C. Sutton, B. Shorey, P. Herbert, C. Hugh.

Wednesday, 5th February, Cup Match, Quarter Final, v Westminster Hospital. Won 2-1 (after extra time).

Having been rescued, in the first match, from a 1-3 deficit, by a thick blanket of fog, Bart's began this replay with a stronger team and renewed spirit. It was apparent from the start that the match was to be played in true "Cup fashion" with the minimum amount of contributive football and maximum spirit. Throughout the first half play swung from end to end with neither side having any particular advantage. Half way through this half Sutton did well to control a pass from Phillips which he slid neatly into the goal.

Bart's maintained their lead until about thirty minutes from time when the Westminster centre forward was brought down in the area and scored with the penalty kick. For a time Westminster, spurred on by their supporters, looked dangerous. However, the Bart's defence gradually regained control. Thus after ninety minutes play the score stood at 1-1, and the two weary teams lined up for extra time.

For the first five minutes Westminster comfortably dominated play and their forwards were only held by considerable courage and through good fortune on the part of the Bart's defence. Once again the Bart's side gradually fought back and contained Westminster's efforts. All this was rewarded, after twenty minutes, when Dorritt, on the left wing, controlled the ball from a bad clearance and calmly beat the goalkeeper from a narrow angle. Throughout the match the team played hard and well.

Team: A. Layton-Smith, K. Rawlinson, D. McGeachie, N. Offen, P. Savage, R. Thew, H. Phillips.

C. Sutton, P. Herbert, G. Mumford, S. Rorritt.

Saturday, 8th February, 1st XI v Royal Free Hospital. Won 5-2.

A somewhat unusual Bart's side won this match easily. The most notable performance came from Layton-Smith, who moved from goalkeeper to right wing and scored a hat trick.

Team: N. Offen, J. Jeffries, C. Vartan, M. Fryer, R. Thew, P. Turner, A. Layton-Smith, P. Herbert, B. Shorey, S. Dorritt, C. Hugh.

Wednesday, 13th February, 1st XI v Lincoln College. Lost 2-4.

The match was played on a very wet, sticky pitch and Bart's never really settled down to the conditions. This, combined with a lack of urgency, appeared to account for the result of the game.

Bart's took the lead after twenty minutes and were apparently holding on quite comfortably, until a Lincoln breakaway led to a goal for them just before half time. Lincoln scored again soon after the interval, but followed this up by presenting Bart's with an own goal. For the rest of the game Bart's had a slight territorial advantage but conceded two more goals.

Team: A. Layton-Smith, M. Fryer, B. Goldhill, N. Offen, R. Thew, P. Turner, H. Phillips, C. Sutton, P. Herbert, S. Dorritt, J. Pemberton.

Saturday, 14th February, 1st XI v Worcester College. Won 4-1.

Apparently fortified by the previous evening's entertainment, Bart's entered this match with much more enthusiasm and vigour. Throughout they tackled hard and played fast, direct football. Worcester scored first but Bart's soon equalised with an excellent shot, taken on the turn by Phillips. During the rest of the match Bart's dominated the game more and more and added three further goals.

Team: M. Fryer, C. Vartan, P. Turner, N. Offen, P. Herbert, S. Dorritt, A. Layton-Smith, R. Thew, H. Phillips, C. Sutton, J. Pemberton.

Saturday, 15th February, 1st XI v Queen's College. Draw 2-2.

The Bart's defence started very shakily and within ten minutes had conceded two goals to the fast Queen's forward line. However the Bart's marking tightened noticeably and play gradually moved further into the Queen's half. This pressure was rewarded by a goal from Vartan. During the second half Bart's played a good deal better, but only Pemberton managed to score. Dorritt and Sutton gave particularly good performances.

Team: A. Layton-Smith, K. Rawlinson, P. Turner, N. Offen, R. Thew, S. Dorritt, J. Pemberton, H. Phillips, C. Vartan, C. Sutton, R. Browne.

Wednesday, 19th February, 1st XI v Charing Cross Hospital. Lost 1-3.

From the Bart's point of view this was a most disappointing match. We lost to a team whom we were quite capable of beating. From the start, simple mistakes were commonplace and continued to be so. The first half was fairly closely matched, both sides scoring, although Bart's had more chances.

During the second half Charing Cross gradually improved and won the match with two further goals—both caused by defensive errors. The only players to emerge with any credit were the full backs Rawlinson and McGeachie who saved the situation time and again.

Team: A. Layton-Smith, K. Rawlinson, D. McGeachie, N. Offen, P. Savage, S. Dorritt, H. Phillips, C. Sutton, C. Vartan, P. Herbert, A. Barclay.

BOAT CLUB REPORT

October & November, 1963.

At the start of the Rowing Year we were lucky to receive an encouraging influx of new members to the club; most of these were novices of whom, at best, we had about twenty, but we were also joined by six oarsmen with previous experience. This helped to ease a situation which, owing to the loss of those studying for 2nd M.B., might have been serious.

Early in the term we formed a senior Light IV, a Pair, and a Junior VIII; these and our Novices had regular outings from Chiswick, and we also had one sculler training at Putney. Later in the term a Junior IV was formed which also went out regularly. On occasions a Double Scull took to the water, but since the crew were usually otherwise occupied in rowing or coaching this was not often possible.

R. G. Nicholson coached the Light IV and J. Currie the Junior VII; unfortunately we were unable to obtain a coach for the pair. M. F. Mackenzie coached the Junior IV and T. J. McElwain, A. B. Ayers, and H. C. Cole-ridge coached the Novices.

Normally for some time before the United Hospitals Winter Regatta some of our crews have outings five or six times a week by boating after dark at Putney; this year however this was prohibited, so that we were limited to two outings a week.

United Hospitals Winter Regatta, 1963.

We entered a crew for every event in the U.H. Winter Regatta, and we were able to enter four crews for the Novice IV's.

Bart's had little success in the Regatta, St. Thomas' Hospital winning seven of the nine

events, but it was enjoyed by those who took part, and though we have little to show for it, the Hospital was well represented.

The Light IV were beaten in the 1st round by St. Thomas'. Our Pair were unlucky to be beaten again by St. Thomas', the race being restarted after a collision when Bart's had been leading by half a length. The Junior VIII won their 1st round, but were beaten in the next by St. Thomas' who, still having Nigel Tubbs, won all the sculling events. Our Rugger IV, the heaviest crew on the water, with an average weight of over 14 stone, were also beaten. Our one success of the day was the victory of our 'B' crew in the Novice IV's, and if they continue to row, this year's Novices should stand the club in good stead in the next few years.

The Annual Dinner on Friday, 22nd November, concluded Boat Club activities for 1963.

January—March 1964.

When rowing recommenced in January, we began the process of preparing VIII's for the real Rowing Season. We had decided some months before that, in order to produce an VIII in the summer which would achieve the success we wanted, we should start early in the year training hard, not only in the Boat but also

in the gym., which had been done before but only to a limited extent. For advice on the latter we consulted J. A. N. Railton, now Director of Training to the A.R.A., who visited us twice before Christmas and set us circuit training until we could get equipment to train with weights. Those who did this circuit training regularly were impressed with its efficiency.

After the Christmas holiday we continued the circuit training until mid-February when Mr. Railton again paid us a visit, to demonstrate the use of weights (with which the Gym is now equipped) in training. Following this we used a combined programme of circuit and weight training. In our outings on the river, while practising technique, we employed a form of interval training and the fitness of the crews improved a great deal.

Since mid-January the 1st VIII, 2nd VIII and Novice VIII have been boating regularly from Chiswick. From early on the 1st VIII and Novice VIII were stable crews, but unfortunately the 2nd VIII had frequently to be changed, and seldom went out without a substitute.

J. Currie, N. Dudley and R. Nicholson coached the 1st VIII, E. Hoare and M. Bessier the 2nd VIII, and T. J. McElwain the Novices, while D. A. Lloyd helped on various occasions.

THE MEDICAL PROTECTION SOCIETY

ADVICE · DEFENCE & FULL INDEMNITY FOR DOCTORS & DENTISTS AT HOME & OVERSEAS

Founded 1892

50 HALLAM STREET · LONDON · W.1

Secretary: Dr. H. A. Constable.

Tel: LANGHAM 9241

The University of London Trial Head of the River Race is on Wednesday, 4th March, the Bedford Head of the Duse is on Saturday, 7th March, the Reading Head of the River Race is on Saturday, 14th March, and the Tideway Head is on Saturday, 21st March. We shall be entering crews for all these events.

The following crews were entered for the Regatta:

Senior IV

Bow, G. I. B. Bennett; 2, M. F. Mackenzie; 3, W. P. Garson; Stroke, A. B. Ayers.

Pair

Bow, D. C. Parr; Stroke, C. R. S. Anderson.

Junior VIII

Bow, P. B. Hoole; 2, B. C. P. Lee; 3, I. Wright; 4, P. McArthur; 5, G. D. Bell; 6, M. Hinds-Howell; 7, M. Castleden; Stroke, J. Tricker; Cox, D. A. Robinson.

Junior IV

Bow, P. Bolson; 2, K. Gilson; 3, A. Nicola; Stroke, C. Clarke; Cox, I. Cole.

Double Sculls

Bow, A. B. Ayers; Stroke, R. G. Nicholson.

Senior Sculls

M. F. Mackenzie.

Junior Sculls

P. A. le M. Amundsen, M. Castleden and W. P. Garson.

Novice IVs

"A"

Bow, C. R. Tait; 2, A. H. Roderick; 3, R. White-locke; Stroke, R. Franks; Cox, R. Weller.

"B"

Bow, J. G. D. Baker; 2, D. Fairbank; 3, P. Cheetham; Stroke, J. S. Lilleyman; Cox, I. M. Cole.

"C"

Bow, V. Selwyn; 2, T. A. N. Waller; 3, J. F. Dostock; Stroke, J. Pilling; Cox, D. A. Robinson.

"D"

Bow, C. J. Hubbard; 2, F. M. Graham; 3, A. Russel; Stroke, D. Wright; Cox, I. M. Cole.

Rugger IV

Bow, O. J. A. Gilmore; 2, R. Bark; 3, R. Roston; Stroke, K. M. Stephens; Cox, P. C. Thornback.

HOCKEY CLUB REPORT

1st XI v The Wellcome Hockey Club. Result Lost 1-2.

The match against the Wellcome Hockey Club was played on a wet pitch and the game was slow. Only four regular members were available. Play was even throughout, but near the close the opposing forwards were a good deal faster and more fit than ours. Our only goal was scored from a corner taken by M. Nightingale. The Bart's goalkeeper, D. Kenyon, who had never played hockey before, gave a spirited display of natural goalkeeping and with more experience will be a valuable asset to the Hockey Club.

Saturday, 22nd February. 2nd XI v The London Hospital. Result, Won 5-0.

This match against the London Hospital was most encouraging as a rehearsal for the Cup Final. Bart's were on top for most of the game and the forwards played particularly well. Success in the Junior Cup Final against Guy's Hospital on March 4th would provide a fitting end to a happy season of enthusiastic hockey at 2nd XI level. With the improvement and experience this year we expect to field two regular teams and raise our standards still higher in the season to come.

CROSS-COUNTRY CLUB REPORT S.W.E.T.C. Race

Twenty-one teams lined up for the start of this 4½-mile annual event on a fine sunny day. Foxton ran very well, catching up places on the road to finish 3rd after negotiating the mud around the lake. Pott, Tunstall Pedoe and Thompson all ran well, being able to support one another as they ran together for most of the way. The team finished 3rd, behind Borough Road College, and University College, a very good result. Yates won the race for University College in a record time of 21 mins. 56 secs.

		mins.	secs.
1	Yates	21	56
2	Moore	22	43
3	Foxton	22	55
17=	Pott	24	0
	Tunstall Pedoe	24	0
22	Thompson	24	15
53	Markham	25	54
83	Hardy	28	59

97 Finished the race.

		points
1	Borough Road College	47
2	University College	77
3	St. Bartholomew's Hospital	113

MEN'S SQUASH REPORT

The month of February has been one of mixed fortune for the team. All except one of our matches were won or lost by 3 games to 2, and could easily have gone either way. The outstanding achievement was the defeat of Middlesex Hospital in the 2nd round of the Hospitals' Cup. They were runners-up in the competition last year and were about the strongest team in our half of the draw. Mitchell and Edelsten won at first and second string, the latter holding on to a close struggle. Downham was unfortunately not at his best, and Edwards went down in four games, leaving it to Delaney

to win us the match. This he achieved with little difficulty despite his having not played much squash this season. We are now due to play probably Guy's or London in the semifinal round. The Cumberland Cup matches have produced some most enjoyable squash and some very close matches, but the results have not been much in our favour. Against H.A.C. and Metropolitan Police the score reached 2-2 in matches, and each time we had to concede the match, as we were missing one player. Apart from these disappointments we defeated Middlesex Hospital, and had an extremely good and close match with Lensbury. They escaped defeat by a hair's breadth and so maintain an unbeaten record in the Cumberland Cup. Mitchell won his match comfortably, but Edelson and Downham were defeated. Then with the score standing at 1-2 in matches and Ken Bowles 0-2 and 4-8 down, the match seemed irrecoverable. But Bowles was set on overcoming his cunning, experienced opponent, almost twice his age. Somehow, by remarkable tenacity and by letting none of his opponent's fine angle shots be winners, he won that game 9-8, and the next two. Delaney, also playing a man twice his age, was very near to victory, but preservation of energy and experience came through in the fifth game.

Results

- v U.C.H. Won 3-2.
 - v Brasenose College, Oxford. Won 4-1.
- Cumberland Cup**
- v Middlesex Hospital. Won 3-2.
 - v Metropolitan Police. Lost 2-3.
 - v Lensbury. Lost 2-3.
 - v H.A.C. Lost 2-3.

Team: S. C. Mitchell, K. R. Browne, A. B. Edleston, B. J. Delaney, M. A. P. S. Downham.

The 2nd V have suffered three defeats in the last month, losing 5-0 to Jeu de Panure, a Lloyds team of some strength. The Bar also had a 5-0 victory, but against Westminster Hospital the score was only 1-4 against. Tom Bates, playing his first game for the club, hammered his opponent with some powerful forehands, and won his match.

Team: E. Edwards, R. S. A. Thomas, D. Chesney, M. Kettlewell, T. Bates, G. Savage, D. Kenyon, A. Chant.

LADIES' LACROSSE CLUB

This season has not been a very satisfactory one for the club. Last year we lost five members from the team, all of whom could be relied on for active support, and although the

new intake last October provided us with several new replacements, we have still too often been forced to cancel matches because of insufficient numbers of players. On several occasions the reason for cancellation has not been ours since the problem of finding lacrosse players seems to be shared by most of the women's colleges in London. The matches that we have played this season have been against St. Mary's Hospital, Guy's Hospital, Farrington's School and Bedford College, and we have easily won them all. This was due largely to Ruth Smiley, who consistently played well, and was responsible for most of our goals. On March 14th is the Women's Inter-collegiate Lacrosse Tournament, a fixture that we have won for two successive seasons, and which we hope to win again.

The following people have played in matches:

R. Smiley, J. Pitt, S. Williams, B. Anderson, E. Webb, E. Bohn (Capt.), A. W. Greig, V. Onians, G. Darch, G. F. Petty, S. Lack, E. Foster, B. Jack, R. Sutton.

LADIES' SQUASH CLUB

The whole of the Autumn Term was taken up with Hospitals' Cup matches. In the first three games of the season we were far from successful, losing 1-4 to St. Mary's Hospital, St. Thomas's Hospital and King's College Hospital. On each of these occasions the game that we did win was gained by W. Rostron. For the match against the Middlesex Hospital the team had had sufficient practice to give us an easy win 4-1. After a walkover from the Royal Free Hospital, and a further win, this time against Guy's Hospital 3-2, we eventually finished third to St. Mary's Hospital and King's College Hospital.

This term has been less successful, partly because the pressure of exams on several members of the team. W. Rostron has played well consistently, and we are very pleased to have A. Vartan playing at second string now that she has returned to the hospital after qualifying. The performance of the team might have been improved by some much needed coaching.

Jan. 27 St. Mary's Hospital Lost 1-4
Feb. 10 Middlesex Hospital Lost 2-3
Feb. 17 University College Hospital Lost 2-3
Feb. 24 King's College Hospital Lost 1-4

The following people have played in matches:
W. Rostron, A. Vartan, J. Knill-Jones, E. Bohn (Capt.), C. Foot, E. Sykes, V. Onians, J. Duckworth, S. James.



CONTENTS

Editorial	171
Correspondence	173
Up to the Minute in a Moment	178
Around & About, by "Argus"	179
The Eric Gill Cover, by J. R. Swain	181
Recent Advances in Cardiology, by D. Weitzman	184
Old People are Still Human, by A. C. F. Green	190
Scandinavian Visit, 1963—II. Medical Aspects, by Norman G. Rothnie	194
From the Ski Slopes	198
The History of View Day, by Nellie J. Kerling	199
The Last Psalm, by "Selah"	204
Three Months in India, by D. S. Tunstall	205
Pedoc	205
Sports News	215

PUBLICATIONS COMMITTEE

Chairman: Dr. A. W. FRANKLIN.
Deputy Chairman: Dr. G. H. FAIRLEY.
Editor: TREVOR P. DUTT.
Review Sub-Editor: G. R. HAMILTON
Social Sub-Editor: Miss I. BELL.
News Sub-Editor: C. J. KELLY.
Sports Sub-Editor: G. HAIG.
Photographic Sub-Editor: B. C. P. LEE.
Manager: G. O. GEY, Jr.
Asst. Man. (Subscriptions): A. R. BAILEY.
Asst. Man. (Advertising): M. A. P. S. DOWNHAM.
Nurses' Representative: Miss M. IRONSIDE.
Charterhouse Representative: G. W. LIBBY.

EDITORIAL

All too often, advancing years bring with them the realisation that our youthful strivings were not as well designed or directed as they had seemed and it may well be that it is for this reason of immaturity that student comment on the medical curriculum is often unjustified and ill-informed. Such accusations cannot, however, be levelled against the latest report to be produced by the British Medical Students' Association. This document, entitled "Report on the Existence and Value of Elective Periods in British Medical Schools", was prepared by the B.M.S.A. Education Officer for 1963* and was published last month.

The Report is divided into four sections. The first sets out the terms of reference and defines the subject, the second consists of an analysis of the results obtained from the three groups of questionnaires sent out, the third section is a discussion on the findings and the fourth sets out the recommendations.

Flective periods are defined as "any period of a month or more during the student's clinical training, when he has a choice of several courses of study, either at his own hospital or at another institution."

The Report gives its complete support to the introduction of such periods into all medical curricula and further recommends that there should be no restriction placed upon the student in the choice of his activity during this period. This is a very dangerous recommendation, for though it may be easy to dismiss the apathetic student and to refer him to the "Finals Day of Judgment" as the report seeks to do, the lazy, slack student is not

* M. W. Casewell, B.Sc.—a Bart's student.