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. Edelston. 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 Intercollegiate 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

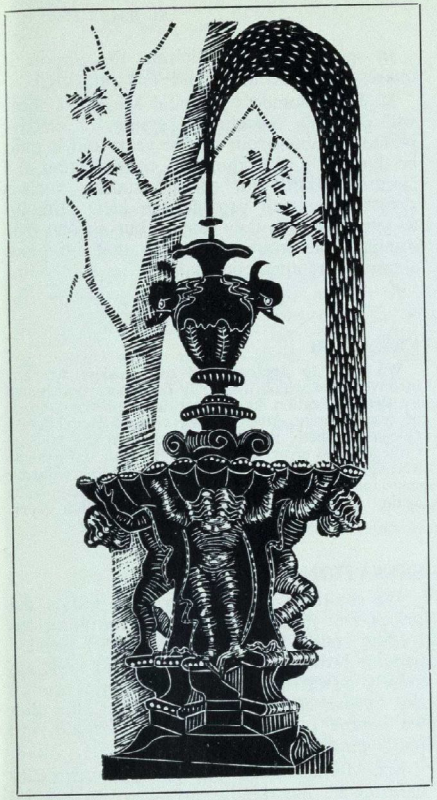
The whole of the Autumn Term was taken up with Hospitals' Cup matches. In the first three games of the season we were far from successful, losing 1-4 to St. Mary's Hospital, St. Thomas's Hospital and King's College Hospital. On each of these occasions the game that we did win was gained by W. Rostron. 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

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.

Elective 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.

sufficient of a rarity for one to disregard the effect on the reputation of his parent medical school if he is to spend at least one month at some other establishment.

The results obtained from the questionnaires are, for the most part, expressed in graphic form with excellent explanatory notes. It was, therefore, all the more surprising that no comment was made on the discrepancy between the main "expected benefits" as expressed by Deans and students alike and the actual benefits felt by students who had experienced such elective periods. The first group state that the most important benefit which they expected to be derived from these periods is "General Medical Education" (mean rating indices 1.71, 1.30 and 1.47 for Deans, participating and non-participating students respectively) whereas in retrospect only 13 per cent of students felt that they had actually gained a great deal in this direction (m.r.i.: 0.55). This surely suggests that, whatever these elective periods are achieving, it is not what anyone intends or expects. This view is further supported by applying the reverse of the above figures; factual knowledge was highest on the retrospective list whilst on the prospective lists it was invariably very low. This does not invalidate any of the conclusions of the Report but it does indicate that the unqualified support which elective periods receive is perhaps a little premature.

In order to avoid the problem of student lethargy and to make best use of the periods it would seem sensible to apply a system similar to that used at University College Hospital. Probably the best way would be for every student to submit to a committee of three members of the staff an outline of the work which he intends to do in his elective period. Should the committee not approve of his suggested scheme, which would be considered some three months before the allotted time, they should then present him with a list of approved alternatives. Such discussion of proposed plans would also satisfy the claim that 61 per cent of students participating had not discussed their choice with anyone (only 18 per cent considered such discussion unnecessary).

One other comment should be made about this report; it was amusing to read on page 4 that the response from the Deans of the medical schools in answering the questionnaire was "almost 100 per cent", while on page 5 the Report explains that "Eighteen of the 25 Deans . . . co-operated" and that "six gave no reply."

In spite of these criticisms, the Report is interesting, informative and well presented.

St. Bartholomew's Hospital Medical College will probably introduce a system of elective periods in about four or five years and it must be done only after thorough consideration and circumspection. For certain students such a system may well provide the ideal stimulus to interest which they require but no one may disregard his responsibility to that infamous creature, the apathetic student.

ERRATUM

We wish to apologise to our readers for any inconvenience which they may have been occasioned by the publication in the last issue of the *Journal* of two different dates for the visit of Her Majesty Queen Elizabeth, the Queen Mother, to the Medical College. The error was the result of an unfortunate oversight by our printers and we are taking vigorous steps to prevent such an occurrence from happening again. The correct date was Tuesday, 28th April.

SENSATIONAL OFFER!

We see these notices everywhere today: cut prices, free gifts and, of course, the notorious trading stamp. Some of these offers provide genuine benefits to the purchaser and some are merely advertising gimmicks, but this month the *Journal* enters the field with an offer that we believe our readers in the Hospital will really appreciate.

Mr. Montague Clifford, the well-known City hairdresser, has kindly arranged for special terms to be allowed to all those connected with Bart's in recognition of the treatment that his family and staff have received at the Hospital. Please turn to page 212 for further details of this generous offer.

Binding the Journal

Anyone wishing to take advantage of this service should send their copies to the Editor, enclosing their full name and address. The cost is 30s. (post free). Back numbers 1s. 6d. each.

Since this editorial was written, we are sorry to hear that the Editor has been admitted to Hospital following a motor accident. We wish him a speedy recovery.

Correspondence

THE RUGGER MYTH? and BLUE STOCKINGS?

Sir,—I see from the April issue that your correspondent, Mr. Lask, has joined that growing army of writers who trot out the old perennial about apathy, parochialism and insularity amongst students of this Hospital. He also has something to say about the Rugby "myth". Just what is this myth? Mr. Lask doesn't really seem to know, or if he does, he is keeping the information to himself.

Now it is all very well to bandy about terms like "sacred cow" and "malignant selfishness" if these things actually exist. I suggest to Mr. Lask that while one or two students may be a little slow off the mark when it comes to supporting things, very few students are malignantly selfish or worship at the shrine of any sacred cows.

Let us get a few facts straight. The main reason why the Rugby Club and Boat Club attract more support than the other clubs is the simple fact that they are the biggest clubs. So long as 120 people play Rugby in the course of a season, it will not be surprising when the Rugby Club gets more support than, say, the Swimming Club, with its ten regular members. Furthermore, Mr. Lask has chosen a strange time to suggest that the Rugby Club is the least successful club in the Hospital when this year it has enjoyed its best season since the war. When the Fives Club and the Chess Club have their results published weekly in the Sunday newspapers, then perhaps they too will attract the sort of support that the major clubs are lucky to have. Your correspondent appeals to the Medical College authorities and what he terms the 'hierarchy" of the Students' Union to do something about this lamentable state of affairs. As a member of the "hierarchy" I should like to point out that it is no business of the Union or any other student body in this Hospital to dictate to students the way in which they spend their leisure time. Personally I feel we are all sick and tired of being told what we ought to do and what we ought not to do, outside the walls of the Hospital.

Finally, it should be pointed out that people support what they like and play what they like because they enjoy it and not because they feel there is anything sacred about what they are doing.

In the same issue, Mr. Lyons seems unduly concerned about the standard of dress in a Hospital where the standard of dress has always been high and still is. Although tidiness and cleanliness are essential it seems extraordinary that he should seriously equate standards of dress with standards of medicine, collar-attached shirts with clinical acumen. I am sure that what is important to patients about their doctors is skill, competence, sympathy and kindness and not sartorial gamesmanship.

Yours faithfully.
T. J. McELWAIN.
3rd April. Abernethian Room.

BLUE STOCKINGS?

Sir,—The *cri de coeur* from Mr. Lyons (April Journal) concerning the sartorial habits of modern students, of both sorts, brings an echo from the past. It was ever thus, though perhaps the Staff of today are not so critical as their predecessors.

A medical clerk arriving late for a round found the Firm at the far end of the ward and somewhat self-consciously had to walk the whole length of the room to join them. He was wearing plus-fours. There was a pregnant silence while Dr. Geoffrey Evans surveyed him distastefully. Then, "Yer can't come on one of my rounds in *knickers*" he said loud and clear, and the venom with which he embellished the word brought a flush to the young man's cheek. "Go home and change!" He then had to retrace his steps between the rows of grinning patients.

I think we all dressed better after that.

Yours faithfully,
MICHAEL HARMER.
6 Hale House,
34 De Vere Gardens,
3rd April. London, W.8.

Sir,—Mr. Alan Joseph Lyons censures the sartorial standards of Bart's students. Would he not agree that in the context of a hospital the only essential qualities of dress are cleanliness and neatness?

As for the elegance which he considers paramount, Boswell records Johnson's observation: "Fine clothes are good only as they supply the want of other means of procuring respect."

Yours faithfully,

MARK CASWELL.
MAURICE LIPSEDGE.

7th March. The Abernethian Room.

FIFTY YEARS AGO
or
THE NEW COVER—AGAIN

Sir,—I was surprised and amused to find that, on page 145 of the current issue, you had printed an old letter of mine protesting against a change in the cover of the Journal.

But I am quite unrepentant and am constrained to write today in similar terms almost exactly fifty years later.

I always look forward to receiving my Journal, which seems to get better and better and the present standard has never been surpassed, but, Oh! that awful bilious green cover with its caricature of our hospital crest!

Many of us old stagers have nostalgic longings for the old orthopædic patients staggering in at the Henry VIII gate, or, at any rate, something more in keeping with our great history and tradition than the recent productions.

I am, Sir,
Yours, etc.

R. E. BARNSLEY,
R.A.M.C. Historical Museum,
Queen Elizabeth Barracks.
5th April. Crookham, Hants.

TELLING THE RELATIVES

Sir,—In your Editorial you raised the subject of "Should the Doctor Tell?", and you seemed to advocate the principle adopted by many doctors—mainly to tell the relatives everything and the patients nothing. It is true that in some cases this principle should be adopted but as a general principle I am convinced that it is wrong for the following reasons:

1. It is doubtful whether it is ever possible to deceive a patient who is dying of cancer. Patients who are physically ill are not mentally ill. Some patients pretend to be deceived to please their doctor or relatives.

2. Most patients prefer the truth to uncertainty. In figures published in Manchester only 7 per cent resented being told.

3. If in years to come the relative of the deceased thinks they have cancer it is very difficult to persuade him otherwise, knowing that the deceased was deceived.

4. If those who are "cured" are not told the public never hears of cures, but always hears of the fatal cases and believe that no case is ever cured. Occasionally a member of the audience will stand up and say "I was cured of Cancer X years ago." That does more good than the whole lecture.

5. This hush-hush is destroying the confidence in the medical profession. Patients will believe the doctor in everything unless they suspect that cancer is present. One member of the audience got up and said "You ask us to visit our doctor if certain symptoms are present because there is a remote chance that it may point to cancer. I could not talk to my doctor about cancer. I hate being laughed at, and in any case he would not tell me the truth."

6. If patients are not told the nature of their illness—"They won't tell you anything in hospital" is a frequent saying—they believe they have cancer. Many women who have had a simple hysterectomy believes that she has cancer because the true nature of the trouble has not been explained.

The principle should be *never* to take away hope, but tell the patient except in rare cases. This can be done gently by saying "it is a kind of cancer", a half-white lie suggesting it is not so serious as a real cancer. Only a fool will make a prognosis of the length of life in a case of cancer.

Yours faithfully,

MALCOLM DONALDSON.
6th April. Cancer Information Association.

[We thank Malcolm Donaldson for his letter but would like to point out that he deals with a subject barely touched upon in the editorial to which he refers. The only mention was to observe that "opinions differ widely".—Ed.].

ROUND AND ABOUT

Sir,—Congratulations on the standard achieved by your Journal, which makes very good reading. However, I would be grateful for the hospitality of your columns to make some comments about the article on Ely Place by "Argus" which appeared in your March edition.

St. Ethelreda is a common mis-spelling of St. Etheldreda's name, but understandable in view of the many different ways in which her name has been spelt—Aethelthryth, Aedilthryde, Ediltrudis. Audrey. She was certainly afflicted by "a very great sweling under her jaw" (St. Bede), but whether this was actually caused by a youthful love of necklaces is open to some doubt. She is on record as saying "I know that I deserved to bear the weight of my sickness on my neck, for I remember when I was very young, I bore there the needless weight of jewels," but she had also prophesied her own death from plague, and the description given by St. Bede is not incomparable with that of a plague bubo.

With regard to the derivation of "tawdry"; this was not a reference to Elthedreda's jewellery but associated with a miracle attributed to her after her death, and described in the "Liber Eliensis". A man in prison in London in the 12th century on rather dubious charges prayed to St. Etheldreda and St. Benedict to come to his aid. The saints appeared to him, and St. Benedict broke the man's bonds and "cast the chain from him with such vehemence that it woke the guards". The man was released after an investigation ordered by Queen Matilda, wife of Henry I, and entered the monastery of Ely after hanging the sundered chain in the Abbey church. Up to the year 1913, mementoes of this miracle in the form of gaudy chains of lace or silk—"St. Audrey's chains"—could be bought at the annual fair at Ely (which was originally held for the entertainment of pilgrims to St. Etheldreda's shrine) and this subsequently became contracted to "tawdry". the word which we now know.

(I have drawn freely from the C.T.S. pamphlet on St. Etheldreda by Elisabeth Wilcocks, which I acknowledge with thanks).

Yours sincerely

N. C. LEE
(Ex-Editor, London Hospital Gazette.).

The London Hospital Medical College,
Turner Street, London, E.1.
7th April. Tel.: BIShopsgate 0644, Ext. 29.

[Argus writes:

We thank our correspondent for these additional details of St. Etheldreda's life.

The threat of redevelopment that has hung over Ely Place for some time has at last materialised and the elegant Georgian terraces are to be sacrificed to the interests of commercialism. Demolition has in fact already begun and anybody wishing to savour this delightful little cul-de-sac before some hideous office block replaces it, is recommended to make their way there as soon as possible].

Calendar

MAY

Sat. & Sun., 2nd & 3rd:
Prof. Scowen
Prof. Taylor
Mr. Manning
Mr. F. T. Evans
Mr. Fuller

4th May: Copy date for June Journal.

Sat. & Sun., 9th & 10th:
Dr. Bodley Scott
Mr. Alan Hunt
Mr. Aston
Dr. R. A. Bowen
Mr. Cope

Wednesday, 13th May: View Day followed by the View Day Ball at the Café Royal.

Sat. & Sun., 16th & 17th:
Dr. E. R. Cullinan
Mr. C. Naunton Morgan
Mr. Burrows
Mr. G. Ellis
Mr. McNab Jones

Sat. & Sun., 23rd & 24th:
D. G. Hayward
Mr. Badenoch
Mr. Manning
D. R. W. Ballantine
Mr. Hogg

Wednesday, 27th May: Sports Day.

Sat. & Sun., 30th & 31st:
Dr. A. W. Spence
Mr. Tuckwell
Mr. Aston
Dr. Ian Jackson
Mr. Fuller

Physician Accoucheur for the month of May is Mr. Beattie.

Sports Day will once more be held on a Wednesday afternoon this year. The date, **27th MAY**. Last year's Sports Day proved to be very successful despite the appalling weather and about a hundred competitors took part in one event or another. It is hoped that there will be many new faces down at Chislehurst this year. The athletic part of the day is usually great fun with many people putting the shot and running the half-mile for the first time since they left school. On the social side, a dance is held in the evening and suppers are laid on. Bowling for a pig was one of the side attractions last year. Who knows—this year it may be a sheep! So make a date for **Sports Day, Wednesday, 27th May**.

The next meeting of the Twelfth Decennial Club will take place at the Royal Automobile Club on Saturday, 9th May, 7.15 p.m. for 8 p.m.

WESSEX RAHERE CLUB

The spring dinner of the Wessex Rahere Club will take place at The Imperial Hotel, Exeter, on May 30th when it is hoped that, as usual, a member of the Staff will be present as Guest of Honour. The Club is open to Bart's graduates practicing in the west country and further details may be obtained from the Hon. Secretary, Mr. A. Daunt Bateman, F.R.C.S., 11, The Circus, Bath.

DR. JAMES BRIAN BAMFORD, M.R.C.S. (Eng.), L.R.C.P. (Lond.), B.A.

The Queen has appointed Dr. James Brian Bamford Sheriff for Cambridgeshire, Huntingdonshire and the Isle of Ely for 1964-5.

Dr. Bamford, a Bart's man and senior partner in a busy general practice in Ely, qualified in 1932. During the war he served as an anaesthetist with the first of the Eighth Army's front-line surgical units and was Mentioned in Dispatches.

He is a member of the College of General Practitioners, having joined it in the early days.

OBITUARY

Dr. Ronald Johnstone Irving-Bell

Dr. Ronald Johnstone Irving-Bell, a First Assistant Medical Officer in the City of Bristol Department of Public Health, died on the 3rd March after a short illness. He was aged 63 years.

Born on the 6th November, 1900, Ronald Irving-Bell was educated at Blundell's School, Tiverton, Clifton College and St. Bartholomew's Hospital Medical College, qualifying M.R.C.S., L.R.C.P. in 1926. He was a Medical Officer in the Royal Air Force Medical Service from 1926 to 1931, and a civilian medical officer to the Royal Air Force between 1932 and 1933. He obtained the Diploma in Public Health at the London School of Hygiene and Tropical Medicine in 1933, and after working as a Medical Officer at the Central Medical Establishment, Air Ministry, in 1934 was employed as Assistant Medical Officer of Health in Norwich and Erith, Kent. Immediately before taking up his duties in Bristol as an Assistant Medical Officer in 1937 he was an Investigating Medical Officer in the Milk Nutrition Survey conducted in England and Scotland by the Ministry of Health and Milk Marketing Board. He was promoted First Assistant Medical Officer in 1952. He was a recognised teacher of Bristol University for the purpose of lecturing to the Health Visitors' Training Course.

For a number of years he worked as a School Medical Officer and his services were greatly appreciated by parents and staff particularly in Boys' Grammar Schools.

Dr. Irving-Bell established the Bristol Male Sub-fertility Clinic, and in recent years had extended his work to the field of Clinics for old people. He was a founder member, Vice-Chairman and Medical Consultant to the Bristol Marriage and Family Guidance Council, and was President of the British Flying Saucer Bureau. He was a member and regular attender at, and contributor to, meetings of the Bristol Division of the British Medical Association, Bristol Medico-Chirurgical Society and the West of England Branch of the Society of Medical Officers of Health.

Dr. Irving-Bell was a man with wide cultural interests and he will be greatly missed both by his colleagues in the Health Department and by the Voluntary Organisations with which he was associated.

He leaves a widow to whom we express our sincere sympathy.

Engagements

CATLIN—WYLLIE. — The engagement is announced between John Lawrence Catlin and Patricia Jane Wyllie.

GEORGE—RAY.—The engagement is announced between William Thomas George and Susan Iris Ray.

HAMILTON—YATES-BELL.—The engagement is announced between Samuel Gordon Ian Hamilton and Caroline Yates-Bell.

LEWIS—SURGEY.—The engagement is announced between Adam Anthony Murless Lewis and Margaret Catherine Ann Surgey.

WATERWORTH—WILKINS.—The engagement is announced between Martyn Wilson Waterworth and Jill Margaret Wilkins.

Marriages

HORE—SHEPHERD.—On March 28, Dr. Brian David Hore to Eva Elliot Shepherd.

HUTCHINSON—CARTER.—On April 4, David Brian Ashton Hutchinson to Helen Rosalind Carter.

MILLER—YOUNG.—On April 4, David Miller to Jennifer Young.

PRICE—HORSNAIL.—On March 28, David John Everard Price to Patience Mary Horsnail.

PEARSON—WILSON.—On February 15, Group Captain R. C. Pearson, O.B.E., R.A.F. *retd.*, to Kathleen, widow of W. J. Etherington-Wilson, F.R.C.S.

Births

AUBIN.—On April 3, to Anne and Dr. David Aubin, a son (Nicholas).

BOWLES.—On April 1, to Anne (née Newbigging) and Kenneth Bowles, a son (Jonathon Andrew Scott).

GRAHAM.—On March 27, to Christine and Dr. Malcolm Graham, a son (John), a brother for Jenny, Wendy and Louise.

WADDY.—On March 26, to Mary (née Lynskey) and Dr. G. W. Waddy, a son, brother for Simon.

Deaths

BALL.—On March 9, Dr. Charles R. H. Ball, M.R.C.S., L.R.C.P., aged 88. Qualified 1901.

ELLIS.—On March 5, Robert Ellis, M.D. Qualified 1910.

FULLER.—On April 5, Ralph Annesley Fuller, M.C., M.R.C.S., L.R.C.P. Qualified 1905.

IRVING-BELL.—On March 3, Dr. Ronald Johnstone Irving-Bell, M.R.C.S., L.R.C.P., D.P.H. Qualified 1926.

SHEEN.—On March 27, Dr. Clive Sheen, L.M.S.S.A., aged 47. Qualified 1945.

WATKINS.—On January 19, Dr. Eric Holmes Watkins, M.A., B.M., B.Ch., aged 67. Qualified 1923.

Change of Address

Dr. and Mrs. D. J. E. Price, *to* Waikato Lodge, Russell Road, Buckhurst Hill, Essex.

Dr. and Mrs. A. M. Hall-Smith *to* 64 North Brink, Wisbech, Cambridgeshire.

Appointments

Mr. E. G. Tuckwell takes the place of Mr. Muir as a surgeon to the Royal Household.

Advisory Committe on Artificial Limbs

Chairman of the Committee: Mr. H. Jackson Burrows. Committee members include: Mr. N. Capener and Prof. J. B. Kinmonth.

Exhibition of Medical Photography

The Pharmaceutical Society Beginners' Trophy has been awarded to Miss Julie Dorrington, St. Bartholomew's Hospital (Gaucher's Disease).

Faculty of Anæsthetists

At the meeting of Council on 13th February, Diplomas of Fellowship in the Faculty of Anæsthetists were granted to the following: Jean Lumley, Robert Laird Buchanan, Cedric Prys-Roberts, and Raymond Colin Birt.

University of London

Mr. J. B. Hume has been appointed Deputy Vice-Chancellor for 1964-65.

Dr. T. A. J. Prankerd has been appointed to the chair of clinical hæmatology at University College Hospital Medical School.

CHEQUERS FOOTBALL CLUB

This is the name of the Bart's porters' football team who entered the North Middlesex league for the first time this season (1963-64). Matches have usually been played on a Sunday morning, often under extreme difficulties as most of the players are on shift work. It has been an outstanding first season, the team having won ten of their eleven matches. They also reached the quarter finals of the cup.

The secretary, Mr. Jewell, did a lot of hard work arranging the matches and transport as also did Mr. Cleck in getting the team together.

Outstanding players were T. Jones, Capt., O. Murphy and Crawley, full backs.

Very little training could be done owing to the men being on different shifts.

The Shield will be on view at a later date. The committee thank all the players and members of the hospital who have assisted so ably to make this first season such a great success.

P.	W.	L.	F.	A.	Pts.
11	10	1	41	14	18

UP TO THE MINUTE IN A MOMENT

An early Easter enlivened the end of the usually damp and dreary month of March. One of the features of recent Easters has been the Aldermaston march. This year the "Committee of 100" cancelled the march and organised instead, an expedition to the United States Air Force Base at Ruislip in Middlesex to "reclaim the base for peaceful purposes"; however only 350 people turned up and were met by 1,000 police. This seems to be the end of C.N.D.

On 2nd April Britain sent her second satellite, Ariel 2, into orbit. On the same day the American airmen, **Captain David J. Holland** and **Captain Melvin J. Kessler,** whose reconnaissance aircraft was shot down over East Germany, were released by the Soviet authorities.

Many of us must have been horified by the strike of Belgian doctors against a new health insurance law which began on 1st April. Most of the doctors quitted the country but left behind an efficient emergency service. Public opinion was quick to condemn the doctors' action but surely no government can impose on the medical profession impossible conditions of service; in the final reckoning doctors have the right to withdraw their services, always providing that adequate provision is made for emergencies. The government were forced to conscript doctors on 12th April, and on 17th April the doctors called off the strike following new government proposals.

On 5th April the deaths occurred of two great men: **General Douglas MacArthur** and **Professor George Payling Wright.**

In Hollywood on 6th April **Peter Sellers** was taken to hospital following a heart attack. After a few critical days, and the use of a pacemaker, the actor pulled through.

After months of suspense **Sir Alec Douglas-Home** announced on 9th April that there would be no election before the autumn. The next day proved this decision to be judicious as Londoners voted for the first Greater London Council and Labour won a sweeping victory by 28 seats. The Liberals, it is worth noting, won no seats and polled only three times as many votes as the communists! What price a Liberal revival now?

In Hamburg on 9th April **Frau Anna Anderson** was urged by the Judge to appear personally before the Court of Appeal where she seeks recognition as the **Grand Duchess Anastasia,** youngest daughter of **Czar Nicholas II,** the last Czar of Russia.

Mr. Winston Field resigned as Prime Minister of Southern Rhodesia on 13th April over the question of independence for that country. He was succeded by **Mr. Ian Douglas Smith.** The future for white commonwealth countries is definitely black.

A report on 13th April stated that **Mr. Kruschev** was dead. Fortunately this report proved false: better the devil we know.

On 14th April **Mr. Reginald Maudling,** Chancellor of the Exchequer, presented an uninspired budget which increased the price of cigarettes and alcoholic drinks. However the Chancellor must be congratulated on not producing an electioneering budget.

On 17th April in great secrecy **General De Gaulle** underwent a prostatectomy performed by **Professor Pierre Aboulker.** A fashionable operation for Statesmen.

In the House of Commons on 20th April **Mr. Kenneth Robinson** said that the Labour Party on attaining power would abolish N.H.S. prescription charges. Any step towards entirely free medicine must be resisted; there can be very few people in this country who cannot afford to pay these charges.

In East Berlin on 22nd April **Greville Wyne** convicted British Spy, was exchanged for the Russian spy Gordon Lonsdale. A case of a spy for a spy.

The Bart's Rugger Club reacted to unfavourable comment in the correspondence column of this Journal by performing brilliantly in the United Hospitals Seven-a-Side competition. Bart's beat Guy's 18-0 in the semi-final but were beaten by a very competent Mary's side in the final. **P. Savage** scored no less than six tries that day.

Brief patches of summery sun, and the arrival of the Australian tourists remind one of the welcome arrival of the cricket season. The Cricket club begins its season on 25th April with 1st and 2nd team matches against U.C.H. The captain this season is **John Harrison.**

The Rowing club completed a series of Head of the River races by beating the rest of the Hospitals in the Tideway Head on 21st March.

The Drama Society are competing in the One-Act Drama Festival at Battersea during the week beginning 11th May. They are presenting "Barnstable" by **James Saunders.** (22nd April).

AROUND AND ABOUT:

3—Fleet Street

By "Argus"

"Fleet Street and the Strand are better places to live in, for good and all, than amidst Skiddaw."—William Wordsworth.

What is so fascinating about Fleet Street? Visitors from the provinces wander up and down its length, looking rather lost, sample the 'pubs' in the hope of seeing the colourful characters they had been told to expect, and leave thoroughly bored, having seen nothing they could not have found at home. For Americans of course the street is a place of pilgrimage where, guide book in hand, they honour the shades of Goldsmith, Pepys, Dr. Johnson, Lamb, Edgar Wallace and Lord Northcliffe. Part of the attraction of Fleet Street lies in its strange mixture of the old and the new. From end to end it is an extraordinary jumble of architectural styles. No two buildings are the same. The whims and fashions of every age are to be found in its brick and stone. It is the archetype of the City, the London street. Add to this the satisfying views to the east—Ludgate Hill and St. Pauls, and to the west—the Law Courts and St. Dunstan's, and you will have the secret of its fascination.

Fleet Street takes its name from the Fleet River or Ditch, converted into a sewer in 1765, which ran along the site of Farringdon Street and New Bridge Street and emptied into the Thames at Blackfriars. The Street starts at Temple Bar, the western boundary of the City, where a memorial of 1880 replaced the original gateway erected by Wren in 1672 and crowned for many years with traitors' heads impaled on spikes, of which the public could obtain a better view by hiring a telescope for a half-penny. On the corner of Chancery Lane is Attenborough's, a delightfully fussy piece of high Victoriana built in 1883. The whole of the red sandstone exterior is covered with carving. Notice the two tremendous gryphons supporting the gilded balls of the pawnbroker's sign.

The church of St. Dunstan's in the West dates from 1833 and replaces a much older church of the twelfth century. It is built rather strangely in the shape of an octagon but its most interesting feature is its clock, made in 1671, with two giants which strike the hours and quarters and turn their heads. It is referred to by the poet Cowper:

Fleet Street, looking East.

"When labour and when dullness club in hand,
Like the two figures at St. Dunstan's stand."

Over the entrance to the school to the east of the church is a statue of Queen Elizabeth formerly situated at Ludgate and erected there in 1580.

The gateway of 1840 is all that remains of one of the smaller inns of court—Clifford's Inn—founded in 1345 and demolished in 1934. The arms of the founder, Baron Robert de Clifford, are to be seen above the gate. Fetter Lane, a name derived allegedly from "fewters" or idle people, though why is not clear, is famous as the dwelling place of that extraordinary Puritan divine, Praise God Barebones, who gave his name to the parliament called by Cromwell after the Rump had been dissolved. Crane Court has largely been rebuilt but there

are two late 17th century houses, Nos. 5 and 6, still standing with pilastered doorways. In a house at the end of this court the Royal Society met between 1710 and 1780, its situation "in the middle of the town out of the noise being very convenient for the society." When night meetings were held, a lamp was hung at the entrance to the Court by order of Sir Isaac Newton. In Red Lion Court, named after a tavern, is another late 17th century building, the printing house of Messrs. Taylor and Francis with a fine sign representing the book trade—a hand pouring oil into a lamp with the inscription "Alere Flammam" (To feed the flame). The interior of the building has some fine door-cases and a beautiful ceiling.

Johnson's Court is not named as might be expected after the London-loving doctor but after Thomas Johnson, a citizen tailor and member of the Court of Common Council until his death in 1626. Dr. Johnson did however write his "Journey to the Western Isles" and his edition of Shakespeare in a house in this court demolished in 1899. In 1820 Theodore Hook started a magazine called "John Bull" at No. 11 and, by libelling Queen Caroline, boosted his circulation to 12,000 copies by the 12th number. It was into a letter box in this court that the young Dickens, aged 21, "with great fear and trembling", dropped the first of his "Sketches by Boz", that were to make his name known to the public.

Bolt Court is named after the tavern "The Bolt-in-Tun" on the opposite side of the street. At No. 3 lived Dr. John Lettsom—a kind-hearted Quaker and a friend of Dr. Johnson. He founded the Medical Society of London He always signed his prescriptions with the old-fashioned intial "I" and thus arose the undeserved epigram,

"If any folks applies to I,
I blisters, bleeds, and sweats 'em,
If after that they please to die,
Well, then—I Lettsom".

An apt comment on the state of 18th century medicine.

Bolt Court leads into Gough Square which was badly bombed in the war. Dr. Johnson's house, No. 17, was only slightly damaged however. Here, with his famous cat Hodge —a remarkable animal fed on oysters, the Doctor lived from 1748 until 1759—a "harmless drudge . . . bearing burdens with dull patience, and beating the track of the alphabet with sluggish resolution (a reference to the composition of his dictionary). The east end of the square has been restored but will look better when the brickwork has weathered. There is a fine bow window above the arch leading to Wine Office Court. At the end of this court is the famous tavern "The Cheshire Cheese"—"a little lop-sided, wedged up house, that always reminds you, structurally of a high-shouldered man with his hands in his pockets". The connection of this 17th century tavern with Dr. Johnson is rather more tenuous than American tourists imagine. Its chief claim to fame is the pudding, "entombed therein, beef steaks, kidneys, oysters, larks, mushrooms, and woundrous spices and gravies, the secret of which is only known to the compounder." The little tobacconist's shop at the end of the court with its gas jet for lighting cigars, dates from 1700.

There are a number of interesting buildings at this end of Fleet Street. No. 44, "Queen of Scots House", is undoubtedly one of the most tasteless examples, on the small scale, of pseudo-Gothic architecture to be seen in London. The "Daily Telegraph" building "neo Graeco-Egyptian turned Modernistic", is not a great improvement. The "Daily Express" building dominates the north side of Fleet Street. Built in 1931, its black glass surface is most striking and the design as a whole, while not particularly beautiful, is functional building of a high order.

The last court of any interest on this side of Fleet Street is Racquet Court, which probably dates from the time of Charles I, when the game became popular. The houses at the end, with their Tuscan pilasters, are again late 17th century.

On the south side of the street the first turning is Bride Lane. Here until recently could been seen the mouth of a pump, dry since the day of George IV's coronation. The well which it served gave it name to the notorious "house of correction for idle, loose, vagrant and disorderly persons, and night walkers who are sent there to receive hard labour." Bridewell was demolished in 1863, but during the 18th century it offered the spectacle of the public flogging of women—a degrading process not abandoned until 1767.

The church of St. Bride (the name is a corruption of the Irish Saint Bridget) was rebuilt by Wren in 1684 and has the highest spire of any of his churches. It has been beautifully restored since being damaged in the war. There are a number of interesting tablets and memorials to famous literary figures to be found in the church.

Salisbury Court, where Samuel Pepys was born in 1633, leads to the secluded Salisbury Square, the forecourt of the London palace of the Bishops of Salisbury. Only one Georgian house, No. 1, still stands, its graceful elegance contrasting strongly with the narrow towering concrete monstrosity of 1936 next door. Unfortunately, many of the streets leading off Fleet Street to the south are dreary and dingy in the extreme, although rich in historical associations. Whitefriars is named after the Carmelite Friary, founded in 1241, which stood there till the Reformation. In a few years the streets that replaced it became a refuge for crooks, thieves, swindlers and prostitutes and remained so until the early years of the last century. Sir Walter Scott described the area in his "The Fortunes of Nigel". Many of the passages running off Whitefriars retain their old names: Hanging Sword, Glasshouse, Ashen-tree and Magpie Alleys, for instance. Bolt-in-Tun Court (No. 65) was originally the coach office of Moses Pickwick, whence Dickens derived the name for his book.

The face of the "Cock" Tavern has been rather altered but the structure is partly 17th century. It used to stand on the opposite side of the road and has many famous literary associations. Here Samuel Pepys entertained the actress Mrs. Knapp, until one night the long-suffering Mrs. Pepys produced a pair of red hot tongs and threatened to pinch her husband's nose unless he reformed. Tennyson was a frequent visitor; he even began one of his poems:

"O Plump Head Waiter at the Cock,
To which I most resort,
How goes the time? 'Tis five o'clock.
Go fetch a pint of port."

Not far beyond the "Cock" is the Inner Temple Gateway, one of the finest pieces of half-timber work in London, built in 1610. On the first floor is Prince Henry's Room with its elaborate plastered ceiling and oak panelling. Prince Henry, James I's eldest son, held his councils here as Duke of Cornwall.

Past the Middle Temple Gateway of 1684 is Child's Bank—one of the oldest banking houses in the country. Among its clients it has included Oliver Cromwell, Charles II and Nell Gwynne, William III and Mary, Pepys, Dryden, the Duke of Marlborough, and the "Canal Duke" of Bridgewater. The bank occupies the site of the "Devil" tavern, favourite resort of Ben Jonson and, of course, Dr. Johnson.

The disappointing thing about Fleet Street is that so few traces remain of its rich and varied history. A busy traffic thoroughfare and the centre of British Journalism, it is hard to imagine it as it was 200 years ago—a focal centre for mountebanks exhibiting dwarfs and freaks and renowned for rebellions and unruliness. The London apprentices fought here with the students of the Temple, so did the Whigs and Tories in the 18th century, culminating in the riots over John Wilkes. In the reign of Queen Anne the street was the haunt of gangs of young toughs, "The Mohocks" who terrorised passers-by, pricking men with their swords, and on one occasion rolling a woman in a barrel down to Ludgate. Juvenile delinquency is nothing new!

THE ERIC GILL DESIGN FOR THE COVER OF THE JOURNAL

By J. R. Swain

In 1937, the block which was used to print the cover of the Journal, a drawing of the Henry VIII gate, started to wear out. It was impossible to prepare another block of the same design and anyway it seemed that the time was right for a new cover to adorn the Journal. At the instigation of the then Editor, Martin Ware, Eric Gill was approached and asked to design a new cover. Sir Geoffrey Keynes, the Chairman of the Publications Committee who run the Journal also wrote a letter to the artist whom he knew personally.

The first design was approved, corrected and subsequently appeared in the February edition of 1938. The Editorial of that issue says:—

"This month we launch the Journal in fresh dress. The central plaque of Marcus Rahere has been drawn by and engraved for us by Mr. Eric Gill. We are indeed debtors to him for such a fine piece of work. The lettering of the cover is also his—one of the Perpetua founts."

It was not until after the Journal was published that the voices of dissent were raised. The opposition to the design grew and grew until the Students' Union took the unprecedented step of passing a vote of censure on the cover. The Students' Union was the ultimate owner of the Journal and this step reflects some of the considerable opposition—particularly the

The Original Block.

fact that the only votes for the cover were those of the Journal representatives summoned to the meeting. The Students' Union in the Hospital always had, and still has Teaching Staff representation as well, and this meant that student representatives in the presence of their teachers and possible future employers were always fairly reticent about expressing unpopular opinions. However, they insisted on a plebiscite being taken without any trial period at all.

The political implications of this were comparatively serious. The Journal decided to conduct its own plebiscite among the readers. The remarks in the Journal March 1938—p. 128.

"We are aware that Mr. Eric Gill's design has called forth a great deal of adverse comment. Certain charges such as "indecency", which by the way we have heard from the most surprising quarters, we refuse to take seriously, but there are people who object on other grounds. We have therefore inserted a printed postcard with this issue so that we may know the opinions of our readers. We would beg those who dislike the design on purely traditional grounds to remember that what is now tradition was once the scandal of yesterday.

The plebiscite was taken and broken down with customary scientific accuracy.

TOTAL

In favour 183 = 33%
Against 377 = 67%

(a) OLD BART'S MEN
345 28½% in favour
71½% against

(b) STAFF
48 22% in favour
78% against

(c) STUDENTS
167 43% in favour
57% against

The Editorial of April, 1938, records this, with other remarks, which I quote when relevant,

"We are immediately struck by the fine response from the old Bart's men and the equally remarkably poor response from the students.

"The next noticeable feature was the fierceness of opposition among the members of the

The Corrected Block.
(by courtesy of the Victoria & Albert Museum).

Staff. It makes us wonder what is the essential difference in taste between these gentlemen and the old Bart's men to account for a difference of 6½%.

"Lastly although the Student's vote was disappointingly low, a full 43% were in favour. This is in striking contradiction to the practically unanimous vote of the Students' Union Council against the cover, the raison d'être of the plebiscite. Although we have removed the offending medallion, the result of this latter vote encourages us to think that given time the majority of students at all events might have become reconciled to the design, if not actually to like it.

"However, the general feeling is clearly expressed by the plebiscite and we have no intention of trying to sway further anything so unpredictable and variable as our readers' taste in covers."

(The Editorial then deals with other suggestions for cover).

"By far the most amusing contributions were on the cards of people who disliked the cover. Although the majority contented themselves by adding some such word as 'intensely' there were a few heroic spirits who gave us their reasons. Three delighted us particularly:

"I do not much like the new cover chiefly because I do not like monks, nor the expression of morbid satisfaction on this monk's face, nor the sickly expression of the sick child, and it must be horrid to be pawed by those long pituitary 'fingers'.

Then a defender of the monastics: 'The design is perfect but the drawing offends the monastic ideals. If it were not so good I should let it stay'.

"Finally a sad little postscript 'N.B.— I cannot leave the Journal lying about in my drawing room.' We are so sorry".

The design was subsequently withdrawn at a meeting of the Committee on March 15th. In the Correspondence Column of the April Journal were two letters, one from Philip Gosse, himself an old Bart's man, congratulating the Journal on the design and suggesting the publication of a limited edition of the engraving be run off. He does however plead for the return of a picture of the main gate to the Hospital which had adorned the cover for some thirty years.

The other was from Sir D'Arcy Power, Archivist to the Hospital, who wrote:— "Mr. Eric Gill has necessarily used some poetic licence to balance the artistic design for the cover. The M before Rahere should be replaced by a P. The first deed possessed by the Hospital is dated 1137. It is the grant by Prior Rahere and the Convent of St. Bartholomew of the Church of St. Sepulchre to Hagno the Cleric. Amongst the witnesses were Haco the deacon: Hugo the Canon: Brother Walter: William the Archdeacon: Harold the Canon: Algar P. Godfrey, son of Baldwin the priest: Richard P. Bardo the cleric. P. stands here for Pater, not Presbyter or Priest. Rahere as Master of the Hospital would probably have been addressed by his friends and colleagues as Father Rahere, whilst in the convent he would have been spoken of more formally as Prior Rahere. If M. be replaced by P. the lettering on the block will be historically correct."

"Editorial Note:— We were lead astray by an old print on which the name Marcus occurred. The M. is being replaced by a second cross, which is artistically preferable to a letter."

The corrected block is now the property of the Victoria and Albert Museum and appears in two of their books published by Her Majesty's Stationery Office, 'A Large Picture Book of the Engraved Work of Eric Gill.' and 'A Catalogue of the Engraved Work of Eric Gill.' priced 12/6d. and 27/6d. respectively. It appears here by kind permission of the Victoria and Albert Museum. It seems a pity that what was once the property of the Hospital should now be the property of the Government.

It is not the purpose of this article to assess the artistic merit of the design, a task beyond the competence of the writer but rather to record the events which led to its rejection.

Perhaps twenty-six years is a sufficient length of time to allow an unemotional reappraisal of the suitability of the design as a cover for the Journal. Would the Students' Union of today be galvanized to a veto if the design appeared now? Would scores of old Bart's men feel embarrassed in its presence? What would the reaction be to its return now? Perhaps readers might write in to tell us their views.

Acknowledgements: I should like to thank those who gave me valuable assistance in the preparation of this article, notably Sir Geoffrey Keynes, Dr. Martin Ware, Dr. E. F. Stewart and Mr. John Physick of the Department of Prints and Drawings at the Victoria and Albert Museum.

RECENT ADVANCES IN CARDIOLOGY

by David Weitzman

The past 15 years have seen great strides in cardiology in respect of diagnosis and treatment. Much of this has followed on technical achievements—advances in diagnostic aids, anæsthesia and surgery. However, the initial selection and appraisal of patients must always depend upon clinical observation, for which there is no replacement. The knowledge gained over these 15 years from the new techniques of investigation, and from the findings at surgery, has enabled us to look at physical signs in a new light, and to correlate them more closely with findings from other diagnostic procedures, and at operation.

The Venous Pulse

The jugular venous pulsation has been recognised for a very long time as an indicator of right atrial pressure and as a guide to the presence and degree of congestive cardiac failure. The correlation of right atrial pressure measurements with other values obtained during cardiac catheterization has taught us that a great deal more may on occasion be deduced from bedside observation of the neck veins. The atrial systolic wave is seen as a momentary upward flick in the jugular pulse immediately preceding carotid pulsation. When the right atrium is trying to pump blood into a hypertrophied, thick-walled resistant right ventricle, this atrial systolic wave may be large and very prominent. The sight of a notable pre-systolic flick in the jugular pulse hence raises the possibility that either pulmonary stenosis or pulmonary hypertension is present. Alternatively, visible expansion of the jugular synchronous with carotid pulsation can only mean that the systolic thrust of the right ventricle is being communicated to the neck veins, i.e., that the tricuspid valve is incompetent.

With the normal tricuspid valve closed during ventricular systole, the venous pressure rises gradually; when this valve opens there is a sharp descent in the jugular pulse. This "y" descent is particularly obvious with constrictive pericarditis or pericardial effusion, because the high venous pressure associated with either of these conditions produces a big gradient across the tricuspid valve as it opens.

The Arterial Pulse

Much can be learned about the character and the severity of a cardiac lesion by careful assessment of the pulse, particularly when there is an obstructive lesion such as mitral, pulmonary or aortic stenosis. The smaller the pulse (and the colder the hands) the more severe the obstruction; or, when several lesions are present, the pulse may be a very good guide to their relative importance. With mixed mitral valve disease a small pulse with cold hands suggests dominant stenosis; if the pulse is fuller and slightly collapsing in character, it suggests that the mitral valve is mainly incompetent. With the combination of mitral stenosis and aortic incompetence the pulse is a valuable guide as to which lesion is the more important. This assessment is of considerable importance from the point of view of any surgical procedure.

In aortic stenosis of any severity the pulse pressure rises slowly and it may be possible to sense a dip—the anacrotic notch—on the upstroke between the percussion wave and the tidal wave. This notch may be so obvious as to give the impression of a double beat to each pulse cycle—the bisferiens pulse. It used to be taught that the bisferiens pulse indicated combined aortic stenosis and incompetence. However, investigatory and operative findings have shown that this is not so; severe aortic stenosis itself can produce the bisferiens pulse. Nonetheless, the pulse remains a good guide to mixed aortic valve disease. Assessment of whether it is slow-rising or water-hammer helps to decide whether stenosis or incompetence is the dominant lesion.

Auscultation

The study of heart sounds and murmurs and our knowledge of how to interpret these clinical data has been greatly helped by graphic recording of heart sounds—phonocardiography. The phonocardiograph enables us not only to make a "sound track" of heart sounds and murmurs, but to record simultaneously a timing signal such as the E.C.G., or a pressure pulse obtained at cardiac catheterization. The study of such graphic records has led to a much clearer understanding of what is heard through the stethoscope and has helped us correctly to relate auscultatory findings to the precise nature of underlying disease. Some examples of this are:

Splitting of the second heart sound (Fig. 1)

The second heart sound is made up of aortic and pulmonary valve closure. In health, aortic valve closure occurs first. Inspiration by temporarily over-filling the right heart, prolongs right ventricular systole and delays pulmonary valve closure; hence physiological splitting of the second sound is heard during inspiration, the sound closing up to a single entity during expiration. If the two atria are in free communication, such differential filling during respiration is no longer possible; hence fixed splitting of the second heart sound (i.e., wide splitting throughout all phases of respiration) is an important physical sign of an atrial septal defect.

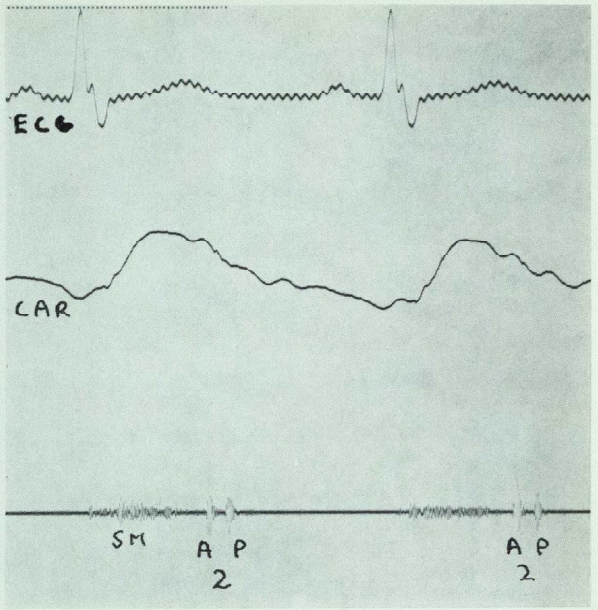


Fig. 1

Widely split second sound in atrial septal defect. "A" and "P" denote the aortic and pulmonary components. "CAR" is an external carotid sphygomogram.

The mitral snap (Fig. 2)

The normal mitral valve makes no sound as it opens. With mitral stenosis, the valve, because of its rigidity and the adherence of its commissures, tends to move as a whole instead of in its two separate leaflets; so that when the left atrial pressure exceeds that in the ventricle, the valve as it opens tends to move downwards in one piece. This produces a sharp sound occurring shortly after the second sound, referred to as the "opening snap" of mitral stenosis. In a case of mitral disease the presence of the snap indicates a valve which is still pliant and supple, and one in which a good result may confidently be expected from valvotomy. When there are clear signs of mitral disease but no snap the valve is badly damaged and probably heavily calcified. Straightforward valvotomy may then not be feasible and carries the risk of producing or aggravating mitral incompetence.

The site of murmur production

The systolic murmur produced by flow of blood through a stenotic valve, rises in intensity to a maximum as ejection of blood is maximal, and then tails off as blood flow becomes reduced. A systolic murmur produced by leakage of blood through an incompetent mitral valve or a ventricular septal defect persists throughout systole. In either case left ventricular pressure is higher than left atrial or right ventricular throughout the duration of systole. Hence, on the phonocardiograph, the murmur of aortic or pulmonary stenosis is "diamond-shaped", i.e., maximal in mid-systole, whereas the vibrations of the murmur of mitral incompetence or ventricular septal defect are pan-systolic.

The recording of heart sounds and murmurs has led not only to more accurate interpretation but has trained the ear so that these points can be appreciated without recourse to the graphic record.

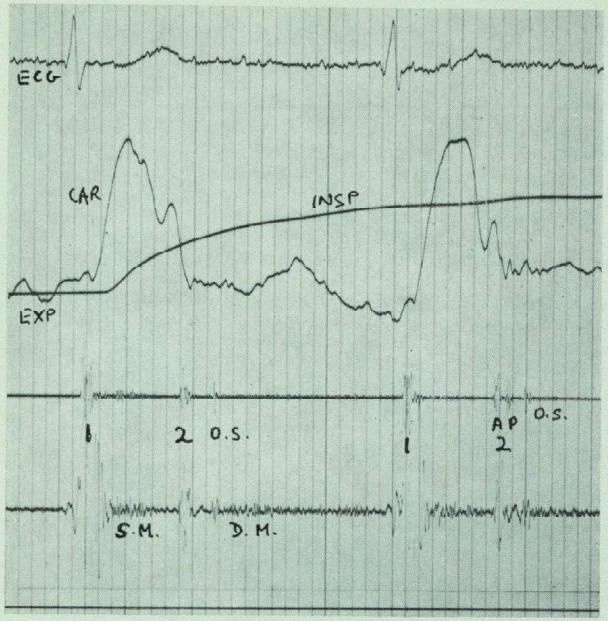


Fig 2

The opening snap in mitral stenosis. Respiration is recorded as the continuous line crossing the carotid pulse (CAR). During inspiration, the second sound splits into its aortic (A) and pulmonary (P) components. The snap (O.S.) follows these.

Axis deviation is also worthy of consideration. This can be produced in the normal heart purely by variation in anatomical position; but when heart disease is present, the position of the axis may have diagnostic significance. A good example is with atrial septal defect. This lesion usually produces hypertrophy of the right ventricle and rotation of the electrical axis so that this is deviated to the right. However, a number of cases with atrial septal defect show left axis deviation. This raises the possibility that some abnormality in the conducting tissue may be present; i.e., that there is an atrio-ventricular or endocardial cushion defect associated with the septal lesion —the os primum defect. This poses more complicated surgical problems than does straightforward closure of a secondum defect, so the differential diagnosis preoperatively is of practical importance.

Electrocardiography

Apart from the conventional use of the E.C.G. in the diagnosis of arrhythmias and of myocardial ischæmia, its important use in context with present-day diagnostic and surgical trends is in the diagnosis of ventricular hypertrophy. In the simplest terms, hypertrophy of a ventricle is indicated by a tall upright deflection (the R wave) and an inverted or flattened T wave over the affected ventricle. Just such a pattern is seen in V1 with right ventricular hypertrophy, and in leads V5 and V6 with left ventricular hypertrophy. Ventricular hypertrophy on the E.C.G. is a good guide to the significance of the lesion. With a normal E.C.G., a murmur suggestive of pulmonary or aortic stenosis may be regarded as indicating a *mild* lesion. The presence of electrocardiographic evidence of ventricular "strain" indicates the need for further investigation and the possibility of surgical intervention.

Mention of the electrical axis reminds one that the heart is a solid organ, and the electrical field which spreads out from the pacemaker with each impulse is necessarily three-dimensional. The conventional E.C.G. represents potentials at the point over which the exploring electrode is placed; one is doing no more than sample the field at various set points. If two sets of leads be placed on the chest mutually at right angles and their combined derivation displayed on the screen of a cathode ray oscilloscope, a loop is seen representing the path and direction of the entire impulse in the frontal, sagittal or horizontal plane. This science of vectorcardiography is still in the process of being worked out. It is expected to yield a great deal of information about many different cardiac abnormalities. The shape of these loops and their direction of rotation have already proved helpful in elucidation of the more complicated congenital anomalities.

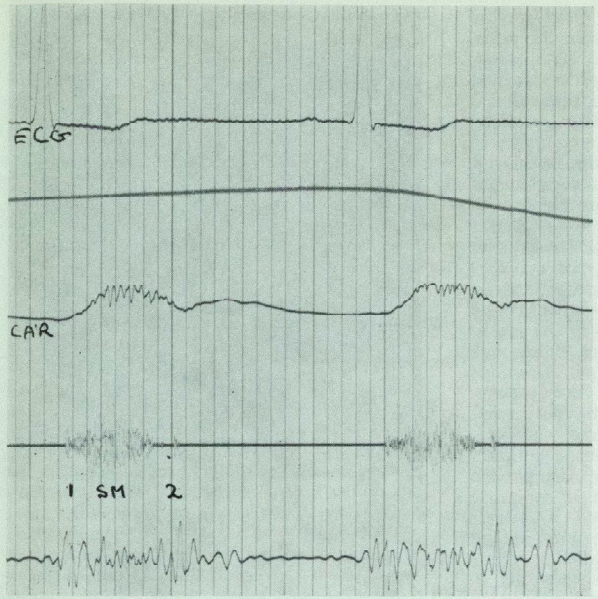


Fig. 3

Ejection systolic murmur (SM) in aortic stenosis, finishing before the second sound (T). Note that the vibrations of the murmur are transmitted to the carotid pulse (CAR).

Radiology

Correlation of X-ray appearances with clinical and E.C.G. findings enables a very complete picture to be built up of the abnormal situation before more detailed investigation is undertaken, and not infrequently renders such further investigation unnecessary. Examples of crucial points that may be revealed by the plain radiograph, or by screening are:

1. The presence of fine horizontal lines in the costo-phrenic angles in some cases of mitral stenosis, due to septal œdema. They indicate a high pulmonary venous pressure and tight stenosis.

2. Evidence of anomalously draining pulmonary veins associated with an atrial septal defect.

3. Calcification of valves in mitral and aortic disease (Fig. 4). The recognition of these has been made much easier by developments in image intensification.

Apart from routine radiology in the elucidation of cardiac problems assistance is often given by **angiography** —injection of radio-opaque fluid into the heart chambers so as to show these in detail on X-ray films. The injection is made through a cardiac catheter and the fluid is injected wherever the necessary information is required. This is referred to as selective angiocardiography. Examples of its value are:

1. Location of the site and nature of valvular obstruction in pulmonary or aortic stenosis.

2. The presence and degree of aortic incompetence. Contrast medium is injected just above the aortic valve to see whether any enters the left ventricle.

3. The identification of Fallot's tetralogy in a case of pulmonary stenosis. If a ventricular septal defect is also present, contrast medium injected into the right ventricle will fill the aorta (Fig. 5).

Cardiac Catheterization

Right heart catheterization for measurement of pressures and localization of septal defects and valvular obstruction has been an established procedure since about 1949. Coloured dyes or radio-active isotopes can be injected through the catheter, and their course through the circulation monitored by either a photo-electric cell (for dyes) or a Geiger counter (in the case of an isotope). An **indicator dilution** curve is thus obtained, and, from its shape, the presence and direction of a shunt may be deduced. More recent advances have concerned the problem of left heart catheteisation. Information about pressures in these chambers is essential for assessing the relative importance of mitral stenosis and incompetence, and the severity of aortic valve disease. Various methods have been employed. These originally involved direct puncture either of the chest wall, or of the left atrium via a bronchoscope.

Chest wall puncture carried the disadvantages of pneumothorax and hæmothorax; bronchoscopy was uncomfortable for the patient. About four years ago a technique was devised in which the left heart chambers were reached by puncturing the inter-atrial septum, avoiding these complications.

For this, a catheter is passed up the inferior vena cava from the saphenous or femoral vein into the right atrium. A long needle with a terminal curve is passed through the catheter and used to puncture the septum. The catheter can then be advanced through the puncture over the needle. By this means information can be obtained about pressure pulses in left atrium and left ventricle. For example, the waveform of the left atrial pressure pulse may indicate the relative degrees of mitral stenosis and incompetence when both are present. Comparison of the diastolic pressures in left atrium and left ventricle, showing what gradient exists between these chambers, indicates how severe any mitral stenosis is. Comparison of the systolic pressure levels in left ventricle and a systemic artery (obtained by needle puncture) shows if there is a pressure gradient across the aortic valve, i.e., whether aortic stenosis be present and how severe this is. (Fig. 6).

Surgery

In the past five years surgical techniques for aortic valve disease and mitral incompetence have been evolved, and closure of atrial and ventricular septal defects has become an established procedure. The indications for such closure are that the leak of blood through the defect from left heart to right should be large and that the pulmonary artery pressure should not be excessively raised. (These data are obtained by cardiac catheterization). When the pulmonary artery pressure is very high the operative risks greatly increase; and, in any case, if the pulmonary resistance be high the shunt is usually not very large and there is little to be gained from closure.

These procedures require arrest of the circulation so that the heart may be opened. Circulatory arrest has been rendered feasible by the development of hypothermia and of cardio-pulmonary bypass. These make it possible to open the heart, and the surgeon can work in a dry field.

This development of open heart surgery has completely changed the method of aortic valvotomy. Previously, attempts were made to deal with this lesion by blind trans-ventricular dilation and the results were not always good. Aortic valvotomy is now done through the aorta; calcified masses can be removed and a formal repair of the valve made.

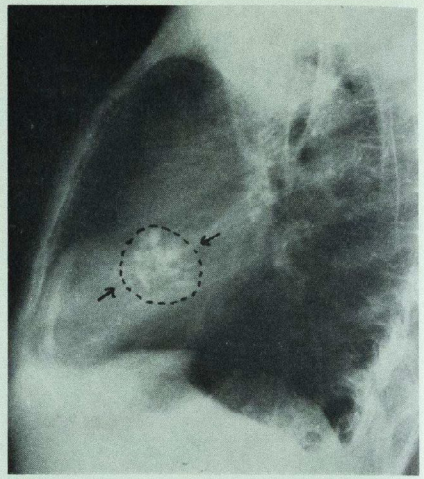


Fig. 4
Lateral chest film in aortic stenosis showing heavy patchy calcification in aortic valve (at arrow).

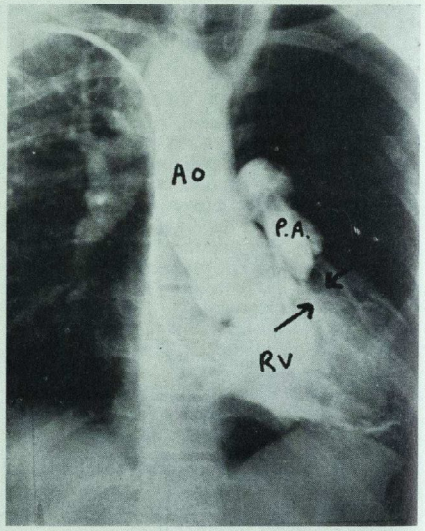


Fig. 5
Angiocardiogram of Fallot's tetralogy. Subvalvar pulmonary stenosis shown by narrowing of right ventricular cavity (at arrow). The aorta (AO) is right-sided and fills from the right ventricle.

The problem of valvular incompetence remains formidable. Pericardium and various synthetic materials have been used to try and repair aortic or mitral valves; but the results have not been encouraging and the operative mortality has been high. The possibility of valve replacement is now being investigated; this has been successfully carried out in a number of centres in the United States and the United Kingdom, including St. Bartholomew's Hospital. Either a plastic ball-valve can be incorporated, or a homograft, i.e., an aortic valve which has been removed from a recently deceased person. It is as yet too early for any knowledge of long-term results; but the immediate post-operative progress is satisfactory and results so far are encouraging.

Fallot's tetralogy remains a big problem. The cyanotic, often undersized and seriously disabled child with this disability is a considerable surgical risk. Total correction, i.e., relief of the pulmonary stenosis and repair of the septal defect is technically feasible but the operative mortality has been a deterrent. Some authorities prefer to do the operation in two stages. The initial procedure is designed simply to increase pulmonary blood-flow by anastomosis of the left sub-clavian to the left pulmonary artery, or else pulmonary valvotomy. The improvement in pulmonary blood-flow helps growth and development of the child and of its pulmonary arteries, so that these are able to take the whole of the right ventricular output when the septal defect is subsequently repaired.

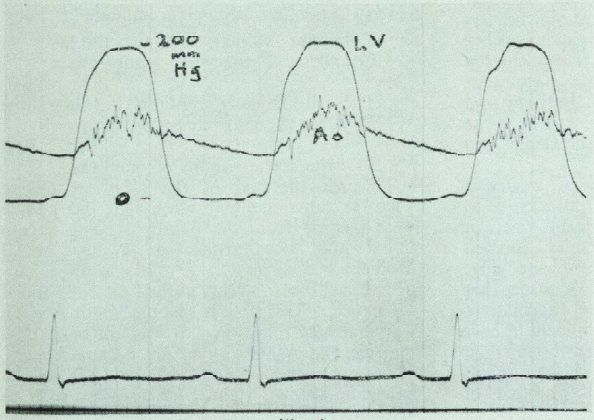


Fig. 6
Pressure tracings from left ventricle (LV) and aorta (AO) in aortic stenosis. The systolic level in the ventricle is considerably greater than that in the aorta.

Coronary Artery Disease

In recent years, the two most controversial issues in this field have been the value of long-term anticoagulant therapy, and the role of the serum cholesterol in the pathogenesis of atheroma. The success of long-term anticoagulant therapy in preventing recurrence of coronary thrombosis has not been very obvious, and most authorities do not now routinely use this measure.

Since cholesterol is present in quantity in the arterial lesions of atheroma, it seemed logical to attempt to lower serum cholesterol in the hope of decreasing further deposition. Diet and drugs have both been tried. Dietary restriction of animal fats seldom has any notable effect on serum cholesterol level; there are three possible reasons for this:

1. The artificial unpalatable diet is not rigidly kept.
2. The processing of vegetable oils into table products saturates them and makes them chemically similar to animal fats.
3. The majority of the body's cholesterol is produced by biosynthesis rather than from ingested lipid.

Drugs, such as thyroid derivatives, nicotinic acid, œstrogens and androstalone ("Atromid") sometimes lower serum cholesterol (though not consistently); but evidence of clinical improvement is seldom apparent. It would seem that the relationship between dietary fat, serum lipid levels and the formation of atheromatous plaques is as yet not completely understood.

Surgical procedures for angina and coronary occlusion have been enthusiastically studied, but are still largely experimental.

Summary

Newer methods of investigation have led to a clearer understanding of the physical signs of cardiac disease. More accurate diagnosis, and advance in surgical and anæsthetic techniques have enhanced the possibilities of correction of a larger number of congenital defects and acquired valvular lesions. However, in the numerically vaster field of degenerative disorders, much still remains to be done.

OLD PEOPLE ARE STILL HUMAN

By A. C. F. Green

To-day there is much talk of 'explosion of population'. Growing numbers may all too soon lead to world food shortage. In many parts of the world medical advance has led to increase in the number of live births.

In countries such as India famine has for centuries jostled, all too often successfully, for a place in the front rank of social problems. Attempts to increase food production and long term projects to educate peasant population in birth control may achieve something.

Growing knowledge increases man's capacity to survive. Not only do live births increase but infant and maternal mortality fall. The means of survival are stretched ever thinner.

Countries such as those of Western Europe, despite two world wars, continue to enjoy the material benefits resulting from the Industrial Revolution. Higher standards of preventive medicine, a more widespread distribution of medical services, and greater food supplies, contribute to the wellbeing of old as well as young. People live on into age groups almost unthinkable in less developed countries.

In Britain with her 'Welfare State' special foods are available for the pregnant mother. The needs of the young child are cared for as never before. The increase in numbers of old people however, seems to have taken the planners by surprise. This must be assumed from the fact that it is among the old that mal-nutrition is found. There are still far too many of them whose survival is existence rather than life. Demoralized after retirement by solitude, and by a lower economic status that leaves them too poor to obtain the food and warmth they need, they sink into squalor. The results of progress in medical knowledge can be paradoxical.

During the nineteenth century recurrent cholera outbreaks brought a foul death to many thousands in Europe and North America. The threat of further epidemics loomed throughout the century, imminent and dire, graver even than the smallpox scourge that preceded Jenner's introduction of vaccination. For many years, before the development of bacteriology made possible the development of epidemiology as a science the cholera threat compelled a reasoned approach to problems of public health.

Standards of cleanliness and food supply improved. Drinking water became safer. In Britain, at any rate, it was at last possible for insurance companies to drop their practice of weighting the premiums of teetotallers. As man made his world more habitable more people began to enjoy long lives.

Man's potential for longevity is greater than his environment usually permits. Historical examples make this clear.

In Westminster Abbey is the tomb of Old Parr. Born in the reign of Edward IV he lived through the remainder of the Wars of the Roses and the entire Tudor dynasty. It is said that at the age of ninety he was censured by the Church for a moral lapse involving a young woman. It seems that when he died, in the reign of Charles I, it was only because he had exchanged the austere diet of his native Shropshire for the luxurious living of Whitehall Palace.

Titian was still painting when attacked by plague at the age of ninety-nine.

> Cato learned Greek at eighty; Sophocles
> Wrote his grand Oedipus, and Simonides
> Bore off the prize of verse from his compeers,
> When each had numbered more than four score years,
> Chaucer, at Woodstock with the nightingales
> At sixty wrote the Canterbury Tales;
> Goethe at Weimar, toiling to the last.
> Completed Faust when eighty years had passed.
> These are indeed exceptions; but they show
> How far the gulf stream of our youth may flow
> Into the arctic regions of our lives.[2]

Towards the end of the reign of Queen Victoria came the realisation that old people were passing from the phase of being exceptional and 'wonderful'—that a new social problem was on its way. As has so often happened in the past, events abroad retarded social legislation. This time it was the South African war that held things up. It was not until 1908 that the Old Age Pensions Act became law.

From a medical point of view old age was an entity in its own right. Its diseases, such as arterio-sclerosis, bronchitis, cerebro-vascular disease, were components of a unity—of an inevitable ageing process.

As in the case of Sophocles and Goethe its development was sometimes mysteriously retarded. To some observers at that time the later consequences of alcoholism or venereal disease seemed an accelerated and aggravated development of senility.

It was still possible for certain devout Victorians to see in this the Almighty's punishment for sin—indeed it was by no means unknown for the setting up of hospitals for the treatment of venereal disease to be actively opposed as blasphemous interference with the Will of God. Those who could accept such punishment of the innocent children of afflicted parents found it still easier to be complacent that the aged should be punished for the sins of their youth. Even when no such aggravating factors existed old age was regarded as a process of decline, of wearing out, as certain as the sunset. It was a twilight prelude to death, whose identity it shared, rather than a medical problem. The quiet terminal pneumonia that curtailed the senile end period of so many lives was spoken of as 'the old man's friend'. Even so great and humane a physician as Sir William Osler accepted old age passively. He spoke of "the uselessness of men above sixty years of age and the incalculable benefit it would be in commercial, in political and in professional life, if as a matter of course, men stopped work at this age."[3]

This was an era of apparent culmination in many aspects of living. In its own field such an invention as the steam engine had brought apparent finality. When Sir William Osler had spoken, the last word had, for the time being, been said.

On Christmas Day, 1932, Mietsch and Klarer published the first German patent for Prontosil. In 1935 Domagk announced its anti-streptococcal efficacy to the world. The sulpha drugs had brought the beginning of a new era not only to the history of medicine but to the history of man.[4]

The spectre of puerperal septicæmia that had haunted young mothers through the centuries was exorcised. The Rockefeller Institute, spending vast sums on research into anti-sera against various types of pneumo-coccus, suddenly found that their labours had become of no more than academic value. The days of such traditional installations as the old "septic ward" at Bart's were numbered. With the coming of the anti-biotics the rate and scope of therapeutic progress increased still more. Medical research turned to new problems.

Some of these arose unexpectedly. In 1937 it became increasingly obvious that war was a certainty within the next year or so. There followed an investigation up and down the country as to the number of beds likely to be available for air raid casualties. It immediately became clear that there were large numbers of old people tucked away in all sorts of institutions—that there was a geriatric problem.

Before the dawn of the nuclear age it was fairly safe to assume that every twenty years or so a major war would curb over ambitious schemes of social legislation. They would be shelved—perhaps forever. In 1939 the geriatric problem had to give way to more urgent priorities. At the present time, unless man elects to take the road to extinction, social legislation is more likely to achieve uninterrupted fulfilment.

By the end of World War II the British geriatric problem was urgent. Altered ways of living, housewives at work all day, lack of domestic service, made it difficult or impossible to care at home for old people in failing health. The extent and urgency of the problem led to methods of admission to the new geriatric units that were sometimes ruthless. Some even said that the *lettre de cachet* had been revived. Of course, in harmony with the new ideas of equality, it was now available to all classes. Certainly disposal was all too often the keynote. One of the earlier geriatricians was talking with a visitor from a teaching hospital—not St. Bartholomew's. "I take it, Doctor", said his guest, "that you do not bother to give these old people any real treatment, that you just make them comfortable for a few months and then . . . !" The reply he received was more in accordance with the spirit of Hippocrates.

Geriatrics, like other medical specialities, owes its existence, not so much to the learning and expertise of those who practise it—important though these are—as to the necessities of those who seek its aid. It could only survive by functioning primarily in this way rather than for the convenience of embarrassed relatives or of consultants in other fields with blocked beds. This has led to the development of the special role of the geriatric almoner.

Geriatric patients have all too often suffered a lowering of social and economic status as a result of retirement. Therefore their problems demand more than purely medical assessment and help.

When the general practitioner calls upon the geriatrician for assistance he is quite likely to find that it will be the full team of geriatrician and almoner that visits the patient's house. This team's assessment must be carried out with tact and circumspection not only towards the patients and relatives but often towards the doctor as well.

For example it is by no means uncommon to find that urinary incontinence has resulted from a failure to diagnose diabetes mellitus or urinary infection. Fæcal incontinence in the old often results from potentially controllable constipation. Mental confusion is as likely to be due to cerebral anoxia, the result of respiratory impairment or congestive heart failure, as to cerebral damage. To detach such patients from confusion-aggravating barbiturates may be an urgent necessity.

In assessing mental status the geriatrician will, in due course, receive invaluable aid from the information the almoner has gathered. This includes, not only the patient's own occupational and social history, but also the intellectual, social and educational background of the family group.

It is important to be able to fit the patient into this group as one of the actors in a cast of family and friends. In this he or she is by no means playing a leading role. Each member of this cast has a separate part to play—a self-image to maintain at all costs. Accurate appreciation of these relationships is essential to true understanding of the present plight and future prospects of the patient. This is particularly so when the patient has suffered as the result of financial or property transactions. People seldom forgive those upon whom they have inflicted an injury. This is yet another important reason for adequate medical and social follow-up after discharge.

Fortunately, most people are not entirely devoid of love and conscience. They may well be thankful to learn of some internal modification of the home, feasible without expense to themselves, such as moving bedroom accommodation to a ground floor or permitting the fitting of a special stair rail, which may make it possible for their aged relative to be with them once again.

Some families are heroic. Sometimes the need of a heavy nursing case have prevented the taking of a proper family holiday for several years. Short term admissions to a geriatric unit can make a break possible. Such holiday relief—and perhaps a little instruction in simple nursing procedures—may well enable the family to sustain this situation for much longer than would otherwise have been possible.

When old people are sick, but have not yet become hopeless invalids, short term admissions for treatment and rehabilitation may promote steady return to active life. This brings about not only an economic use of hospital beds but an increase in the sum of human happiness.

Always rehabilitation must be the aim. Otherwise the patient is left without hope.

The skilled use of drugs and surgical procedures is an obvious component of treatment. Yet this is only true in so far as may be necessary to help the patient traverse the phases of a regimen leading to re-adaptation to an extra-hospital environment. Such a regimen must concern itself with the patient's occupation, diet, exercise, and day-to-day activities.

From a therapeutic point of view occupation refers to the various aspects of occupational therapy. Most of its importance lies in the fact that the patient is called upon to use both memory and mind. Contrary to generally accepted belief many old people learn and retain techniques previously unfamiliar to them.

Many patients reach a geriatric unit at the moment when rejection by the social/family group is likely to lead on to the disaster of self-rejection. The benefit derived, in restored self-respect, from even small payment following the sale of their occupational products is hard to exaggerate.

Dietary habits, even when income is sufficient, have often been unsatisfactory prior to admission. Therefore patients' menus need close supervision. Full swill bins mean unsuitable food. It is better to give smaller quantities even of slightly more expensive items that actually get eaten.

When overt malnutrition is present various proprietray protein supplements may help. If the patient still needs these after discharge it is important to remembers that as foodstuffs they cannot be prescribed on a National Health Service prescription. A patient's poverty may render purchase of such extras impossible. When this is so it may well be necessary to approach the Friends of the hospital, or some similar organisation, for help. Additional aid to feeding is available in many areas where the WVS or Red Cross run a "meals on wheels" service.

Yet another aspect of regimen is exercise. Today no geriatric patient is allowed to remain in bed if this can be avoided. Mobility is of the essence of successful treatment. The various aspects of physio-therapy such as breathing exercise for bronchitics, or walking exercise for those recovering from strokes are fundamental. For the physio-therapist the slow progress and frequent setbacks of older patients are all to often too great a challenge.

A patient's ordinary daily activities should cover as wide a range as possible.

Frequent visitors make is possible to maintain contact with the outside world. Where this support is lacking from family or friends, voluntary bodies may be willing to help by visiting the lonely. Some derive great benefit from the visits of their spiritual advisers.

An adequate library service helps to keep minds active. It is almost possible to stratify the age group of patients in terms of the periods of their favourite authors such as Mrs. Henry Wood, Marie Corelli, or Hall Caine. In addition such up-to-date stimulants as radio and television must by no means be neglected.

Group activities, such as a Darby and Joan club meeting periodically within the precincts of the hospital can aid progress.

It is essential to compete with the rigours and uncertainties of climate. Not only is adequate warmth in winter essential but also a rapidly controllable heating system for combating the sudden cold spells of the summer months. Every opportunity should be embraced to make it possible for patients to enjoy the full benefit of warmer weather.

It is now becoming possible for the general practitioner to acquire first-hand experience of geriatrics by obtaining a clinical assistantship in a nearby unit. Because old people are becoming more numerous the number of geriatric problems in evry general practice is also increasing.

As yet research has not led far towards a fundamental understanding of old age. Arteriosclerosis and chronic bronchitis remain common diseases of later life because so little is known about them. There is no need, however, to await the results of the investigations of the gerontologist. At this very moment there is much that the doctor, whether general practitioner or geriatrician, can do to make life easier, happier, and healthier for the aged patient.

REFERENCES

1.—Sir Julian Huxley—The Future of Man—Evolutionary Aspect: Man and his Future. J. & A. Churchill Ltd.
2. Longfellow—Morituri Salutamus.
3. Sir William Osler—Johns Hopkins Hospital. Address 22 Feb. 1905.
4. Thomson, William A. R.—From Antisepsis to Antibiosis. Chemistry in the Service of Medicine. Pitman Medical Publishing Company Ltd. 1963.

SCANDINAVIAN VISIT

2. MEDICAL ASPECTS

By Norman G. Rothnie

General and Medical Training

The pattern of general and medical education is similar in the three Scandinavian countries and will be considered as one, though the emphasis is on Denmark where I spent most of my time. Primary schooling starts at the age of seven so that Scandinavian parents have to amuse their children for two years longer than in this country. I feel sure that British parents would be fiercely opposed to this later beginning, but many Scandinavians think it premature and almost cruel of us to send our "little darlings" to school at five or even earlier.

There then follows a comprehensive education until the age of 14 to 16 years. There is only one system of schooling which is co-educational and free, and it is controlled and financed by local governments with state subsidies. English is usually started early in the school curriculum.

The students, after this, can have further education in preparation for their passing on to universities or other higher educational institutions at the age of 17 or 18. Tuition in all of these is also for the most part free and in Denmark especially there is no limit to the numbers wishing to enter the university faculties as long as they pass a certain examination standard. Denmark, therefore, produces more doctors in proportion to its population than its neighbours and has plenty to supply her own needs and exports them to Sweden and North America.

There are two universities in Denmark and both have medical schools. One is at Copenhagen (founded 1479) and two-thirds of the students are here; the other is at Aarhus in Jutland and was founded in 1930 to cope with the increasing student population of the country.

Sweden has four medical schools at the universities of Uppsala, Lund, Stockholm and Gothenburg; that at Stockholm is centred on the famous Karolinska (or Caroline) Institute. In Norway the main medical school is at Oslo with a smaller one at Bergen formed since the last war.

The medical schools, unlike Bart's, are of the university type with two terms from September to December and February to May. Examinations are held between terms and the vacation periods provide opportunity for practical work. For example, senior students often deputise for housemen and get useful clinical experience as well as receiving a very welcome remuneration. The seven years (and usually more) of medical study can be financially burdensome to the present-day student, quite a number of whom are married. Although their education is free they nevertheless have to buy books and equipment and have to live and eat. In a survey, about four-fifths of all students at Copenhagen University were found to have regular paid work and their studies often suffered as a result.

Instruction at the medical schools is centred round a lecturing teacher. To many students the transition period from secondary school teaching to the more free and easy traditional university education offers many difficulties. Today there is a trend towards more guidance and small group instruction in the early stages so that it is not left to personal initiative to find out where to make a quick and safe start, and subsquently plan a course of study. Tutorials are preferred by students to lectures.

A basic course in philosophy, logic and psychology common to all faculties of the university is given during the first year to the medical entrant and after this some "weeding out" of students takes place. He then passes to a study of anatomy (dissection is limited because of insufficient material and some students find their way to this country for vacation courses), physiology, bio-chemistry and genetics, physics and general chemistry for two years and at the end of this time he takes his Part I examination.

Following this his clinical course occupies four or five years and instruction in the various subjects aims to combine theory with practice in lectures, small group tutorials and ward and theatre work. It is carried out mainly at the University Hospital but time is also spent at the surrounding municipal hospitals. Courses are also given in the specialised subjects. On paper the medical curriculum sounds much like our own, but I got the impression that the students were not so well organised or guided by their teachers as in this country and that they lacked bedside tuition and personal handling of patients.

After completing his clinical training the student presents himself for his Part II or Final Examination consisting of written, oral and clinical parts. This is usually carried out by internal examiners and they test the student's ability to apply his theoretical and practical knowledge to the handling of the patient. His qualifying degree is *candidatus medicinæ et chirurgiæ* and this he can achieve seven years after entering the university but on the average he takes eight and a half years! In fact, in Denmark only ten per cent pass their finals after seven years—undergraduates take heart!

The newly qualified doctor now spends two to three years in hospital residencies in various fields equipping himself for general practice or to train as a specialist. His specialist training is based on the principle of the master-apprentice relationship. The masters get to know their apprentices well; they know their background, capabilities and ambitions and assist them in obtaining the right positions for promotion in due course. There are disadvantages to this system in a small country. If disagreements occur between master and apprentice future advancement may be hard for the trainee specialist! This system is gradually changing and rotation of trainees between a number of masters does occur. He is becoming less of an apprentice and more of a student of surgery.

Special boards exist for the licensing of doctors as specialists within various fields and in most of them a long period of training is required. In surgery usually eight to twelve years in recognised hospitals and then a period of research work combined with clinical work for an M.D. thesis. The surgical specialist is often in his mid-forties before he becomes a consultant in his own right but his experience and ability are considerable. Senior registrars take heart!

As in this country there is an increasing interest especially by the universities, in post-graduate education and research projects. The University of Copenhagen has a modern, well-equipped Experimental Institute with skilled technical and medical staff. It is open to specialists not only from the university hospital but to those from the municipal hospitals. The Institute is an excellent example of the team-work and concerted effort between departments which is so essential for fruitful present-day research.

Hospital Services

Many and varied social services have been in existence in Scandinavia for a long time; Denmark was the first country in the world to introduce them. Included in these are efficient health services on much the same lines as our own. The bulk of the population receives free hospital treatment and few use the limited private facilities in the state hospitals. Private practice is small and there are few private nursing homes. Sweden being more industrialised and wealthy caters more for the private patient.

The great majority of the hospitals are built and maintained by the local government authorities with state subsidies. The State is entirely responsible for the university hospitals and their staffing by professorial units. Each surgical unit is headed at the apex of the staff pyramid by an all-powerful professor. He usually has two or more full-time consultants under him and they work as a team. The pyramid staffing pattern is much the same in the municipal hospitals. The aim of a surgical specialist is to climb to the top of the pyramid and become the head of a surgical division in one of the hospitals so that even in his fifties he may have to change hospitals (Consultants take heart!).

Most of the hospitals are in old-established buildings in pleasant garden surroundings which are hidden in Copenhagen behind rather formidable chateau-like entrances. These old hospitals have been modernised structurally and decoratively inside. Alongside, in recent years, have been added new ward blocks and residencies of modern design, for there is no lack of land for expansion around most of the hospitals, and expanding they are. The more recently built hospitals are of typical Scandinavian architecture and are proudly exhibited as showplaces.

The wards are usually of six to ten bed units but conditions are rather cramped with little individual privacy. In fact, the other ward occupants keenly witness the interrogation and examination of a fellow patient (I even saw a public P.R. done!), but all this is accepted by doctor, nurse and patient and feelings are not considered in most cases.

Such a ward system demands a greater number of nurses than here at home but because of the attraction of less strenuous, less responsible and more lucrative jobs with regular hours and time off, there is a chronic

shortage of all grades of nurses. This is particularly so in Sweden and Norway and forces whole departments to close down for holiday periods. This means that a surgical unit, including the run-down and build-up period, may be out of action or at half-steam for nearly two months every year!

The standard of nursing in the main centres is quite high and more use is made of the married nurse (even with children) than in this country. The hours are made to suit her and she works on the wards, in the operating theatres, in research departments and as an anæsthetist. I was much impressed by their ability in this latter field; they certainly made a pleasant attraction at the head of the operating table! (There are unmarried nurse anæsthetists too).

The hospital laboratory, radiological and other ancillary services are up-to-date and fully developed. This is particularly so in the X-ray Departments where techniques and equipment are well advanced and have a world-wide reputation. Here mechanisation and automation are used to the full.

The clinicians make extensive use of the ancillary services and tend to adopt an investigative approach to the elucidation of a patient's complaints. I felt at times that more attention could be paid to the discerning eye and experienced hand.

Clinical Aspects

The general practitioner usually carries out much of the investigation and steps in diagnosis of a patient before referring him to hospital for more detailed investigation and treatment. Part of the fee for this is paid by the patient and this can be reclaimed through insurance schemes. As an alternative to the G.P. in Sweden the patient can choose to attend the hospital out-patient polyclinic. This is usually overcrowded and is run by the junior hospital staff who are paid for this by a capitation and item of service system. These clinics, though unpopular with the staff, do help to augment their income.

In general the pattern of the daily surgical routine varies little because the specialists are appointed full-time to one hospital. The day starts between 7.30 and 8 a.m., but to compensate for this they usually finish around 4 to 5 p.m. The first item of the day is usually a ward round followed by a discussion by the staff on new patients and current problems. There is then a meeting with the radiologist to review and discuss the previous day's X-ray films. These are very profitable conferences and form a characteristic feature of Scandinavian hospital routine. The daily operating list then follows and stretches into the afternoon interrupted briefly for a "smörbröd" or sandwich lunch. The pace of the lists is more leisurely than here at home and I don't think our theatre sisters would allow us to keep them waiting as they do in Copenhagen!

Out-patients are seen by the consultants at intervals during the morning in his office in the surgical department.

While attending the various surgical centres in Denmark, Sweden and Norway I partook as fully as possible in the daily routine of the departments. The difference in language is a barrier to complete participation and to the full appreciation of the surgical management of the patient. Most of the time every effort was made by the surgical and nursing staff (and some of the patients) to converse in English, their command of which was excellent. However, there were times when an immediate understanding, rather than a translation, of clinical arguments between members of the staff or of exchanges between doctor and patient would have been beneficial in appreciating fully their approach to surgical management and to "bedside manners."

I was particularly interested to learn of their approach to the management of upper gastro-intestinal, biliary, peripheral vascular and thyroid disorders and to discuss and exchange facts and ideas on these subjects.

The investigation and treatment of duodenal ulceration in Denmark was on similar lines to ours at Bart's but in Sweden they still favour partial gastrectomy.

There is a high incidence of biliary disorders in Scandinavia and they have a wide experience in their management and the treatment of post-operative complications. Acute and chronic pancreatitis is also more prevalent and is considered immediately in the differential diagnosis of any acute abdominal emergency.

I did not find the peripheral arterial work as far advanced as in this country. The reason for this I think is that in these small countries there is little room for narrow specialization. They were, therefore, interested to learn of our approach to peripheral vascular problems. Their surgical units are more general than ours (and include accident and pediatric work) so that it is unusual for a surgeon to be able to glean an extensive experience in any one field.

In Stockholm I attended a hospital where one

of the surgeons had however managed to establish over the years a reputation in thyroid diseases. He runs a busy thyroid unit supervising the medical and surgical treatment of thyrotoxicosis and taking a keen interest in the management of thyroid carcinoma. He was the first to use cortisone in the treatment of subacute (de Quervain's) thyroiditis of which they see quite a number of cases.

Scandinavian surgery has in the past been under German influence but the younger surgeons are striving to discard this approach and are more influenced now by American and British principles.

As a stranger in their midst I found the Scandinavians warm and friendly. They were pleased to take a visitor from these Isles into their daily routine and into their homes. I think they found it a (dare I say—welcome) change to the more frequent and hurried visitations of North Americans.

There is no doubt that my surgical as well as general experience was widened and I hope I have been able to forge another link between Bart's and Scandinavia. I am grateful to Professor Taylor for allowing me to make this visit, to Mr. Ian Todd for contacting on my behalf his many surgical friends in the centres I visited, and to the Governors of the Hospital and the Medical College for their support in this venture.

Scandinavia is not far away and I assure you it is well worth a visit.

FIFTY YEARS AGO

From the Bart's Journal of May, 1914

EDITORIAL NOTES

There is no doubt that the prospects for those who are beginning their course of training for the medical profession are exceedingly bright. For several years past the authorities of most of the hospitals in the neighbourhood of London and in the provinces have found it difficult to fill the post of House-Surgeon and House-Physician. Whereas formerly there was a good competition for these resident posts, it not uncommonly happens that no candidates whatever apply, even though the salaries have in many cases been largely increased. The death of young doctors has not for many years been so acute as at the present time, and local authorities in London and throughout the country are finding the greatest difficulty in filling vacancies. Some of the Borough Councils are now paying as much as £500 a year for medical officers in dispensaries, positions which only a short time ago were easily filled, although the salaries were only half that amount.

The position now is that any young qualified medical man can, immediately on obtaining his diplomas, secure a post worth at least five guineas a week all found.

The chief reason for this dearth of young medical men is the decreased number of students who for some years past have entered the profession.

The Dean tells us that the average number of students entering the full curriculum during the decade 1880-1889 was 130 per annum; for 1890-1899 the average was 105 per annum; whereas in the decade 1900-1909 the number of full students fell to an average of 71 per annum, and last October the entry of full students reached the lowest figure on record, namely 53 full students.

Instead of the Insurance Act having worked detrimentally to the medical profession, the contrary has been the result, for in many cases doctors, whose practices were small and in significant, are now busy with panel patients, and are receiving good fees. With the recent increase in the number of lucrative public appointments and the probability of still further increase in the near future, this dearth of medical men becomes a serious public question.

FROM THE SKI SLOPES

SAUZE d'OULZ

It is fashionable nowadays to go on a ski-ing holiday, so a varied assortment from the profession, consisting of two housemen, three midwives, two almoners and ten medics set off to the Italian Alps one Sunday morning in March.

Sauzé d'Oulx is a rather unattractive village on the Italian side of the French border, near Frejus, and is popular purely as a ski-ing resort. The ski-ing is good, but there tends to be a certain amount of difficulty in communication, as all the instructors speak Italian, with a smattering of French and no English. Every Sunday and Feast day, of which there are many, great crowds would appear from Turin, fifty miles away. Ski-ing tends to be a little perilous, with highly daring types brushing past at high speeds.

Après Ski.

Some of the party relaxing.

Snow Maiden.

The social life started after dinner with the inevitable drinking and singing sessions in one of our rooms. The row was impressive and soon attracted a large number of followers amongst the other occupants of the hotel. After the party we all moved to a nearby underground cellar. This highly artificial *bistro* had a juke box, and was the only place where the dancing was at all acceptable. We spent most of our evenings here.

The weather was variable, with bright sun one day and snow the next. This did not prevent most of us attaining a respectable sun-tan. We returned with this status symbol fully established, and a few twisted ankles in addition.

ZURS

The Bart's Ski Club, having rendezvoused at the Golden Arrow bar, left Victoria station on 18th January, a mixed bunch consisting of 11 men and 14 women. Our destination, Zurs, was reached at 11.30 next morning and by the afternoon we were out on the slopes. Unfortunately as the days went by the ski-ing conditions became worse and worse. The runs became very icy and stony and patches of ground began to show through on the lower slopes, however a fall of snow in the second week vastly improved the conditions which were becoming very good by the time we had to leave. Casualties were few.

Bart's first major victory was in the Twist Championship of Zurs in which John Graham Pole carried off the honours. Parties were held almost every night and, besides this, the Night Clubs of Zurs were invaded every night. It was in the night clubs that the beautiful ladies of our party excelled themselves. Having had a hard day on the slopes they twisted and shook till the early hours of the morning by which time the men were absolutely flaked out.

The party arrived in London after an uneventful return journey except for when our twist champion who was too intoxicated to find his own compartment and woke to find himself in a compartment full of middle aged women.

THE HISTORY OF VIEW DAY

By Nelly J. Kerling, Ph.D., Archivist.

The history of our annual View Day is intriguing. When did it start and why? Were outsiders always allowed to visit the hospital on that day? To get an answer to these questions we have to go back a long way.

When St. Bartholomew's Priory was dissolved in 1539 there must have been a feeling of great frustration among those who were in charge of the Hospital and they probably felt that it was no use planning for the future in such uncertain times. Money for rents of the property seems no longer to have been collected and the necessary equipment was not bought. When the City took over in 1546-7, the Governors found that of the Hospital's property some houses were "in great decaye and some rotten ruynous". In the Hospital itself they found "so much of householde ymplementes and stuffe towards the succouryng of this hundred poore, as suffised thre or foure harlottes, then lieng in chyldbedde, and no more, yea barely so muche, if but necessary clenlinesse ware regarded". No wonder that it was felt that what was needed in the first place was to secure a regular income with which any essential commodities could be bought. The minutes of the Governors' meetings which have been preserved from 1549 onwards, show how conscientiously the administrators pursued this task. On nearly every page of the 16th century Journals it is stated that some property was "viewed", repairs were discussed and new leases arranged. Sometimes the Governors went as far away as Hendon in Middlesex or Dunton in Essex. After 1551 it became the custom to visit the Hospital's land and tenements in the City and suburbs of London regularly once a year. It is understandable that this viewing of the extensive London property was a long and tiring work which sometimes took two days and one can imagine that the viewers were ready for a good meal afterwards. Because the money for these annual View Day dinners was paid by the Hospital, we can follow the history of this event in the Treasurer's Account. The first of these dinners took place on 9th March, 1568-9 when the steward was paid 40 shillings for the "fewe dynner". After that year they were held regularly, sometimes in the "Pope's Head" in Lombard Street, sometimes at the "Shipp neare the Exchange". The last of these dinners seems to have taken place in 1730 when the Treasurer accounted for £12 15s. 0d. Th next year no dinner is mentioned in the accounts, neither is there any reference to an annual View Day of the London property in the minutes of the Governors' meetings. In 1732, a new entry appeared in the ledger of the Treasurer: "paid for a dinner at the View of the house, £16 1s. 6d." The Hospital was at that time being completely

rebuilt by James Gibbs. He began in 1730 and in 1732 two admission rooms for patients next to the great staircase (now part of the Clerk's office) were finished. Was the "View of the house" a view of these new rooms? It seems quite likely for every year during the 18th century the new buildings were "viewed", generally on the Monday two weeks before Easter Monday. Though views of the Hospital property were still carried out by the Governors, an annual view of the London houses seems never to have taken place after 1730. After 1748 a surveyor was employed who, whenever necessary, carried out surveys, thus relieving the Governors of this strenuous task.

So far we have not mentioned any patients but here again we have to go far back into history to explain how it happened that a view of the building in the 18th century changed into a view of the wards and the patients as we know it today.

In the Middle Ages special services were held in Easter Week in the Priory or Hospital of St. Mary Without Bishopsgate generally called St. Mary Spital. They were held to attract people's attention to the Hospital and to induce them to give money and to arrange for bequests to this charity. In the 15th century the City of London became interested in these services and the Lord Mayor and Aldermen nominated the preachers for them. When the Priory was dissolved in the 16th century, the tradition of these Spital services as they were called, continued. Originally five public services were held in the City at Easter time, three of which were at the Spital but after 1660 the number was reduced to three, only one being held at the Spital: In 1675 there were complaints about the "ruinous state" of the pulpit and in 1680 the ceremony was therefore held at St. Bride's. After 1797 it was held regularly on Easter Monday in Christ Church, Newgate Street. As this church was destroyed in the last war, there is now a yearly service in St. Lawrence Jewry in the second week after Easter.

Ever since the Reformation the Lord Mayor invited the Governors of the City hospitals: St. Bartholomew's, St. Thomas's, Bridewell, Bethlem and Christ Hospital. They formed a procession in which the physicians and surgeons joined. In the 17th century the apothecary of St. Bartholomew's also attended, together with Mrs. Worth who treated the "scaldheads". There was a strict order of precedence. In 1687 it was decided that surgeons had to walk before the Governors. They arranged themselves according to seniority which sometimes caused some trouble as for instance in 1699 when the senior surgeon of St. Thomas's beat one of his colleagues who had not given him precedence. In 1720 the surgeons of the outhouses of St. Bartholomew's complained that they had to follow the assistant surgeons of the Hospital and it was decided that they would in future be allowed to walk before these assistants. The aim of the Spital services was always to attract attention to the City's hospitals. They were generally attended by many well-known people. On 13th April, 1669, Pepys noted in his diary, "I by hackney coach to the Spittle and heard a piece of a dull sermon to My Lord Mayor and Aldermen."

For some time after the Reformation the medieval idea of showing the actual patients was apparently still carried out. We do not know how long this custom continued, perhaps the Civil War, the Great Fire of London of 1666 or the years of the plague in the 17th century brought it to an end. They certainly were no longer present at the end of the 17th century, and outsiders had to be impressed by a view of the Governors, physicians and surgeons, or by a special sermon rather than by seeing diseased people. Somehow the 18th century Governors must have felt that this change in the Spital services was not an improvement and when they began to view the new hospital buildings they invited certain outsiders, not only to see Gibbs' design but also the patients. The idea was the same as in the Middle Ages: to attract attention to the work in the hospital and to try to get money. Mostly those who might be eligible for the position of Governor were asked to the ceremony, for in those days one way of becoming a member of the Board was to give a donation of at least £50. The names of these 18th and 19th century donors are still to be seen on the walls of the Great Hall. The View dinner held afterwards was no doubt a special attraction for future Governors and their ladies.

In 1824 the physicians and surgeons advised the Board of Governors that it was "extremely desirable" to hold View Day at a "less inclement season" and it was decided to fix it on the second Wednesday in May instead of two weeks before Easter Monday, as it had been since 1732. One wonders why the doctors were worried about View Day. Were they thinking of the health of the visiting Governors or of the patients? If the patients suffered, was it because walking patients were asked to be on view to visitors much on the same lines as at the 16th century Spital services? The minutes of the Governors' meetings do not mention any details and perhaps we will never know why View Day has been held in May ever since 1824.

When the novelty had worn off Gibbs' buildings View Day remained only a view of patients and of the wards, carried out by the Treasurer and Governors. In the 19th century visitors were no longer allowed to join them during this inspection. Until 1882 medical students were present but in that year the Governors complained of the inconvenience caused by their conduct in the wards during the annual view. The problem was discussed in the Medical Council and it was agreed that it was not advisable to abolish View Day altogether "since it caused many Governors to take an interest in the hospital", but that it should no longer be a holiday. As the Treasury did not wish to issue an order against the attendance of students, the Council agreed to ask the medical staff to "use persuasion" to induce students not to go into the wards when the Governors were present. Inspection of the wards became the most important factor in the course of the 18th century and prizes were given to the sisters and nurses responsible. In 1848 Mr. Matthew Lucas, President of the Hospital from 1831 to 1848, left money for a yearly prize to be distributed on View Day to the most deserving sisters and nurses "as an encouragement to them to be kind and attentive to the poor patients". In 1857 Mr. James Bentley, Treasurer from 1842 to 1855, instituted a similar prize and both these rewards are given to this present day.

With a few exceptions View Day was held regularly on the second Wednesday in May from 1824 onwards. In 1869 it was postponed because the President, the Prince of Wales, who wanted to be present was abroad in May of that year and in 1872 there was no annual view because of the illness of the Treasurer. Twice in this century View Day was changed, once in 1937 because it coincided with Coronation Day and once in 1945 when it would have been on the same day as V Day. Even during the years of the First and Second World Wars the wards were inspected annually, though in 1941 the visitors who were invited to tea had to pay 1s. 6d. each.

The history of View Day is complicated because it has its origins in the medieval Spital services where outsiders were shown something of the Hospital's good work, and in the annual views of the London property which were urgently needed to improve the Hospital's financial situation in the 16th century. It was not until after 1730 when much money was needed for the re-building that the idea behind the Spital service was revived and the view of the new buildings was combined with a view of the patients for the purpose of collecting funds. Apparently the staff became gradually accustomed to introduce on that day outsiders other than prospective Governors and now that private donations are no longer required, View Day is the day on which relations and friends of the staff, after the wards have been viewed by the Treasurer and Governors, can get a glimpse of the important work carried out in this Hospital.

NOTE: I am indebted to Miss McInnes, Archivist of St. Thomas's Hospital, for giving me the information about the order of precedence of the surgeons at the Spital sermons and for drawing my attention to a passage in the *Analytical Index to the Remembrancia* of 1616 in the archives of the City of London in the Guildhall in which it is said that the poor of the hospitals always attended the Spital services.

THE ROYAL AND ANCIENT HOSPITAL OF ST. BARTHOLOMEW

VIEW DAY BALL

THE CAFÉ ROYAL · WEDNESDAY, 13th MAY, 1964

9 p.m. - 3.30 a.m.

DINNER TOMBOLA BILL SAVILL GAMING CABARET

DOUBLE TICKET : 90/-

CUT HERE

nd this to:
ecretary, View Day Ball Committee, Abernethian Room,
. Bartholomew's Hospital, London, E.C.1.

I, ... (Name in block caps.)

ish to apply for ..... Double Tickets and enclose cheque/

ish for the sum of £ : s. d.

ddress .....

I understand the Committee cannot guarantee to refund oney for returned tickets.

ate ..... Signed .....

N.B.—Cheques payable to St. Bartholomew's Hospital Students' nion, cossed "Ball a/c".

Receipts will only be sent if requested. No tickets will be sent out efore 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).*

VIEW DAY BALL

Wednesday, 13th May, 1964

The View Day Ball, under the patronage of the Countess of Leicester, will run from 9.00 p.m. to 3.30 a.m. at the Café Royal and will be in aid of the Royal College of Nursing.

The Ball will be held on the 4th, 5th and 6th floors of the Café Royal. There will be dancing throughout the evening to Bill Savill, Rus Henderson and Bobby Cristo and the Rebels on two floors in the Napoleon and Dubarry rooms. A 3.30 a.m. extension will cover bars on all floors. The bars will sell drinks at very reasonable prices — both whisky and gin being 2s. 3d. a measure.

A four-course dinner will se served at 10.30 p.m. in the Napoleon room and the cabaret will probably take place at 1 a.m. in the Dubarry room. The Café Royal's wine list includes many good table wines at 20s. a bottle and champagne at 42s. From midnight there will be gaming, probably chemin-de-fer, in the Marquise room.

The Tombola prizes will be on show in the Dubarry room and tickets will be on sale throughout the evening. Already many splendid prizes have been generously donated; they include dinners at leading London restaurants, a return steamship passage to the Continent and a fine selection of wines and spirits.

The Charity

The Royal College of Nursing was founded in 1916 to promote the art and science of nursing, the better education and training of nurses and to give assistance to its members in adversity. Union with the National Council of Nurses took place in 1963 and this amalgamated body represents nursing opinion at all levels.

Please help the College to continue its all-important work. Donations would be most gratefully received by the Secretary of the View Day Ball Committee, for Lady Heald, O.B.E., Chairman of the Appeals Committee, and further information may be obtained from the Appeals Secretary, Mrs. E. A. Daveport, RCN/NCN, 1a, Henrietta Place, London, W.1.

Café Royal

The Café Royal is in its hundredth year. However well acquainted people are with the Restaurant and Grill Room, it is sometimes not realised that these elegant rooms are only a small part of the extensive edifice which makes up the Café Royal. There are eight floors of banqueting suites above the main entrance and two floors beneath, with the cellars extending under Regent Street.

In 1865, 'Nicols' Thevenon opened the 'Cafe Restaurant Nicols'. As an ardent Royalist, and also with an eye to the spending power of the many French Royalists exiled in London from the regime of the Imperial Napoleons, he re-named his Restaurant the 'Café Royale'. His son-in-law, Pigache, who was associated with him in the business, was an equally ardent supporter of the Emperor Napoleon. Pigache, in his constant irritation over the uncongenial name of the Restaurant, devised a plan to induce into it a little Imperialistic flavour. He knew that Nicols was vain enough to accept a suggestion that his initial should be permanently engraved over his pride and joy. And in fact Nicols was delighted that his Café Royal was to be dotted with his 'N' and readily gave his consent. Pigache thereupon promptly surrounded the initial with an Imperial laurel wreath, capped it with an imperial crown, and his 'N'—which was no longer Nicols's but Napoleon's—was planted in every conceivable open space on the walls of the Café Royal, engraved on the cutlery, stamped on the crockery, embroidered on the napery and printed on every menu, wine-list and piece of stationery in the place. Nicols realised too late how he had been fooled and never really forgave his son-in-law.

THE LAST PSALM

To the members of the Fountain Club

The story that the Bard now sings
Is taken from the Book of Kings,
And that, I fear, will have to be
Sufficient bibliography.
Stricken in years, and very old,
King David's limbs grew stiff and cold,
A painful change indeed to mark
In one who'd danced before the Ark,
And previously, as we know,
Had laid the giant Goliath low.
Though heaped with clothes from head to feet
We're quaintly told "he got no heat";
The harp fell from his palsied palms—
It seemed the end of all the Psalms!
They found a virgin young and bright
Called Abishag, a Shunammite.
They put this damsel in his bed,
To keep the old man warm, they said,
And stimulate the aged king
Perchance one last sad Psalm to sing.
With something of his ancient fire
The monarch smote once more his lyre;
The old fierce rhythm was revealed,
And Gracious! how that damsel squealed!
The first exponent of that craze,
So fashionable nowadays,
When to their screaming fans' delight
The Beatles wheel their droning flight.
So that last Psalm was sung, and played,
And joined the Hebrew Hit Parade.
I'm told they still perform the thing
In choirs and places where they sing,
On Sunday morning every week
We hear that shrill soprano shriek;
It still sends shivers down the spines
Of daughters of the Philistines,
And gives teenagers quite a thrill—

The Psalms are all best sellers still!
What is the relevance, you say,
Of this old history today?
And why recall this spicy bit,
Of ancient Jewish Holy Writ?
Your Bard has reached the allotted span
The Psalmist found applied to Man;
He, too, at three score years and ten
Is conscious of a flagging pen,
And at this game of writing rhyme
He, too, has played out extra time.
He quite appreciates the cause
Of this poetic menopause;
It would be foolish to deny
The effect of "anno domini".
And so he thinks it only fair
He should vacate the Bardic Chair,
And all those hard-earned bays discard
That decorate the Fountain's Bard.
Too out-of-date—Ay! there's the rub!
For this rejuvenated club,
A square peg in a rounded hole,
And ripe for going on the dole.
The laureate hands his laurels back,
And claims his due reward—the Sack!
Unless, of course, you should decide
To club together and provide
The kind of treatment that availed
When David's circulation failed.
From all this screaming teenage swarm
Find him a fan to keep him warm!

Of course I realise the snag
Is first to catch your Abishag,
The Welfare State quite disregards
The basic needs of ageing bards—
You cannot advertise for maids
For use as geriatric aids,
Nor can you claim, from lack of wealth,
To get one on the Public Health!
You can't prescribe one Shunammite
To be applied with care at night"—
The days of Shunammites are gone
The proposition is not "on".
One might preserve the thermal status
With some non-human apparatus,
Providing for the Bard at night
An artificial Shunammite;
But due to this same female dearth
Electric blankets cost the earth!
The Bursar, on the Clerk's advice,
Would just refuse to pay the Price,
And faced with such a bill to meet
Would damn well see "he gat no heat"!
So not without regretful qualms,
The Bard concludes his Book of Psalms,
And like King David, as it ends,
That cryptic signature appends

SELAH

THREE MONTHS IN INDIA

by D. S. TUNSTALL PEDOE

The Nuffield Foundation has given Bart's a scholarship which will enable one student each year to spend three months in Delhi at the All India Institute of Medical Sciences.

In this short account I can do no more than touch on different aspects of my very enjoyable stay there and hope that it will encourage many students to apply for the scholarship this year.

I hope to describe some of my travels and more of my experiences in a further article.

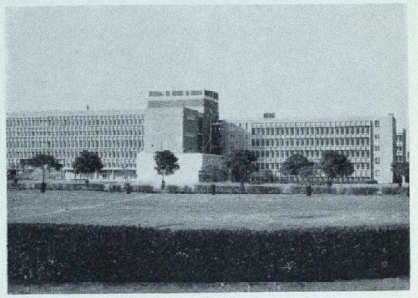
I was in Delhi from October to the end of December and Mr. Cope, the Dean, and the Cambridge Faculty Board of Medicine kindly allowed me to count this as my second medical appointment.

Leeds is partnering Bart's at A.I.I.M.S. and my companion was a charming girl from Leeds. We flew out by Boeing 707 and arrived at the Institute to find that no one really expected us, but nevertheless we were made very welcome by the Director. Vivienne was placed in the girls' hostel, which had a barbed wire fence all round it, and I was given a room in one of the mens' hostels, three hundred yards away. The room was furnished with a metal desk, metal bedstead, chest of drawers and hanging cupboard, and had an overhead fan. Indian students rapidly rallied round with sheets (no blankets needed), pillows and decorations and made me comfortable. The sanitary facilities included cold showers and catered for both Indian and European tastes.

Vivienne and I were very pleased to live in the hostels since the Institute is five miles from the centre of New Delhi and living in a hostel is the only way of really getting to know the students.

The Institute is still building its main hospital and the patients are housed in what was originally planned as the Nurses' Home. There are about 350 patients and 300 undergraduates undergoing a 4½-year training, with one year working as rotating interns, followed by house jobs.

At present the number of patients is small for the number of students and postgraduates. On the other hand there are no ferocious sisters to guard the patients so that one can

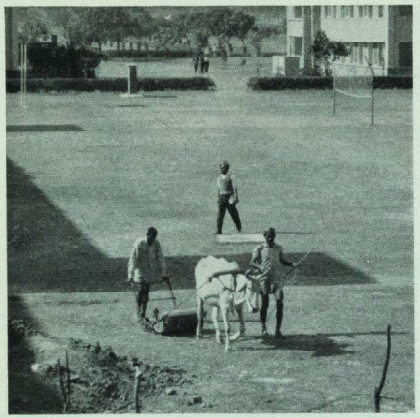


The All India Institute of Medical Sciences.

breeze into any ward and examine any interesting patients and it is left to one's own discretion not to interfere with patients who are obviously very ill or tired. I should add that most Indian patients are only too happy to tell their histories and bare their chests for yet another doctor.

The Indian students are chosen by open competitive examination from all over India. They are, on the whole, pretty bright and very knowledgeable. They are brought up on the "learn this list by heart" tradition of Indian teaching. They are being groomed at the Institute as future lecturers for medical schools throughout India and as a result the amount they are expected to know as undergraduates seems to be considerably greater than the amount we are expected to know, but to achieve this object they are, by our standards, "spoon fed". Their course of lectures is more extensive and intensive than ours. For instance, they had four lectures on conjunctivitis with a long series of ophthalmology lectures, and their dermatology lectures embrace in detail all the common conditions.

They have a series of demonstrations at a nearby T.B. hospital where the whole emphasis is on examination of the chest. The Director stands over the students while they are examining the patients and is not happy until they are completely systematic and are all convinced of the physical signs. He lays on different types of bronchial breathing, suc-



Cutting the lawn in front of A.I.I.M.S.

cussion splashes, pleural rubs, pathological and therapeutic pneumothoraces, pleural effusions and even a therapeutic pneumoperitoneum for good measure. He also puts out patients as test cases and every student had to write down his findings. I found that the students were very knowledgeable but were not so good at clinical decisions. They tend to be unwilling to be independent in their judgment, agreeing with the previous student's findings and not approaching the patients with an open mind. Perhaps it is part of their more sociable character and innate politeness that they do not like to disagree with their friends.

They have virtually no responsibilities for patients as undergraduates. They never scrub for an operation but spend a year as interns learning practical procedures and taking responsibility for the patients under the houseman.

The students are marked during their work and have surprise tests to keep them up with their reading. The marks from these are used in conjunction with their final examination results in the allocation of house jobs.

The students are as diverse in language, features and even customs as any selection of Europeans. There are several Messes to cater for their different tastes.

So that I could eat meat twice a day, I ate in two Messes, in the evening at the South India Mess where the food is hottest and you eat with your right hand. I soon got used to the highly spiced food. Eating with your hands involves learning how to squash a suitable handful into a bolus and flicking it into the mouth by extending the flexed phalanges of the thumb. When you become more expert you only use the tips of your fingers.

To boost the rather meagre protein ration and to soothe the abused mucous membranes I ate Dahi (Yoghurt) with every meal. Eating this with your hands is a real test of proficiency as well as being reminiscent of the sensuality of childhood.

I should add that many Northern Indians find the food in the South India Mess too hot and were very surprised that Vivienne and I liked eating there.

The students and staff were genuinely delighted to have English students among them and their kindness and hospitality was overwhelming. Invitations to meals were frequent and the Director took me sightseeing with two of the most attractive girl students as company.

Many people have asked me about the health risks there, especially if one eats out. I ate in many restaurants, cheap hotels, private houses, railway station canteens and ate and drank refreshment offered to me by peasants in the villages (it is very rude to refuse). I admit I was probably lucky but I did not have a single attack of dysentery and I suspect that hot food may afford some protection by raising the stomach acidity. Infective hepatitis is relatively common among the students and is their equivalent of glandular fever. Most of them have been infected with trachoma.

If one is too sensitive about what one is eating it is very easy to give offence and elementary precautions and faith in ones inoculations are all that are necessary, though I must admit seeing and handling the lesions of 50 leprosy patients in one day and made me wonder if I might be one of the small number of people who are very susceptible. I found the best way to stop worrying about leprosy was to go round a smallpox ward of 60 patients. The people working in the leper hospitals were far more worried about picking up filariasis.

However, the commonest infection is the common cold which seems to be potentiated by the wide daily temperature range in Delhi of 30° F. Colds tend to drag on and the students dose themselves with streptomycin and penicillin despite all Vivienne's and my entreaties about doubtful efficacy, emergence of resistant strains of bacteria and sensitisation to penicillin.

Sport is very popular at the Institute but not taken too seriously. The summer weather may explain this (over 120° F.). Most of the students are very unfit and their average hæmoglobin is said to be only about 10 gr. %. They walk very slowly and get tired easily. They play cricket, badminton, volley ball, table tennis and, of course, hockey.

The students are very pleased if you participate in their sports. I ran for the Institute and also in an invitation 5,000 metres race before a large crowd in the Railway Stadium. This was a true example of Indian hospitality. My sponsor, an ex-rival from Oxford University, Ranjit Bhatia, spread the word around that I was far from fit (only too true). The ten runners included many of the best long distance runners in India and one from Rhodesia. Many of them were Sikhs and they all ran in a distinctive Indian style. I came sixth, winning a last-lap duel, with most of the crowd chanting "Come on the Englishman" in Hindi. All the runners commented on my English running action and pointed out that I was the first Englishman to have run in India since 1945 whereas the Germans and Americans have sent visiting teams.

The Institute runs a village Dispensary at Kurali, 30 miles from Delhi, and all the interns have to spend three months there and at a Primary Rural Health Centre nearby, which has a few beds. They live in special quarters and run clinics in the morning and act as G.P's, help in morbidity surveys and acquaint themselves with particular families for the rest of the day.

The Institute Dispensary has far more drugs to dispense than any other Dispensary in India. It serves a population of 20,000 and is a showplace for visiting dignitaries. I spent a week there in all and met Princess Margarethe of Denmark and the Deputy Speaker of the Ceylon Parliament on successive days.

The pattern of disease was, for the most part, unfamiliar; one of the few common denominators being chronic bronchitis, which is very common in Northern India (One wasted old lady spat into the basin, blocking all the waste pipes and caused a minor flood). Scabies is very common, usually secondarily infected and often eczematised. It becomes commoner in winter because the peasants have little bedding and keep each other warm. The obstetricians are busiest nine months after the peak incidence of scabies.

Other pyodermas and fungal infection are also common. T.B. and bronchiectasis abound and also weird and wonderful eye conditions, often the sequelæ of trachoma.

On my first visit to the Dispensary we had a pædiatric emergency in the evening. A child of three was brought in by her father. She had had diarrhœa for three days and was grossly undernourished, her anterior fontanelle would still admit a finger tip and she had beading of the costo-chondral junctions. Her skin was dry and inelastic and her tongue was coated and dry. Her eyes were sunken and her breathing irregular and she was obviously moribund from dehydration. The Dispenser had gone home with the key and lived several miles away and anyway there were no intravenous fluids or catheters at the Dispensary. There was no transport into Delhi and no means of contacting any. As a sop to the father, the intern gave the child an injection of streptomycin, at which the child defaecated once more and was dead within two hours. The next day the mother told us that this was her eighth child in succession that she had lost in this way and that she had not brought it along earlier because she knew what would happen.

I subsequently met a Pædiatrician who, in the same circumstances, weighed out bicarbonate by hand, mixed it with tap water and gave it with a 10 ml syringe and saved a child's life. We heard that the Dispensary was subsequently stocked with the necessary equipment and fluid.

The interns at the village hold seminars every week with the Professor and staff of the Department of Preventive and Social Medicine. When we were there this was on "Acclimatisation to High Altitudes". The war with the Chinese at heights of 18,000 feet presents many medical problems. Many soldiers died from pulmonary œdema and many more were ill with chronic mountain sickness. The "Emergency" is still in full swing and the medical students have to join the cadets and do target practice on Sundays. There is a Defence exhibition full of pictures of Indian heroes and slogans such as "How can a man die better than facing fearful odds, for the ashes of his fathers and the temples of his gods?" The Indians do not think that the fighting is over.

Social life at A.I.I.M.S. is, to a European, very amusing. Most of the students will have their marriages arranged for them and most of the girls seem happy with this system. As

a result the students do not go out in pairs but in groups, especially to films or for coffee. A.I.I.M.S. is very introspective and if a boy and girl are seen talking to one another they are teased unmercifully and can become very embarrassed. They are very sentimental and apparently lacking in Western cynicism.

Public displays of affection are notably absent and even married couples don't hold hands or link arms although men will walk along holding hands with each other as a sign of friendship. You have to get used to it.

The nurses are nearly all from Kerala in the south and since nursing is *infra dig* for a Hindu girl most of them are Christians. They are tiny dark girls, many with B.Sc.s, who walk around with umbrellas to keep the sun off even when it isn't shining. They don't mix with the students at all.

In the skin O.P's you see every form of, pyoderma, fungal infections, the different types of Hansen's disease (leprosy), as well as pemphigus, lichen planus, lupus vulgaris, scleroderma, and, to make you feel at home, contact eczema and even acne.

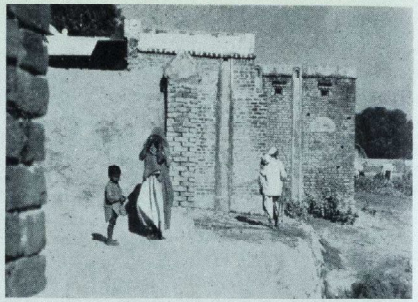
The nursing can be pretty slapdash and a needle dropped on the floor will be hastily placed back on the syringe and may be used for several successive injections.

There are far fewer nurses and most patients seem to have a friend or relative who comes in to look after them. In the childrens' wards all the beds are full size so that the mother or guardian (often an elder sister) can sleep with the sick child.

The pædiatric wards are some of the most interesting. You see children with miliary T.B., meningitis, intestinal obstruction (often worms or T.B.) rheumatic fever, congenital heart disease, kidney disorders, thallasæmia as well as scurvy, ricketts and protein deficiency. In the kids' O.P's there is a wealth of clinical material, scroufula (tuberculous cervical adenopathy), infantile cirrhosis, severe anæmia from hookworm (which also gives rise to a typical facies), and every now and then and old English friend like pica.

Orthopædic out-patients will produce a Volkmann's contracture nearly every day as a result of native medical practice.

The patients one sees in India have often allowed the disease to progress much further than their English counterparts would before seeking medical attention. They have often sought the services of a "Native Specialist" first and may be covered with small knife cuts or burns used in the treatment.



An Indian village street.

They are usually suffering from several diseases as well as having the illness aggravated by their poor nutrition and low resistance. One does not look too hard for a unifying pathology if some of the presenting symptoms are manifestations of common diseases since the patient is probably suffering from several distinct disease entities. The best example I saw of dual pathology was a girl of 22 with exophthalmos, tremor, hyperkinesia and a large hyperæmic thyroid. However, she was complaining of formication over her left hand and on palpitation the ulnar nerve was grossly thickened. She had mononeuritic tuberculous leprosy as well as thyrotoxicosis.

The majority of the poorer patients are malnourished and physically poorly developed. They are almost invariably anæmic and chronic iron deficiency anæmia from hookworm infection can present with a hæmoglobin as low as 2 grams % (about 15%). With this degree of anæmia there is sometimes peripheral neuritis and fever even when it is a pure iron deficiency anæmia.

The hookworm infestation can give rise to mucosa atrophy and a chronic malabsorbtion state.

The patients are fatalistic in their approach to illness and this is a very major problem in the control of disease. Even if Indians allow themselves to be vaccinated, they often rub cowdung on the injection or try to neutralise it in other ways since they believe that smallpox is a form of divine retribution and that they should not interfere with it.

The cow being a sacred animal, cowdung is used for everything—to cover burns and to put on the cut end of the umbilical cord after birth. This causes neonatal tetanus, an awful disease which I saw in a Mission hospital 40

miles from Delhi. I heard that even hospital-trained midwives will say that the cow, being a sacred animal, has sterile gut contents and so will sanction the use of cowdung for this purpose.

Naturally language presents a problem since one cannot learn much Hindi in three months. Although all the teaching is in English the majority of the patients do not understand it and at the very least one has to learn enough to ask them to breathe in and out, open their mouths, count up to three and so on. Taking a case history through an interpreter is very tedious and it is best to take histories from patients who do speak English.

The Indian accent takes a bit of getting used to—for example, a lecturer who says "scissors" means "seizures", but after the first week one should have no difficulties.

I hope that this scrappy account will give some idea of the All India Institute of Medical Science in Delhi and what a wonderful and informative time one can have there. Next month I hope to give a short account of the 4,000 miles of travelling that I did in India and of the fantastic hospitality that I was offered wherever I went.

In conclusion I would like to thank the Nuffield Foundation for giving this scholarship to St. Bartholomew's Hospital and enabling me to see so much of India, and Mr. Cope for allowing me to spend three months away from Bart's and to count it as my second medical appointment.

SAINT BARTHOLOMEW'S HOSPITAL SPRING, 1964

Examination Paper, Doctors, for the use of.

Bed-side Manner—FINALS.

Entrants are to attempt ALL questions. No extra marks will be awarded for legible handwritings.

DOCTOR-PATIENT RELATIONSHIP

1. Describe how you would examine an unco-operative child who has armed himself with your hypodermic.

2. How would you ascertain whether a patient's medical knowledge had been gathered from:

(a) Emergency Ward 10.
(b) Dr. Kildare.
(c) Reader's Digest,
(d) Carry On Nurse?

Describe your approach to each type.

3. You discover that a particular patient turns out to be a better diagnostician than yourself. How would you retrieve the situation whilst retaining the patient's confidence? Give two or three clinical examples, with jokes where necessary.

4. "What seems to be the matter?"
"That's what you're supposed to know."
Suggest three replies.

5. Prescribe tactfully *either*
(a) "Teetotalism" for an alcoholic Scotsman.
or (b) "Soap and water" for a girl with spots.

6. "We don't want to upset Grandma, so could you drop in this evening and have a look at her without her knowing?"
Discuss this possibility

7. Give (or choke back) your first reaction to the following:
(a) "Mumsy-wumsy's precious doesn't like doctor-man."
(b) "She wouldn't let us send this morning because you are so busy, but when it got to midnight. . . ."
(c) "Our last doctor was more of a friend, you see. . . ."
(d) "If you're bad again he'll take you away in that little black bag."

NEW PENGUIN BOOKS

Claudine at School, by Colette. Penguin Books at 4s.

Claudine in Paris, by Colette. Penguin Books at 3s. 6d.

Claudine Married, by Colette. Penguin Books at 3s. 6d.

Claudine and Annie, by Colette. Penguin Books at 3s. 6d.

"Claudine at School" was Colette's first novel and was published in 1900 under the name of her infamous first husband, Willy. She was twenty-two when she wrote it and with rare observation and sensitivity she captured the feelings, passions and innermost thoughts of a sixteen-year-old schoolgirl on the fringe of a mature emotion and sensuality. The novel was to a large extent autobiographical and the skill with which Colette conveyed the mind of the adolescent in its innocence, impulsiveness and malice shows the brilliance and acute observation which are apparent in her later novels.

French women novelists seem to have a special talent for this kind of writing and it is impossible not to compare Colette to Francoise Sagan and perhaps also to Simone de Beauvoir although Colette's heroine tends to be more confiding and down to earth than the mixed-up adolescents that the latter two specialise in, and the writing is a great deal more sophisticated and light.

The four novels form a continuum, and follow Claudine's career from her emotional awakening at the village school to Paris where she hesitantly moves towards deeper maturity and love. Excursions are made into a series of bizarre emotional entanglements involving lesbianism and homosexuality, into the world of the fashionable and into the world of the demi-mondaines and artistic hangers-on that parasitise it, until her final emancipation is reached in "Claudine and Annie".

The novels are at times near-pornographic and yet are saved from pornography by the precision, lightness and humour of the writing.

The genius of Colette lay in the acuteness of her observation and her sense of humour and sophistication. Beside Colette, the writings of Mlles. Sagan and de Beauvoir appears heavy and lumbering. Her novels remain as the best examples of a style that she very largely invented.

Shane Douglass.

The Europeans. Henry James. Penguin Modern Classics. 3s. 6d.

"The Europeans" was one of Henry James's earliest novels and is largely free of the wordy, strained, metaphorical style of presentation that makes the reading of his later works so difficult. Its dominant theme is one found throughout most of James's work, the "international subject" as he called it, the relationship between America and Americans on the one hand and Europe and Europeans on the other. In this book the sophisticated "Europeans" that he introduces into a small section of Bostonian society are in fact Americans but born and educated in Europe. The subtle influence that the Baroness Münster and her artist brother Felix exert on the sober, well regulated, prim and Puritan life of the Wentworth family and their friends is developed with all the graceful irony that we associate with the novels of Jane Austen. The innocence of the Wentworths, eager for new experience, does not, as in James's later novels, lead to their corruption at the hands of the sophisticates although it is evident in the opening chapter that the Baroness and her brother have intentions other than mere curiosity in visiting their cousins. The Baroness is the most finely developed character in this short tale—aloof, almost disdainful, but exerting an irresistible attraction for Robert Acton, a close friend of the Wentworths. The intricacies of the plot depend on the usual Romantic conventions, nevertheless the reading of this book filled me with a respect for Henry James's abilities as an author which I was unable to find in the past.

Gervase Hamilton

Sexual Deviation. By Anthony Storr. Pelican, 3s. 6d.

This is the first book of a new series on "Studies in Social Pathology" and is eminently readable. In common with other books of this size a number of topics are ommitted, but on the whole it is a fairly comprehensive survey on sexual perversion. A chapter is devoted to each form of deviation ranging from Guilt, sadomasochism, fetishism and homosexuality to buggery and pædophilia, with two chapters on treatment of the disorder.

The book is intended for the layman and the author has rightly directed his attention to giving numerous examples rather than dwell at great length on technical explanation and hypothesis of such malpractice. He gives the impression of being a widely knowledgeable person by quoting from authors as far apart as Guy de Maupassant, Dostoievsky, William Golding and Marcel Proust, as well as drawing numerous examples from contemporary films. On the other hand he is apt to make some rather unnecessary comments, as in the chapter dealing with pædophilia, by stating "(if) the seduction of boys . . . arouse violent emotion . . . the waiting list for entry to public schools would hardly be so long as they now are."

In common with certain sections of psychiatric thought the author has an inherent distrust of medical and surgical treatment for psychiatric cases of this kind, and advocates analytical psychotherapy as a treatment of choice. He believes in teaching the patient to live with his illness rather than to regard it with pathological fear and disgust.

This, then, is a book by an author who has put aside a great deal of the standard of morality set by society and the Church, in an attempt to view the subject of sexual deviation objectively; and by a series of examples drawn mainly from the Kinsey Report to persuade the public to adopt the same attitude. Recommended for a light evening's entertainment.

B.L.

OTHER REVIEWS

The Teaching of Biochemistry to Medical Students —Edited by G. E. Francis. Published by the Biochemical Society.

This monograph arrives at an interesting period for teachers and students of Biochemistry in the London medical schools, since at the present there is much discussion in the University about the place and status of medical biochemistry. It is probable that the time is not far distant when biochemistry will become a whole subject in the curriculum and cease to be examined as one third of Physiology, so this pamphlet is most welcome as it gives an indication of the feelings of some of the people who teach the subject.

The monograph is a report of a meeting which was held in the Department of Biochemistry of the Medical College of St. Bartholomew's Hospital on 21st September, 1962. There are five papers and a report of the discussion that followed. The subjects range from "Pre-clinical Examination Systems" by E. D. Wills to "Possibilities for a Unified Presentation of Chemistry, Biochemistry and Clinical Chemistry within the Medical Course" by J. B. Jepson.

In his opening remarks Dr. Francis draws attention, yet again, to the fact that most medical students regard biochemistry as a bridge to be crossed, an examination to be passed on the way to the greener pastures of clinical medicine and not as a scientific end in itself. He also remarks that on average the academic ability of medical students is lower than that prevailing in a science faculty. If he means the average scientific ability of the candidates nobody can disagree. If he means the overall ability of some students, anyone who has seen a first class General Practitioner practising medicine in a social setting may feel that he is, at least in part, wrong. In another context Jonathon Miller has remarked that Medicine tends to recruit from the intellectually maimed, meaning that most medical students lack a real understanding of mathematics and the pure sciences. Perhaps this is the price that Medicine pays for people with a sufficient catholicism of mind to find its uncertainties and inexactitiudes challenging and satisfying.

Professor Arnold H. Schein contributes a fascinating and tolerant paper on biochemical teaching in the U.S.A. There can be no doubt that the American student is more industrious and more eager to acquire a knowledge of the basic medical sciences than his British counterpart. This is mainly due to his greater age, his possession of a university degree before entering his medical school and the fact that "he is highly motivated". Professor Schein suggests that this is largely because his clinical teachers are more sympathetic towards biochemistry and accord it greater importance in the practice of medicine. He also gives details of courses in other American Universities where there are integrated courses and where the aim seems to be to produce medical scientists primarily. It is all very interesting and must be very satisfying, at least for the biochemists.

Dr. E. D. Wills examines Pre-clinical Examination Systems. His paper is mainly a plea for more examinations and the adoption in British medical schools of the "objective" type of examination paper. He feels that Biochemistry should be upgraded to the status of Anatomy and Physiology and suggests that if Biochemistry were allotted a higher percentage of all the marks awarded at 2nd M.B. its status would rise in the mind of the medical student. Personally, I find this doubtful. What is wanted is more stimulating and relevant Biochemistry teaching, not quicker or slicker examination systems.

Dr. Wills rejects the viva type of examination on the grounds that it is no better than a written examination and often unnerving to the candidate. The latter point may be true but I think he has forgotten that the practice of medicine ultimately rests upon a face situation the doctor-patient relationship, and that in this situation both parties are assessing one another. The patient's assessment of the doctor is as important as its converse if the therapy of the whole man is to be achieved. For this reason it is desirable that the embryo doctor is assessed face-to-face by his teachers.

A strong argument is put forward for the objective type of paper. It is represented as fairer, quicker and more all-embracing. The fact that it is popular in the United States is also put forward as an argument in its favour. Dr. Wills' statistics show that it compares almost equally with essay examinations if the distribution of marks obtained by the same group of students for the two types of examination are compared. That this fact is a good argument for retaining the essay type of question is not considered.

To the argument that objective papers discourage the writing of good English Dr. Wills replies that it does not matter so long as essays are retained for examinations in Arts subjects and anyway why should scientific teachers be expected to teach or evaluate English? Here, he seems to me to be shrugging off the most important objection to one word answer papers. For better or worse, English is the recognised means of communication in British medical publications and between doctors. Surely it is important that medical men should be able to communicate in a profession that depends so much on accurate self expression. Does he seriously suggest that literacy should be reserved for Arts graduates?

Finally Dr. Wills suggests that practical examinations should be abolished. I do not think that many people will disagree with this suggestion, at any rate so long as biochemistry practicals continue to have a strong odour of Mrs. Beeton attached to them. Dr. Wills objects to them mainly because they are too easy and give a chance for the weaker student to gain marks, and because they are expensive and time consuming for laboratory staff.

Dr. John B. Jepson's paper on the possibilities of a comprehensive course is stimulating and appropriate at a time when many students feel that Biochemistry would be better appreciated if its

relation to medicine were more apparent. I feel sure that if what is being done at the Middlesex Hospital could be done in other centres a great deal of good would come of it.

There are several more papers in this excellent monograph that space does not permit me to mention. But the whole enterprise demonstrates that medical biochemists today are anxious to reach the student and clinicians. It is obvious that a great deal of effort is being expended in biochemistry departments today to see that this happens. The thing that struck me most was the desire on the part of all present at the meeting to make biochemistry exciting and intelligible to the medical student.

T. J. McE.

Lecture Notes on Pharmacology, by J. H. Burn, M.D., F.R.S. 7th Edition. Blackwell Scientific Publications. Price 10s. 6d.

This seventh edition of Professor Burn's already well known and much used little book has now had a few useful alterations made but remains basically as it always has been. It contains the meat of forty pre-2nd M.B. lectures and would be extremely useful for revising for this exam, but it cannot be, and is not designed to replace a pharmacology textbook or missed lectures. The clinical student wishing to "brush up" the basic principles of pharmacology and prescribing will also find it useful reading, giving him a better appreciation of treatment than many a longer book. As with all note form presentations, however, accuracy has had sometimes to give way to shortness, and even in this new edition there are one or two statements that require qualification. Besides the basic classes of drugs, those used in the treatment of skin conditions, malaria and other tropical diseases are enumerated and discussed. I feel, however, that to make this a really complete book a short chapter on the cytotoxic drugs would have been very useful.

C.C.

Psychiatry, by E. W. Anderson, M.D., M.Sc., F.R.C.P. (Lond.), D.P.M. Concise Medical Textbooks, published by Baillière, Tindal and Cox. Price 16s.

The professor of psychiatry at the University of Manchester has written an excellent introductory account of his subject for this new series, designed to bring textbooks within the purchasing range of students. The book is also within the average student's mental capacity, clearly written and crisply phrased, though a stricter reading of proofs and a more liberal use of commas may be hoped for in the next edition.

Dr. Anderson presents a psychopathology based on the work of Karl Jaspers, rather unfamiliar to most British readers but useful in stmulating thought. He is somewhat sceptical about Freud and psychoanalysis, so his treatment of psychotherapy and the more dynamic aspects of child psychiatry is rather lightweight. It is a pity, too, that he lends his authority to the comforting opinion that alcoholism is no longer a major social problem in the U.K., at present estimated to have some 300,000 alcoholics merely in England and Wales. The chapter on neurasthenia might well have been reduced to a terminal paragraph of that on the anxiety states, the space saved being devoted to some mention of residential and day hospital treatment of psychiatric patients.

The book is however much more to be admired than criticised, and the reviewer only regrets that its equal was not available in his own student days. The chapters on schizophrenia, the personality disorders, drug treatment, and the social aspects of psychiatry are especially valuable. One last plaint: why no glossary, or more consistent use of explanation of technical terms in the text?

F.R.C.C.

Allergy and Tissue Metabolism. by W. G. Smith. William Heinemann Medical Books Ltd. (1963). 107 pages. Price 25s.

Dr Smith intends this short book to interest 'practising allergists and physicians' as well as basic medical scientists. He attempts to review existing knowledge of the immunological basis of allergic diseases and anaphylaxis in animals and man, assessing and relating researches in pharmacology, biochemistry and experimental pathology. The implications of such knowledge for therapeutics and clinical medicine are considered.

The concise accounts of the fundamentals of antigen endothelial system and chemical mediators in local acute inflammatory and hypersensitivity responses (chapter three) can be recommended to both undergraduate and graduate students. Histamine, 5-hydroxytryptamine, bradykinin and the 'slow reacting substance of anaphylaxis' are discussed separately, and laudably, from a metabolic as well as conventional pharmacological point of view. The author is on his home ground when considering the absorbing alterations in intermediary metabolism accompanying anaphylactic shock.

Unfortunately, the style of this book does not always allow assimilation of the subject matter at a first reading. The index is quite inadequate and there are needless repetitions in the text and extensive reference list. Discussion of clinical matters is minimal but nevertheless contains inaccuracies. Few believe that angina pectoris and cardiac arrhythmias have important allergic components. The author's surprise that 'it is even suggested by some that—psychological disturbances lead to the advent of bronchospasm' is itself surprising. Auto-immunisation receives but scant mention.

G.M.B.

Ocular Pathology. By C. H. Greer. Blackwell Scientific Publications. Price 42s.

This book on ocular pathology is addressed to beginners in Ophthalmology. The author has had considerable experience as a general pathologist for some years and at the Institute or Ophthalmology, London and has devoted himself to the pathology of the eye, and so brings to this special field a wide experience and philosophy. He is now pathologist in charge of the Royal Victorian Eye and Ear Hospital at Melbourne University. Dr. Greer's expert selection of his material, the rejection of some, and the clear manner in which he deals with such complex problems as lens reactions and the histogenesis of ocular melanomas marks him as an able teacher.

The substance of this book is the courses of instruction which the tutor gives for the Diploma of Ophthalmology of Melbourne University an the Fellowship in Ophthalmology of the Royal Australasian College of Surgeons.

The subject is treated widely in terms of general pathology, is well arranged, and is concisely expressed.

The illustrations are from photographs of the macroscopic appearances of bisected eyes and photomicrographs of the relevant morbid histology.

Some omissions are inevitable in a work condensed for examination teaching purposes. Some mention might have been made of binocular malignant melanoma of the choroid in the other. Also that excision of an eye for malignant melanoma of the iris is only indicated in the rare event of extra-ocular extension. The operation of partial iridocyclectomy is worth while. It is incorrect to state that the proximity of a malignant melanoma to the macula and optic disc makes it unsuitable for irradiation for there have been a number of successes when the neoplasm has been at these sites in an only eye.

The author comments that a cure is effected in 50-80per cent of retinoblastomas if the second eye is excised early. Provided this neoplasm is not larger than 10mm in the second eye irradiation with ^{60}Co applicators effects successful destruction of the neoplasm with conservation of sight in 90 per cent

The book is admirably produced. Candidates for the Diploma and the Fellowship in Ophthalmology and indeed many practising ophthalmologists will wish to have this excellent book in their library.

H.B.S.

Teach Yourself Physical Fitness, by Lindsey W. Batten, M.B., M.R.C.P. Published by the English Universities Press Ltd. Price 6s.

The title of this book leads one to expect its contents to be chapters of detailed methods of attaining peak physical fitness with much reference to complicated exercises, weight training and graphs illustrating improvements in performance due to these methods. However, the author has avoided any such reference and has produced a short concise account of the factors involved in maintaining a degree of physical fitness not equal to that of the professional athlete, but such that will allow the enjoyment of strenuous leisure time activities.

Although this book has rather the air of authority of Readers Digest it goes a long way towards dispelling many misconceptions that the population at large has built up in respect to fitness and physiological processes of the body. As such I would recommend this book to any person who wishes to obtain or maintain an adequate degree of physical fitness in themselves or in people they may influence, particularly parents and teachers.

C.J.S.

A Textbook of Human Embryology. By R. G. Harrison, M.A., D.M. Published by Blackwell Scientific Publications. Price 47s. 6d.

This book, now in its second edition, is written primarily for medical students, and is based on the author's own lecture course. It aims to present embryology in a concise and readable form, suited to the present crowded pre-clinical curriculum There is a rather heavy bias towards the functional side of the subject. The first quarter of the book deals quite extensively with the male and female physiology of the pituitary and suprarenal glands—reproductive systems and with the anatomy and in these sections the author draws on his own researches. In contrast, the purely descriptive morphological accounts are often very brief; for example, the thymus and parathyroid glands are dismissed in eleven lines in the chapter dealing with the special senses. Some of the descriptions would seem scarcely adequate for fulfilling two of

the purposes for which embryology occupies a place in the medical curriculum—to elucidate normal anatomy and to provide some understanding of congenital malformations. The book is well illustrated largely with clear and simple line diagrams and some photomicrographs of human embryos. Recent work is freely referred to in the text and each chapter concludes with a list of modern references. The book is completed by both author and subject indices. This textbook should prove useful to pre-clinical students, perhaps ideally as a complement to a lecture course dealing more particularly with the purely morphological aspects of embryology.

O.J.L.

Hydronephrosis. James C. Anderson, O.B.E., T.D., F.R.C.S. Published by Wm. Heinmann. Price 25s.

The author of this short monograph is one of the originators of an excellent operation for hydronephrosis. As befits his principal hobby, the evolution of his thesis is somewhat on agricultural lines. He delves deeply into the historical presentation of the condition and fully discusses its etiology, symptomatology and pathological sequelæ. A valuable section is the analysis of 185 personal operations on 172 patients. He uses the term functional in describing the case where no mechanical obstruction is demonstrated. This term usually connotes a psychosomatic content which, I am sure, is not present and is not intended, and one would think the term idiopathic to be more generally acceptable. I would agree with the author's guiding principles and they are necessary in any operative procedure. They are that:

(1) Any etiological factor is dealt with.
(2) Good dependent drainage is established.
(3) A new anastamosis must be of adequate length and without constriction.
(4) Splinting and nephrostomy should be avoided.
(5) All the renal blood supply must be conserved.
(6) There should be no tension at the line of the anastamosis.

Chapter III could well be expanded. There did not seem to be mention of intermittent complete obstruction which is a fairly common cause of presenting symptoms in adults.

There are several entirely different types of operations employed in the treatment of hydronephrosis and these are fully described and commented on by the author.

Whilst there are a few cases where the Foley Y plasty, the Culp flap and even the Davis' intubation may be the most applicable procedure, I would be very much in favour of the auhtor's operation in the majority of cases. The Anderson-Hynes pyeloplasty is probably more often done with success in this country than all the other procedures put together, and is an excellent operation.

This Monograph will appeal more to urologists than to any other group but can well be read with advantage by every student under or post-graduate.

A.W.B.

Dermatology, by R. M. B. McKenna and E. L. Cohen. Concise Medical Textbooks. Bailliere, Tindall & Cox Ltd. Price 17s 6d.

The pedigree of this book, with clarity and elegance of exposition yoked with concise erudition, should ensure its impact. The book is one in a series of Concise Medical Textbooks intended for the student and newly-qualified doctors and appears to be a more elegant successor to the Aids to Dermatology books by the same publishers and authors, and has become a little too large, now, to slipped easily into a coat pocket. The illustrations consist of a black and white frontispiece of normal skin and four line drawings. With the present easy availability of coloured slides in all teaching hospital skin departments and in many non-teaching hospitals this lack of illustration, which keeps down the cost of the book, is probably justified, but some line drawings of the basic pathological processes and types of cell would be welcome.

The diseases are classified by ætiology or pathology in the traditional manner and each one is discussed under a set pattern or definiiton, ætiology, pathogenesis, signs and symptoms, etc.; this makes for ease of reference but entails some repetition.

Textbooks of dermatology are at present in the throes of discarding much of the old and rather cumbersome nomenclature based on minute morphological distinctions and there is as yet no general agreement how far this process should extend. From the point of view of the hard-pressed student the fewer names he has to memorise the better and one might consider that the authors could have been more ruthless in this respect, particularly with the sections on leprosy, impetigo and some of the -id eruptions.

The section dealing with eczema-dermatitis are always an important part of any dermatology textbook, and here one would like to see a more clear-cut distinction between primary irritant contact dermatitis and allergic contact dermatitis. The chapter on drug eruptions, admittedly a difficult subject to explain, lacked sufficient indication of the relatively few more common reactions which account for the majority of cases. One would like to have seen a mention of auto-immunity, and dermatomyositis is only briefly touched upon under poikilodermatomyositis, with no mention of polyarteritis nodosa. Especially good were the sections on nomenclature of skin lesions, the general principles of treatment, the parasitic infestations, pruritus and prurigo, the sebaceous glands and diseases of hair.

M.S.

Pharmacology For Nurses (Third Edition), by J. R. Trounce. Published by J. & A. Churchill Ltd. Price:

A pharmacology book must be popular enough to require a new edition at frequent intervals or it falls out of date. Dr. Trounce's book has had three editions in six years. It is a paper back on good paper, and opens more readily than most such books.

The field covered is wide, and includes water and electrolyte and acid-base balance. This is such an intractable subject that it is not surprising that this is a very difficult chapter. It is however a topic on which nurses are always asking questions, and if they have a knowledge of chemistry they may find in this chapter the answer.

There is a good account of the diuretics and of the antibiotics. The distinction between approved and proprietary names is by no means clear, and if one wants to know whether a drug is controlled under one of the Acts, one must refer to an appendix. Perhaps in the next edition this information could be incorporated in the text.

A Textbook of Obstetric Nursing, by C. W. F. Burnett. Blackwell Scientific Publications. Price 30s.

In this Textbook of Obstetric Nursing, Mr. Burnett has described adequately and in sufficient detail the anatomy of the pelvis and pelvic organs, for the student nurse taking obstetric training. The section dealing with the management of pregnancy gives a clear idea of how to achieve the principal factors underlying good antenatal care, namely adequate history taking, correct 'booking' of patients for hospital or domiciliary confinement, detection and treatment of abnormal conditions in pregnancy. Mr. Burnett has also dealt in detail with the normal body changes which are apparent at the various stages of pregnancy. The content of the sections entitled 'Physiology and Management of Normal Labour' and 'The Normal Puerperium' really does place the emphasis on 'normal', and gives the student nurse excellent detail of her care of the patient at these times. Mr. Burnett in pursuing his emphasis of the 'normal' has included just sufficient complications to comply with the introduction to abnormal midwifery required by the syllabus of this course.

The general arrangement of the text and type makes for easy reading, but the shading in some drawings causes confusion, as does the labelling of certain diagrams, particularly those showing degrees of flexion (page 64) and placentae (page 206); the latter, although correctly labelled do not correspond to the subdivisions of the text.

This textbook is excellent for the Obstetric Course and every library should possess several copies. Unfortunately the price puts it outside the range of most nurses for such a small section of their General Training; if they continue to Midwifery Training they would do well to buy a more comprehensive textbook in the first instance.

H.E.G.

NEW MAGAZINE

The International Journal of Nursing Studies. 10s. Quarterly. Pergamon Press Ltd.

The aims of this new quarterly Journal are to draw attention to the Community's needs for all types of nursing care, to prepare young people to assume nursing duties and responsibilities, and to encourage all aspects of nursing research—this last most important of all. The first edition with articles on the changing hospital attitude, advances in nursing the mentally sick and University education and the future nurse, successfully justifies these aims. The publishers are to be congratulated on meeting a long felt need to combine in one magazine all the most recent world developments in the rapidly advancing field of Nursing.

SPORTS NEWS

RUGBY CLUB

Welsh Tour

Over Easter week-end the Rugby Club went down to South Wales and played Glymneath on Good Friday evening and Treorchy on Saturday afternoon.

Glymneath have a fine record, with an unbeaten record at home for four years, and they proved to be the best team that Bart's has met this season. The game was hard, fast and open and greatly appreciated by the large crowd.

The first half was keenly contested and both teams seemed evenly matched. Half-time came with no score to either side. Soon after play started again Gibson kicked a good goal to put Bart's in the lead—for a short time. Glymneath worked a fine move from the back of the line-out and scored under the posts. Then their full-back fumbled when picking up a mis-clearance, was allowed to play on and kicked a drop goal. This heralded a black spot of ten minutes for Bart's when Glymneath kicked ahead each time they had the ball and, it seemed, put a spell on the ball, for it bounced awkwardly for Bart's and right into the hands of the Welsh. Three tries were scored in this fashion. Then Bart's came back into the game and mounted some fine movements. One from a short penalty, resulted in a well deserved try for Johnson. Thus the final score was 17-6 to the Welshmen.

Next afternoon, after shaking off the effects of the previous evening's festivities and after watching Cambridge win so easily in the boat race, Bart's met Treorchy and gained their first victory in Wales since the Hospital started visiting there in 1958.

Bart's started in fine style and shook the opponents. Although coming near to scoring in the first twenty minutes it was not till after Treorchy had kicked a penalty goal that Bart's scored via a Gibson try following a fine foot rush from the line-out.

Some fine movements by the three-quarters were spoilt by badly-timed passes at the final stage and it was left to second-row forwards Chapman and Bates to show the team how to score tries. This they did to the merriment and amazement of themselves and the team.

Throughout the Welsh tour the team had played well as a team and was well led by

C. J. Smart, who must be congratulated on his season as captain. Not only has it been most enjoyable for the players but also the records show it to be the one with the most wins since the war. The record is won 18, drawn 2, lost 15. For 358. Against 211.

The Seven-a-Sides

The Inter-firm seven-a-sides were played at Chislehurst on Saturday, April 11th, and from amongst a multitude of assorted firms, "2nd time Clerks and Dressers", "Finalists", "The House", and "Kids and Specials", graced the semi-finals. Much to everyone's surprise the latter put "The House" well and truly in place, but weren't quite strong enough to hold off the "Finalists" who won the competition. The last word was had in the evening by the—αbeats, whose cacophony reached a volume of shattering proportions, as does their popularity.

RUGBY REPORTS

Saturday, 7th March, v Streatham, away. Won 9-8.

On a cold day with a strong easterly wind, Bart's beat Streatham for the first time in five seasons. The margin of the win was small but Bart's did prove themselves the better team even though they left their main effort till the last twenty minutes. Playing against the wind and sun in the first half, Bart's did not have much trouble in containing the opponent's attack and Johnson, playing in the centre for a change, made some good breaks. However, the first score went to Streatham when a high kick ahead by their wing bounced awkwardly for the Bart's defence. In the second half, Gibson soon equalised with a fine penalty but Streatham again had a lucky bounce and used it to score another try which was converted. Another penalty by Gibson reduced their lead. Bart's at this stage were not playing well and the threequarters were not making any great progress and a change of tactics was indicated. High kicks upfield were then used and from the opponents "25" quick loose heels were used to start numerous attacks. Eventually, Letchworth made a nice break and linked up with Griffiths who scored. At the final whistle Bart's were still pressing hard.

Team: E. D. Dorrell, S. G. Harris, S. M. Johnson, N. J. Griffiths, E. Sidebottom, A. T. Letchworth, D. C. Pope, O. J. A. Gilmore, A. O'Kane, A. J. S. Knox, T. Bates, M. M. Orr, J. A. Gibson, C. J. Smart (Capt.), D. Goodall.

Saturday, 21st March, v Old Millhillians, away. Lost 0-3.

A week of heavy rain had made the pitch at Meadstone Lane a muddy quagmire. These conditions suited Old Millhillians who had a very weak back division but a pack that gave away nothing in the loose. Bart's won most of the possession and had territorial advantage for ninety per cent of the game. In the first half the Hospital based their attack on the backs who made some good moves but found the ball difficult to control. One slip gave the Old Millhillians a gift try which they thankfully took. In the second half the Hospital changed their tactics and kept the ball close to the scrum. Ground was covered by these tactics but no score came despite many close shaves for the opponents.

Team: J. P. Davies, S. G. Harris, P. A. R. Ninen, P. E. Savage, N. J. Griffiths, A. T. Letchworth, D. C. Pope, O. J. A. Gilmore, M. G. Revill, A. J. S. Knox, G. Chapman, T. Bates, J. A. Gibson, C. J. Smart (Capt.), D. Goodall.

Wednesday afternoon.

During March, Bart's inflicted two heavy defeats at Chistlehurst on Middlesex United Industries (29-0) and Public School Wanderers (31-6). In both these games the threequarters scored most of the tries and there were a lot of good moves and passing. The pack did well in each game, winning possession which is all important especially from loose mauls.

SOCCER REPORTS

Wednesday, 26th February, v London Hospital, away. Lost 3-1.

The match was being played for 4 points—two for the United Hospitals League and two for the University of London League—so that it was keenly fought from the start.

London had the advantage of a stormy wind during the first half but failed to use it. Their moves were thoughtfully built up but nearly always come to grief at the edge of the penalty area, at the hands of a strong Bart's halfback line. Meanwhile, the Bart's forwards were less prominent but more direct in their play. They were rewarded when Phillips outran the London centre-half and pushed the ball to Shorey, who scored.

In the second half London played better with a re-arranged forward line and against the wind. Added to this, the left side of the Bart's defence seemed bewildered by the new opposing right wing. As a result London scored three goals, two of them being from centres.

Wednesday, 4th March, v London Hospital. Cup Match. Lost 5-1.

Bart's entered the Hospitals' Cup Semi-Finals with a stronger team and the confidence necessary to win, despite the previous result. Throughout the game Bart's either shared, or had the advantage, in mid-field, but their attack was continually blunted by the London defence.

During the first half defence was strongest, with most of the play taking place in mid-field. London led, however, at half-time through a breakaway goal. The London inside-right flicked a hopeful centre over his own head, beating two Bart's defenders and ran forward to place the ball in the corner of the net.

For the first 15 minutes of the second half Bart's were in complete command but very little was gained from their efforts, although an excellent volley from Herbert just scraped the crossbar. Two defensive errors let London increase their lead to 3-0. Their defence then relaxed momentarily and allowed Shorey to break through and score. This seemed to goad London, who scored two more goals before the whistle.

Team: A. Layton-Smith, K. Rawlinson, N. Offen, P. Savage, R. Thew, H. Phillips (Capt.), C. Sutton, P. Herbert, S. Dorritt, B. Shorey, D. McGedine.

BOAT CLUB REPORT
March, 1964

U.L. Trial Head, March 4th.

The first event of the new year was the University of London Trial Head of the River Race, from Putney to Mortlake. The Novices had missed several outings in the VIII during the few weeks before this and it was decided that little or nothing would be gained by entering them for such a race at this stage. The 1st and 2nd VIII entered, the 1st VIII starting 16th and the 2nd 20th.

The 1st VIII had a fair start, settled to a rating of about 30, and at once began to move up on crew No. 15, the Royal Dental Hospital. We passed them as we approached Hammersmith. The rating then dropped to 29 and over the next stretch during which we were pushed right out of the stream by a group of barges travelling upstream, we approached and passed crew No. 14, Chelsea College. As we passed Barnes Bridge we gave a spurt and increased the rate of striking. By now we were closing on crew No. 13, Queen Mary College II. For the last two minutes we raised the rate again; cover was fair, and we finished about three lengths down on the Queen Mary College crew, and over 100 yards clear of the crews we had passed. The row was fair but rather too comfortable, and the result was disappointing. We moved up four places to 12th but were beaten by Mary's and Guy's.

The 2nd VIII had not been together as a crew as much as they had hoped, and they were hardly ready for racing. They had a fairly rough row and had the misfortune to encounter some heavy washes during the latest half of the course. They finished 26th, dropping six places.

It was evident from the results that we had to improve a great deal and we were glad that this had been brought home to us early.

Results—

St. Mary's Hospital	10th	20 mins. 31 secs.
Guy's Hospital	11th	20 mins. 38 secs.
BART'S I	12th	20 mins. 53 secs.
Royal Dental	20th	22 mins. 16 secs.
Westminster	25th	22 mins. 42 secs.
BART'S II	26th	23 mins. 4 secs.

Bedford Head. March 7th.

At Bedford, unfortunately, our usual stroke was not with us, so 4 stroked the boat and we rowed with a substitute. John Currie came down to coach us and we had an outing over the course in the morning. This practice outing was very depressing; the balance was frightful and the rowing lifeless. The 2nd VIII were rowing two hours earlier than the 1st and had no time for a practice outing, but instead went out earlier before the race. Alas, they broke a blade on their way to the start, and the extra time was occupied returning to the boat house for a replacement.

There was a strong wind blowing over much of the course, which is not a simple one to steer, and the 2nd VIII's row was about as uncomfortable as the 1st VIII's practice outing had been. The result was disappointing.

The 1st VIII rowed at 4.00 p.m.; the headwind was still blowing and did not help our efforts to raise the rating which was fairly low throughout, but we tried to hold the strokes right out to the finish and it was a hard row all the way.

Result—

Guy's	20th	8 mins. 29 secs.
BART'S I	27th	8 mins. 39 secs.
BART'S II	48th	9 mins. 20 secs.
St. George's Hos.	51st	9 mins. 40 secs.

Reading Head. March 14th.

The weather was unpleasant, though an improvement on last year, and the place was a sea of mud by the end of the afternoon. We arrived at Reading before lunch, but had no time for a morning outing as crews had to be off the water by noon. David Dunn and Edmund Hoare came along to take us out before the start. As is normal at Reading we took to the water a long time before the race. On the way up to the start the 1st VIII had some encouraging stretches of paddling when the boat ran well, and we had high hopes for a good row.

The 1st VIII starting at 42nd had only an hour to wait on the water this year; the 2nd VIII at 133rd had considerably longer, but the rain this year was a steady drizzle and was not accompanied by the biting gale force winds by which last year's crew remember Reading Head.

The 1st VIII started behind Queen's College Cambridge. We went off from the start at 40; the rating remained high and after about three minutes we were still striking 36. We went right up on Queen's and at one point our bow was level with their rudder. At this moment a marshal told us that we were not allowed to overtake on that part of the course. The announcement had an unfortunate effect on the crew. We stopped going up, but at this rating, which was higher than we were accustomed to, we never managed to get into our stride, and Queen's then went away from us again.

We had left behind crew 43 but during the second half of the course, crew 44, Fitzwilliam House, gained steadily on us, we held them off for a time and at one stage began to go away from them again, but eventually they passed us. We were not pleased with the row, but even so were horrified to find that we had dropped 52 places to 94th.

The 2nd VIII had an unfortunate accident, they were rowing in the middle of the river, and were being overtaken by a boat on their right when another approached from directly behind, they had no room to pull over and the boat behind them collided with them and drove them into the bank. It took them some time to get going again, and they were not surprised to finish last.

Results—

80th	Guy's	17 mins. 5 secs.
94th	BART'S I	17 mins. 16 secs.
99th	London Hospital	17 mins. 20 secs.
115th	Westminster	17 mins. 35 secs.
122nd	St. Mary's	17 mins. 45 secs.
137th	Royal Dental Hos.	19 mins. 2 secs.
138th	BART'S II	19 mins. 43 secs.

Tideway Head. March 21st.
Mortlake to Putney.

After the result of the Reading Head when, in retrospect it seems, we were so rating conscious that to maintain a high one was our main aim at the expense of work through the water. We decided to go over the course at about 30, a rate well within our power, and one at which we could really concentrate on each stroke and on our coverage.

The 1st VIII went off at about 36 and after 20 strokes settled into a stride at about 30, working hard through the water. At this rating cover was quite good and we began to go up relative to the crews in front and behind us. Through Barnes Bridge we continued to improve our position and at one stage were separated from the crew in front by only one length of clear water. At Chiswick Steps the position remained unchanged, but passing Chiswick Eyot the crew was tiring and we gradually lost our position. As we approached Hammersmith, crew 102 had come up to us, and despite our efforts to hold them off they passed us. At the mile post crews 103 and 104 were pushing us. Crew 104 got an overlap, but we took the boat home from the black buoy and held them off to the finish. Except for a short period before Hammersmith when the rating dropped slightly, it was maintained at the intended level throughout. Cover was not bad at any stage, and the crew worked hard all the way. We regarded 101 as too low a position and were again disappointed to find our final place as low as 140. But we were pleased that in our final attempt we beat the other Hospitals which had been a major aim. The average weight of the crew was about 10 stone 12 lbs. This is low for rowing which is a considerable disadvantage in Head of the River racing.

The 2nd VIII rowed with a substitute due to a casualty on the day of the race. They started at 209; they, too, were overtaken and finished 287th.

Eight Gentlemen, including a coxswain, turned up in time for the race and one outsider was asked in to fill the boat. They started 307th, were overtaken by two crews and were proud to have overtaken one. They arrived at Putney in need of refreshments, and

parked for a while at the London Rowing Club. They arrived back at Chiswick rather later than most crews after a return journey perhaps no less uncomfortable than the row down.

	Results:	mins.	secs.
140	Bart's I	19	00
160	Guy's I	19	08
	London I	19	08
172	St. Mary's	19	12
186	Old Lambethians (St. Thomas')	19	18
271	Royal Dental Hospital	20	16
286	Bart's II	20	30
289	Bart's III	20	39
290	St. George's	20	40
291	Guy's II	20	47
200	London II	21	13

Our next event is the U.H. Bumps, this year to be held on 5th, 6th and 7th of May. Both the 1st and 2nd crews will be greatly altered by then. We hope that the 1st VIII will be a heavier crew in the summer, but again the toll taken by 2nd M.B. limits our choice.

We will have to work very hard between the start of the term and the Bumps. On the results of these the future of the 1st VIII will be decided.

We should like to thank our coaches for the work they have put in, for the discomforts they have suffered and for the risks they have taken. If we succeed in our efforts to acquire a launch their task will be pleasanter and less hazardous in the future.

The crews for the Head of the River Races were as follows:

1st VIII: Bow M. Castleden, 2 M. Hindshowell, 3 M. Simmons, 4 C. R. S. Anderson, 5 D. C. Parr, 6 W. P. Garson, 7 H. C. Coleridge, Stroke A. B. Ayers, Cox D. A. Robinson or I. Cole. Spare man P. A. Le M. Amundsen.

2nd VIII: Bow K. Gilsman or R. Boston, 2 R. Franks, 3 P. Cheetham, 4 C. Clarke, 5 A. Kirby, 6 Dr. Jones, 7 J. Wright, Stroke J. Tricker, Cox J. Pilling.

Gentlemen's VIII: Bow A. Nicola, 2 J. Merrill, 3 A. N. Other, 4 B. S. Bennett, 5 B. Husband, 6 T. M. Buckwill, 7 D. A. Lloyd, Stroke K. M. Stephens, Cox P. S. Crawley.

HOCKEY REPORT
March, 1964

2nd XI—Junior Cup Final v Guy's. 4th March. Chislehurst. Lost 2-1.

This was our second meeting with Guy's this season. On the first occasion we didn't see much of them as the game was shrouded in thick fog. By reputation we knew them to be a formidable team, consisting mainly of dental students, beating us in the Final for the previous two years. But this year we were hopeful of avoiding the hat-trick and returning with the Cup. It looked as though our ambition might be fulfilled as Bart's were leading 1-0 at half-time from a penalty kick scored by A. Gordon. Unfortunately Guy's woke up in the second half and scored two goals in quick succession after some dithering in the goal area. And so with 20 minutes left we were 2-1 down and play remained consistently even with little to distinguish either team. P. Russell, who had recently joined the club played a good game but on the whole the team were not playing with the spirit of previous Cup matches. Guy's had the advantage of vocal support which spurred them on particularly towards the end. It is discouraging to report that no Bart's support was there. Only when some enthusiasm is kindled and more interest shown will we restore Bart's to the top with a reputation of sporting achievement. Once again it is a pleasure to thank Mr. and Mrs. White for excellent pitches and teas throughout the season.

Team: S. Campbell-Smith; C. Frears, R. Browne; T. Billington, M. Nightingale (capt.), P. Russell; A. Chant, A. Letchworth, S. Heyworth, A. Gordon, M. Bracton.

Results of Matches since January:

1st XI	11	4	2	5	18	26
2nd XI	6	2	0	4	12	14
Total	17	6	2	9	30	40

CROSS-COUNTRY REPORT

Wednesday, February 19th. University League (Div. I) at Petersham.

The start of this 5-mile race around Richmond Park is notoriously fast so our tactics were to start slowly and work up through the field. Pott, in particular, did this to good effect working his way up, right from the back to come in third, a very good run. Thompson, whose running has improved greatly of late, came in 12th with Tunstall Pedoe close behind. Hardy, although near the back scored valuable points for us and it was regrettable that not more turned out to run, however badly, for due to the lack of support we finished 7th out of the 10 teams competing.

			mins.	secs.
1	Yates	U.C.	26	32
2	Domleo	Goldsmith's	27	46
3	Pott	Bart's	27	58
12	Thompson	Bart's	28	35

15	Tunstall Pedoe	Bart's	28	48
48	Hardy		32	27

51 finished

Since no results could be drawn from the O.M.C. 7½, where the runners went the wrong way, the S.W.E.T.C. race was counted as a League Match in its place. This was to our advantage for we finished second behind University College.

The Petersham race concluded the University League for the season in which we finished 5th compared with 2nd last year.

		points
1	Unviersity College ...	1527
2	L.S.E.	1373
3	King's College	1336
4	Goldsmith's	1165
5	Bart's	1127
6	St. Mary's College ...	1115
7	Imperial College I ...	1063
8	Battersa C.T.	710
9	Guy's	577
10	Imperial College II ...	531

Saturday, February 22nd. Hyde Park Road Relay.

This exciting event was run on a cold bleak day, but in spite of this the support was better than we have ever experienced before. We much appreciate this and hope it will continue. We are only sorry that although some fine exciting running was to be seen we did not finish as high up as we had hoped. Tunstall Pedoe, who excels on the road, ran the first of the six 3-mile laps around The Serpentine, finishing 14th of the 81 starters. This was an encouraging beginning, but although a good run, his time was not his best for this event. Thompson ran well on the second lap and gained two places, but Foxton, who had been ill the previous day, had a disappointing run, finishing 16th at the end of the third lap. Hardy, although running his best, prefers marathons, and so we were 31st when Markham took over for the penultimate lap, and although he had a good run, lost another place. Pott ran the last lap, and although he made up a lot of ground, only gained two places, with the result that we finished 30th. Pott was passed by Turner of Queen's College, Cambridge, the inter-counties champion, on the last lap, and in doing so ran a record time of 13 mins. 36 secs., and in finishing 17th his team won the cup for the smaller colleges. Although 30th, we were third in this category, and since the competition came from universities and colleges throughout Great Britain our position was by no means disgraceful.

1	Liverpool University
2	Loughborough College
3	Borough Road T.C.
17	Queen's College, Cambridge
30	St. Bartholomew's Hospital

80 teams finished.

		time	position
1	Tunstall Pedoe	14 min. 56 secs.	14th
2	Thompson	15 min. 9 secs.	12th
3	Foxton	15 min. 42 secs.	16th
4	Hardy	16 min. 41 secs.	31st
5	Markham	15 min. 13 secs.	32nd
6	Pott	15 min. 33 secs.	30th

Wednesday, March 4th, v Imperial College v Guy's, at Barnet.

Pott made most of the running in this race which was run over the muddy U.H. course. Foxton ran with him and Thompson did well to keep up with these two, and in doing so ran his fastest time over this course. We would not have been able to win, however, if it wasn't for Hale and Hardy coming in 10th and 11th position, their efforts being just as important as those at the front.

		points
1	St. Bartholomew's	27
2	Imperial College	42
3	Guy's	51

The individual times were:

1	Pott	31 mins.
	Foxton	
	Thompson	
10	Hale	36 mins. 8 secs.
11	Hardy ...	37 mins. 15 secs.

The West Ham "8", March 11th, 1964.

This, the penultimate event of the cross-country season is an 8-mile road race sponsored by West Ham College of Technology. It attracts teams from all over the country but has the big advantage for Bart's that only three runners from a team of four score.

The 85 runners went off very fast with Mike Turner, the Cambridge University International in the lead. Foxton led the Bart's team for the first two miles and then had a "rough patch" and was passed by Tunstall Pedoe and at four miles by Pott and Thompson. Tunstall Pedoe went well on the road, which suits his action, but at six miles, a hill and the distance reduced his speed and Pott and Thompson who moved well through the field in the later stages of the race closed to within 150 yards of him by the finish, with Foxton not far behind.

Bart's finished third behind the Parachute Regiment and Cambridge University. This was a creditable effort by the team over an unfamiliar course which was marked by foreign

gentlemen who seemed to have less idea than the runners of the distance to the finish.

The race, run on an unusually warm afternoon, was enjoyed by all the Bart's runners who had obviously benefited greatly from their regular "rush-hour" training sessions along the Embankment.

Results (85 runners):

		mins.	secs.
1	D. M. Turner (Cambridge U.)	39	6
15	D. S. Tunstall Pedoe (Bart's)	42	15
17	N. Pott (Bart's)	42	35
17	R. Thompson (Bart's)	42	35
21	T. Foxton (Bart's)	43	00

Teams:

1	Parachute Regiment ...	3-8-10	21
2	Cambridge University ...	1-12-20	33
3	St. Bartholomew's Hosp.	15-17-17	49
4	Belgrave Harriers ...	6-7-47	60

Saturday, March 14th. Orion "15" at Chingford.

		points
1	St. Bartholomew's Hospital	21
2	Orion Harriers	30
3	Thames Valley Harriers ...	36
4	Cambridge University	37
5	South London Harriers ...	42

This race provided a great finish to the season and shows the strength of our runners over long distances. Rain had been falling for the previous two days and continued throughout the race. The mud, formidable at the best of times, was thus particularly thick, which suited us. Our team wisely started off slowly and gradually worked their way up the field until after about three miles Pott and Foxton were second, with Thompson and Hardy close behind. The course was marked with soluble paper which normally serves its purpose very well, but on this occasion the paper dissolved in the rain rather quicker than was intended, with the result that Pott and Foxton went the wrong way, but managed to rejoin the race having run an extra half mile and having lost about ten places. They remained in this position until the eighth mile when Foxton got his second wind, and shouting encouragement to Pott, these two made their way up through the field to finish 3rd equal, an excellent run for both of them. Thompson, who only had plimsolls to wear, ran a good race, finishing in 18th position. Hardy ran well to come in 33rd and our participating President, Mr. H. B. Lee, finished 45th for Orion. He informs us that he found the course even muddier the following day. The hospitality of our hosts was much enjoyed by all, and we thank them for organising this unique race.

1	C. Fitt (Cambridge)	1 hr. 40 mins. 50 secs.
2	N. Channin (S.L.H.)	1 hr. 42 mins. 42 secs.
3	N. Pott (Bart's)	
	T. Foxton (Bart's)	1 hr. 44 mins. 55 secs.
18	R. Thompson (Bart's)	1 hr. 58 mins. 5 secs.
33	F. Hardy (Bart's)	2 hr. 11 mins. 40 secs.
45	Mr. H. B. Lee (Orion)	2 hr. 23 mins. 40 secs.

60 started, 50 finished.

The Orion "15" concluded the main part of another successful season in which we won the Kent Hughes (Inter-Hospitals') Championships for the fourth year in succession. We also retained the Porrit Cup for the Hyde Park Race but unfortunately lost the Roehampton Cup for the smaller colleges of the University to St. Mary's Hospital. We won the Orion "15" for the first time and finished third in the S.W.E.T.C. race. With the loss of Littlewood, who was captain of London University Cross-Country Club last year, early in the season, and with Tunstall Pedoe being away for the first half of the season, the overall standard has dropped this year, as is shown in the University League, where we have dropped from second to fifth. We were lucky to keep Pott this season, as a result of his conflicts with the examiners and he has made all the difference to the team. Foxton has had an excellent season, running well for Bart's, United Hospitals and London University, as well as encouraging the rest of us to train and run faster. We continue to provide the majority of the runners for United Hospitals, Pott, Tunstall Pedoe, Foxton, Sanders and Thompson having run regularly for the first team. The latter two have been awarded U.H. colours. Thompson has greatly improved since he had such a good run in the Kent-Hughes. Hardy, Phipps, Hale and Markham have all played their part in producing a successful team.

SWIMMING REPORT

February and March

After many years with Shorey, Shand, Groves and Ruoss as the backbone of the team, we have for most of this term had to make do without them. The new team has taken a long time to settle down but is now gradually establishing itself, having won four of its last six matches. Previous to these, the outstanding performances were the 8 goals scored against Q.M.C. and, with the help of Stan Clarke, the British Olympic swimmer at present working and training in the Gloucester House pool, the 10 goals against Charing Cross.

The last match of the term, also against Q.M.C., was honoured by the presence of Mr. Badenoch, our President, who kindly came along to support us. We were sufficiently stimulated to win a fine game during which Shand scored the first goal, following a good passing movement, Lask the second from a well-taken corner by Britton, and Kettlewell the third, with a shot from the halfway line, so powerful that no goalkeeper could have stopped it.

We would very much like to thank our lady followers for their continued and invaluable support.

The following have represented Bart's in the last two months:

Britton, Lask, Hillier, Haig, Gibbs, Hanley, O'Kane, Knight, Kettlewell, Barclay, Shorey, Shand, Groves and W. A. M. Davies.

Next fixtures: Mid-May, United Hospitals' Cup, at St. Mary's; May 28-31, Annual Tour.

SQUASH REPORT

On Wednesday, March 25, the Squash team defeated the London Hospital 3-2 in the semi-final of the Hospital's Cup, and so are due to play St. Mary's in the Final. This is the first time the Hospital has reached this stage of the competition for some years.

John Mitchell had a comfortable win at No. 1, and David Latham and Mike Downham both played well to give a winning 3-1 lead.

John Mitchell has been selected to play in a combined United Hospitals and London Unviersity team to tour Sweden at the beginning of April.

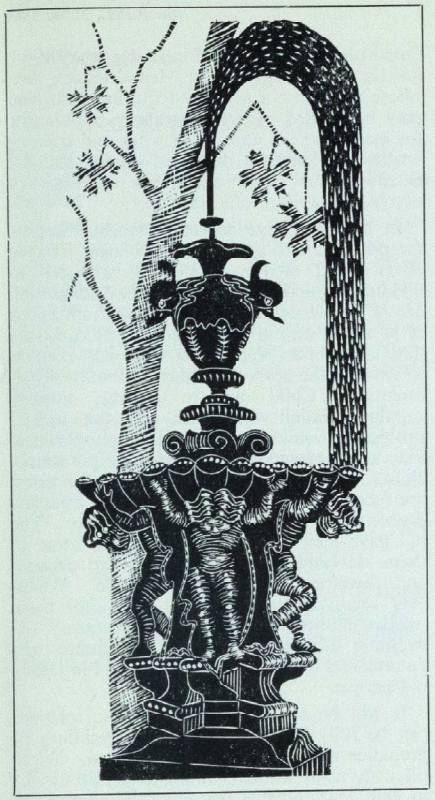
In the last month the team had a good win over the Jesters, and lost a match to the Escorts.

Team: J. C. Mitchell, K. R. Bowles, A. D. Edelsten (capt.), D. J. Delaney, D. Latham, M. A. P. S. Downham.

2nd Team

The team are due to play Westminster Hospital in the semi-final round of the 2nd Team Hospitals' Cup. They defeated the Middlesex Hospital in a closely-fought match, winning 3-2, Chris Edwards came back to win after being 1-2 down against a very useful player. Kettlewell and Thomas also did well to win.

Team: C. Edwards, R. S. A. Thomas, M. Kettlewell, D. Chesney, G. Savage, A. C. B. Chant.



CONTENTS

EDITORIAL

MENTAL HEALTH

Have we really progressed so far in our attitude towards mental illness as recent developments would have us suppose? Superficially the interest in mental health would appear greater than at any other time in our history, but deep down many of the old prejudices still remain. Physical illness or injury provokes ready sympathy but mental illness touches some secret uncertainty that induces horror, fear or disgust in the mind of even the most kindly disposed of individuals. It is so much easier to shut the mad away and therefore conveniently to forget their existence. The layman has perhaps an excuse for reacting in this way, the doctor has none. His neglect of the mentally ill could, in the past, be excused as the result of the feeling of hopelessness and frustration that overcomes the physician when a disease has no known aetiology or cure. Thirty years ago to hold a resident post in a mental hospital was often regarded as the last refuge of the destitute—only for those who had failed to make the grade in medicine or surgery. Even today, in spite of recent advances, there is a regrettable tendency among some medical men, surgeons especially, to rank psychiatry a subject of minor importance. How else can one explain the miserably short length of time devoted to the subject in the curriculum of most medical schools in this country? Nor is the general practitioner altogether free of criticism in this respect. As Balint shows in his book, *"The doctor, His patient and the Illness"*, by creating "ranking orders" of illness and subconsciously if not deliberately placing the physical before

the mental, the practitioner is contributing nothing towards restoring his patient to normal health; he is, like the layman, merely evading the issue.

All this is not to belittle what has been achieved at considerable cost already. A great advance away from the locked door and compulsory custodial care was made by the Mental Treatment Act of 1930. This authorised patients to come in for treatment on a voluntary basis, a principle extended and reinforced by the more recent Mental Health Act of 1959. While such a far-seeing Act is to be welcomed, it is unfortunate that its terminology should be confusing, for the recommendations of the Royal Commission embodied in the Act are concerned mainly with mental sickness and not mental health. Treatment and rehabilitation are mentioned, but not prevention which, to quote Chesterton's comments on Christianity, "has not been tried and found wanting, but has been found difficult and not tried". Admittedly the development of a state of positive mental health in the community at large is a problem of considerable dimensions extending beyond the doctor's sphere into social and sometimes spiritual matters, but this is no reason for leaving the task undone. The magnitude of the problem is confirmed by statistics. Nearly 40% of all hospital beds are occupied by mental patients. In a survey carried out by the Medical Research Council, it was found that, in a random sample of 3,000 factory workers, neurotic illnesses caused between a quarter and a third of all absences from work. If pressure on bed space in our mental hospitals is to be eased, society must abandon its traditional approach to the problem of the mentally sick and adopt a more positive attitude. To wait till the patient has reached the mental hospital before doing anything is often too late.

It is towards the local health authorities we must look, rather than to a central government already overburdened with social responsibilities, for the driving force behind a constructive approach to the problems of mental health. One of the most difficult tasks will be overcoming the initial hostility of society towards any scheme which involves closer contact with the mentally unbalanced. Such contact in the rehabilitated cases must be, and is being encouraged. What so often causes the relapse of a patient newly released from mental hospital is the indifferent, if not actually hostile approach of society towards him and his problems. Opportunities must be found for setting up hostels (as envisaged in the Mental Health Act) where patients not actually requiring treatment may be housed near the ordinary population, for increasing the number of work and training centres for mentally disturbed adults, and for extending the scope and range of work of psychiatric welfare officers.

In the preventive aspects of mental health, the problem is to know where to begin. In the development of the sane, well balanced individual a good home and family background are of the utmost importance. The foundations of so much mental illness are laid in early life that the proper preparation of young couples to assume the responsibilities of family life is essential. Child welfare centres, already capably dealing with many of the mental problems of children of school age should have their scope extended to deal with the pre-school child. The earlier departures from the norm are recognised, the easier it will be to treat the problems of adolescent and adult life. The old have their own mental problems, some of them associated with natural physical changes and therefore not always avoidable. Whenever relatives are unable to look after them welfare homes can provide the necessary occupation and good company to counter the anxiety and depression so often found in lonely old people.

It will be some time before these schemes can be fully implemented for the residium of prejudice will first have to be removed. While there are many who are willing to pay lip service to new developments few have the courage or determination to carry them out. We should always remember that the society that really cares for the mentally sick and takes active steps to promote mental health benefits itself as well as the patients under its care. Such benefits may not be readily discernable but when so much has been achieved already who is to say what cannot be achieved in the future?

That variety is the spice of life is, of course, a truism. During the last few months we have tried to include in the *Journal* articles of other than purely medical or parochial interest, a policy that has met with the approval of our readers. This month we publish a short story on page 256. Short stories were a regular feature of the *Journal* before the war and it is hoped that one will appear in our pages from time to time in future.

Correspondence

GENERAL PRACTICE

Sir,—It may not be well known that a list of openings in general practice is kept by the Medical College.

These practices are often of the best type, in pleasant localities and with a forward outlook. They are usually offered by old Bart's men whose traditions and interests are the same as those of graduates to-day. We try to fill these posts by personal recommendation based on a knowledge of the interests of the applicant rather than by indiscriminate publicity.

At present the practices available outnumber the applicants by about five to one. Any Old Bart's Man looking for a vacancy is invited to communicate with me at the Sub-Dean's Office.

Yours faithfully,

G. MELOTTE,

Adviser in General Practice.
The Medical College of
St. Bartholomew's Hospital
West Smithfield, E.C.1.

30th April.

THE LAST PSALM

Dear Sir,

Your "Bard" of May reveals
The low lewd longings that he feels.
For years Bart's Journals he has scored;
His pen was mightier than his sword.
How can he now learn all the tricks
He should have learnt at twenty six?
Indeed, his oats (to coin a clause)
Should have been sewn between the Wars.
'Tis time that he made way, alas,
For youthful keen enthusiasts.
And as the old man dreams at night
Of Abishag, the Shunammite,
Her modern counterpart perhaps,
Will go to warm up younger chaps.

Yours faithfully,

5th May. GOLIATH.

SYNTAX

Sir,—Mr. Malcolm Donaldson and I were at Cambridge at the same time and on the resident staff of St. Bartholomew's at the same time. I find it, therefore, hard to believe that his letter to the Journal of 6th April is a true record of what he wrote such as "The relative thinks they . . . persuade him: public . . . hears . . . believe: women . . . believes . . . she has." The Journal, p. 174, May 1964.

Argus wishes "anybody . . . is . . . make their way." Did Argus have no education? p. 175.

Yours faithfully,

T. E. OSMOND.
"Compton",
The Avenue,
Clevedon.

10th May.

STAGGERED HOLIDAYS

Sir,—During the Bacteriology and Pathology courses, we are allocated our fortnight of holiday between certain dates.

It seems rather unnecessary that for the three months of July to September, the fortnight must fall at the busiest and most expensive time of the year, i.e. the last week of July and the first of August, which includes August Bank Holiday.

Could not the Royal and Ancient Hospital, together with numerous other establishments in the country, join the trend to move holidays away from the peak period?

If the course could be split here, surely the fortnight could be given at any other time in the three months—or is the teaching bowing to the technicians?

Yours faithfully,

RICHARD F. ATKINSON.
Abernethian Room.

12th May.

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.

Calendar

JUNE

1st June: Copy date for July Journal.

Sat. & Sun., 6th & 7th:
Prof. Scowen
Prof. Taylor
Mr. Burrows
Dr. T. B. Boulton
Mr. Cope

Sat. & Sun., 13th & 14th:
Dr. Bodley Scott
Mr. Alan Hunt
Mr. Manning
Mr. F. T. Evans
Mr. McNab Jones

Sat. & Sun., 20th & 21st:
Dr. E. R. Cullinan
Mr. C. Naunton Morgan
Mr. Aston
Dr. R. A. Bowen
Mr. Hogg

Sat. & Sun., 27th & 28th:
Dr. G. Hayward
Mr. Badenoch
Mr. Burrows
Mr. G. Ellis
Mr. Fuller

Physician Accoucheur for the month of June is Mr. Fraser.

Engagements

HAMILTON—UMNEY.—The engagement is announced between Dr. John Hamilton and Elizabeth Umney.

BOWN—SMITH.—The engagement is announced between Dr. Robert Leslie Bown and Miss Pauline Margaret Smith.

Births

EDMONDS.—On April 10, to Ann and Dr. Michael Edmonds, twins (Richard and Catherine).

Deaths

ALMENT.—On April 23, Dr. Edward Whyte Alment, aged 86. Qualified 1902.

MACLAY.—On April 27, Dr. Walter Symington Maclay, C.B., O.B.E., F.R.C.P., aged 62. Qualified 1927.

SIMPSON.—On May 2, Reginald Hugs Simpson, M.D., F.R.C.P., aged 73. Qualified 1924.

Change of Address

Dr. L. W. Barlow *to* 34 Dennington Avenue, Winston Ridge, Johannesburg.

Maj.-Gen. R. E. Barnsley *to* R.A.M.C. Historical Museum, Keogh Barracks, Ash Vale, Nr. Aldershot, Hants.

Dr. C. Martin Dale *to* The Swiss Cottage, Old Church Road, Colwall, Malvern.

Dr. K. E. Gray *to* 12 Chaucer Court, Winnals Park, Haywards Heath, Sussex.

Mr. D. Robertson, F.R.C.S., *to* 287 Glossop Road, Sheffield, Yorks.

Dr. W. Norman Taylor *to* 74 Mildred Avenue, Watford, Herts.

Dr. D. W. P. Thomas *to* 15 Charlotte Square, Rhiwbina, Cardiff, Glam.

Dr. C. R. Williams *to* Redhill General Hospital, Redhill, Surrey.

Dr. C. S. Wise *to* Watlingate, 144 New Dover Road, Canterbury.

Appointments

Mr. J. B. Hume, F.R.C.S., has been appointed Deputy Vice-Chancellor of Queen Mary College, London, from 1st September.

Royal College of Surgeons.

Mr. H. Jackson Burrows is a candidate for election to the Council of the Royal College of Surgeons.

PROFESSOR WORMALL

We are sorry to report the death of Professor Wormall after a long illness on 9th May. An obituary will appear in next month's issue.

UP TO THE MINUTE IN A MOMENT

An announcement towards the end of April must have gladdened the heart of many a pessimist: on 24th April the State Department announced that analysis of captured military documents proved that Chinese government strategy was based on the assumption that they could not be defeated in a nuclear war. It is cheering to note that if this presumption is not valid at the moment it very soon will be.

Tony Ambatelios, the Greek communist seamen's leader, was released by his government after 16 years imprisonment on 28th April. His release is welcome if only because the West must not indulge in the very crimes of which she accuses the East.

The **Queen Mother,** on 28th April, visited Charterhouse to open the new science building.

In quick succession the **Duchess of Kent** and **Princess Margaret** on 28th April and 1st May respectively both gave birth to daughters.

3rd May was an eventful day at home and abroad. At home West Ham were very fortunate to win the F.A. Cup in the closing minutes. Abroad even more momentous events were taking place: **Major-General J. H. Cubbon,** G.O.C. Land Forces Middle East, stated that two S.A.S. men had been decapitated and their heads displayed on stakes at Taiz, Yemen. Although the truth of this statement was soon questioned the finding of the decapitated bodies soon provided their own grim proof.

The L.C.C. on 5th May passed a private members motion brought in by **Lady Petrie** to ban smoking in all cinemas. A tremendous outcry followed from all those incapable of forgoing their nauseating habit for only a few hours. The sooner cinemas follow the lead of most theatres and concert halls the better.

The annual London-Brighton medical students walk took place on 8th May. Bart's improved on last year's performance by coming fifth.

By 10th May at the end of the borough and district elections it was apparent that the swing to the left had been checked. Although Labour made considerable gains they were not able to recover the massive losses they incurred in 1961.

The Bart's Drama Society performed "Barstaple" by **James Saunders** at the Battersea Drama Festival on 12th May and won fourth place. However their main triumph was the winning of the 'Cup for the Most Promising Actor' by **John Graham Pole.**

The Labour Party leaders indulged in a bit of May madness towards the middle of the month. On 10th May **Mr. Richard Crossman** proposed half day schooling for five year olds and was publicly rebuked by **Mr. Harold Wilson. Mr. George Brown** always good for a laugh, announced on 13th May, that Labour would win the Devizes by-election. The great sickness of the Labour Party has always been its poor leadership and as we see the malady lingers on.

View Day, the hospital's great social event, took place on 13th May and was fortunate to get good weather. In the evening the View Day Ball took place at the Café Royal and was a great success although the cabaret by **Hope** and **Keen** was a poor mixture of the very old and the crude.

In the election of 14th May the Conservatives held the seats at Devizes, Winchester and Bury St. Edmunds but lost at Rutherglen. The tide has turned.

With Transport Minister **Ernest Marples** away getting ideas in North America the Whit weekend holiday was marred by more deaths on the road than ever. This was not the only tragedy over the holiday period; at both Margate and Brighton youths belonging to rival gangs took part in riots and several of them were sent to detention centres.

Sportwise the main event has been the arrival of the cricket season. The Bart's cricket team have had some good wins and several entertaining games. Against Romany on 17th May Bart's needed only four runs with five wickets in hand at close of play. The batting has lacked depth although **R. A. A. Thomas** has had several very high scores. The mainstays of the bowling have been **C. Vartan** and **P. Savage,** who have both had excellent averages. Bart's have a bye in the 1st round of the Hospital Cup but meet the London on 9th June in the 2nd round.

The Ladies Tennis team was knocked out of the hospital cup by Mary's on 29th April and also out of the University cup by Wye College on 13th May.

In the Bumps on 5th, 6th and 7th May the Bart's 1st VII finished third and though rowing faster than Mary's could not quite catch them. The Novices VIII got two bumps and the Rugger VII got one. In the Allom Cup Regatta on 16th May the 1st VIII lost in the final to the Royal Veterinary College and the 1st IV lost in the final to U.C.

A HUNDRED YEARS OF MEDICAL WORK AT NAZARETH

By A. J. M. Brodribb

It is not often, during a medical training, that one is able to have six months free for travel in the Near East, or that one has the opportunity to spend half that time working in a British hospital out there. I was very glad therefore to take just this opportunity last year. Having had a number of relations living in Palestine over the last century, I soon found myself comparing my impressions with theirs. The most striking thing in such a comparison is the speed of change and this can scarcely be more clearly seen than in the medical sphere.

The "Suk" or market place, Nazareth.

Hardly a hundred years have passed since the first qualified doctor set foot in Nazareth to practise his profession. European medicine had no doubt been practised in the imposing Latin monastery which dominated the town for a great many years, but little of value seems to have been disseminated outside its massive walls. There was no shortage of remedies for any manner of disease or affliction. Their number and colourful nature were however matched only by their ineffectiveness and crude barbarity.

The personal diary of Rev. J. Zeller, my great grandfather, and for twenty years a missionary in Nazareth, records many of the local "cures" as they were observed from day to day.

Burning and bleeding were universal remedies for most conditions; for diarrhoea, vomiting or dyspepsia, burning of the abdomen (with hot iron or nail) was used, for toothache burning on the arm or ear, and between the breasts for a cough. Bleeding from the hand was considered most beneficial for 'sideache', and a complex pattern of cautery was required for lumbago. An annual bleed by the local barber was considered a wise precaution for those who wanted a year without fever.

Issues were made for chronic trachoma and painful joints, and were kept discharging for years by inserting a pea. They were very common, usually on the arm.

Amongst the various applications and medicaments used, the urine and saliva of a fasting boy were recommended for ophthalmia, earwax for ringworm, and goat's dung, dried, dissolved in vinegar and applied locally, for enlarged spleens (a condition attributed to swallowing fingernail fragments). Fever patients were 'strengthened' by being fed with camels' milk stirred with the animal's tail till quite dark in colour, and mad dog bites were treated with a certain powder obtainable from a neighbouring village. (This, observes Zeller, was a violent purge).

Charms were frequently used. These were usually sentences of the Koran written in saffron by a sheik. The charm was either worn (e.g. for a headache), swallowed, dissolved and drunk, or even burned and the smoke inhaled. One might have to drink half and inhale the rest.

The sheiks were also consulted for exorcism and appeared to have considerable success with functional disorders. Visits to various shrines were advocated, especially for insanity, and grass from a certain tomb burnt like incense before the sickbed was a common remedy for ague.

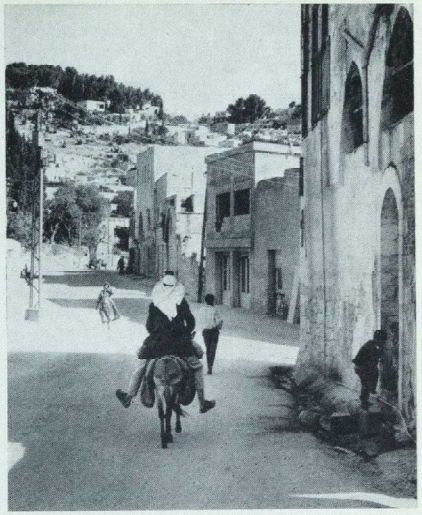
Cure by transference was practised. For example, if a person had a fever for a long time, the relatives would take dough from three people with the name of Miriam or Fatmeh and knead it with oil. They would then stick a candle into it and put it in a place where four roads met, protecting it with stones. The belief was that he who knocked it down would get the fever and the sick man would be cured. Since the dough was a great attraction to passing dogs, it was usually the canine race that suffered.

Children had a tough time. As a boy had his cord cut by the midwife he was often allocated his future bride (i.e. the daughter of so-and-so). Such a betrothal was binding. The baby was immediately bathed in strong brine (including its eyes), anointed with oil, and wrapped tightly so that all movement was impossible for seven days. The soiled clothes were then removed and after washing and anointing, the child was rewrapped. This was continued weekly for the first forty days of life.

The nomadic Bedouin who roamed the plain, just south of Nazareth, had a different technique. They smeared the child with melted butter and placed it in the sun to harden it against the heat (which averages over 80°F. in the *shade* during the summer).

As the child grew up any illness or screaming without good cause was put down to the malignant influence of the 'Evil Eye'. This cult, which went to the very depth of the people's convictions, affected many of the local customs. "One must never praise or admire a child", wrote Zeller, "without adding 'Esm Allah Alsik' (invoking the name of God) or people think you may harm it." Many children were kept unwashed, dressed in the shabbiest clothes or ones specially left in the street to be trodden under foot, to avoid the Evil Eye. Others were called by repugnant names such as Jackal or simply left unnamed. Countless charms were used for added protection.

If a child, despite all this, wasted away or became thin and miserable it was thought that an evil spirit had exchanged the child. The changeling was therefore completely buried in a dung heap except for its face and left for quite some time in the hope that the real child would be restored.



A street scene, with the hill on which Dr. Vartan proposed to build his hospital in the background.

Numerous other well authenticated examples could be given but these suffice to illustrate that disease was largely attributed to evil spirits, and its treatment aimed at inducing their departure. Prognostication was fatalistic.

The simplest rules of public health were neither observed nor realised. This is made abundantly clear in 'Hygiene and disease in Palestine' by my grandfather, Dr. E. W. G. Masterman.

Most houses swarmed with vermin, and in summer when these were most active the inhabitants generally found the rooftops a more congenial dwelling place. To be lacking in lice was considered unhealthy and their sudden departure was held to be a sign of mortal illness. Indeed it was a common expression: 'May God not remove them (the lice) from me.'

With almost an entire lack of sanitary arrangements, most villages were surrounded by a narrow area of exposed human excreta and heaps of refuse accumulated in the narrow streets. The flies in their countless myriads thus had a perfect breeding place until the rains came and, as often as not, washed the lot into the village water supply. Under such conditions it is scarcely surprising that wounds became infected with maggots, that dysentery, typhus, enteric fever, and cholera were rife.

and that intestinal worms of all sorts were so common that the doctor would ask which one the patient had, without bothering to enquire first if he had any.

The real scourge of the country, however, was malaria. So common was it that fifty years ago malaria parasites could be demonstrated in the blood of 27% of 7,700 people in Jerusalem from all conditions and classes during the summer months. Mixed infections of the Tertian, Quartian and Malignant forms were not infrequent.

Nazareth, though perched on the edge of the Galilean hills with little standing water in the immediate vicinity, overlooks the plain of Esdraelon, which a hundred years ago had many undrained swamps. Ague, such a common complaint among the town's 5,000 inhabitants, must have done much to undermine their health.

Other factors too had a detrimental influence. Intermarriage within the narrow confines of the village or family was the rule and had been for centuries. It is surprising that this created no higher incidence of congenital abnormality than in Europe. It is possible that such babies were quietly disposed of, or faced such additional childhood rigours that few survived to adult life. Certainly today the more inbred communities give the impression of having a relatively lower standard of health.

The whole health situation was aggravated by an undercurrent of malnutrition or even starvation. In Nazareth this was often mild, but sometimes it was pathetically acute.

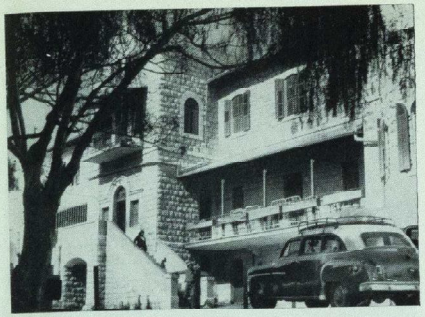
Some years the rains failed or were at the wrong time. At other times the locusts would swarm over the land in their millions and destroy the harvest. Cattle plague would cause havoc amongst livestock. The Bedouin would seize the crops on the plain, and pillaging between rival sheiks was frequent. Finally the Turkish Government demanded exorbitant taxes of a nature especially ruinous to the farmer, discouraging increased productivity or the growing of trees so necessary to the land. These taxes were collected by notoriously corrupt and unscrupulous individuals who vied with each other for this, the most lucrative of jobs in the country. Provided they paid the Government sufficiently, they could bleed the local population as they pleased without redress.

It was against this background that Dr. Kaloust Vartan set about his medical work in 1862. An Armenian, born in Constantinople, he had fought in the Crimean war. So impressed was his commanding officer by him that he advised him to go to Britain. This he did and studied medicine at Edinburgh. After some experience at Beirut and Damascus he devoted the rest of his life to the work at Nazareth.

Within three years of his arrival a cholera epidemic swept the country with a severity which has, I believe, never since been repeated. Originating as usual in Egypt it spread north like a wind of death devastating some towns and causing universal panic and terror. As it hit one place the inhabitants would flee to the next, ever perpetuating and extending it. Nazareth had its share of refugees from the stricken towns of Haifa and Acre, and the cholera soon took its hideous toll. All commerce, for which the town was a local centre, was brought to a standstill. The town's reliance on spring water probably saved it from an even higher mortality.

Beginning only with a small supply of medicines for starting a dispensary, the Edinburgh Medical Missionary Society soon strengthened Dr. Vartan's hands and enabled him to start a very small ten-bed hospital in one of the Arab houses. Soon this proved inadequate and he converted his own house to provide an extra ten beds.

As the years went by, the need for building a much larger, properly designed hospital became an urgent problem, for the work was growing constantly. Dr. Vartan therefore bought 35 acres of ground on the slopes to the north of the town and £3,000 were raised for construction. The foundation stone was laid in 1883. No sooner was this done than the Turkish authorities began creating difficulties. The alleged root of the opposition was that Dr. Vartan was an Armenian, though he had been recognised as a British citizen five years previously. The building was alleged to be a fortification and the *firman* (govt. licence) granting the land was declared defective. The ground, it was argued, was crown land and ought never to have been sold. Despite an appeal to the British Ambassador in Constantinople and to Lord Granville, the Minister for Foreign Affairs, the Turkish authorities refused to yield on the issue. Apart from a totally inadequate compensation the entire effort was lost. Dr. Vartan himself was attacked by wild Muslims and severely hurt. For a generation the unfinished hospital on its magnificent site stood dumbly appealing to the future, while Dr. Vartan heroically started once more in a hired house.



The present hospital built by Dr. Scrimgeour.

This situation continued for the next twenty years while the Turkish administration showed no change for the better. English doctors wanting to relieve the country's tremendous medical needs were discouraged by having to sit extra exams in Constantinople and, once in the country, could expect little co-operation. It is salutary, before passing judgment on the Arabs for their standards of hygiene, health and medicine at this time, to realise that they were only a few centuries behind us and that under a similar administration we might have progressed little faster. The futile attempts to stop the 1902 cholera epidemic in Jerusalem is but one example of how the Turks failed with public health measures. An excellent account of this can be found in the Bart's Journal for 1903*. A number of commendable restrictions were made on travel to and from infected areas, but these could always be waived if one was prepared to pay for the privilege. Furthermore, a railway engine was considered a source of infection as serious as any cholera patient. After a medical meeting to discuss preventive measures the authorities completely failed to prevent a rumour spreading that the doctors had secretly agreed to poison all patients suspected of having cholera.

In 1905, Dr. Scrimgeour, the son of a Dundee merchant, was appointed as Dr. Vartan's assistant, and within a few years he took on sole responsibility for the work. A new effort was made to establish a proper hospital, and an excellent site obtained on the hillside to the west of the town. Meanwhile, he maintained the temporary eighteen-bed hospital close to the old dispensary, assisted by one English nurse and a few probationers from the local C.M.S. orphanage.

Dr. Ian Macfarlane, who came out in 1911, immediately after qualifying, to help him for a couple of years, describes in a letter home the sort of conditions under which he had to work. He had to ride out to the village of Cara, where he found a sick woman. She lay on the dirty mud floor, in the presence of a camel, a donkey, a number of fowls and about twenty inquisitive onlookers. An operation was urgently required and he said chloroform was necessary. They all shouted "No" in Arabic. He packed his instruments and made for the door as if to go. They eventually yielded. No one, though, would assist him as he gave the anæsthetic, boiled up the instruments, prepared towels and operated single-handed. When all was sucessfully completed he was considered the hero of the day. After having his hand repeatedly kissed and blessings poured on his head, he was pressed to a feast which it would have been a grave insult to refuse. It appears that the patient did well—a common occurrence despite conditions.

After the First World War the British administration set about many urgent improvements of the country, such as roads, water supplies, sanitation and general public health measures. The land enjoyed an almost unprecedented peace and prosperity and these changes, coupled with attempts to increase education, greatly enhanced the health of the people. Ignorance alone must have been a formidable problem. To give but one minor example—a most respectable guide book written by a European in 1923 states that while the drinking of water in the country was most unwise, the addition of a few drops of coffee made it quite safe.

In Nazareth the new hospital was soon completed and under the supervision of Dr. Bathgate, later assisted by his niece, Dr. Wilson, the medical work expanded still further. As the years went by the hospital increasingly won the respect, confidence and gratitude of the local population. It was a time of hard work but one of security and co-operation.

The situation was not to last. As more and more Jews came to settle, the Arab population became restive. The Jews were buying land wisely and were cultivating it to produce more than had ever been thought possible by its old landlords. As tension rose there was a foreboding of troubled days ahead.

* *St. Bartholomew's Hospital Journal, Vol. X, No. 4, p. 62.*

Nazareth, together with the villages around it, nestling in the hills of Galilee, remained entirely Arab. Feelings were perhaps less fanatical than in most parts, for the large number of Christians in the area were prepared to co-operate with the Jews to a far greater degree than were their Muslim neighbours.

When the British left in 1948 outright war broke out and the future of the hospital became precarious. It was not long before the Jewish army threatened to attack the town. Nazareth had seen the conquering armies of Romans, Muslims, Crusaders, Turks, Napoleon and the British. It decided not to oppose the Jews and surrendered peacefully. Because of this it became, with the emergence of the new state of Israel, one of the few centres of the Arab minority.

Those who worked in the hospital will never forget the black days of the fighting—the doubt and uncertainty, the sudden loss of British authority that had almost been taken for granted. Supplies became so short that much of the work had to cease. There cannot be many hospitals which have been through a prolonged period when the only roll of elastoplast was kept in the matron's pocket, and could never be used without the most careful consideration. There were many voices advising the immediate and permanent closure of the hospital, but the staff persisted and with heroic patience and courage struggled on.

As the acute difficulties of survival diminished and a new status was established, it became clear that the hospital, geared for an Arab community and with a large number of Arab staff, was not only still needed, but was essential while strong Arab-Jewish suspicion remained in Israel.

Radical changes had occurred in both medical and surgical practice since the hospital had been established. The Jewish hospitals in the country were creating standards as high as any in Europe. If the work at Nazareth was to continue to play an integral role in the medical care of the country it had to modernise quickly. As Dr. Bathgate retired in 1956 and Dr. Tester, the present superintendent, took over it was realised more than ever that unless this was to be accomplished its days were numbered.

Within eight years the place has been transformed. New equipment, modern techniques, specialist staff, new building and modernisation of the old have all come into being. A new out-patients' block, children's ward, labour

The new nurses' home. Doctors' house to the right, part of the hospital on the left.

ward, pathology laboratory and a second operating theatre have been built. This year will see the completion of a fine new nurses' home and possibly the start on a new C.S.S.D.* All this has been made possible entirely through voluntary donations. The post-war medical staff of two has grown to six or seven. Dr. Tester is now accompanied by Dr. Bernath, a highly qualified Swiss surgeon (known in the surrounding villages as the miracle worker), by Dr. Maddock, full-time physician, and by Dr. Runa Mackay, who specialises in the pædiatrics, gynæcology and obstetrics. These are supplemented by two or three housemen. Although the hospital is recognised in Britain for pre-registration posts, the jobs are usually filled by more experienced doctors.

The hospital now has 10 permanent European sisters with a number of younger S.R.N. nurses, assisting as sisters for periods up to a year or more. It runs a nursing school for Arab girls recognised by the state as efficient and with standards as high as any in the country. A midwifery school was started last year. There are two fully trained pharmacists, one Arab and one British, and two trainee laboratory technicians, one Arab and one Swiss. The laboratory work has been expanding rapidly in the last few years. Anything not within its capabilities, such as biopsy specimens, is sent to the large government hospital at Haifa. This system is now well organised and is very satisfactory for a hospital of only 120 beds. It enables the advice of highly experienced pathologists to be sought and the results returned with little more delay than

* *Central Sterile Supply Department.*

in a single large hospital. Similarly, close co-operation with the state hospitals enables any case requiring specialist care to be quickly transferred to a suitable unit. Under the Jews public health measures have become most efficient. Perhaps their biggest triumph has been the eradication of malaria, but they seem to have succeeded equally in many other fields.

The hospital running costs, including the salaries of all but the European staff, are paid from the income of the hospital (not by the E.M.M.S.). Yet it receives no grants and charges low fees for treatment—none if the patient is too poor. This is only possible through the large midwifery department. It occupies nearly half the hospital beds with an average delivery rate of over 200 a month. This might appear a surprisingly large department unless it is realised that in the average Arab family there are 5 to 10 children. To encourage health standards the State pays women to come to hospital for their deliveries and pays the fees. With care and efficiency this goes a long way to subsidise the rest of the work.

From what has been said it might be thought that the work is now similar to any small provincial hospital in England. The medical standards are probably comparable, but I soon found that that was where the similarity ended.

The nature and incidence of diseases differ. To give but a few examples—dehydrated babies, the shape of skeletons, were depressingly frequent admissions; patients with leeches attached to the back of their throats were no rarities. I was struck by the number of cases of rheumatic fever and typhoid in the hospital, but the lower incidence of carcinoma. The latter is, I believe, genuinely less common.

It is sad that patients there still tend to consult the doctor only when their condition is well advanced. One particular tragedy made a great impression on me. A man of about fifty was carried in semi-comatose by his relatives. He had an enormous strangulated hernia of some days' standing. In theatre it was found that most of his intestine was gangrenous and his peritoneum rotted to tissue paper consistency. The smell was revolting. He died some six hours later.

Arab custom and etiquette is far removed from that of Britain. Disease is dramatised, elation or depression are intensified, and death is met with much wailing and beating of breasts. The fact that a sick man should be visited by all his relations unless they wish to cause the deepest offence becomes a hospital problem of some importance when families are so large. Visiting times are near chaos. Afterwards nurses sometimes discover such objects as a dried chameleon's head amongst the babies in the nursery, left to ward off the evil eye.

Other superstitious beliefs are not yet dead and one such greatly hampers the running of the small blood bank. Many Arabs feel that the loss of a pint of blood will for ever prevent them from having male children a matter of supreme importance to them. Kamel Abdu, the Arab lab. technician, and my working companion, told me how he has had to argue for hours with relations. One man resisted the most skilful argument for three hours until 2 o'clock in the morning while his beautiful young wife was bleeding almost to death. Blood is, of course, given at once to such patients but the relatives are not told this till they have provided more.

Finally a word must be said about the European staff. They have all come to the hospital at considerable personal sacrifice, and with a desire to demonstrate their Christian convictions in a practical manner through the work. Such a united spirit creates an atmosphere of peace which withstands the most trying circumstances and must be rare indeed.

Fifty years ago there were British mission hospitals in nearly every centre of population throughout Palestine. To the best of my knowledge, Nazareth is now the only one left in the entire Near East. Without the faith, vision and courage of a few men there would be none.

References

Personal Writings, 1857-80. J. Zeller.
"Haifa, or Life in Modern Palestine", 1887. L. Oliphant.
"Hygiene and Disease in Palestine". E. W. G. Masterman, M.D., F.R.C.S., D.P.H.
"The Cholera Epidemic of 1902". Bart's Journal, 1903. E. W. G. Masterman.
Personal Writings, E. W. G. Masterman.
"New Guide to the Holy Land". 1923. B. Meisterman.
"Ian Macfarlane, Soldier and Missionary". 1935. N. C. Macfarlane.
"Israel Guide". 1963. Z. Vilnay.
Medical Missions at home and abroad.— Several volumes.
Edinburgh Medical Missionary Journal—several volumes.

I should also like to express my gratitude to the staff of the E.M.M.S. Hospital, Nazareth.

FIFTY YEARS AGO

From the Bart's Journal of June, 1914

A CASE OF ICTERUS GRAVIS FROM THE SURGICAL WARDS

By G. L. Keynes. M.R.C.S.

The following is an account of a rare condition which is seldom diagnosed during life, and, in this case, presented a characteristically puzzling clinical picture.

The patient, a young woman, æt. 24, was admitted to Mr. Waring's wards on March 22nd, 1914, complaining of jaundice. She stated that she had given birth to a healthy child on June 13th, 1913, which was weaned in the following September. Shortly after her confinement she noticed that she was becoming jaundiced, and she suffered from loss of appetite and vomiting, but she does not appear to have been very ill until, in September, 1913, she had a sudden attack of acute pain, starting in the right hypochondrium and travelling upwards in the mid-axillary line and downwards into the right iliac fossa. The pain was accompanied by rigors, sweating, and vomiting. In December, 1913, she had another severe attack of pain, but noticed that after the attack she became more deeply jaundiced. She had a third attack in January, 1914; the jaundice again became darker, but after this varied in intensity.

On admission in March, 1914, the patient was obviously jaundiced, but did not appear to be very ill. There was some tenderness in the region of the gall-bladder, and on percussion the liver dullness, which started above at the fourth intercostal space, did not quite reach the right costal margin; otherwise nothing abnormal was discovered. The case was felt not to be a clear one, but in view of the history a provisional diagnosis of cholelithiasis was made. Dr. Garrod was asked to see the patient before any operation was done; he agreed with the provisional diagnosis, but also felt that the case was not a straightforward one.

On March 30th, 1914, the gall-bladder was exposed, but no stones could be found in the gall-bladder or ducts. The surface of the liver was seen to be irregular, and a swelling seen in the right lobe of the liver near the neck of the gall-bladder was explored with an aspirating syringe, but nothing except blood could be drawn off. The walls of the gall-bladder were thought to be somewhat thickened, and it was therefore removed; a section subsequently showed it to be the seat of acute catarrhal inflammation. Nothing further was done, and the patient made an uninterrupted recovery from the operation. The stitches were removed on the eighth day, and the wound was then found to have healed by first intention. The patient did not appear to be more ill than she had been before the operation, and she was definitely less jaundiced. On the following day, however, March 8th, she was evidently worse, and had a hæmatemesis of about an ounce of dark blood; occult blood was also found in her stools. She had no further haematemesis, though hæmorrhage appeared to continue in spite of treatment, and she died early the following morning with all the signs of acute anæmia.

A post-mortem examination of the abdomen was allowed and the following condition was found: The stomach, small intestines, and peritoneal cavity were full of blood, which had not come from any bleeding point, but had occurred as a general oozing from the omentum and from the mucous membrane of the stomach and intestines. The liver was somewhat small and contracted and the surface was rough: the stump of the cystic duct was firmly tied off and a probe could be passed down without obstruction into the duodenum. On section, the liver, especially the right lobe, was studded with enormous numbers of small, brilliantly yellow areas, which had somewhat the appearance of new growth. A microscopital section showed degenerating liver-cells and strands of fibrous tissue enclosing numerous so-called "regenerating bile ducts." The pancreas appeared normal.

This was therefore a case of icterus gravis simulating cholelithiasis and is of some interest, both medically and surgically. Death did not take place until nine months after the patient was confined, and it may be doubted whether there was any connection between the two events. Since the diagnosis of icterus gravis had not been considered during life, the urine was not examined for leucin and tyrosin, which are said to be present in this condition.

The liver from this case has been added to the specimens in the museum.

I am indebted to Mr. Waring for permission to publish these notes.

ABDOMINAL PAIN

By L. S. Castleden

The group of cases embraced by the term "acute abdomen" are naturally of the greatest interest to both the family doctor and the surgeon. Apart from the fact that mis-diagnosis can be disastrous, interest is ensured by the fact that pathology is often displayed at laparotomy. Furthermore surgical cure is obtained in a high proportion of cases.

What is not always realised is that these cases are a highly selected group from a mass of patients who are attended by their family doctor for "belly ache".

It was with the idea of trying to find out what all these "belly aches" are about that I made a list of one hundred consecutive cases seen personally in a rural general practice. In all the principle complaint was of "pain in the stomach". All were seen in only four months!

Patients coming with abdominal pain as their principal symptom make up about 1/25th of the patients seen in general practice. I calculate that I saw some 2,500 while collecting the list described, though naturally some of this vast number were seen on several occasions.

The most numerous group of patients is labelled "gastro-enteritis" which comprises a typical general practice collection. The presenting symptom being pain, the vast number of cases of "winter vomiting diseases" are excluded. In the majority of the 17 cases described, a colicky abdominal pain was followed by vomiting in many cases and diarrhoea in most. A rise in temperature often occurs after a few hours. The symptoms normally subsided in 24-26 hours on fluids and a Kaolin mixture.

The presence of both diarrhoea and vomiting, especially when the disease is prevalent, is reassuring. The cases which are followed by an "acute abdomen" seldom have diarrhoea. Nevertheless, as I hope this collection will emphasise, there are snakes in the grass. The retrocaecal appendix can be tricky—one of the appendix cases was situated like this and diarrhoea was present.

Also concealed in the group of gastro-enteritis are mild specific dysentries such as Sonnei and typhimurium salmonellosis. I have remarked that headache and pain behind the eyes and blood in the stools often lead to a bacteriological diagnosis.

In our practice, which is rural, salmonellosis is not unusual among farmers and their families and is one of the hazards of rearing "barley beef" from calves in a covered farm yard. An enquiry if an epizootic has caused scouring in the calves makes a stool examination of both human and bovine patients desirable. A tip to enthusiasts is to beware of taking the vet's job! Canny farmers may ask you to examine the animals. Sometimes this is to seek admiration but it *might* be because N.H.S. doctors cannot charge fees! Also the vet has ethical cause for disquiet, if you don't seek his advice.

As regards the gynaecological group, dysmenorrhoea can be most distressing and it is interesting to observe how it often becomes worse when a girl leaves school to take a job. The family doctor can relieve the psychological tensions as he often knows what the job involves as well as the background and childhood of the patient. There is no doubt that the use of "the pill" to produce anovular cycles is effective, but the doctor must ponder carefully the ethical factors. Personally I don't like concealing from a patient the nature of the drug which is being used. In some cases the knowledge of this therapy might be disturbing.

Spontaneous abortion is not uncommon. It appears to occur in about 10% of pregnancies. The pain and shock can be serious and a threat to life from haemorrhage is not unusual. Proper management is essential and the help of the district midwife is necessary.

One septic abortion followed an admitted criminal operation. The girl was desperately ill with high fever. It is the duty of the doctor to report these cases to the police because people who use Higginson's syringes and soapy water are dangerous. It is unpleasant if a court case follows but, personally, I have no doubts that these dangerous people must be stopped. On the other hand it is not part of the doctor's duty to delay the admission of a very ill patient to Hospital while acting as a sleuth. If the case is not reported of course on could become implicated as an accessory after the fact.

One case was diagnosed as post partum intraperitoneal haemorrhage. I have seen

several cases of the same sort. The patient quite suddenly complains of stiffness and pain in the abdomen two or three days after delivery. There is pain on movement and the abdominal muscles can be taut. If pain referred via the phrenic nerve to the tip of the shoulder is present, it can also suggest peritoneal irritation. If there was fever or a rise in pulse rate, such a case would need admission to hospital as suspected peritonitis. The complete lack of general signs of ill-health leads me to suppose that a seepage of blood via the Fallopian tube or perhaps rupture of a small cyst has occurred. As such cases do not require anything except rest and observation, the pathology as in so many minor ills remains a mystery.

Finally a word about the psychiatric cases. Over-anxiety can develop in anyone suffering from abdominal pain, and the family doctor must treat this aspect of every case with as full an explanation of the disease as possible, supported by reassurance. A careful history and physical examination will exclude serious physical disease. Knowledge of the patient's background and stresses will enable a psychiatric diagnosis to be reached in some cases at once, and treatment commenced by the G.P. All the cases described were treated without reference to a hospital or consultant, mostly in one or two interviews.

Some interesting cases from this series

1. A married woman of 38 years who has had three children sent for the doctor at about 11 p.m. She had been unable to sleep because of pains in the abdomen. The pain was constant and made her feel sick, but she had not vomited, nor had she any diarrhoea. For several months she had noted that her abdomen was getting gradually larger but thought this was due to "middle-aged spread". There was no amenorrhoea. There was no frequency or dysuria.

She was emphatic that the pain was *not* intermittent, but it was improving during the interview. On examination T=98.2, P=65, R=18. She was well-nourished, alert, and lying quietly in bed.

The abdomen showed a fullness below the umbilicus and on palpation there was a smooth swelling arising from the pelvis. The swelling was tender. It was soft; the size was that of a 20 weeks pregnancy. There were no contractions. There were no signs of breast activity. There was no vaginal bleeding. On rectal examination the uterus could be felt seperate from the abdominal swelling.

A diagnosis of ovarian cyst with torsion was made. In view of the hour and the good condition of the patient she was given 100 mgs. of pethidine by mouth at once and kept at home, the hospital being ten miles away.

This course was justified in that her condition was improving when seen early the next day. She was then transferred to the gynaecological department of the hospital. At laparotomy later in the day the swelling was found to be a serous cyst arising from the right ovary. The pedicle was twice twisted, but the cyst itself was not gangrenous. Cyst and ovary were removed. The patient made an excellent recovery and was able to take her family to the sea-side on holiday fifteen days later, thereby saving her deposit.

2. I received an urgent call at midday from a 32 year-old woman who had collapsed with severe pains in the stomach. The house was near enough for me to arrive within 5 minutes. There the patient was discovered in bed, pale and swooning.

One hour earlier she had had a sudden sharp pain in the upper abdomen which made her sit down. It went off, but returned with great violence so that she collapsed on the floor. She had retched but not vomited. Her husband had come in and helped her into bed.

The degree of shock was remarkable. The pulse was very weak. The rate was 65 per minute. Respiration was rapid and shallow. The lips were greyish and there was a coldness of the extremities. The patient proceeded to faint.

After raising the foot of the bed on a chair and removing all pillows a careful examination was made. The patient indicated pain in the upper abdomen. There was no rigidity. No viscas could be felt. There was definite epigastric tenderness. Bowel sounds were present but not unduly loud.

The diagnosis lay between perforated peptic ulcer and internal haemorrhage with pancreatitis as a possibility.

She was so shocked that an immediate injection of morphia 1/4 gr. was a *must* although we were rightly taught that morphine should be withheld until as definite a diagnosis as possible can be reached in hospital.

The case was carefully discussed with the surgeon. He was told that the patient had been treated at home for a similar sudden abdominal illness ten years before. This was

then described as "acute gastritis" and recovery had occurred in three days.

Laparotomy was undertaken that afternoon. Cholelithiasis was discovered. There was a stone firmly impacted at the sphincter of Oddi. Early acute pancreatitis was present. Cholecystectomy and sphincterectomy were performed. The biliary tract was carefully explored and all stones and mud removed. In spite of initial shock the patient made a good recovery and has had no recurrence of her pains.

There were four cases of cholecystitis in the series. The other three cases were much less dramatic as regards onset. There was little shock. The tenderness was typically under the right costal margin. In two cases the pain was referred to the right shoulder blade region. Only one of the four cases was treated as a surgical emergency. One other had a cholecystogram done.

There were three deaths in the series; one in hospital, from carcinoma of the colon and acute obstruction; two at home, carcinomatosis of the liver (cancer of the breast), and coronary thrombosis.

Ages varied from six weeks to eighty two years old. There were 52 females and 48 males.

The most surprising fact was that there were 40 different diagnoses! One can think of quite a few more which were not represented, e.g. mesenteric thrombosis, intussusception, tabetic crises, etc. 85 of these cases were treated at home. The fifteen admitted cases comprised the "acute abdomen" series. They were made up as follows:—

Acute appendicitis four cases, and then one each of the following conditions: gastric ulcer; acute retention of urine due to benign prostatic hypertrophy; epididymo-orchitis with pyelitis; intestinal obstruction due to carcinoma of the colon; torsion of an ovarian cyst; fibroids; septic abortion; pelvic cellulitis; acute pancreatitis; basal pneumonia in a diabetic; acute cholecystitis.

The above are the final diagnoses. Two of the provisional diagnoses were incorrect viz. the acute pancreatitis which was found to be due to a stone impacted at the sphincter of Oddi, was thought to be a perforated peptic ulcer. The basal pneumonia and diabetes presented with much pain and vomiting, and was thought to be mesenteric thrombosis by candlelight!.

That clinical diagnosis was wrong in two out of fifteen cases makes me rather shy of presenting the full list of the 85 home cases because pathological, X-ray or second opinion was only available in 14, so there are inevitably errors.

The cases can be grouped as follows:—

I—Alimentary.

Colic due to gastro-enteritis	17
Indigestion	9
Gastric Ulcer	4
Duodenal Ulcer	4
Appendicitis	4
Cholecystitis	4
Constipation	4
Dysentery (Salmonellosis)	3
Diverticulitis	3
Oesophageal reflux	2
Infantile colic (feeding difficulties)	2
Carcinoma of stomach	1
Carcinomatosis of Liver (breast)	1
Carcinoma of colon	1
Probable adhesions	1
Incarcerated hernia	1
Swallowed foreign body	1
Acute pancreatitis	1

II—Gynaecological.

Dysmenorrhoea	3
Spontaneous abortion	3
Normal labour	1
"False Alarm" labour	1
Pregnancy "stretch pains"	1
Post-partum intra peritoneal haemorrhage	1
Torsion of Ovarian cyst	1
Fibroids	1

III—Urological.

Cystitis	3
Epididymitis	2
Pyelitis	2
Acute retention	1
Hydronephrosis	1

IV—Medical.

Diaphragmatic pleurisy	3
Strain of abdominal muscles	2
Coronary thrombosis	1
Colic due to mag. sulph.	1
Subacute pancreatitis and Hyperparathroidism	1
Acute Tonsillitis	1

V—Psychiatric.

Neurosis	5
Endogenous depression	2
Hysteria	2
Cancerphobia	1

The complaint of abdominal pain does not permit the making of a "spot diagnosis". In all cases a careful examination is essential as well as an accurate history. In the psychiatric cases this examination is very much part of the treatment and a prelude to an attempt to discover the actual cause of the disease.

The management of the colic and indigestion cases is also important because further examinations and investigations may well become necessary. A proportion of these cases will have to be reassessed as peptic ulcer, cholystitis or even carcinoma or chronic appendicitis, depending on their course. Nevertheless an effort must be made to come to a provisional diagnosis based on clinical examination, backed by a "short list" of alternatives. Finally, brief clinical notes must be kept.

One hears from the Teaching Hospitals of a lack of clinical cases. This may partly be due to the fact that General Practitioners are not granted access to the X-ray, pathology and cardiographic departments in some Teaching Hospitals. Naturally a G.P. will refer his patients to a hospital which will grant him these facilities. He prefers to send the more exotic cases there, thus giving the undergraduate a false impression of the wide field of medicine.

The only way to glimpse this exciting field is to visit a G.P. on his native heath. Such visits can be arranged. There are plenty of patients; all are very intriguing.

A Surgeon Comments

By Martin Birnstingl

This article emphasizes the wide variety of abdominal conditions that may be met by the family doctor. The diagnosis of the acute abdomen needs a high order of clinical astuteness and there is no better place to cultivate this than in general practice. It also requires humility, because one must be prepared to alter one's original diagnosis and perhaps explain this to the relatives, as new features emerge during the course of an illness. From the angle of the surgeon, the main decision to be made is not what is wrong with the patient, but whether he needs an operation. Similarly, the general practitioner should ask himself, each time he visits a patient with abdominal pain, the question: "Would this patient be better off in hospital?" It is this, rather than a diagnosis between appendicitis and, say, mesenteric adenitis, that will influence the patient's recovery.

It would be wrong to criticize a doctor who sent a case to hospital with a diagnosis of appendicitis, later to learn that it turned out to be dysmenorrhoea, as to chastise a surgeon for removing a "white appendix" on a clinical suspicion of acute inflammation. Both are cautious and wise men who know the consequences of untreated peritonitis.

Delay in the diagnosis of acute appendicitis still leads to many deaths, often in young patients and even children. Serious mistakes are most common in a typical appendicitis. The author rightly mentions diarrhoea, which is fairly common when the appendix lies in the pelvis, and appears occasionally when it is in the retrocaecal position. Diarrhoea also occurs in other conditions complicated by pelvic peritonitis, such as diverticulitis. Rectal examination must therefore never be omitted. The most useful clinical sign in the diagnosis of the acute surgical emergency is abdominal tenderness. Where the history is suggestive, the patient looks ill and abdominal tenderness is present, he needs to be sent to hospital.

Not all will agree with the implication that a doctor should report a criminal abortion to the police. A reliable estimate of the number of illegal abortions in this country is 100,000 annually. Most of these women fortunately recover, without needing admission to hospital. Nevertheless, the Emergency Bed Service reported a 40% increase in the demand for abortion beds, during the period 1954-1962, whereas the demand for acute surgical beds remained constant. This suggests that the problem is increasing. The threat of police interference might very well dissuade dangerously ill patients from seeking early medical help. And with regard to the legal implications of this complex problem it should be remembered that a doctor's first duty is to his patient.

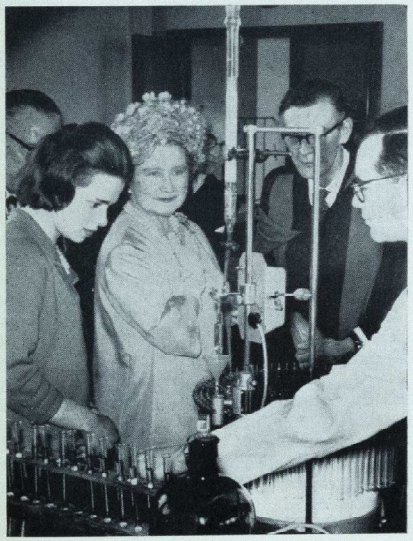
VISIT OF THE CHANCELLOR OF THE UNIVERSITY OF LONDON TO CHARTERHOUSE SQUARE

By Our Special Correspondent

The English weather, surely one of the main reasons for the rising emigration figures, traditionally does its best to ruin our important social or sporting occasions. Even though the visit of Her Majesty Queen Elizabeth the Queen Mother in her position as Chancellor of the University of London, to open the new five story science buildings at Charterhouse Square on Tuesday, 28th April, was very much an indoor affair, the weather played an important part. The onset of torrential rain just before Her Majesty's arrival at 3.00 p.m. seemed as though it would spoil the day for those sightseers without tickets for seats in the lecture theatre where the speeches were to be made; however, by the time Her Majesty left, just over two hours later, the sun was shining out of a blue sky.

Her Majesty was welcomed at the main entrance to the new building by the Mayor and Mayoress of Finsbury, Alderman and Mrs. A. Goldshaw. It is appropriate that this year the Mayoress should be Mrs. Goldshaw who has been Women Students cloakroom attendant at Charterhouse for twelve years. Having been received by the Vice-Chancellor and the Principal of the University, Her Majesty was met by Mr. Perrin, President of the Medical College, Dr. Harris, the Vice-President, Mr. Cope, the Dean and Mr. Hill, the Sub-Dean. The main entrance is in the half of the building most recently finished and from there the Queen Mother passed into the part of the new building that has been up for the last nine years.

The Chancellor viewing a typical experiment.



The Chancellor's party entered the physiology lecture theatre which was packed to capacity with staff and students. Dr. Harris welcomed the Chancellor on behalf of the college. In his speech Dr. Harris rejoiced to see how successfully Her Majesty had "outmanoeuvred a painful and frustrating illness, and, to use a Physician's rather crabbed phraseology, the effects of surgical intervention." Dr. Harris then went on to explain that it is in this part of the college that our medical education begins with the learning of the basic sciences. He then went on to give an excellent history of the Charterhouse Square site which was in the hands of the hospital as early as the 14th Century, was sold in 1340, and repurchased in 1936 when Sir Girling Ball, then Dean, raised enough money "to buy back this part of the land for exactly 1,000 times the sum the hospital had got for the whole 600 years before." The site was heavily bombed during the war but thanks to grants from the War Damage Commission, the State, the Medical Research Council and private sources such as the Welcome Trust, the new buildings have been paid for. Dr. Harris ended by inviting Her Majesty to start us off on our new course with her blessing.

The Chancellor, replying, congratulated the college on its beautiful surroundings. Her Majesty commented on how appropriate it was

that her visit coincided with the bicentenary of the birth of Abernethy who gave the school its form. Her Majesty said that as Chancellor she was pleased to note that there were present not only Bart's men but also undergraduates from the Royal Dental Hospital and the London Hospital Medical College. The presence of these latter students came as a surprise to many clinical students. The Chancellor finally hoped that "all who teach or study in this college will be blessed with that wisdom and understanding which is so important in the practice of medicine" and declared the building open.

The Chancellor meeting Dr. Bodley Scott. On the left, Mr. Birnstingl and Mr Hogg; on right, Mr. Cope.

The Dean, Mr. Cope, then thanked the Chancellor on behalf of the College in the sort of excellently delivered speech we have come to expect of him. The Dean admitted that the lecture theatre had been in use for the last nine years but that further sections of the building had only been added as further funds became available and hinted that there was still room for possible development. Mr. Cope hoped that the Chancellor would return to Bart's at a later date to receive our one honour —perpetual studentship of the College. Another departure into history followed as the Dean ended "Two hundred and fifty years ago an English General of the same name as myself ran away from the Scots at Prestonpans. There is, I believe, in Scottish folk lore, an old song which goes 'Hey Johnie Cope are Ye Waulking yet'. But this afternoon, Chancellor, I would ask if you will walk *with* me through our laboratories where we shall see both undergraduate and postgraduate students at work."

The Chancellor and her party then toured the laboratories meeting not only senior members of the departments but also men like Mr. Hudson, who has served as technician in the Biochemistry Department for nearly forty years, and Mr. Shippey, who has been with the Physics Department since 1928. The Chancellor was able to see pre-clinical students at work in the laboratories on 'typical' experiments. Work was in full swing as Her Majesty entered the Pharmacology Laboratory and it was interesting to note that all the experiments were working perfectly; Her Majesty showed interest in the effects of drugs on the isolated heart of a rabbit.

The Chancellor next saw some of the work of the 1st M.B. students as she entered the Histology laboratory and saw the Zoology department at work. In the Physics department, the next on the list, Her Majesty found students using very expensive equipment of an electrical nature. The linear accelerator, the proudest possession of the department, was displayed on closed circuit television and explained by Professor Rotblat.

The Biochemistry department, on this occasion, had been specially transferred from its rather shabby quarters to the Physiology teaching laboratory. Like most of the other departments the Biochemists could not resist the temptation to display their more expensive pieces of equipment and Her Majesty was attracted towards the clickings and flashings of a geiger counter. From here the Chancellor passed into the small Physiology teaching theatre where Her Majesty saw a physiological demonstration in process.

Down once more to the main entrance hall where the Chancellor was introduced to the architect, Mr. S. E. T. Cusdin, and more Hospital and College notables including Mr. Morris, Mr. Hogg, Mr. Birnstingl and the surely familiar Dr. Bodley Scott. Mr. Perrin, as President of the College, in a short speech, invited the Chancellor to unveil the tablet commemorating her visit. Her Majesty performed the short ceremony with practised ease and moved into the main library to be introduced to Dr. Cullinan, Mr. Naunton Morgan, Mr. Goody and Miss Loveridge, Matron of the Hospital. The Chancellor then met eighteen students representing almost all the main activities of the medical college.

Her Majesty took tea in the Research Library with seven students chosen, no doubt, for their conversational qualities allied to a certain importance in college affairs. Indeed, according to reliable reports, conversation never lagged and ranged over such diverse topics as Australia and breakfasts. After tea, on her way out through the Library, the Chancellor was presented with a bouquet by Miss Susan Williams and Her Majesty mentioned that she had greatly enjoyed her visit to Bart's.

The first royal visit to Charterhouse Square ended at 5.15 in a blaze of April sunshine, an appropriate ending.

[*Photographs reproduced by courtesy of Photographic Department*]

The Chancellor with Mr. Tuckwell and Mr. Cope.

AROUND AND ABOUT:

4—Inns of Court—Gray's Inn

By "Argus"

"Gray's Inn is a great quiet domain, quadrangle beyond quadrangle close beside Holborn, and a large space of greensward enclosed within it. It is very strange to find so much of ancient quietude right in the City's very jaws, which yet the monster shall not eat up—right in its very belly indeed, which yet, in all these ages, it shall not digest and convert into the same substance as the rest of its bustling streets. Nothing else in London is so like the effect of a spell, as to pass under one of these archways, and find yourself transported from the jumble, rush, tumult, uproar, as of an age condensed into the present hour, into what seems an eternal Sabbath." So the American novelist Nathaniel Hawthorne recorded his impressions of the northermost and in some ways the most attractive of the Inns of Court. These congregations of lawyers' chambers extend in a narrow band north from the river at Blackfriars to Holborn, west to the Strand, and with their quiet dignified lawns, closes and quadrangles resemble in a remarkable way some of the Oxford and Cambridge colleges. They seem to express, in their mantle of London brick, red, grey, brown and black, the majesty and respect for age and precedent of the English Law.

Gray's Inn is possibly the oldest of the Inns of Court, although the records of the Society of Benchers date only from 1569. It takes its name from Walter de Grey, Chancellor of England in the reign of King John, from 1206 until 1214. The de Grey family lived in property on the site of the Inn, known as the Manor of Pontpoole, until the death of the first Lord Grey of Wilton when Judges, lawyers, clerks and students took up residence there. In 1513 the manor was bought by the convent of Charterhouse at Sheen and rented, with licence from the crown, at a sum of £6 13s. 4d. annually, until, at the dissolution of the monasteries in 1539, it became Crown property. Most of the buildings, except the hall and parts of the chapel, are 17th or 18th century, some of them restored since the war.

Entry to the Inn by the Holborn gate is at present impossible, the gatehouse being wreathed in steel scaffolding prior to its restoration. It was originally built in 1594 and the brickwork, for some extraordinary reason, covered with cement by the benchers in 1867. The rooms over the gate were formerly the Gray's Inn Coffee House, and readers of Dickens will recall that here David Copperfield stayed, having journeyed from Kent to see his friend Traddles, and was greatly impressed by the gigantic four-poster bed in which he was to sleep. Entrance to the Inn is made by Warwick Court turning thence into South Square. Gray's Inn was badly bombed in the war and most of the square has been rebuilt to the original plans. Only No. 1, dating from 1685 remains unaltered and it was here that the young Dickens worked as a clerk in the offices of Messrs. Ellis and Blackmore. While he was still with the firm the office was transferred to No. 1 Raymond Buildings on the West side of the Inn Gardens. One of his employers recorded that Dickens, "was a bright, clever-looking youth, and several instances took place in the office of which he must have been a keen observer, as I recognised some of them in his *Pickwick* and *Nickleby*." In No. 2, South Square, David Copperfield's friend Tommy Traddles "shared a clerk", at a cost of half a crown a week, with three other embryo lawyers. Here also were the chambers of Mr. Phunky, Pickwick's junior Counsel in Bardell v. Pickwick. On the north side of the square is the Hall with transomed windows and attractive stepped gables at each end. It dates from 1560 and was badly damaged in the war. The interior (not always open to the public) contains a magnificent oak screen with a carved minstrels' gallery above, the gift to the Inn of Queen Elizabeth I, which fortunately survived destruction. The Hall was often used for banquets and feasts for distinguished guests and, in Elizabethan times, masques and plays, including the first performance of the "Comedy of Errors" in 1594. The benchers still drink to the "glorious, pious and immortal memory" of Elizabeth I on Grand Days in Hall every term. Adjoining the Hall is the Chapel which has been rebuilt so many times little of the original structure of 1315 must now remain. Reduced to a shell during the war, the interior is modern though some of the surviving Tudor windows can still be seen. To the north of the chapel is Gray's Inn Square whose chambers resemble those in South Square but are of earlier date. The north and west sides are of 1686, the other sides modern restorations. The gatehouse stands on the site of the original gatehouse of the Manor of Pontpoole. The poet Dryden's publisher had his shop here, and during a dispute between publisher and author Dryden sent him the following verse picture of himself:

> *"With leering looks, bull faced, and freckled fair,*
> *With two left legs, and Judas coloured hair,*
> *And frowsy pores that taint the ambient air".*

"Tell the dog", said the poet to the messenger, "that he who wrote these can write more". No. 1 is the site of Sir Francis Bacon's chambers, burnt down in 1684. Passing into Field Court, on the right are the gardens of the Inn laid out probably at the instigation of Sir Francis. He is also wrongly supposed to have planted the old bowed catalpa tree at the north end of the gardens, which are entered by an extremely fine, but not fussy, pair of iron gates of 1723 bearing the initials of William Gilbey treasurer of the Inn at the time. The gardens were a fashionable resort in the 17th and early 18th centuries. Pepys visited them on "Lord's Day" 1661, "seeing the fine ladies walk there" and 1662 went with his wife "to observe fashions of the ladies, because of my wife's making some clothes". Addison's Sir Roger de Coverly strolled there and Wesley and Count Zinzendorf used to come to argue about theology. The gardens are bounded to east and west by Verulam and Raymond buildings whose construction in the early years of the 19th century annoyed the essayist Lamb. He regarded the gardens as "the best of any of the Inns of Court, my beloved Temple not forgotten—they have the gravest character, their aspect being altogether reverend and law breathing. Bacon has left the impress of his foot upon their gravel walks."

Field Court leads to Gray's Inn Place. Here there are a pair of early 18th century houses with only two stories and plastered fronts. The rear elevation reveals a fine set of Regency ironwork balconies. They contrast well with a block in modern style on the corner of Field Court which respects the atmosphere of the Inn by being built in brick and having finely proportioned windows. A gate leads from the Inn into Jockey's fields and at the Junction of this street with Bedford Row (a fine wide street of about 1700 with a good range of door cases of different dates), is an old pump, one of the few left in London. Not perhaps as famous as its sister at Aldgate it is worth studying for a minute or two. Note the double spout and the elaborate lamp above it. Readers of Austin Freeman's Dr. Thorndyke adventures will recall that the socket for the pump handle was used in one of the stories to conceal a rope of stolen pearls.

Gray's Inn is an undoubted example of English visual planning at its finest. The contrasting heights and sizes of the courts and squares are perfectly balanced. To be properly appreciated, Gray's Inn, or any of the Inns of Court, should be seen on a dusky autumn evening with the leaves beginning to fall and the lamplighter going his rounds. Yours are the only footsteps to echo through the courts and it is difficult to imagine you are in London at all. It is worth glancing at some of the lawyers names as you pass the entrances to their chambers. For richness and variety and unusual combinations of names the legal profession is extraordinary. The Dickensian firms of Dodson and Fogg and Kenge and Carboy have their counterparts in real life.

A SYNDROME OF MULTIPLE MOTOR ACCIDENTS

By R. Courtenay-Evans

Case Report on a patient admitted to the Neurological Unit, Addenbrooke's Hospital, Cambridge, in February, 1964.

The patient, Mr. C., was a man of 51. He was a well known eccentric figure in the neighbourhood whose driving had always caused some despondency to onlookers and passengers alike, but as far as could be ascertained he had a clear record until the day of admission here. His past medical record was also clear apart from occasional dizzy attacks culminating in a blackout a few years ago, for which he was admitted to the general medical wards and investigated. On this occasion he was found to be normotensive with no abnormal physical signs and an electroencephalogram showed mild non-specific dysrhythmia.

Apart from these spells he had been quite fit until the day before his admission on this occasion. That day he noticed that his voice had become slurred but no other abnormality was noted by the patient at this time. The following afternoon in view of the lack of improvement in his condition he decided to attend his general practitioner's evening surgery across the other side of town. Duly he set forth in his pre-war and heavily fendered Vauxhall, but after 100 yards of leaving his front door became involved in the first of a series of incidents which culminated in his admission to Addenbrooke's. Just prior to turning left off the main road he proceeded to crash into the car directly ahead of him which was travelling in the same direction. No harm was done and after a slurred apology and exchange of names and addresses Mr. C. continued his journey uneventfully along a straight road to his doctor's surgery.

At the consultation with his practitioner it was noticed that he had a marked right facial palsy and, not without reason in the absence of any other physical signs, it was diagnosed as a Bell's Palsy. His speech slurring was

thought to be secondary to this. He was duly reassured and set forth on the homeward journey—and what a journey it was to be.

The road from the surgery led downhill and bearing round to the left: along this Mr. C. drove steadily for 100 yards or so, but then he was seen to cross the central white line and to proceed facing the oncoming traffic. The first car coming up the hill saw this strange sight and attempted to avoid Mr. C. by pulling up onto the pavement on his side of the road. He escaped with his on-side rear door smashed-in by a glancing blow from the Vauxhall's front fender and ended straddled across the pavement. Mr. C. having bounced off the first car carried on downhill unheeded to collide almost immediately head-on with car No. 2 proceeding uphill (which incidentally was later found to be a complete write-off). In the course of this collision car No. 2 was pushed backwards down the hill onto the front of another car, car No. 3, coming up the hill which had also attempted to take refuge on the pavement. This car got off with a crumpled front off-side wing and also came to a stop across the pavement. Mr. C. temporarily halted by the blow of the impact was not, however, to be daunted and was in the process of backing his now somewhat battered car out of the heap of wreckage round him to continue his homeward journey, when the three uninjured but irate owners of cars Nos. 1, 2 and 3 descended on him, demanding an explanation. The police in the meantime were also taking a pertinent interest in the whole affair.

Mr. C. finally brought his car to rest and slightly baffled by this onslaught, got out of his car. His distorted face and slurred voice immediately gave the impression that he was somewhat intoxicated but his ability to heel-toe walk with ease and to give a perfectly sober, even if partially unintelligible account of himself, gave doubt to first impressions. To confirm his sobriety he told the police that he had only that moment left his doctor who had not questioned his ability to drive, and this was duly endorsed by the doctor in question. Ever-resourceful the police decided that it must be his brakes at fault and under heavy police escort he was taken to a nearby stretch of straight, unfrequented road where his car was fully tested and found, apart from its recent trauma, to be in perfectly good working order. And so once more reassured he set off home, but after scarcely 100 yards from leaving the police he decided to turn left and yet again was found to be on the wrong side of the road facing an oncoming car, which to cut a long story short ended up straddled across the pavement with a bumper scar along the whole length of its side. The police were rapidly summoned to the scene once more and somewhat surprised, if not somewhat exasperated, to see the medically and mechanically vouched for Mr. C. again in exactly the same predicament as twenty minutes before. But in spite of his apparently infallible alibis he was now duly run in and the police surgeon was sent for. This doctor, without very much further ado, decided that he must have a cerebral tumour and forthwith arranged his admission to Addenbrooke's.

In hospital he appeared slightly ashamed of his evening's experiences but by no means perturbed though he could give no very good explanation for having had these accidents.

On examination generally he was quite fit, although he looked a little undernourished, and systemic examination was quite normal. But the specific examination of the central nervous system immediately revealed that he had a very marked expressive dysphasia (cortical motor dyphasia), with a slurred voice and an apparent memory defect for simple current events, which obviously frustrated him very much and he often ended unfinished sentences with expostulations. Once one had penetrated the barrier of this dysphasia it was obvious that he was perfectly well orientated in time and space. There was no evidence of meningism and his skull was perfectly normal to external examination. Examination of the cranial nerves showed that he had a complete right homonymous inattention field defect and a less marked right homonymous hemianopia to confrontation. The only other abnormality was a very dense right upper motor neurone facial palsy, in which the lower part of the face was mainly affected though there was some definite defect of elevation of the right eyebrow, and the palsy became considerably less obvious when he smiled or frowned. In the right limbs there were minimal pyramidal signs with bilateral flexor plantar responses, but no other abnormality.

On these signs on admission a diagnosis was made of a cerebrovascular accident, probably a thrombosis of a branch of the left middle cerebral artery. Investigations were carried out as follows :

Skull and chest X-ray were normal.

Lumbar puncture revealed normal pressure and normal constituents.

E.E.G. showed some slight increase in the generalised dysrhythmia noted before. This time it was more marked on the left than on the right side.

Blood count and basic chemical investigations were also normal.

In hospital most of his signs rapidly improved and a week after his admission the dysphasia had become minimal and the visual fields when charted on the Bjerrum screen a fortnight after admission, showed minimal suggestion of the homonymous defect. Strangely though, the right facial palsy remained almost as dense at the time of his discharge as it was on his admission.

Discussion :

This man's story illustrates two important yet simple neurological facts.

1. The differentiation between an upper and lower motor neurone facial palsy is not always as simple as it might appear, and
2. The importance of testing visual fields and attention as a routine in even the most cursory neurological examination.

The former of these two is simple; in a lower motor neurone palsy the whole side of the face is densely paralysed with no differentiation between the muscles of the upper or lower part of the face, and there is no improvement in this paralysis with emotional facial movements. In an upper motor neurone palsy, usually that incorporated in part of the hemiparesis, the paresis is less dense and the lower part of the face is more obviously involved than the upper, owing to bilateral upper motor neurone innervation of the upper facial muscles, and often upper motor neurone facial palsy may be so minimal that it is only detectable by the less complete burying of the eyelids or slightly slower movement of the affected side. The other differentiating factor is that the spontaneous emotional movements such as smiling, frowning, etc., were markedly less involved than the pure voluntary movements, since these emotional movements are involved in the pathway originating in the opposite frontal lobe and are not transmitted via the pyramidal system. Thus some lesions of the frontal lobes will involve emotional movements of the face only, and in other cortical lesions voluntary and emotional movements will be affected evenly.

The confusing factor in this case was the denseness of the facial palsy compared with the minimal signs of hemiparesis in the arms and legs and also the fact that at first glance both upper and lower facial movements were both equally affected. The minute the patient smiled, as he did when being questioned on his evening's excursion, the diagnosis was obviously apparent.

This routine examination of visual fields is of particular importance since at first sight often even a gross defect is not necessarily obvious and it is a symptom that the patient is seldom aware of himself initially. There is the story of the farm labourer who presented at a casualty department with a black eye given to him by one of his colleagues who repeatedly threw manure in his face when digging up an allotment patch together. The patient was found to have a bitemporal hemianopia and on direct questioning admitted to having given up shaving several months previously, and yet there was no very obvious evidence of this in the form of a beard.

The patient in the case illustrated presented with a homonymous inattention defect. This means that though he had a fair visual field in both eyes when each eye was tested in turn; when he was confronted with two objects, each in one temporal field he failed to recognise the presence of the object in the right field and thus ignored it, and this was painfully obvious from his evening's motoring experiences. Visual attention is a function of the superficial parietal lobe, probably between the cortex and the optic radiation and a defect of this cortical function often precedes a full homonymous hemianopia, and this man did show that to confrontation he had an incomplete homonymous hemianopia. By the time he was fit enough to be tested on the Bjerrum screen a few days after admission both his field and inattention defect had almost disappeared.

In summary this is a right handed middle aged man who had sustained a mild left cerebral thrombosis affecting part of his parietal lobe. The most striking thing about him is the unusual way in which he came to be admitted to hospital, having become involved in a series of moderately serious motoring accidents all of an identical nature, brought about because he was completely unaware of all cars coming into his right field of vision.

Acknowledgement.

I am grateful to Dr. M. F. T. Yealland for allowing me to publish this case report.

AN UNQUALIFIED ASSISTANT IN 1895

By Carruthers Corfield

In these days when early retirement, whether voluntary or forced, is becoming so commonplace, it is pleasant to find a professional man still working. Dr. Carruthers Corfield is aged 91 and still in practice, a practice that includes two childrens' homes, one of them for diabetics.

I must have been one of the last of the Unqualified Assistants before they were abolished by the G.M.C. in, I think, 1898.

They had carried on the work and traditions of the Apprentice and when they disappeared no-one was left to take their place nor was there any way of learning the Arts and Crafts of General Practice. I knew of several instances where the student's father was a doctor so he was able to carry on in the practice, the G.M.C. notwithstanding.

Their disappearance was a great loss to both the doctor and the assistant and this came to be realised over the years. Now means are being sought to teach the art before the qualified man is somersaulted into his consulting room with complete practice allotted to him by the Executive Medical Committee.

When I qualified in 1897 I put up a plate and waited hopefully for patients. I was prepared!

I was in my fourth year whiling away the time on a hot summer afternoon in the Abernethian, when a man I knew blew in. He told me he had been an Unqualified Assistant to a doctor in Whitechapel and was leaving. Having lost my father, I was short of cash, so I went to see the doctor. We apparently took to each other and he engaged me at once at the princely salary of £45 per annum and all found.

He was a giant of 6 ft. 2 in. with tawny hair and a pointed beard. The household consisted of himself, his sister and a brother, who came occasionally when he was out of a job; he lived on locums and had no practice. There were two maids and a coachman who lived out, and also a friendly dog—of which more later.

The living was first class; his sister was a good manager and an excellent cook. I had a wonderful bed which I was always loath to leave at 7 each morning.

Once up, my job was to dust the dispensary and bottles arranged as in a chemist's shop over a multitude of drawers, the contents of which had to be memorised.

I finished by 8 when we had breakfast, at which we frequently had a huge haddock, not dyed but smoked with oak dust in Whitechapel by one of the patients. I complimented him on this, when his reply was "We always have a good relish for breakfast." This was a new one to me as I had always thought that relish applied to Worcester Sauce or Batey's Nabob Pickle. Heinz had not yet come from Canada nor had Daddy's Sauce appeared.

At 9 the patients began to arrive and I became busy dispensing. The tawny one told me that I was the slowest dispenser he had ever had. I said this was my first job and I was anxious to leave him a few live patients. He retracted his opinion later.

At 10 he departed on his rounds in a high dog-cart, driven by the coachman. The horse was unshod; he was taken to Court by the R.S.P.C.A. for this but the case was dismissed as the horse was in excellent condition.

He returned to lunch at about 1.30, with a sheaf of prescriptions which kept me busy in the afternoon.

After tea, evening surgery and more dispensing, with a break for supper and some reading if I was lucky. And so to bed.

One of my jobs was to make pil. morph. gr. $\frac{1}{4}$ on a pill-making machine. I made him a urinometer set out of cigar boxes, of which he had stacks. Previously I had to dodge about for the various re-agents required.

Occasionally I was invited to a special tea held for visitors by the sister. Like the visitors she was a lady of uncertain age, who, I understood later, had thought to present her brother with a brother-in-law from the long line of assistants. It never came off! I was safe as early on I had mentioned casually that I was engaged, although fluttering eyelashes and a soft-eyed ogle now and then told me that I could jump into the practice at any time.

My principal had been called to several of the Whitechapel Jack-the-Ripper murders, one of which occurred at his back door. I arrived soon after the last one.

When the doctor was visiting, I saw and treated casual patients and repeated medicines. I was allowed to open boils and abscesses and treat carbuncles, using the old method of boring the site with carbonised matchsticks. I also syringed ears.

The major (sic) surgery was done by him. The only operation I ever saw him do was a circumcision on a lad of 19; no anæsthetic of any sort was given. He did not make a sound yet I remember still the look of agony on his face.

We kept a supply of lump sugar in a drawer for syrups. It seemed to be going too rapidly and the medicine boy was suspect so I was told to empty the drawer leaving one large attractive lump on which the doctor put one drop of croton oil. The next day the boy's mother came to say he couldn't come for a day or two as he had a bad attack of diarrhœa. The pilfering stopped!

My principal smoked only cigars; he must have had hundreds in unlocked cabinets in the consulting room; they were good ones. I smoked cigarettes!

When visiting in the squalid streets I never suffered any harm although I wore a heavy silver Albert across the waistcoat as was the custom then. I found everyone most respectful and kind; there were no rioting teenagers in those days.

Once when Tawny Beard paid a social call in the evening he took me with him to visit a friend in practice on "The Mount", so called because it was on top of a plague pit which had never been levelled out. This man was the inventor of a soothing syrup for babies which had a very large sale. There was a bell-push attached to his chair. After the dispenser had received the prescription he would chat with the patient and if he found that he was better off than usual would ring the bell and say to the dispenser, "Put a little *quinque* in Mr. Smith's medicine," which meant "Charge him 1s. more as he leaves."

Once a patient consulted him for vague pains in the left kidney region which he was unable to diagnose. He said, "I think you must have something in your kidney," so he whipped out a lancet and making a deep incision held up a round bullet all bloody. "No wonder," said he, "you have been shot!" This was too much for the patient. He never came again.

Conan Doyle tells a similar story in one of his tales of a country practice so I think this story was probably apocryphal.

I did all the confinements under two guineas —and there were plenty. He did those above that figure but when he was away or for other reasons I did them. I did not always agree with "other reasons" but it is only fair to say that his parting injunction was, "I will come if you want me." I did not receive any part of the fees for this work. It was all in the £45.

After a year he said he would give me £60 when I qualified. I was not quite ready for the Conjoint Finals but I could do the L.S.A., so I borrowed £10 10s. and got through. I then reminded him of his promise which he did not carry out beyond saying that I must agree to stay a further year or so. We parted company.

I had nearly forgotten the story of the dog. One morning it was found dead. After burial the basket was put in the loft and the blanket was folded and put away. I found out *where* in the night when I was awakened with intolerable itching and found the blanket had been put under my mattress. It was time I left.

VIEW DAY 1964

By Our Special Correspondent

Those who are new to View Day may experience a fair amount of disappointment. There is certainly an atmosphere of expectation, but it is never quite fulfilled; no planned programme for the visitor; no rousing central ceremony; and this year even tea was more difficult to come by and therefore less of a focus for the day. The more experienced viewer, however, realises that it is this very absence of organised activity which makes the day such a pleasant and useful one. The hospital is being seen as it is: admittedly dressed in its Sunday best, with clean windows, tighter perms and whiter shirts, but still functioning as it does every day—or as near as possible with several hundred conspicuously dressed extras on the set.

For those who need reminders that they were seeing a realistic picture, there were plenty the upset dustcart in the square, nicely coinciding with the governors' procession to lunch; the patient who chose the moment when his ward was asked by the Steward for complaints, to vomit both profusely and conspicuously; and a typically crowded accident box, though it is true that this may partly have been due to the remarkable display of flowers in Central Registry.

Pleasant though it is to have a complete and classless freedom of access, this by itself would not be enough to demonstrate all of the hospital's activities, and on this View Day there was a plentiful stock of exhibitions. In the library a fascinating collection of historical documents and prints vivified our impressions of some of our great ancestors, and reminded us of the uses of Smithfield first as a jousting ground, then as a fair ground with burning at the stake a frequent attraction, and finally as a livestock market until 1855.

The photographic exhibition was sparse but good, a striking feature being the juxtaposition of a portrait of a consultant and a feline study entitled "The Pride of an Aristocrat".

A revival which was welcomed by many was that of the Journal exhibition, which was exceptionally well laid out, and gave a clear insight into the work which is put into each edition of our excellent hospital magazine.

From the library to the department of Medical Illustration, where we were reminded how useful photography is as a shorthand method of clinical recording, and shown the Victorian beginning of medical photography, when the patient, whatever his disability, was made to pose as elegantly as a Noël Coward character. Upstairs there were some frighteningly realistic anatomical and pathological models; and a corner had been reserved for

"The Procession."

some mementoes of the "Life in your Hands" programme of January, including a strip of speckled wallpaper, which proved to have represented the flow of corpuscles along the femoral artery.

Of the many interesting things to see in the Dispensary, the collection of historical references to Pharmacy, devoted largely and appropriately to Shakespeare, and with its mascot leeches, was the most absorbing; there was much furtive interest in the Bard's recipe for facial beauty, involving cowslips. It was also nice to discover that the Hospital had managed for over 400 years without drugs of any kind; it was only in 1568 that the first "Pothcary" was appointed and paid £20 for his supply of drugs to the Hospital over the year.

Poorly advertised, but perhaps the best exhibition of the day was that in the Histology department. As a short, simple demonstration of their work it would be difficult to beat.

Which way did they go?

Finally, and rather wearily, we came to Gloucester House to find that an enormous amount of work and thought had been put into a wide variety of projects. From a pictorial warning against road accidents, starring a Mrs. Jones who suffered a compound fracture of her tibia and fibula, we moved to a more sublime exhortation to remember our "past neighbours"—Lamb, Newton, Wren, Donne, Betjeman and Milton. So with a "hence vain deluding joys" on our Puritan lips we proceeded to a room packed with information ,mostly financial, where we received the salutary reminder that a bottle of Occultest costs 7s. 1½d., and a nurse's white belt 2s. 6d.

An unfortunate addition here, and one that surely insults our student nurses' mentality, was a section on programmed learning, from which a sample question ran: "If a dose of insulin is changed from 20 units to 10 units, is the new dose twice or half the old dose?

Your correspondent enjoyed his View Day very much, and he has only one constructive suggestion to make, and that is that the visitors might be provided with rather more information. As the clocks of the City were echoing 6 o'clock, and the sound of the fountain could be heard again above the few remaining voices, a grateful lady passing out of the gate was heard to say, "I did so much enjoy my visit to St. Thomas's."

View Day photographs by courtesy of the Department of Medical Photography.

VIEW DAY BALL

By Our Special Correspondent

We had been given a thumb-nail sketch of the history of the Café Royal with the order form. In 1805 "Nicols" Thevenon opened the "Café Restaurant Nicols". An ardent Royalist, with an eye to the pockets of the exiled French aristocracy, he soon changed the name to the "Café Royale". His son-in-law, Pigache, whose allegiance lay with the Emperor, persuaded Nicols that his initial should be engraved over his pride and joy, and the vain Nicols delightedly gave his consent. Pigache thereupon promptly surrounded the initial with the Imperial laurel wreath, capped it with an imperial crown, and planted Napoleon's "N" in every conceivable space in the Café Royal. With this theme in mind we had imagined impressive dining halls, huge Napoleonic ballrooms and a flavour of the Empire and the greatness that was France. We were not disappointed; one swept from the candelabra'd Napoleon room to the mirror-lined Dubarry room in grand style. Everywhere there was gilt and crystal, velvet drapes and silver mirrors it was very ornate. I felt that it was all a little too plush, but then I was the only person who liked last year's "bare bricks" at the Hilton. Like Pagache I will stay loyal to the ruling Empire.

Later in the evening, however, the Napoleon room looked particularly splendid, especially from the balcony. The crowded floor, the dimmed lighting, in that huge, elaborate room; but for the steel band we could well have been at Fontainebleau. The atmosphere at the Café Royal was certainly more spacious than at the Hilton where one felt rather locked into the one ballroom. Here one was free to wander through three floors and there was more variety of entertainment than ever previously. The reception was in the Dubarry room and while many danced the main attraction seemed to be the Tombola where tickets flew fast and furiously. There were some excellent prizes: Cunard Line tickets to France, dinners at Quaglino's and Cunningham's, an enormous supply of liquor, clothes, meat and hundreds of other prizes. I won a Bird's Eye voucher and a tin of tongue, but one can't be bitter, the Royal College of Nursing is a most worthy cause. Mr. Alan Hunt won a bottle of claret, one of the resident anæsthetists, a fetching confection of lace and elastic, while Mr. Robin Anderson is adequately stocked up with groceries for the rest of the term.

Dinner was served at ten-thirty in the Napoleon room. The service was swift and

Mr. & Mrs. Alan Hunt and party.

the meal good, especially the main courses, though the ice-cream and fruit salad was a bit unimaginative. An important feature was the price of wines and spirits which compared most favourably with previous years.

The Cabaret came directly after dinner, an excellent move. Everyone had seats, a good view, time to digest their meals and none of the infuriation of being dragged away from the dancing. Our star artists were Hope and Keen, an American pair of great versatility. We'd heard all the jokes before but they were well put over and the whole presentation was very slick. By this time in the evening most of us were in a mood to laugh anyway.

"Mods and Rockers!"

After dinner the floor was cleared in the Napoleon room for dancing to Russ Henderson trio and later to Bill Savill and his orchestra. Upstairs Bobby Cristo and the Rebels were more in the groove but rather less in demand. This was entirely the reverse from last year, perhaps the change in atmosphere from the Hilton to the Café Royal had something to do with it. The bands were excellent and I found the omission of pipers no great loss. Few of us can do the Highland Fling and those who can normally find it rather more difficult by 1 p.m.

Looking round there seemed fewer consultants than in previous years and in fact the numbers in general were lower. This was sad for the Ball was excellently organised, efficiently run and, judging by those around me, thoroughly enjoyed.

At twelve the gambling instincts which had been in evidence at the Tombola were given a full rein. This was the newest venture of the View Day Ball Committee and, from the entertainment point of view, it was a great success. The George Suite where the gaming took place was a good-sized room with a very crowded central table at which it was exceedingly difficult to get a seat. Judging by the professional way in which many people handled their chips there has been much extra-mural activity in the casinos of the world.

Mr. Robinson spent some time at the tables but George Ellis preferred to watch the fortunes of his friends. The Bank unfortunately made a loss so we may not see this diversion again. This would be a pity for it was an excellent idea and provided a great deal of entertainment.

The last few hours passed very quickly. The dancing became perhaps a little more sedate as people drifted down to the Napoleon room but the pace never flagged. Had everyone been in training? It wasn't until three-thirty that couples drifted home.

I drove home through a deserted London with the sun coming up and the dawn chorus singing. I contemplated the pitting œdema of my ankles and the out-patients clinic five hours away and went to bed. Verdict—a great success.

Ball photos by JALMAR.

A HYPOTHETICAL CRIME

By Andrew E. Adam

About a year ago I was working as a reporter on a West Country paper. The editor was a tiresome man who divided his day between lunching on other people's expense accounts and inventing unbelievably trivial assignments for his staff reporters. Most of us lived in a state of chronic exasperation at him and occasionally played truant whenever the strain became too heavy.

I did this one glorious afternoon in the summer, when a warm Cornish sun and an exhilarating Atlantic breeze made me reach instinctively for a fishing rod. It was not hard to bribe a colleague to take on my day's assignment, then I threw my rod and tackle into the back of my tourer (this was before the ten year test) and rattled down the coast road in search of some stolen relaxation.

The road led to the village of Clevarnwick, which lies in a wooded combe at the head of a sheltered bay. Nothing seems to have happened there since wrecking was suppressed in the last century; you can barely park a car without blocking the only street, and the only place to get a meal is the back parlour of the Blue Anchor.

It was to the Blue Anchor that I eventually repaired just before six o'clock, after an afternoon fruitlessly spent on the rocks at the head of the bay. Usually there are some good rock salmon to be had there, but that afternoon the current seeemed far too vicious. I stopped outside the pub to tell my grievance to an old man smoking his pipe at the rail, and like me obviously waiting for the door to open.

He spat contemptuously into the water and remarked, "'Course you won't be getting much fishing this week, mister. 'Tis the time of the equinoc'ls and the biggest tide of the year were yesterday. Only a fool'd try to catch fish in an equinoc'l."

Just then a dirty white motor boat rounded the headland at full throttle and made for the jetty. "'Tis young Pierson," said the old man, "he's been laying pots down Hawksmead way." A discussion of the merits and faults of all the lobster lines in the neighbourhood was interrupted as the man in the boat drew alongside and shouted at us: "Bill lad. get Tom Dace down here right away! There's summat he ought to see down at Hawksmead." The old man prepared to ask a question, but the other on silenced him roughly. "And hurry, gaffer, the tide will be over it in an hour. I'll keep this engine running."

As the old man hobbled off I clambered down the steps to question the man Pierson. If there was a story I meant to get it. At first he was hostile but as a small crowd gathered, he admitted darkly that he had found a wooden crate bound with iron exposed below the usual low water mark.

While we digested this bit of news the man Dace arrived, policeman's tunic thrown incongruously over khaki trousers and canvas shoes.

Having questioned Pierson rapidly about the nature of his find he detailed two other men to follow in their boats with rope and grapnels, and then leapt down beside him. They roared off before I could beg a place, but one of the following boatmen immediately became hospitable when offered ten bob.

As we rounded the headland and got into the main swell he explained the need for haste. "Young Pierson must have found this thing somewhere on the late ebb, sir. And she turns in about half an hour, just like putting on a tap." He sucked hard on an empty pipe and added seriously, "What's more, this being our last bit of real equinoxial spring, the object will probably be submerged for another six months. And then there's no saying that you can ever find the same spot twice on this coast."

Looking at the line of the shore I could well believe him. To our left the cliffs rose about a hundred feet in jagged, irregular lines, sometimes sheer to the water. Here and there the hard faces were broken by a sloping funnel or overhang, and we could hear the rushing noises as water ran in and out of granite caves. Occasionally a strip of shingle was revealed just above the surging water line, but the black marking along the base of the cliffs told us that these rightfully belonged to the sea bed. The whole area was littered with reefs of all sizes and the dark shapes of submerged rocks against which the water surged noisily.

We ploughed on through a rising swell for half an hour more until the leading boat slowed down and hesitantly threaded a course through the rocks. We jockeyed carefully in its wake until we stood off thirty feet from the shore, where there was a narrow strip of black glistening shingle. "Don't come any closer lads!" shouted Pierson. "We've left it too late and you may not get off again."

With that he gave the tiller to the third man, and he and Dace jumped overboard and waded ashore. Three of us from the other boats followed them, slipping on the weed and shivering at the chill of the water. But despite all, Pierson's navigation had been pretty good. A few yards down, jammed between two rocks and half covered in shingle was a long wooden crate, bound with rusted steel strip and covered in weed and barnacles.

As Dace splashed about, testing the wood and trying to measure it, I was struck by the similarity of his action to the way an undertaker would measure up a coffin, and a chill ran down my back. Then he straightened up and said: "Gather round, lads, and we'll try to lift it clear." We bent ankle deep in the rising water and tried to get a grip on the sodden wood, but it weighed several hundredweight and was slippery as grease. As we scraped away the shingle to attach a couple of ropes to handles at either end, a large wave came bounding over the rocks and two men lost their footing in the bubbling chaos.

"We'll have to leave it," said Dace, "or we're all dead men! Jim! Where's that marker of yourn?" By the time we had fixed up fifteen feet of rope and a bright yellow marker buoy to the box, the tide was above our waists and already starting to swirl at the foot of the cliffs. We half waded, half swam back to the boats and I collapsed next to the engine cowling for warmth, wondering just what it was that had attracted me to treasure hunting as a small boy.

As soon as we landed at Clevarnwick I made straight for a telephone. My news editor did not share my enthusiasm: "Iron-bound boxes are washed up every day on these coasts," he snapped, "and I don't intend to risk my reputation on a crate of rotten oranges. Anyway, what the hell do you mean by playing Paul Temple at Clevarnwick (wherever that is) when you were supposed to be reporting a bowls match at Truro?"

Indignant and a bit shaken, I entered the Blue Anchor and sought the permission of the landlord, a tall unsmiling man called Mawe, to change into some dry clothing in the back parlour. Then I went into the bar-room where half the menfolk in Clevarnwick were gathered, determined to solicit some views on the contents of the box. In such cases one must first go through the ritual of buying drinks all round —a costly business at the best of times but the only way that an outsider can establish himself conversationally at the Blue Anchor. So three minutes later, having bought twelve pints of best bitter and three Scotches, I had the respectful attention of exactly fifteen pairs of ears.

The general conversation that followed my questions gave no real clues. Two old men smoking endlessly in a corner supplied some colourful tales about treasure supposedly buried nearby. P.C. Dace scorned the possibility of grisly remains inside ("All you journalists are after the same sort of thing," he grumbled) and other tales followed about wrecks and smuggling, no doubt well known to every one there but me. The general view seemed to be that Pierson had stumbled on some flotsam or jetsam that had become waterlogged, sank and was then covered by the movement of the shingle.

Dace left about 9.30, having organised another party to the marker buoy for the following evening. "I've rung through to Truro," he announced authoritatively, "and we may be gettin' some specialist chap for tomorrow's tide."

"A waste of time, son," said one of the old men. "Even at low tide you'll be working in seven foot of water. Come back this time next spring tide."

Dace ignored the laughter and added: "Won't be easy, but we got ropes around it now, and a marker buoy. If we can't get her into the boats we might pull her out from the top of the cliff, if she don't break up." As if to forestall further criticism he turned to Mawe and said, "'Night Jim. Don't forget 't ain't summer closin' yet. You turn these rowdies out sharp at ten."

However, the pub began to empty before then. Fishing folk must be up early and they left one by one with many noisy goodnights. This left Pierson, myself and the only other foreigner, a red-faced, retired doctor, who was on a shooting and fishing holiday and staying at the Blue Anchor. Having been drinking whisky all evening he was now pleasingly drunk, and apparently keen to reduce Pierson

and myself to the same condition. Mawe, however, objected and pointed out that it was ten o'clock and that he was closing the bar."

"Nonsense!" said the doctor a little incoherently. "This fine fellow is my guest"—he indicated Pierson—"and this other one is evidently in no condition to drive home, so he'd better have your other guest room. That makes him a resident, too, so fill 'em up again landlord."

With a bare show of protest I capitulated. Experience told me that I had drunk enough to make the drive home pretty hazardous; besides, I was enjoying the evening.

Mawe looked sadly at us as he refilled the glasses. "Very good, doctor," he said, "but I hope you won't make it too late. I have to be up early, y'know that. Now I'll just go and prepare the extra room. Excuse me, sir," he added apologetically to me, "but I'm single-handed at the moment."

As his heavy tread faded on the staircase behind the bar, Pierson sniggered, "Silly arse," he said in a hoarse whisper. "Everyone in Clevarnwick knows about it but he don't realise. His missus ran off with a sailor from Plymouth last year. Apple of his eye, she was, but too lively for old Mawe," and he chuckled into his tankard. This intelligence led to a prolonged discussion about the infidelity of women, and thence to a large number of unrepeatable jokes, of which the doctor had a limitless fund. Mawe drifted back in and filled the glasses again,but stayed the other side of the bar flicking the pages of a magazine. By midnight he had disappeared, leaving us with a bottle and the slate, and Pierson was snoring horribly in his seat.

Finally, the doctor rose unsteadily and shook me solemnly by the hand. "Good nigh', old chap. Been charmin' to make the acquaintance of an educated man on this Pontine shore." He seemed to have forgotten completely his suggestion for me to stay. "Better take that drunken oaf with you when you go," he said as he lurched up the stairs.

Feeling a bit betrayed I directed all my concentration towards following him. The crazy inclines of the stairs made progress difficult, and I reached the landing on all fours and staggered gracelessly around trying one door after another until I found my own. There I collapsed on the bed without undressing, and after conquering a strong bout of vertigo, fell asleep.

Usually I sleep the sleep of the dead after a jag like that. But on this night I woke suddenly at about 3.30 and for no apparent reason. My mouth tasted as if someone had been shovelling compost into it, and I sat for some minutes trying to cure it with a cigarette, and thinking over the previous day's events. It was a great pity that Dace had decided to bring in officialdom: if one of the national dailies got wind of it then goodbye to my exclusive and all hope of pacifying the editor. Cursing my fortune I stubbed out the fag and undressed rapidly, then crossed to the window to give myself some more fresh air. Below the inn the little harbour lay bathed in the soft radiance of the moon, and I could see the dark shapes of boats and buoys lying stranded on the sand. With a start I remembered the night tide—probably the last in this series of spring tides to leave the shore at Hawksmead uncovered. It would have provided the perfect opportunity for a bit of undisturbed investigation.

But who the hell cares?—I thought bitterly as I climbed into bed, I'm not risking my neck more than once on this job. Anyway, the old boy was probably right, and the box probably holds nothing more exciting than fruit or soup powders. I pulled up the bedclothes and tried to put the whole thing out of my mind. But the picture of that damned box lying half buried and awash at the foot of the cliffs kept coming at me like something out of a pirate film.

Suddenly a new thought struck home, and I sat bolt upright in bed. It was something Dace had said in the bar about trying to haul the box clear from the top of the cliffs. So far everyone, myself included, had assumed that the thing had come from the sea and had been buried by the movement of the tide. Dace's remark suggested another, sinister possibility: could it not equally have been lowered from the cliff top at a previous spring tide, and then been buried by hand?

The thought excited me beyond any chance of sleep, and I began to dress without having any real idea of what I was going to do. It was now four o'clock and at a rough calculation it would be low tide in half an hour. To steal a boat was out of the question. I could not hope to find the place by day, let alone by night. The only chance was to try and locate it from above and perhaps to climb down.

I stole downstairs. The bar-room was empty and the back door unlocked, so Pierson must

have left hours ago. Outside the car started with unusual ease, and I trundled through the narrow street and up the hill. At the top I changed gear and began to have second thoughts. Everything depended on being able to spot the buoy from above, but I had absolutely no idea where to begin looking.

Abruptly I stopped the car and lit a cigarette, thinking hard. The road followed the coast for three miles or so among thick woodland. Now, if the box had been planted from above, someone must have sweated blood and tears to get it to the edge of the cliff. If he were sensible he would have carted it as near as possible in some sort of vehicle, which meant leaving the road. I got out and swivelled the fog lamp over the right hand bank, and drove on scanning the side of the road.

About five miles down I found it, a narrow track which led downhill between the trees and ended twenty yards from the cliff top. I turned out the light and approached the edge cautiously. A hundred feet below, the sea shimmered in a pale light. The strip of uncovered shingle was there alright for I could see the waves breaking some yards out, but the dark pattern cast by the rock and the shadows made it totally impossible to identify anything. In fact, at that distance the box would have been quite indistinguishable from the rocks and the seaweed, except for one thing—the figure of a man labouring silently by the water's edge with a spade.

With a mixture of fear and intense excitement I stole back to the car and selected my heaviest adjustable spanner from the toolbox. Having got so far it did not occur to me to go back now. The man below must have made it somehow, and where he had gone I meant to follow. Again my luck held; a few hundred yards to the left there was a narrow sloping re-entrant which would provide a hazardous descent. My rope and torch would be no use, so I put them aside and began to clamber down. Everything went well until about twenty feet from the bottom when I started a small landslide which carried me the rest of the way with a noise like thunder.

There was little point in caution now, so I ran along the shingle grasping my spanner like a truncheon, my shoes crunching on the stones. Just when I thought that I must have over-run the spot I came right upon it: there were the two rocks, and between them the box—or what was left of it. One side had been stoved in so that the lid could be forced off, and the contents—whatever they were—had obviously been lifted out. The only other object in sight was Pierson's marker buoy now floating on the rising tide with its rope neatly severed.

For perhaps two or three seconds the scene imprinted itself on my eyes like a photograph—the broken box, the moonlit sea, the seaweed-strewn shore and the bobbing buoy.

Then a quick sound behind me made me turn to one side, and I had just the impression of a lifted arm before something struck me heavily behind the ear and the moonlight vanished.

I'm afraid the rest of the story is pure anti-climax, from the moment that I awoke to find myself back in bed at the Blue Anchor. Mawe woke me with difficulty at eleven in the morning as if nothing had happened, but under pressure admitted that he had found me apparently dead drunk in a chair in the bar when he rose at six, and had helped me to bed. He received my story with an air of sad disbelief.

Nor did anyone in the village seem to believe me; the conviviality of the previous night had disappeared and I was now no more than a trouble-making pressman. I got steadily more angry at their hostile indifference and came near to blows with Pierson who seemed to think I was out to cheat him in some way. My only possible ally, the doctor, had left early that morning by car.

Dace alone was prepared to take my story seriously when I turned up at his cottage yelling murder and assault. When I had told the full story he seemed sceptical, but he was quite prepared to reconstruct the venture with me. Imagine, then, how appalled I was to find every detail of it disproved point by point. The car was exactly where I had left it the day before in front of the inn, and my ropes and torch replaced on the back seat. Even the spanner was in its usual place in the tool roll.

I could feel Dace's disbelief mounting as we drove up the hill and on to the coast road. The lane was there alright, but the approach seemed different by daylight and I motored past it twice before identifying it. We found the way down too, but Dace remarked sceptically that it would have been hard going for a mountain goat; by daylight the drop down that funnel was quite terrifying, especially with the sea now beating angrily at the bottom of the cliffs, and I marvelled at my own temerity. There were, it is true, one or two traces of my tyre marks on the track where the ground

was soft, but Dace remained unmoved. "Could have been anyone, sir," he said firmly, "picnickers, or courting couples most likely."

In fact, on top of these contradictions my only concrete point, the missing buoy, was a poor trump. In the morning, of course, Dace took it as final proof that the whole thing was a fabrication or a dream, and assured me that we would in fact find the marker further down the coast. But when we went out again in the afternoon in three boats, accompanied by a Coroner who had come up from Truro, and found no trace of it, nobody was impressed. Dace himself was the first to recall how hastily it had been tied on, and the other men testified to the strength of the tidal currents at the equinox.

On the way back I told my story to the Coroner, who heard it in silence with a distant expression on his face.

When we landed he still had not delivered judgment so I stopped him on the quay and demanded his opinion. He looked at me steadily for a moment or two, then said quietly: "You must appreciate, my friend, that as a Coroner I have some experience of both treasure trove and buried bodies, so please accept my opinion with some respect." Sucking noisily on his wet pipe, he continued, "I won't insult you (as I believe the villagers have done) by suggesting that this is all a fabrication on behalf of your paper. What I do say is that yesterday's events may have preyed so heavily on your mind that, under the stimulus of alcohol, your subconscious, which was innocently striving to provide a logical explanation for the box, invented this one as you slept."

"And *how*," I said quietly, "did my subconscious concoct this huge bump on my head?" The Coroner gave a short laugh. "My dear man, Mawe told me that the three of you drank three bottles of whisky last night. With a load like that you can expect a little local damage. Good afternoon. . . ."

I left Clevarnwick in disgust, and so far I have not returned. Needless to say, my editor repeated almost exactly what the Coroner had said in much blunter terms, so I could not follow the matter further. For weeks, I must admit, I had the little doctor as my No. 1 suspect. His sudden disappearance so early in the morning, plus the fact that neither Mawe nor anyone else knew his name or address, pointed him out as my assailant. Later, as the months went by I seriously began to doubt my own wits, and by the following January I was halfway to believing that the Coroner had been right.

Then one day I ran into the doctor, quite by chance, in a pub in Plymouth. He was in much the same condition as when I last saw him, but he recognised me with a bit of prompting, and thrust a drink at me. "Well, well," he chuckled, "my old friend, the geni of the magic box. By heaven, you *were* in a sorry shape when I last saw you."

"Oh, and just where was that?" I said, struggling to keep calm despite an eerie premonition of some disclosure.

"Why, outside the Blue Anchor back in April the morning I left," he said, downing his brandy.

"*Outside*?" I echoed, almost in falsetto.

"Yes, you poor sod, and all covered in blood and sand. Old Mawe was carting you in by the armpits at about six o'clock. Told me he had found you lying on the steps down to the beach, stinking of liquor, and with a bruise the size of an egg. He was quite disturbed, so I had a look to make sure you weren't mortally hurt. Thick-headed drunkards, you journalists."

I had met him too late, of course. Mawe had sold out within a week of the box incident and gone abroad, ostensibly because he had news of his wife in Brazil or somewhere—no one knew for sure. But I think I know better and at the next equinox I mean to take a spade and do some serious digging on the shore at Hawksmead. I have the strongest feeling that *Mrs*. Mawe did not get far from Clevarnwick after all.

PENGUIN REVIEWS

The Fox in the Attic, by Richard Hughes. Penguin 2069.

"The Fox in the Attic" is the first part of a trilogy planned by Richard Hughes to be called "The Human Predicament". The story concerns the life of the hero, Augustine, in the period after the First World War in England and moves to Munich at the time of the early abortive Nazi revolt. Richard Hughes is perhaps best known for his book, "High Wind in Jamaica" and is reckoned by some critics to be a British Tolstoy.

That this book is a great novel there is no doubt. It has a compelling quality which gives the reader the certainty that he is in the company of something great. The whole effect is achieved with great economy of effort and unconscious ease of style, flowing along with impressive smoothness. The language becomes sheer poetry at times: "On top of those empty high downs, above the hanging woods of ancient yews clinging to their chalky sides there was only a thin skin of rabbit-rubbed turf that was more thyme than grass and a sky full of larks."

The three sections of the book are divided into about thirty small chapters, each a masterpiece in its own right. This is a brilliant book which requires reading several times so that one can savour more fully its delicate flavour.

J. R. Swain.

Death of a Huntsman, by H. E. Bates. Published by Penguin Books. Price 3s. 6d.

"Death of a Huntsman" includes four short stories, the title of the book being the title of the first story. This story is of the decline and death of a married, middle-aged commuter who, in a series of week-ends, has the misfortune to fall for the daughter of a recently widowed ex-lover of his youth. This tale is a superb tragedy and, like the other three stories is exquisitely unfolded. This volume will please all H. E. Bates fans and it can be recommended to anybody with a yen to read perfectly formed short stories. The author is one who still has that quality of being able to get his readers to identify themselves with his characters. Apart from this he has the ability to sketch any situation with a deft word picture. Possibly the best story in the book is "Night Run to the West"—a very uncharacteristic Bates setting concerning a long-distance lorry driver who develops an interesting relationship with a young lady along his route who is married to an old dodderer with a large fortune. The story tells how the wife tries to rid herself of the husband by using the unwitting driver. Another example of how Man's inhumanity to Man is only outclassed by that of Woman to Man.

C. J. Kelly.

The Whispering Land, by Gerald Durrell. (Penguin). 3s. 6d.

Gerald Durrell is well endowed with the gift of character portrayal. There are, among many, the 21-foot long bull elephant seal which wept bitter tears when disturbed; Claudius the tapir, whose greatest delight was munching begonias, and the parrot which greeted the author with a shrill "Hijo de puta!" (son of a whore). Happily it is not only the animals that receive Durrell's attention. There is, for instance, Josephina, the fearless driver in whose wake cries of "animal!" rise from the streets of Buenos Aires.

Durrell's style, though, I find rather overpowering after a few chapters, and his books have about them the elements of the age-old travelogue in which every anecdote has to be told, whether in context or not. He is poles apart from his brother.

C. S. B.

Conjugal Love by Alberto Moravia. Penguin 3s.

Moravia has an undeniably lush and latin talent for a pansexual ethos in the ways of men; however it is an ethos which displeases the Vatican sufficiently for the book to be refused the Papal approval in the imprimatur. The basis of the refusal?—that it is "amoralista", whereas the "immoralista" is occasionally approved of on grounds of artistic merit. However, despite the intriguing distinction, "Conjugal Love" contains much that is by turns fascinating and irritating; fascinating because of its insight into the creative process, and irritating for its obvious limitation in action.

Silvio, a writer as yet manqué, has aspirations which outstrip his talent, and to boost the latter he adopts a continent course, which according to his perverse rationale will create for him the vital situation with his wife which will help towards self-realisation in writing. Leda however is an unwilling celibate, who only brings Silvio his self-realisation in adultery. The fascination of their relationship lies in the ambivalent feeling that these two have for one another when continent. Routine is restricted, facts become novelties, details incidents, until in the end one is entirely bewildered by the complexity of two apparently ordinary individuals. Everything has two faces, the pre- and post-tumescent.

Perhaps most people have more than enough of emotional crises, which are Moravia's stock in trade, to draw vicarious pleasure from this work. Perhaps indeed the subtle sophistries are irrelevant and the casuistry academic, but for all that here is one relationship explored to its end, where of most of us desist in boredom and despair.

Patrick Smith.

"Why Conservative?" by Timothy Raison. Penguin Special. Price 3s. 6d. **"Why Labour?"** by Jim Northcott. Penguin Special. Price 3s. 6d.

People do not vote for the party whose programme approximates to their ideal of social justice, but for the party which they think will maintain or improve their own economic status. The social psychologists have attempted to explain anomalies in voting behaviour. The basic paradox is why the party which represents the working class does not recieve all the working class votes and thus gain an electoral triumph with a numerical majority roughly proportional to their fraction of the population. The explanation appears to depend on social mobility and regional and religious interests which may transcend economic considerations. The Ulster labourer in Liverpool or the former lorry driver who has bought a tobacconist's shop with his life savings has one vote to satisfy his complex aspirations and loyalties.

Bernard Shaw wrote: "Democracy substitutes election by the incompetent many for appointment by the corrupt few". These two books are for that minority of the incompetent many whose choice of party at a general election is rational rather than instinctive.

"Why Labour?" is more factual than Timothy Raison's book with a copious appendix full of statistical corroboration of the author's arguments. This documentation ranges from: "In maintained primary schools in January 1962, 759,000 pupils (18.3% of the total) were in classes of 41 or more, and a further 2,265,000 (54.9% of the total) were in classes of 31-40," to the relative cost of television licences in all countries of Western Europe. In "Why Conservative?" the Editor of "New Society" displays more of the vague philosophical, romantic and Disraelian sentiment than would have been expected of the founder of a journal which is severely practical and constructive.

Confronted with Mr. Northcott's detailed notes on, "the effect of taxes on the incentive to work", and "the benefit from change in terms of trade 1951-1961", Timothy Raison responds with, " . . .I believe that the place of the Tory party is as the masculine party and that what it has to show is that it is the masculine qualities of vigour, courage, independence, self-reliance and clear sightedness, that the country needs at the moment—though they must always be coupled with compassion".

But since neither of these books is intended to be read as the official statements of party policy, it is unfair to expect them to be purely factual. Both avoid that childish abuse of their rivals which marks topical political writing. Here is an example from "The Alternatives" published by the Right Angle Books: "If one mark of the Labour Party is sourness, another is confusion".

With the prospect of an autumn general election there is still time for Shaw's "incompetent many" to do their homework. It is a pity that there is no "Why Liberal?".

Maurice Lipsedge.

The New English Bible—New Testament. Penguin Books. 5s.

At a cost of five shillings the Penguin edition of the New English Bible must be the best literary bargain ever made, a far cry from the first hand copied translations, made illegally for which the cost was death or exile.

The story of Christ is told simply and realistically, but what surprised me most about this new translation was the portrayal of Christ. Here is no archaic figure smiling and gentle but a dynamic, brave man fighting alone for Truth in the middle of a sea of hatred, jealousy, hypocrisy, and intrigue. It depicts a Christ who said things which hurt, who told parables directly against the most powerful pressure groups of the nation, who gave better than he got and who finally paid the penalty for his words by death, and in dying, wrecked for ever the efforts of his enemies to quieten Him.

The coming of the Holy Spirit, the spread of Christianity by men suffused with certainty, the early controversies about doctrine, and the way of life under the Roman Empire are all clearly and movingly portrayed in the "Acts of the Apostles".

The Epistles are the greatest triumph of all for the modern translators. These, the earliest Christian writings, some of which even St. Peter found obscure (2 Peter 3.16), are now understandable even to those of us who have no bible scholarship. What was "seen through a glass darkly" in the Authorised Version we now "see face to face". Some passages are still difficult, but the translators have largely removed the old ambiguity.

The book of "Revelation", so steeped in symbolism is easily understandable literally and remains the "happy hunting ground" for the theologian.

This is a book to be read by all, especially the cynical. The reality and attainment of Eternal Life is contained in its pages, a remarkable bargain for five shillings.

A. T. R. A.

OTHER REVIEWS

Aids to Pharmacology for Nurses, by R. E. Bailey. Published by Balliére, Tindall & Cox. Price 10/6.

No author works harder than the one who writes a book on pharmacology, and we all owe a debt of gratitude to those who reduce the enormous amount of information about modern drugs to a form from which we can benefit. It is difficult for the author to classify material; there are drawbacks both to the chemical and the physiological methods.

Miss Bailey's book is a new one and the layout and type are well suited to her material. At 10s. 6d. it is excellent value. Approved names are given in bold type and proprietary names in italics, and drugs that are Scheduled Poisons or Dangerous Drugs, are so marked.

One naturally turns to the newer drugs to find how up-to-date a book is, and here drugs used in Psychiatry are well and fully covered. There is a useful and unusual section on the drugs used in diagnosis, and a clear exposition of vaccines and sera.

Since Miss Bailey is a teacher in the School of Nursing, we must declare an interest in her book. We know that what she writes will be accurate and informative, and we wish her every success with her first book.

W.E.H.

Body Fluids and their Neutrality, by Halvor N. Christensen. New York. Academic Press, 1963. 197 pp.

Professor Christensen, of the University of Michigan, is the author of "Diagnostic Biochemistry" from which the present booklet is abstracted. It is intended "as a supplement to instruction in biochemistry and physiology . . . or for the physician or biologist who wishes to review the basic subjects of electrolytes and neutrality."

This intention is well fulfilled. The treatment is, on the whole, lucid, accurate, convincing and up-to-date. Many of the questions asked are extremely searching; quite a few of the "Library Problems" included after each chapter, which are intended to involve the reader in extensive library research before arriving at a satisfactory conclusion, will probably tax his capabilities to the utmost.

The general clarity of expression is unfortunately marred occasionally by distressing lapses into typically transatlantic polysyllabic pomposity, and many readers will regret that in a few cases, notably in the interpretation of the CO_2 absorption curves of blood, subjects where more detailed explanation would be welcome, are dismissed over briefly.

The text is also not without contradictions. In the first chapter, devoted to a clarification of the significance of different terms and units, we find a completely false statement of the relationship between weight of solute (units unspecified!), number of milliequivalents, and equivalent weight, and a definition of *flux* which is implicitly denied on the next page. Moreover ,the first Library Problem is so badly worded that its exact meaning is quite doubtful. On page 75 a figure is given for serum "phosphate" without stating in what chemical form it is expressed; on page 18 we find the surprising statement that acetic acid solutions above pH 8 contain nothing that tends to bind $H+$ or $OH-$, and the statement on page 134 concerning urinary excretion of $H+$ as $NH+$ is impossible to reconcile with that on page 136 that it is NH_3 which is actually excreted!

Nevertheless, the critical reader can hardly fail to improve his understanding of this important but difficult subject by a careful study of Professor Christensen's booklet.

G.E.F.

Undergraduate Medical Curricula Changes in Britain by Rowe & Williams. Pitman Medical Publishing Co. Price 10s. 6d.

All who are concerned with medical teaching realise the urgent need for radical changes in both pre-clinical and clinical undergraduate curricula. Many of the time-honoured methods of teaching are quite unsuited to imparting present knowledge to medical students. The present training system endeavours not only to produce general practitioners but to give all types of would be specialists some basic training to suit them for their speciality. It is probable that these two objects are irreconcilable. The rapid advance and the widespread application of the basic sciences in clinical problems means that continuous change must be made in the pre-clinical curriculum and its methods of teaching Recent advances in such subjects as genetics and nuclear physics make the biology taught in schools quite unrealistic in the training of medical students. If exemption from the first M.B. is still be granted on 'A' level subjects studied at school the pre-clinical course at medical colleges will have to cover much of the early ground again, stressing its applications to medical problems.

This book is a brief account of the attempts made by Birmingham, Glasgow, Sheffield and the Middlesex Hospital to solve some of these problems and it also tells of the difficulties that these schools have met. All are trying to solve the problems of maintaining the student's interest through almost six years of intensive training. The problem of spreading the examination load is discussed and balanced against the General Medical Council's statutory duty to examine students and see they are fit to have care of patients. The integration of clinical applications with the teaching of pre-clinical subjects is tackled by all the schools with a varying degree of success but there is no doubt that this portion of the course is a most important one and a most difficult section to organise satisfactorily. The proposed revision of the teaching at Barts which will start in October, 1965 in the pre-clinical school and two years later in the clinical school will embody many of the ideas mentioned in this booklet. All who are interested in medical undergraduate education either from the active or the passive aspect would do well to read this booklet which gives some inkling of the magnitude of the task facing medical educators to-day.

I. M. H.

Diagnosis and Treatment of Blood Diseases. By M. C. G. Israels. 1963. 200 pages. William Heinemann Ltd., London. Price 35s.

This concise, yet comprehensive, small textbook is written by a well recognised authority on both the clinical and laboratory aspects of blood diseases, and one who is a consultant physician with a special interest in Hæmatology, as well as a practical hæmatologist.

Laboratory investigation is required for any patient deemed to have a blood disorder and it is essential that a consultant physician in charge of such cases should be familiar with those laboratory methods which may prove helpful in diagnosis as well as being able to assess their significance and limitations.

The book is primarily designed for practising physicians and post-graduate students who desire to employ up-to-date diagnostic and therapeutic methods in the diagnosis and treatment of their patients suffering from a blood disease and it fulfills this aim most efficiently. It will also prove valuable and broaden the horizon of any pathologist concerned with hæmatological investigations by presenting, in a compact manner, clinical aspect and management.

Commencing with brief, but useful, general sections on clinical diagnosis and laboratory investigations there follow detailed chapters on the Anæmias, including Hæmolytic anæmia and Pyridovine-responsive anæmia, the Leukæmias including Myeloma, Polycythæmia and Myelosclerosis, the Reticuloses, the Hæmorrhagic Diseases, and finally a description of the routine laboratory techniques used in hæmatology. Coloured illustrations of the bone marrow cytology in the various blood disorders (taken from the author's own Atlas) are supplied as an appendix.

This short monograph has the stamp of a small classic and it is surprising how much information is contained within its compass. It can be recommended to any medical graduate physician or pathologist concerned with patients afflicted with a blood disease.

H.F.B.

Hæmatological Technique. 3rd Edition. 1963. By E. M. Darmady and S. G. T. Davenport. Messrs. J. and A. Churchill Ltd. Price 30s.

This is the third edition of this comprehensive book on practical hæmatology which is intended primarily for laboratory technicians engaged in this field and working for the I.M.L.T. examinations in Hæmatology, and also for medical students. For such it is very adequate.

The techniques of routine investigations which may be carried out on a patient suffering from a blood disease are fully covered and there are useful diagrams, examples of calculations and lists of apparatus and reagents required for particular tests. In the third edition, there are brief sections on the haptoglobins, folic acid and vitamin B12; a detailed account is given of the estimation of the latter by the Lactobacillus leichmanii method which most workers now favour in preference to Euglena gracilis because of the shorter incubation period and the employment of standard apparatus. Other technical additions are the estimation of fœtal hæmoglobin, the demonstration of leucocyte alkaline phosphatase (listed as phospate activity in the index) and of ribonucleic acid, and details of the latex fixation test. Although the authors state that this simplest test is gradually replacing the older Rose-Waaler, it is probably not so valuable in assessing severity and prognosis in rheumatoid arthritis.

Satisfactory to note in this new edition is the inclusion of the photo-electric oxyhæmoglobin method of estimating hæmoglobin since this is now the standard practice in most hæmatological departments combining rapidity and simplicity with accuracy. In the chapter on Blood Coagulation, the internationally agreed nomenclature for the diverse clotting factors has been employed.

The subject matter in the book is arranged in 25 chapters and includes blood grouping and cross-matching, prothrombin estimation, elementary genetics and the theory of errors in hæmotological procedures. Most workers now regard the laborious Price-Jones technique for the measurement of red-cell diameters as obsolete since the information given can be obtained more easily from the examination of a stained film. Difficulties of maintenance, both mechanical and electronic are a significant factor in retarding the widespread use of electronic red cell counters. In a subsequent edition, a note on sex determination from nuclear morphology of the neutrophil leucocytes and also mention of the rapid slide test for the anti-nucleoprotein factors often found in Systemic Lupus Erythematosus would be valuable.

The bibliography provided at the end of most chapters and a glossary of terms are useful; a full but concise table of normal hæmatological values for easy reference could also be an asset.

The book contains a great deal of information and clear practical instruction and can be recommended both for technicians and students.

H.F.B.

The Anatomical Lectures of William Harvey. Prelectiones anatomie universalis. De musculis. Edited, with an introduction, translation and notes by Gweneth Whitteridge. E. & S. Livingstone, Edinburgh, London, 1964. lxiv, 504 pp. £7. 7s.

William Harvey was the most distinguished member of the staff of this Hospital in the seventeenth century, and his international reputation has increased with the passage of time. Celebrations in honour of his birth and death, and the publication of his writings, have resulted in spates of books and papers honouring the occasions, if not always adding to our knowledge of Harvey. Exceptions are notable in the Harvelana contributed by Bart's scholars and students of Harvey, such as Sir Geoffrey Keynes and Professor K. J. Franklin. One of the most significant, original contributions was the translation of **De motu locali animalium** by Mrs. Gweneth Witteridge, published on behalf of the Royal College of Physicians in 1959, and Mrs. Witteridge has rendered this additional study and translation.

Two manuscripts in the Sloane Collection at the British Museum contain the anatomical writings of Harvey, the **Prelectiones anatomie universalis** and **De musculis,** the latter of which is printed here for the first time. The **Prelectiones** was published in facsimile for the Royal College of Physicians in 1886, together with a very poor transcript, and a translation based on this transcript was published in 1961. Fortunately at this time Mrs. Whitteridge's work had progressed sufficiently far for her not to be deterred from her labour of love, and the resultant publication represents not only a scholarly translation, but a reincarnation of Harvey's thoughts. A complete new transcript of the **Prelectiones** is reproduced with all contractions and abbreviations expanded, revealing a readable text for the first time. Facing the pages of transcript we have Mrs. Whitteridge's translation, fully documented with invaluable footnotes, and representing many years of toil tracing Harvey's references and ideas through the writings of his contemporaries and predecessors. The resultant volume must remain an invaluable source book for all students of Harvey and the anatomy of his period.

Introductory matter details the history of the **Prelectiones** and their derivation, the bibliography provides information on the authorities used by Harvey, many of which he cites from Bauhin, and we are enabled to reconstruct Harvey's knowledge of physiology, surgery and pathology at this stage. Unlike most editions of Harvey's writings this one is provided with an index.

A reviewer might be tempted to devote several pages to an evaluation of the text, quoting significant passages and comparing them with the text published in 1961. The contrast between the two is striking; suffice it is to say in this notice that Mrs. Whitteridge is to be congratulated on her perseverance in bringing this monumental work of intensive scholarship to a successful conclusion.

J. L. T.

SPORTS NEWS

EDITORIAL

During April, the Cross-Country Club won yet another cup, the Squash team reached the final of the U.H. Cup, and the Rugger Club, unfortunate enough to be drawn against Wasp's, were defeated in the 1st round of the Middlesex Seven's, but did very well to reach the final of the U.H. Seven's, beating Guy's on the way, with only the linesman to cheer them on.

Whilst lack of support for Bart's teams is proving to be quite a controversial topic, mention must be made of the Canoe Club, fuller details of which are to be found elsewhere in this month's Journal. The Canoe Club is without doubt the most successful of Bart's teams at the moment, and intense research into the history of Bart's sport would be unlikely to reveal any more successful club at any time. It is not often that a University College can boast possessing National Champions and International Representatives in any sport, and that Bart's should be able to do this twice in less than a year—R. Nicholson is now secretary of the University of London Boat Club, which last June won the Henley Grand Challenge Cup and represented England in the European Rowing Championships—is something that should not pass unheralded. C. Evans and B. Watkins deserve as much encouragement and support as possible in the next few months, during the pre-Olympic period.

B.L.

JUNE CALENDAR

Saturday, May 30th
Ladies' Tennis v Bedford College, 1st (H) 2nd (A)
Sunday, May 31st
Golf v Mr. Hankey's Team, Tonbridge.
Friday, June 5th
Ladies' Tennis v Newnham College (A).
Saturday, June 6th
Ladies' Tennis v Girton College (A).
Rowing—Walton Regatta.
Sunday, June 7th
Ladies' Tennis v Cambridge University (A).
Tuesday, June 9th
Rowing—Metropolitan Regatta.
Wednesday, June 10th
Rowing—Metropolitan Regatta.

Thursday, June 11th
Rowing—Metropolitan Regatta.
Wednesday, June 10th
Ladies Tennis v St. Thomas' Hospital (H).
Thursday, June 11th
Swimming v O. Stortfordians (A).
Saturday, June 13th
Rowing—Reading Regatta.
Wednesday, June 17th
Ladies' Tennis v Charing X Hospital (A).
Friday, June 19th
Swimming v Bank of England (A).
Saturday, June 20th
Ladies' Tennis v London Hospital 1st (A). 2nd (H).
Rowing—Marlow Regatta.
Wednesday, June 24th
Ladies' Tennis v School of Pharmacy (H).
Swimming v Old Paulines (A).
Saturday, June 27th
Ladies' Tennis v Guy's Hospital (A).
Wednesday, July 1st
Swimming v Old Citizens (A).
Ladies' Tennis v Royal Free Hospital (H).
July 1st—4th
Rowing—Henley Royal Regatta.

GOLF CLUB REPORT

Wednesday, March 25th, v London Hospital at Blackheath. Lost 5-0.

This match was played on a bitterly cold day with an under-strength team. The London's team was far superior and had a decisive win.

Team: Atkinson, Bowen, Weston-Burt, Morrison.

Wednesday, April 8th, v Charing Cross Hospital at Roehampton. Cup Match. Won 3-2.

This match was played in perfect conditions over the rather flat Roehampton course with a full-strength team. Stephenson, Vartan and Weston-Burt are to be congratulated for fine wins, particularly the latter who achieved an exceptional '9+7'.

Team: Atkinson, Stephenson, Thomas, Varton, Weston-Burt.

Wednesday, April 15th, v Guy's at Croham Hurst. Lost 4-1.

Playing in perfect conditions with a stiff wind on most of the outward 9 holes, Weston-Burt secured our only victory against a Guy's team containing 4 University players. Bowen did very well to take McCay, the University Champion, to the 18th green.

Team: Atkinson, Bowen, Thomas, Varton, Weston-Burt.

R.A.

CANOE CLUB REPORT

The first National Long Distance Race of the season was held at Oxford on March 11th. The course was 13 miles of smooth water with four portages.* There was very little opposition and the Bart's pair, C. Evans and B. Watkin paddled over to win in a new record time of 1 hr. 52 mins.

The Royal Canoe Club's Long-Distance race was held on the Thames, two weeks later, over 12 miles and two portages. The same Bart's pair led all the way up stream to the turning point, but were unable to shake off the Lincoln C.C. pair who remained in close contact. On the home run Bart's were first into the portage, and rowed away to a 70 yard lead. With 15 mins. paddling left, the Bart's crew were confident of victory, but in the last 500 yds. their timing completely disappeared, and the Lincoln pair won by four feet in 1 hr. 24 mins. 5 secs. This was our only defeat in a long-distance race in this country since May 1962, and the long period of success has led to complacency and neglected boat-work. There followed three weeks of hard training and the crew went to Leamington on April 12th determined on revenge.

The course at Leamington is 13 miles with four rather tricky portages, and due to the number of boats (132), Bart's had to start two minutes behind the Lincoln C.C. pair. After paddling through virtually the entire field, we caught them about a mile after the turning-point. After an exhausting tussle, we passed them, crossed very fast over the third portage, and pulled away to finish 1 min. 23 secs. before them, in a new course record of 1 hr. 46 mins. 12 secs.

The Canoe Touring Club long distance race was held over 15 miles and 2 portages on April 25th, and the Bart's pair, C. Evans and B. Watkins made a fast, clean start and soon drew away from the opposition. At the first portage, six miles out, they had established a lead of 1½ minutes. Increasing the speed on the smooth water above Teddington Lock, they drew further away, and crossed the Lock with a four minute lead and paddled strongly home to win by a margin of 5 mins. 50 secs. in a new record time of 1 hr. 42 mins.

Latest result—Bedford L.D.—Won easily in new course record.

* A 'portage'—carrying necessary between 2 navigable rivers.

FENCING CLUB REPORT 1963/64

The Fencing Club has at last re-established itself, after a disappointing 1962/63 season. The club had great difficulties in obtaining professional tuition and an organised training time, following a brief and unsuccessful amalgamation with a new nurses club. Many new members, both experienced and otherwise, brought the number of fencers at the beginning of the season to the largest since the club's foundation.

Many newcomers to the sport fail to keep it up owing to their inability to progress as fast as they hoped. This very specialized sport does in fact need constant practice and a good deal of patience before the beginner can fight freely and really enjoy it. However beginners often fight in matches by their second season.

In October, Professor Anderson, the C.C.P.R. coach, gave us an excellent lecture/demonstration on the basic principles of fencing with all three weapons, Foil, Epée and Sabre. This was a very instructive evening and was a good start to the season.

We were fortunate indeed to find a new Professor, Mr. P. Pearson to teach us for an hour every week, and he proved a valuable asset to the club, it being essential for any club to have professional tuition if it is to thrive. Mr. Pearson gives good and comprehensive lessons to both beginners and veterans during the training sessions held every Tuesday from 6 p.m. onwards. The gymnasium is available for individual practice at any time.

This season the club had both men's and ladies' foil teams with matches against Bexleyheath, Wye Cottage, Barclays Bank, L.S.E. I.C. and National Provincial Insurance. A number of inter-hospital matches had to be cancelled.

Results:
Men's Foil—Won 2, Lost 4.
Ladies' Foil—Lost 3.

The individual fighting was of a high standard, and we were unlucky to lose in many close fights.

Men's Foil team: N. Richards, I. Cole, G. Kerrigan; also fought C. Ashley, I. Corrall, R. Farmer.

Ladies' Foil team: P. Kumar, H. Gordon, J. Lack.

We would like to congratulate Miss P. Kumar on being selected to fight for the University of London Foil team.

ATHLETICS

London University Athletics Championships, 1st and 2nd May.

Only 3 competitors and no supporters indicates the interest that these championships arouse at Bart's. However, the competition did have the moral but muted support of Dr. Charles Harris and Roger Sanders who were acting as officials.

On the Friday evening Chris Sutton ran the 440 yards in 53.3 seconds, a personal best, but failed to qualify for the final. However, he should prove a very useful runner for Bart's and U.H. Brian Scott (440 Hurdles) and Dan Tunstall Pedoe (1 Mile) qualified easily for their Finals on the Saturday.

On the following day, Brian Scott, hurdling with tremendous power and confidence, ran heats for the 120 and 220 Hurdles, came second in the 120 High Hurdles final in his own best time of 16.7 seconds, won the 220 Hurdles in a very close decision over Morgan of Guy's in the excellent time of 25.6 seconds and then in his fifth race of the day came second to Morgan in the 440 Hurdles in 60.3 seconds to Morgan's 68.3 seconds, amassing an individual total of 16 points.

Dan Tunstall Pedoe, last year's U.H. 3-mile champion, but considerably less fit than last year, ran himself right out in a slow tactical mile final, which included Giddings (a 4 min. 2 sec. miler) of Woolwich, to cover the final lap in under 60 seconds and break the tape 15 yards ahead of his nearest rival. He attempted the 3 miles which was only 30 minutes later but had to retire at 1½ miles with cramp.

So Bart's collected 22 points from two athletes and finished fifth out of the 30 teams competing and were only beaten by Goldsmith's (24 points) for the small colleges' cup. But where was the cross-country club spirit and where were the strong men for the field events who could have given us the two or three points we needed to win the small colleges' cup?

Results:

120 yards Hurdles, second, B. Scott (Bart's), 16.7 seconds.

220 yards Hurdles, first, B. Scott (Bart's), 25.6 seconds.

440 yards Hurdles, second, B. Scott (Bart's), 60.3 seconds.

1 Miles, first, D. Tunstall Pedoe (Bart's), 4 min. 22.8 seconds.

SOCCER CLUB

Season 1963-64

Record: Played 35, Won 13, Drawn 8, Lost 1

The improvement in the team's performanc this season is amply reflected in the recor of the results. However, there is obvious considerable room for further improvement.

The semi-final of the U.H. Cup was reache for the second time in three years, after defea ing King's College and the Westminster Ho pitals. Further progress was prevented by th London Hospital. The University of Londo League was taken rather less seriously than should have been, the final position bein fourth out of eight in Division II.

The improvement in the standards of pla was largely due to the effects of the five fresh men who played regularly for the 1st XI namely, Layton-Smith, Thew, Turner, Sutto and Derritt. Provided next year's intake con tains the usual number of footballers it should be possible to field a second XI regularly. This combined with the low average age of this year's 1st XI makes the future look bright for the club.

Once more Herbert proved of great value at inside-forward, being joint highest scorer with Sutton. Rawlinson moved from wing-half to full-back and improved his play considerably. He and McGechie provided a solid foundation for the defence. Finally one must mention Phillips who was elected Captain for the second year in succession. He has played extremely well this season and towards the end was rewarded by being selected to play for the United Hospitals.

TENNIS CLUB

This season the Hospital has three remaining from last year's team that reached the Hospital's Cup Final. We shall therefore have to rely on some new players. There appear to be a large number of people keen to play, who will form a good second team with plenty of competition for the lower pair of the first team. The outlook is healthy and promising.

The grass courts at Chislehurst should play well this season, and given some fine weather, some good tennis may also be played. A full fixture list includes a Cambridge Tour and an Oxford week-end. We are due to play St. Thomas's Hospital in the first round of the Hospitals' Cup.

A.D.E.

LADIES' HOCKEY CLUB

nited Hospital's Cup Final. Bart's 0, St. Mary's 9.

This match was played on the Middlesex round in late March. Bart's suffered badly rom not having their best team available and were swamped by Mary's in the first half. Seven goals were scored against them due both o excellent forward play by Mary's and a certain lack of co-ordination in the Bart's defence. However, an attempt was made to retrieve the situation in the second half and our forwards, especially S. Ketting, E. Saunders and W. Smith must be congratulated on their valiant efforts, which were always frustrated by the Mary's backs at the last moment.

I hope that members of the Hockey Club will show a little more enthusiasm for playing next season as apathy seems to be our main barrier to success.

Team: E. Saunders; W. Smith; S. Ketting; S. Macdonald; J. Thoroughgod; J. Bell; J. Young; M. Childe; P. Dengate; E. Evans; E. Neech.

CRICKET CLUB

Sunday, April 26th v London House, Home. Drawn.

The match started at 2.30 p.m.—the weather being very fine indeed. Bart's lost the toss and batted first. R. S. A. Thomas played a fine innings as opening batsman, supported well by B. Goldhill who scored 26. Bart's declared at 5 o'clock at 156-7, leaving the visitors—mostly Australians—120 minutes for the runs. The close of play score was 114-8, a draw well in the favour of Bart's.

Saturday, 3rd May, Home. v University of Sussex Won

Play started in the morning, rather later than 11.30 a.m., the appointed time. Bart's lost the toss again and were put in to bat. After rather a shaky start, Bart's were 70 for 5 at lunch. Helped by a score of 41 from C. P. Varton, Bart's finally arrived at a total of 134, leaving the visitors about 2½ hours to get the runs. P. E. Savage opened the bowling and in two spells dismissed five batsmen for only 13 runs.

We won this match by 52 runs, University of Sussex scoring 82. C. P. Vartan 41 not out.

P. E. Savage 5-13, C. P. Vartan 3-13.

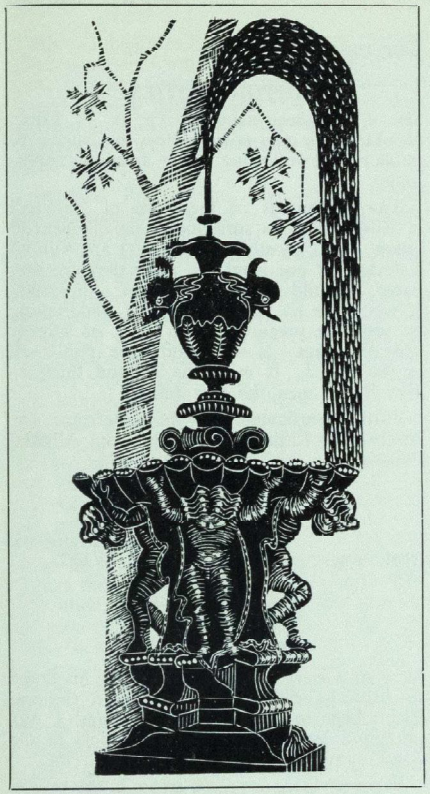
Sunday, 3rd May, v Putney Eccentrics, Home. Lost.

After heavy rain the evening before, the day turned out to be remarkably fine. We played, however, off the "square". We won the toss and elected to bat first. After a good opening partnership of 38, R. S. A. Thomas failed to run 22 yards in a short enough space of time. The wicket began to take a lot of spin and at the conclusion of our innings the Putney off-spin bowler R. James had taken 6-46. We were all out for 106. On the whole our bowling was ineffectual, although D. Husband bowled well. Putney Eccentrics made 108-7 a quarter of an hour from the close of play.

Wednesday, 6th May, v Royal Veterinary College. Away. 2.30. Drawn.

We were put in to bat at the Royal Veterinary College ground. The wicket was hard, the ball kept low but did not move much of the pitch. Despite this Bart's made a catastrophic start and continued in the same vein until all out for 50, three of which were extras. N. Griffiths applied himself to the job in hand and scored a useful 25. Having delayed tea for as long as possible our tail-enders were removed without further score, leaving them about 75 minutes to chase the runs, which to our surprise they found great difficulty in doing. J. R. Harrison and C. P. Vartan opened the bowling, the latter taking 6 wickets for 19 runs. The score at the close of play was 44-7—and the match was drawn, not without expressions of relief.

N. Griffiths 25, C. P. Vartan 6-19.



CONTENTS

EDITORIAL

This month the *Journal* celebrates the bicentenary of the birth of John Abernethy. We need make no apology for so honouring the man who can be regarded as the founder of our Medical College. With the gradual and seemingly incipient birth of the present-day methods of teaching medicine it is appropriate that we pay tribute to the man whose organisation and lecturing so popularised the school that a new lecture theatre had to be built for him.

Before the middle of the seventeenth century teaching was undertaken only in the theory of medicine but in 1662, nearly 540 years after the foundation of the Hospital, we first hear of students attending and learning in the Hospital itself: this has come to be the very basis of modern Bart's training. Today it is the essence of our medical training in this Hospital that the student be encouraged not only to learn by attending lectures but also by the actual participation in the theatres, wards, clinics, etc. And if at times it may be argued that the student is too often used as a porter, the system as a whole is successful in that it enables men trained at Bart's and similarly inspired medical schools to be a better equipped to deal with medical practice than those whose medical training is almost all theoretical.

After the introduction of students into the Hospital in the mid-seventeenth century progress was still very slow and it was not until 1734 that leave was granted for formal lectures to be given in the dissecting room. In January 1788 John Abernethy, as Assistant surgeon to the Hospital, started his lecturing. From this time onwards Abernethy set about the task of giving a form to the medical school. This is the debt owed to Abernethy and for which he will be remembered long after his eccentricities have been forgotten. Despite this it was not until 1921 that the medical school was granted a charter of incorporation and known as 'The Medical College of St. Bartholomew's Hospital in the City of London'.

Apart from the Library and the Museum for which we can also thank him, John Abernethy founded what we now know as the Abernethian Society. This is the oldest of all Bart's societies and one that is wholly run by students, the policies are in no way inspired or controlled by staff, an admirable state of affairs.

Throughout his lifetime Abernethy came into conflict with authority. As a result of this he never really received the recognition he deserved from the Hospital. Unlike those great men who, although largely unheralded during their lives, have been duly recognised after death Abernethy seems to be still unloved by authority. The bicentenary of his birth has gone unnoticed by Hospital or College apart from a brief mention in the Queen Mother's speech at the opening of the new buildings at Charterhouse. Bart's has often been accused of placing too much emphasis on its history but this is surely an occasion to mark in suitable style. It is to be hoped that the lead given by the Journal will be followed. This year has seen the welcome renovation of the Great Hall, one of Bart's most treasured possessions, and this would provide a suitable venue for some form of celebration. A proud past can be the basis of a successful future.

"Argus" will be back as usual next month.

Correspondence

OPPORTUNITIES

Sir,—I have been asked by Dr. A. W. Little, an old Bart's man now resident in Canada, to publicise the following rather splendid opportunity.

The inhabitants of the town of Vauxhall in Alberta and its surrounding neighbourhood (about 8,000, mostly rich farmers) are without a doctor. If one would go there they are prepared to build him a house *and* a hospital! It would be an adventure worth undertaking by someone prepared to do a bit of surgery and obstetrics. It will shortly be publicised in the B.M.J. It might be a good thing to give Bart's men the first refusal.

Further particulars may be had from: Dr. Andrew W. Little, Box 640, Nanton, Alberta, Canada.

Yours faithfully,
GEORGE ELLIS,
15 King Edward Mansions,
23rd May 8 Grape Street, W.C.2.

Sir,—As a Bart's man who has made his home in Australia rather than work as a General Practitioner in the N.H.S. in England I was interested by Kenneth Carroll's article in the April number which has just reached me.

However there are some errors in the article. There is very definite selection and restriction on the number of students accepted for the medical course at the Universities of Melbourne, Monash and Adelaide. This has been so for some years, and the University of Western Australia also limits its medical intake. The result is that Australia produces fewer doctors than are needed to maintain a steady doctor-patient ratio in face of a rapid natural increase and an active immigration policy. I understand from *The British Medical Journal* and *The Lancet* that the United Kingdom has a doctor shortage due to emigration. Australia has a doctor shortage in spite of immigration of many doctors.

In Victoria, at least, it is not necessary to do 12 months House jobs before coming fully registered. However most people do take these jobs to get experience of doing things which they do not do as students.

Carroll mentions the Association of General Practitioners. I am sure that the Council of the Australian College of General Practitioners would be most hurt to think that news of their incorporation as a College had not yet reached Queensland (where I presume Dr. Carroll is to be found).

Medical Practice in Australia is Private practice much the same as it was in England before the war. But it has been improved by the Commonwealth Medical Benefits scheme, which has been in its present form since 1953. The Government pays the Benefit Societies a standard sum for any particular service, and at present there are 1,714 different items, and the benefit organisation matches the governmental contribution. The patient claims from his Benefit Society and receives up to 90% of the doctor's bill as a refund. As from the first of June a £1 1s. 0d. consultation fee will bring a minimum refund of 16/-. (Incidentally my bank allows me 16/- sterling for each £A1 I remit to England). This scheme means that the patient pays his doctor, who can if he wish reduce his fees for the needy, 5/- or less each time he sees him. So the harder the doctor works the more he earns, which is some compensation for disturbed nights. The standard of surgery accommodation the Australian G.P.s offer their patients is much higher than anything I saw in England. The G.P. can afford to invest money in his premises as he knows that good working conditions enable him to practice better medicine. Pensioners are treated under agreements with the Commonwealth Government for a reduced fee. They sign a voucher when they see the doctor and he forwards the vouchers to the appropriate department who send him his cheque.

Modern medicine is dependent to a large degree on expensive drugs required for his treatment under the Pharmaceutical Benefits Act, at a cost of 5/- for each prescription. Pensioners get their drugs free.

Living in Queensland, Carroll would see a different form of hospital practice from the rest of Australia. There is a free Hospital Service in Queensland, elsewhere the patient pays at least for his board and lodging in hospital, and if he cannot pass a means test he pays his doctor as well.

Though the Australian Labour Party has promised a free health service it is unlikely that the A.L.P. will obtain power for many years as their left wing flirts too openly with the Communists for the party to attract many new voters. The Liberal Party, at present in power, introduced the present scheme. Doctors in Australia working in hospitals or for the Government are entitled to a 40-hour week with overtime, though it is not often claimed, and a 24-hour N.H.S.-type G.P. service on those terms is too expensive to contemplate. If there is an extension of free medical care it will be on the lines of the New Zealand scheme with fee for service for the G.P. and free hospital treatment.

I thoroughly enjoy my very busy life (I have been trying to find time to write an article on General Practice in Australia for over a year) and would not wish to practice anywhere else in the world. It is a grand country with every variety of climate and all sorts of medical opportunities, and a large number of Bart's men Come and join us.

Yours faithfully,
R. J. KNIGHT,
P.O. Box 97,
Morwell
Victoria,
28th May. Australia.

BELL RINGERS

Sir,—Would any bell-ringers who would be interested in ringing a quarter peal with other members of the hospital staff please contact Miss G. Sims or Miss D. Hopkins, Pharmacy.

Yours faithfully,
GILLIAN SIMS.
28th May. Pharmacy Dept.

C. N. D.

Sir, I should be most interested to learn if it is the normal editorial policy of the Hospital *Journal* to print direct and unfounded lies as statements of fact. May I also express the very sincere hope that the writer of your "Up to the Minute in a Moment" column is not a member of the medical staff, for should he apply his diagnostic formula of: "Take two mis-statements of fact and have a guess based on these", as he does in his writings to

patients' bodies I shudder to think of the result.

I refer, of course, to the beginning of this column in the May issue of the *Journal* and will now quote verbatim the passage in question:

"One of the features of recent Easters has been the Aldermaston march. This year, the Committee of 100 cancelled the march and organised instead an expedition to the U.S.A.F. base at Ruislip in Middlesex to reclaim the base for peaceful purposes; however, only 350 people turned up and were met by 1,000 police. This seems to be the end of C.N.D."

I am a member of the London Committee of 100, was present in person at Ruislip, was working 18 hours a day (approx.) over the holiday period, and as a believer in moral honesty would like to give your readers a true picture of what did, in fact, happen this Easter.

Long before there was a Committee of 100 there was an Aldermaston march, organised originally by the now extinct Direct Action Committee as a walk from London to Aldermaston, and from 1959 onwards from Aldermaston to London by C.N.D. It would, therefore, be somewhat difficult for the Committee of 100 to cancel something we never organised. You also state that only 350 people turned up at Ruislip. Certainly only 350 arrests were made (just under that to be precise), but let us disregard our own estimates and take instead those of the British Political Police, known as the Special Branch, who stated quite correctly in open Court that thousands of people had come to Ruislip to demonstrate. Some of my friends are still in prison as a result of that demo, but let no-one say that H.M. half-brick force are not completely detached for was not the Rev. Charles Stimpson, an old man of 74, in very bad physical condition only just released from the Scrubs; and is not Lily Lee, another Old Age Pensioner in bad health, still inside Holloway with Pat Arrowsmith and the other young girls.

As for C.N.D. and Aldermaston. The Government will shortly be closing Aldermaston. In view of this and the fact that the march had lost its original impact, the National Executive of the Campaign decided that there would be no Aldermaston this year. Instead, the various regions were to concentrate on local activity for three days and there was a mass rally in Central London on Easter Monday (Police estimates? 12,000). I am afraid that for the Monday I cannot give you my own estimates, for as Committee Welfare Officer I had to go down to Ashford Remand Centre to see some lads under 17 who had been arrested; and from there to the airport to see off some friends of mine in the Belgian Peace Movement whose guest I had been a few weeks earlier.

I should like to close by asking anyone in the Hospital who is interested in the ideas and future activities of the Committee to contact the dispensary porter who is, of course, the writer of this letter.

Yours sincerely,

TONY P. M. MURPHY,
33 Wendover Buildings,
Chiltern Street,
7th June. London, W.1.

MEDICAL EDUCATION

Sir,—The May issue of the Journal contained a review by T. J. McE. of the Report of the Symposium on the "Teaching of Biochemistry to Medical Students". As this Symposium was held in Charterhouse Square in September, 1962, it seems a pity that more detailed prominence was not given to it in the Journal shortly after the actual event. So far as I am aware, no similar Symposium on this subject has ever been held before.

It was perhaps natural that the reviewer should discuss in most detail my own contribution on "Preclinical Examination Systems", which dealt mainly with the merits of Objective Examinations. I, personally, feel that in this Department of Biochemistry we can take some pride in the fact that 7 years ago we were one of the first Departments in the country to start investigating this relatively new type of examination. Now, Objective Examinations are accepted as part of the 2nd M.B. Biochemistry, are in use in other Universities and even in Final clinical papers. T. J. McE., however, comes out fairly strongly against Objective Examinations and woven into his criticisms is much of his own philosophy of medical education. Many of the views expressed are, I believe, incorrect and I should like to redress the balance.

T. J. McE. is enamoured with viva voce examinations, mainly on the grounds that the examiner-pupil test imitates, to a certain extent, the Doctor-Patient relationship. I suggest that he does not understand the primary function of examinations. This is, to find out as quickly, accurately and as fairly as possible just how much of the subject the student has learned and understood. Written examinations accomplish this end in the best possible way. It is not the function of examiners to arrange examinations which play act possible or even probable future roles of successful students! Viva examinations are generally a slow, exhausting and inaccurate method of assessing students, but in certain limited circumstances they may be desirable; in re-assessing students who have borderline marks in the written examination, in selecting special students for scholarships or when the subject matter of the examination is especially suitable, e.g. clinical medicine.

T. J. McE. agrees that it is possible to obtain very similar examination results using either the Objective or Essay examination and suggests that this fact argues for the retention of essay examinations. I feel that he does not appreciate the fact that most university teachers in the country are extremely conservative, and that they, having used essay examinations for many decades, would reject Objective Examinations immediately if an equivalence of the two types of examination could not be substantiated. As I have explained in my article, I am sure that Objective Examinations actually have many advantages, a few of which may be quoted: large syllabus coverage, absolutely fair marking and a great economy of time both in writing and marking. For example, it is now easily possible for students to sit a complete Objective 2nd M.B. examination and for the papers to be marked in a single day!

One criticism of Objective Examinations which has often been made is that they do not provide training in the writing of good English. I have drawn attention to this fact in my article and have stated that "it is difficult to see why teachers of scientific subjects in a university should be expected to teach or evaluate English," a statement which has been taken up and used by T. J. McE. as a strong argument against Objective Examinations. I reject this criticism and stand by my original view. It may be sad that teachers in science do not teach or evaluate English but it is a fact. There is simply insufficient time to do this. When marking biochemical essays, we search diligently, and, too often in vain, for accurate biochemical facts or properly understood concepts. Having found a few such facts and a certain limited understanding, would your reviewer then wish us to reduce the awarded marks on the grounds that some words are mispelled, some of the grammar is incorrect or that the style is poor? Too few pass the examinations at present! Conversely, does he really believe that well written nonsense should be given good credit?

American students, who are brought up with Objective Examinations almost from Infant School, do, in my opinion, write very poor English and for this reason I have suggested that written examinations of some type should not disappear from schools, and certainly not from traditional Arts Subjects. By the time that British students come to university I do feel that they should have a reasonable command of adequate English and that scientific teachers should not be expected to educate them further in this field. If further training in writing English is necessary I do not believe that essay examinations are the best way to accomplish this end. It would be much better to request the writing of relatively long reports on scientific subjects.

It is interesting that American students speak English very well, in spite of their lack of writing ability. Objective Examinations do not appear to have impaired their prowess in conversation and they are very much more accomplished in the technique than their British counterparts. In modern life it is surely a great asset to be able to communicate confidently by the spoken word.

T. J. McE. also implies that students would respond much more readily to stimulating teaching and to interesting subjects than they would to the threat of examinations. Most, if not all, university teachers wish that this were the case, but all the facts point in the other direction. On numerous occasions interesting subjects without examination status have been introduced into 2nd M.B. and other courses, e.g. Psychology in the Preclinical 2nd M.B.

course here, and several other subjects of interest, Genetics, Radiobiology at a neighbouring Medical School. In every case the verdict has been the same; that although a few students will work hard without examinations, most students will not attend or work diligently at a subject unless an examination is incorporated.

Physical laziness is apparent for all to see but intellectual laziness is more insidious and much more difficult to check. It is mainly for this reason that examinations are essential. Dabbling into a subject is an easy and possibly pleasant occupation, but the intellectual effort required for mastery of the subject is quite another thing. This effort usually brings a reward, as interest develops as the subject is learned and understood. Examinations in university were originally instituted to protect the public against charlatans, and now, with a large public investment in every student, they are more essential than ever before.

The problem is world wide. American students work hard but are subjected to examinations with great frequency. In Universities in the U.S.A. examinations are held monthly and sometimes more frequently, all marks being added for a final assessment. Objective examinations fit ideally into this pattern of frequency.

In summary, if T. J. McF. really believes all he has written, I feel that he appears to be living in a dream world where all students are perfect. Perhaps he could encourage some of them to come to Bart's?

E.D.W.

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.

Calendar

JULY

Sat. 4th:	Dr. A. W. Spence Prof. G. W. Taylor Dr. R. W. Ballantine
Sun. 5th:	Dr. A. W. Spence Mr. A. H. Hunt Dr. R. W. Ballantine
Mon. 6th:	Mr. C. Naunton Morgan
Sat. & Sun., 4th & 5th:	Mr. Aston Mr. Fuller
Sat., Sun. & Mon., 11th, 12th & 13th:	Prof. Scowen Prof. Taylor Mr. Burrows Dr. Ian Jackson Mr. Cope
Sat., Sun. & Mon., 18th, 19th & 20th:	Dr. Bodley Scott Mr. Alan Hunt Mr. Manning Dr. T. B. Boulton Mr. McNab Jones
Sat., Sun. & Mon., 25th, 26th & 27th:	Dr. E. R. Cullinan Mr. C. Naunton Morgan Mr. Aston Mr. F. T. Evans Mr. Hogg

Physician Accoucheur on Duty for the month of July is Mr. J. Howkins.

Please note that owing to the closure of Mr. Tuckwell's firm during July, the Monday Surgery Duty is taken by the firm doing the weekend duty.

Engagements

PLUMPTRE—ROBBINS.—The engagement is announced between Martin Plumptre and Janet Robbins.

RITCHIE—BURN.—The engagement is announced between Russell Hamer Ritchie and Ruth Margaret Burn.

STEVENS—WILLOUGHBY.—The engagement is announced between John Edward Stevens and Priscilla Jane d'Eresby Willoughby.

KUUR—MARTIN. — The engagement is announced between Johannes Berend Gerard Kuur and Carol Rosemary Martin.

Marriage

KNOX—WILLIAMS.—On May 16, Dr. Andrew John Stuart Knox to Catherine Susan Juliet Williams.

Births

MILLER.—On May 7, to Jane (née Evans) and Dr. Richard Miller, a daughter.

PARRISH.—On May 27, to Elizabeth (née Corlett) and Dr. Anthony Parrish, a daughter.

STEEL.—On May 14, to Rosamund (née Sapwell) and Dr. Peter Steel, a daughter, sister to John, Sarah and Caroline.

TREHARNE.—On May 9, to Hermione and Dr. P. G. Treharne, a second son (Andrew David).

TATLER.—On May 22, to Christine (née Hicks) and George Tatler, a son (Simon).

Deaths

MACLAY.—On April 27, Hon. Walter Symington Maclay, C.B., M.D., F.R.C.P., D.T.M. & H., D.P.M., aged 62. Qualified 1927.

O'CONNOR-PARSONS.—On May 18, Dr. Eric O'Connor-Parsons, L.M.S.S.A. Qualified 1933.

SIMPSON.—On May 2, Dr. Reginald Hugh Simpson, M.D., F.R.C.P., D.T.M. & H., aged 73. Qualified 1914.

STARKEY.—On April 24. Group Captain H. S. Crichton Starkey, O.B.E., M.D., D.P.H., aged 78. Qualified 1909.

WHITE.—On May 15, Dr. Ernest White, M.B., B.S. Qualified 1910.

Appointments

Royal College of Physicians of London

At a comitia of the College on April 30, the following were elected to the fellowship: J. H. Hunt, David Weitzman, A. M. Joekes, H. Lehmann, George Simon.

The following were elected to the membership: J. A. Bonn, E. G. Cantrell.

Sir Christopher Andrewes has been elected to associate foreign membership of the National Academy of Sciences in Washington.

Dr. R. Bodley Scott has been appointed senior consultant physician to British European Airways.

Obituary

PROFESSOR ARTHUR WORMALL

D.Sc.(Leeds), D.*hon.caus.*(Sao Paulo), F.R.I.C., F.R.S.

Arthur Wormall was born on January 17th, 1900, educated at the Boys' Modern School, Leeds, and the University of Leeds, and joined the teaching staff of Leeds University in 1922. From the very beginning he showed abundant evidence of those qualities which were to make him such an outstanding success when he came to Bart's in 1936 as the first Professor of Biochemistry and Chemistry at a London Medical College.

He had a profound influence on the teaching of Biochemistry to medical students, and built up from an amalgamation of Chemical Physiology and the old Chemistry Department, with a very meagre staff, the flourishing Department of Biochemistry which exists today. He was always insistent that the biochemistry taught in his department must be relevant to medicine and persistent in his efforts to secure closer integration between preclinical and clinical biochemistry. His students were encouraged from the very beginning to carry out experiments on themselves, and many of today's doctors will remember his words, as he gently encouraged a stomach tube down their reluctant throats: "If you're going to do this to your patients you must be prepared to do it to yourself!" Many, too, will remember his insistence that it is never too early for a doctor to cultivate cleanliness of habit, and even in the laboratory " . . . the bench should be clean enough to eat your dinner off it!"

His chief research interest was in the field of immunology, but his colleagues were continually amazed at the breadth of his interests

and knowledge. Besides his work on hæmolytic complement and immunology, and general reviews on Immunology, the Physiological Aspects of Additions to Foodstuffs, Heparin and Animal Biochemistry, his publications include accounts of work on problems of plant physiology, the influence of thiocyanate on salivary diastatic action, a survey of vitamin C nutrition in war-time students, and studies on the biochemistry of skin.

In 1930 also, he spent a year in Uganda at the request of the Colonial Office studying the use of the drug Bayer 205 (Antrypol) in the treatment of trypanosomiasis; and he often spoke of ". . . doing research under a banana tree in the middle of Africa with only a native boy to turn the hand centrifuge." Experiences such as this made him sometimes a little impatient with those who demanded more and yet more expensive equipment before they could start work.

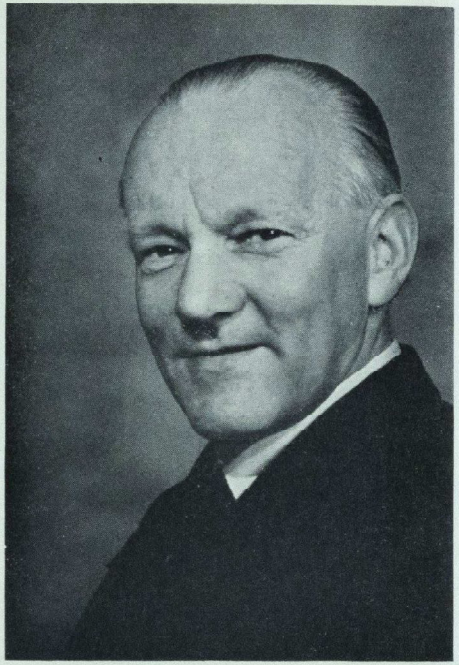
He took justifiable pride in the carefulness and accuracy of his work. It was characteristic of him that after discovering the fourth component of complement he spent nearly a year in meticulously checking his findings before publishing the results in 1926, and manuscripts submitted by him for publication never required more than the very minimum of editing.

In addition to his pioneer work on complement, he was also the first in this country to use radioactive isotopes in biological investigations, starting work on mustard gas in 1937 at a time when not only the isotopes, but also the measuring equipment had to be manufactured by the investigator himself. His pioneer work in this field received recognition by the conferment on him of a Doctorate *honoris causa* by the University of Sao Paulo in 1953 after he had conducted there the first Latin American course on Isotope Methodology.

For his services to science he was elected an F.R.S. in 1956, the same year in which he became a member of the M.C.C., and it is very doubtful which of these two distinctions he valued the more!

He was a highly respected and invaluable member of very many College and University committees, and was a Governor of the College and Hospital.

However, it is not for his professional attainments that most of us will remember



Professor Wormall

him, but as a true friend, always considerate, always courteous, and always exhibiting a truly personal interest in all his students and his colleagues. None was ever too unimportant for his attention; his encyclopedic knowledge was freely at the disposal of all, and in any joint endeavour he was always meticulously careful to ensure that most of the credit went to his collaborators.

Somewhere in the Elysian Fields I hope Arthur Wormall has recovered his dexterity at one-handed juggling with a golf-ball, and finds time for the cricket and golf he has so sadly missed of recent years.

Our deepest sympathy goes out to his widow and his two daughters on their loss. But we shall miss him too.

G. E. FRANCIS.

EXAMINATION RESULTS

University of London
Final M.B., B.S. Examination
April, 1964

Honours

Tucker, A. K. (Distinguished in Obstetrics and Gynæcology)

Pass

Abayomi, I. O.
Abell, E.
Bailey, R. G.
Bean, B. E.
Bodley Scott, D. D.
Bond, J. V.
Bown, R. L.
Britz, M.
Da Silva, A. H.
Frears, C. C.
Fry, D.E.
Gilkes, J. J. H.
Groves, R. J.
Haig, G.
Hamshere, R. J.
Hillier, E. R.
Hunter, D. L.
Jackson, J.
Knill Jones, J. G.
Knox, A. J. S.
Kohli, S. C.
Latham, D.
Letchworth, A. T.
Matthews, J. M.
Platt, N. D.
Poore, P. D.
Reeve, D. R. E.
Ritchie, R. H.
Salisbury, N. S.
Shearman, J. K.
Shorey, B. A.
Stephens, K. MacG.
Sutton, D. R.
Tam, Y. D.
Thoroughgood, J. E.

Part I. Supplementary Pass List

Anderson, B. T.
Barretto, J. H.
Billington, B. M.
Bucknill, T. M.
Chant, A. D. B.
Clements, E. A. F.
Danesh-Haeri, A. A. C.
Fletcher, M. W.
George, W. T.
Harris, S. G.
Herbert, T. J.
Houghton, A. L.
Labrum, A. S.
McLaughlin, J. E.
McNie, D. J. M.
Milla, P. J.
Nicoll, J. M. V.
Percival, G. M.
Phillips, H.
Pitt, J. M.
Powles, R. L.
Ratcliffe, J. F.
Shand, D. G.
Williams, C. S. J.

Part II.

Cadle, D. R.
Davies, W. A. M.
Howat, I.
Phillips, M.

Part III.

Harper, D. R.
Howat, I.
Kenyon, S. P.
Phillips, M.

Part IV.

Burnham-Slipper, C. J.
Cadle, D. R.
Davies, W. A. M.
Harper, D. R.
Kenyon, S. P.

Conjoint Board
Final M.R.C.S., L.R.C.P. Examination
April, 1964

Abell, E.
Bean, B. E.
Bown, R. L.
Da Silva, H. A.
Fry, D. E.
Jackson, J.
Knill-Jones, J. G.
Knox, A. J. S.
Letchworth, A. T.
Matthews, J. M.
Pott, N. H.
Salisbury, N. S.
Shearman, J. K.
Sutton, D. R.
Thoroughgood, J. E.

Supplementary Pass List

Pathology

Shorey, B. A.
Bucknill, T. M.
Chant, A. D. B.
Danesh-Haeri, A. A. C.
George, W. T.
Pine, R. C.
Wilkinson, J. M.
Morison, S. R.
Billington, B. M.
Cooke, T. J. C.
Foxton, A. T.
Nicoll, J. M. V.
Underwood, J. C. E.
Anderson, B. T.
Brooks, W. A.
Clements, E. A. F.
Fletcher, M. W.
Percival, G. M.
Williams, C. S. J.

Medicine

Reeve, D. R. E.
Petty, H. R.
North, P. J.
Kohli, S. C.
Haig, G.
Groves, R. J.

Surgery

Shorey, B. A.
Ritchie, R. H.
Platt, N. D.
Haig, G.
Groves, R. J.
Burnham-Slipper, C. J.
Davies, W. A. M.
Howat, I.
Thomas, M. G. W.

Midwifery

Ritchie, R. H.
Reeve, D. R. E.
Cadle, D. R.
Burnham-Slipper, C. J.
Owen, D. G.
Morison, S. R.
Carden, E.

HOUSE APPOINTMENTS

JULY 1964

Jun. H.P. to Dr. Cullinan	Catlin, J. L.
Jun. H.P. to Dr. Spence	Hunter, J. E.
Jun. H.P. to Dr. Bodley Scott	Perring, M. A.
Jun. H.P. to Dr. Hayward	Sutton, D. R.
Jun. H.P. to Professor Scowen	Shearman, J. K.
Casualty House Physician	Shorey, B. A.
Jun. H.S. to Mr. Naunton Morgan	Hunter, D. L.
Jun. H.S. to Mr. Hunt	Stephenson, T. P.
Jun. H.S. to Mr. Badenoch	Hamshere, R. J.
Jun. H.S. to Mr. Tuckwell	Knox, A. J. S.
Jun. H.S. to Professor Taylor	Ritchie, R. H.
Casualty House Surgeon	Richards, C. J.
Jun. H.P. to Children's Dept.	Littlewood, P.
Jun. H.S. to Gynæ. & Obst. Dept.	Tucker, A. K.
H.S. (3) to Orthopædic Dept.	Bown, R. L.
	Haig, G.
	Kohli, S. C.
H.S. to Ear, Nose & Throat Dept.	Letchworth, A. T.

ADVERTISING NEWS

A new tourniquet, specially designed for use when taking intravenous samples of blood, has been produced by **Seton Products Ltd.,** see their advertisement inside back cover.

Cliffords, the hairdressers, have opened a new branch which they claim is their most luxurious yet; it is called Figaro, and is in the Smart Weston store at 131, Victoria Street —
Telephone: VIC 2948

Bartholomew Fair has recently opened opposite the Hand & Shears; it specialises in stockings and birthday cards.

FIFTY YEARS AGO

From the Bart's Journal of July, 1914

NATIONAL HEALTH INSURANCE ACT

To the Editor of the 'St. Bartholomew's Hospital Journal.'

Dear Sir,—It was with a feeling of indignation and disappointment that I read in the May number of the *Journal* that the benefits of the National Health Insurance Act were held out as an inducement to men to join the medical profession.

No doubt it is true that many "small and insignificant" practices have been improved pecuniarily, but, on the other hand, many practices, especially in country districts, have been degraded. Indeed, the greatest fault of the Act, to my mind, is that it tends to reduce medical work to the dull level of mediocrity, and, as to the man who has to treat panel patients only, it were better for him that a millstone were hanged about his neck, and he cast into the sea.

Panel patients are taught not to expect, and medical men are not required to give, more than ordinary club-practice attention, and most of us know how very inferior that can be. The incentive for a doctor to do his best for his patients is removed, and in difficult cases his responsibility ends with telling the patient that some particular treatment or operation ought to be carried out.

The effect of the Act in my experience has been to increase fourfold the proportion of panel patients who come on the sick list, as compared with members of friendly societies as they existed before the Act, and during the last year no less than fifty per cent. in one county and forty in another, of all the patients on my panel list have been on the sick list at least once, and several of them on more than one occasion.

A panel doctor is no longer a free agent; he has to be in his surgery at stated hours every day, no matter what other engagements he may wish to make, and the records entailed by the Act involve an immense amount of clerical work of a very aggravating nature—for instance, in order to get payment for medicine supplied to "sanatorium patients" it is necessary for the doctor to write out the prescriptions which he himself dispenses, and to price every item of drugs therein, and this he has to repeat in detail for every mixture or pill supplied, although the same prescription may have been dispensed many times before to the same patient.

There certainly ought to be greater uniformity in the matter of certificates, as at present each friendly society has its own rules which are very different and very confusing.

As a whole, I consider those whom the Act is meant to benefit are very dissatisfied. Especially is this the case with the large body of better class domestic servants, who formerly were treated as private patients and now have to conform to irksome regulations laid down for panel patients. The people who really benefit by the Act are the employers of these servants, who formerly paid the doctor's bill, but who now expect to get them treated as assiduously as ever by the panel doctor, and who are relieved of all responsibility by the payment of 3d. per week, of which the doctor gets only a small proportion.

In conclusion, I consider the Act (i) bad for the patient, because he is apt to obtain only superficial treatment; (ii) bad for the doctor, because he is tempted to scamp his work and is harassed by clerical work; and (iii) bad for the profession, because the best men are discouraged from entering it.

G.P.

VOX

Home

Sneezers deserve sympathy: the pollen count has been around the 400 mark for the past few weeks, while last summer it never rose above 120.

The typhoid epidemic in Aberdeen, although it has lasted 4 weeks and involved 450 cases, has been overdramatised. Treated early it is never today a dangerous disease, and in this instance the organism was of relatively low virulence. Only one death was recorded, and even then typhoid was no more than a contributory cause. It chanced that on the day of the first news of the outbreak, the papers also drew attention to the release of some antique stocks of corned-beef, bought by the Ministry of Agriculture as an emergency reserve in 1950. When the infection was traced to a meat-slicer, and it was further pointed out that an Argentina canning factory cooled its tins in unchlorinated water, public opinion had been sufficiently muddled to pin the blame squarely on the drooping shoulders of the Government. It would be less circumstantial and more constructive to focus attention on the overcrowding and archaic sanitary arrangements that persist in Aberdeen: not more than one family in three has its own private toilet facilities.

A good thing to come out of the epidemic has been a new look at the hygiene, or rather the lack of it, at some of our food markets. Criticism has been levelled at Smithfield and Covent Garden in particular.

Despite increased labour majorities at Faversham and the Scotland division of Liverpool, N.O.P.'s latest is a drop from 8.7% to 7.0% in the Labour lead. If this is extrapolated, it means a Labour majority of 70 seats at a General Election. The Government can gain some comfort from the unemployment figure which is at its lowest since 1961.

Many parking meters are to increase their appetite from 6d. to 1/- or 2/-. And if you don't want to park, you will probably have to pay even to drive in London soon, with a meter fitted to your car. The Barts area would be a cheap one—only 2/6 an hour.

The Salvation Army are entering the pop world with a group called the Joy Strings.

Abroad

The discovery in the walls of the American Embassy in Moscow of 40 microphones, which had been there for 11 years, produced some blushes from the State Department. The *Daily Mail*, however, reacted well with a cartoon of two Bolsheviks, deep underground, listening to the lunch-time scoreboard.

Meanwhile **Senator Goldwater's** surprise victory over **Mr. Rockefeller** in the Californian primary, has made him a hot favourite for the Republican Presidential candidate. He is an extremist; and although he can hardly be a serious challenge to **President Johnson,** his popularity is no small cause for anxiety. Some of the factors that have led to his emergence are **General Eisenhower's** reluctance to use his influence. **Mr. Rockefeller's** divorce and remarriage, and the Republicans' determination to unite a party which has been in pieces since 1960.

Deaths

On May 27th: **Mr. Jawaharlal Nehru,** the first Prime Minister of the Indian Union; he was a great mediator, and one of the few statesmen in whom vocation outlived personal ambition.

On June 9th: **Lord Beaverbrook,** for 50 years a force in politics and journalism; he was admired by **Sir Winston Churchill.**

On May 17th: **Lord Brabazon of Tara,** adventurous and versatile; the aircraft industry owes much to him.

Sport

The first Test Match, blighted by rain, was nearly saved from the inevitable draw by a majestic innings from **Dexter.** Apart from this the standard of cricket was low.

A referee's decision in a soccer match between Peru and Argentina at Lima, led to a riot in which 300 people were killed.

The Frenchman, **Eric Tabarly,** is leading in the single-handed transatlantic yacht race; the Wightman Cup stays in the States, but we beat Yugoslavia 3-2 to get into the last four of the European zone of the Davis Cup; and Santa Claus won the Derby at 15-8—now who doesn't believe in him?

Local

Dr. Ronald Bodley Scott was awarded a K.C.V.O. in the Queen's birthday honours list; we give him our sincere congratulations. Also ran—**Sir Billy Butlin.**

Mr. J. E. A. O'Connell performed a successful operation to separate Siamese twins on June 8th; one twin died, but this was inevitable.

The Squash team were beaten in the final of the Cup by St. Mary's.

THE TRIBULATIONS OF JOHN ABERNETHY

Commemorating the bicentenary of his birth.

By Alfred White Franklin

Address to the Abernethian Society of Saint Bartholomew's Hospital, 23rd April, 1964.

PART I.

Piety demands that this College of St. Bartholomew's and this Hospital keeps green the memory of their own immortals; William Harvey, genius, man of imagination; Percivall Pott, surgeon of ingenuity, William Lawrence, man of intellect; James Paget, man of virtue, and John Abernethy, man of character.

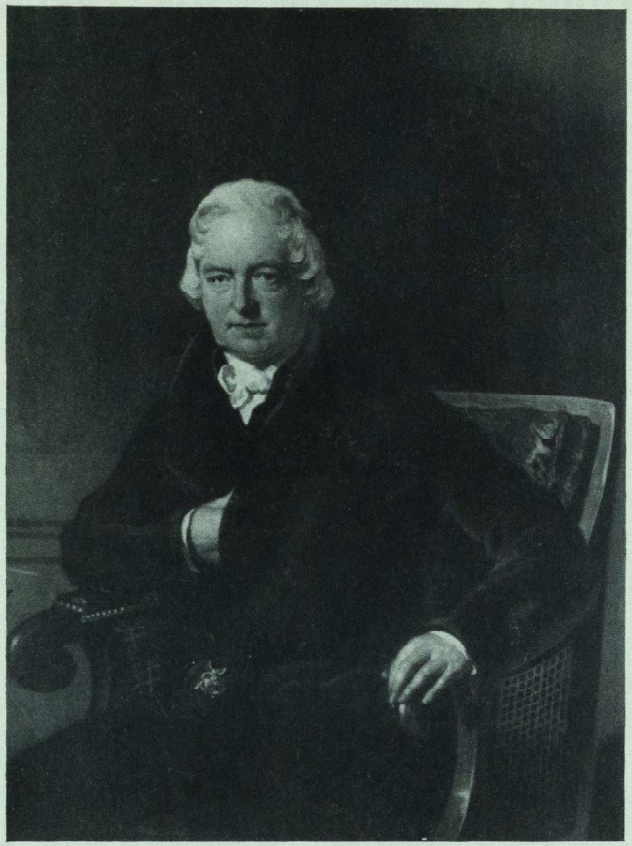
I do not propose a biography of Abernethy tonight. George MacIlwain, "one of the numerous and grateful pupils", published in 1853 a formal life which went into a third edition in 1856. One hundred years later our own John Thornton diligently pruned from MacIlwain its sentimental verbosity and searching successfully for new material wrote a short and readable life. My purpose is to describe some of the controversies into which Abernethy was drawn. From their analysis something may be learned of the character of the times and of the personality of our Founder as he adjusted himself or failed to adjust himself to the changing world of the early nineteenth century.

Abernethy founded this Medical College in 1791 and this Society in 1795. A Surgeon to the Hospital, he enjoyed a large practice, and as Teacher of Anatomy, he attracted to his lectures a vast crowd of medical students. He wrote and published a number of Essays, Lectures and Addresses and in 1809 his famous "Surgical Observations on the Constitutional Origin and Treatment of Local Diseases", a monograph on "Bowel Toxæmia" which achieved eleven editions in the ensuing twenty years. This he called "my book" and his patients were exhorted to buy it and to digest it, especially page 72, along with his prescription for Calomel at night and Magnesium Sulphate in the morning.

At the College of Surgeons he was Lecturer in Comparative Anatomy and Anatomy, Hunterian Orator, member of the Court of Assistants, Examiner and President. Perhaps he is best remembered as the hero of quotable anecdotes, brusque to the point of rudeness, but always practical; as when a loquacious Bostonian clergyman consulted him and kept mentioning his little "flock" that he had left behind to make the consultation possible. Abernethy said, "Damn your little flock, sir, stick out your tongue." Yet this bluff Northern Irish Scot was not everybody's hero. In posterity's foreshortened view a successful man's contribution to history appears bathed in a false light of inevitability. Nothing worth doing—and Abernethy accomplished much in his three score years and six—is ever easily done. To found an institution, to change the ways of a hospital already heavy with the traditions of six and a half centuries, means character, means that a man is ready to do battle, and battles mean enemies.

"Revolutions turn into institutions," wrote G. K. Chesterton in his Life of St. Thomas Aquinas, "revolts that renew the youth of old societies in their turn grow old; and the past, which was full of new things, of splits and innovations and insurrections, seems to us a single texture of tradition." Abernethy's portrait, serene, unruffled, comfortable, as Charles William Pegler saw him, presides over the Residential College. For all this pictured serenity, his life held more than its fair share of battles, and tonight, as a tribute to his memory, let us recall some of the "new things", of "the splits and innovations and insurrections"—in short, the tribulations—that made up the texture of John Abernethy.

John Abernethy was born into this world of tribulation on 3rd April, 1864, in London,, the second son of another John and his wife Elizabeth Weir of an Antrim family. After a preliminary education in Lothbury in the City he was sent away to Wolverhampton Grammar School and in 1780 on leaving school aged fifteen he was bound apprentice for seven years to Charles Blicke. Blicke had been appointed assistant surgeon to St. Bartholomew's fifteen months earlier and was in a good position for obtaining, as the fashion then was, a staff appointment in due time for his pupil. Abernethy became a member of the Company of Surgeons on completing his apprenticeship in March, 1787, and by good fortune Blicke was promoted to Surgeon on Percivall Pott's retirement four months later. On that same day, Abernethy, at the age of twenty-three, was elected by 53 votes to Valentine Jones's 29 to be Assistant Surgeon in his master's place. So far, life for



Painting of John Abernethy by Charles William Pegler.

Abernethy had led smoothly to a professional place in the sun. The foundation was his apprenticeship to a hospital surgeon for which he would have paid about £150, permitting him to attend in the wards of the hospital. He heard the lectures of Percivall Pott. He also entered the course at the London Hospital given by Dr. Maclaurin and William Blizard for whom Abernethy prepared dissections. Cases discussed in Abernethy's own lectures reveal that he also heard the Anatomy lectures of Dr. Andrew Marshall in Bartlett's Buildings, Holborn, and that he attended John Hunter's four-guinea course on the Principles and Practice of Surgery probably in Hunter's house in Castle Street, given from October to April on every other evening from seven to eight o'clock. Abernethy's academic as opposed to his practical instruction has been treated in some detail, because difficulties and arguments in which he was deeply involved were later to arise over these very matters,

private apprenticeships as the regular road to the hospital staff and the attempts of the Royal College of Surgeons to organise the academic instruction of medical students in a more orderly manner.

Teaching and the Medical College

Abernethy, as Assistant Surgeon, quickly established himself as an attractive lecturer. A note in *The Times* or *Daily Universal Register* (January, 1788) advertises his Anatomical Lectures and on 17th September, 1788, the full syllabus is revealed—of lectures to the gentlemen of the Hospital, Pott on Surgery, Abernethy on Anatomy, Dr. William Austin, the physician, on Medicine and, with a modern ring, on the application of Chymistry to Medicine. Dr. Krohn continued to lecture on Midwifery with the aid of a mechanical "fantom", and "on those (diseases) peculiar to the infantile state". These lectures were mainly given at 17 Bartholomew Close, some in the lecturers' homes, none in the hospital.

The earliest definite approval by the governors of teaching by lectures within the Hospital is found in a minute of 20th February, 1767, when, upon their request, the physicians and surgeons were given leave to use "the operating theatre and the room adjoining to read lectures to their pupils in. The Beadles are to keep a fire in the room, so as to make it fit to be thus used." A proposal from the House Committee in 1734 to allow anatomical lectures to be read in the dissecting room had been negatived by the governors. In 1791 the governors approved the plans of George Dance, surveyor to the Hospital, for "building a surgeons' theatre in Windmill Court at the expence of £875 and within three months", and from this time is dated the founding of the anatomical school. In this matter of dating the foundation, buildings that can be seen and that have to be paid for are more important than teachers, whom the students paid direct.

Abernethy was certainly one of the great attractions of the school, and in 1821, as its senior teacher, he attended on the governors to persuade them to rebuild this anatomical theatre no longer, after twenty years, large enough for his classes. The governors needed persuading since the "strict letter of the charter" did not include a clause dealing with medical education. Abernethy's arguments are still of interest—that good could be done to sufferers outside St. Bartholomew's because students had seen what was done to sufferers inside, that the medical officers needed students to help carry out their duties, that the presence of students meant that the officers were carrying out these duties publicly, an encouragement to diligence and skill and that an increase in the number of students advertised the value of the hospital's medical practice. There were also questions of the collection of specimens "of various diseases and injuries" made by the medical officers, amounting to several thousands, which should be properly housed by the governors.

Besides this museum there was the library. The formation of the library had been since 1800 one of the objects of the Medical and Philosophical Society, which became in 1832, after the Founder's death, the Abernethian Society. By 1821 the Hospital funds had recovered from the great expense of replacing the eighteenth century timbers badly affected by dry rot, and the governors overlooked their scruples about the Charter and approved.

By their building in 1791 the governors of St. Bartholomew's had fallen into line with the London Hospital where the first regular medical school in London had been founded in 1785. These two were shortly followed by the United Hospitals of Guy's and St. Thomas's. That these arrangements were inadequate is shown by the growth of private schools, which flourished in the next twenty-five years, usually in collaboration with one or other of the general hospitals. Dr. William Hunter's Great Windmill Street School in connection with St. George's, Grainger's Webb Street School eventually taken over by St. Thomas's, and the Aldersgate School associated with St. Bartholomew's, and many more.

So grew up side by side the private schools and the medical schools of the general hospitals. But schools cannot prosper without the favour of the licensing authorities, and during this same period was also growing the Royal College of Surgeons. The Court of Examiners at the College carried over from the Surgeons' Company the privilege and duty of approving what hospitals and schools should be recognised and what lecturers and teachers should have their certificates of instruction accepted. Until the end of the Napoleonic Wars in 1815 the need for service doctors had tended to lower standards. The Society of Apothecaries, after the Apothecaries Act of 1815 became law, held an examination which was compulsory for those who wished to practice medicine outside London. The higher standard required by the Apothecaries led the College of Surgeons to tighten their regulations and

this they did stage by stage until in 1824 they proposed to accept in London only certificates of instruction from the Schools of recognised hospitals and from the physicians and surgeons to those hospitals. This not only threatened ruin to the private schools where teaching was in the hands of first-class anatomists but also led to some searching questions. Who were the physicians and surgeons of the great hospitals? And by what methods were these men appointed, who were now to have the monopoly of teaching and of collecting fees? The inevitable revolt quickly found leaders, and the leaders had organised themselves to fight by 1826. In 1826 John Abernethy was elected President of the Royal College of Surgeons.

Tribulation came to Job as an act of God. To Abernethy tribulations came as they come to hospital doctors today as acts of men and of committees.

Colleague trouble and the twenty-eight years wait

Abernethy had to wait until 1815 before succeeding Sir James Earle as full surgeon. Earle was Percivall Pott's son-in-law, and the vacancy created by Abernethy's promotion was filled not unexpectedly by Sir James's son Henry. At this period the tenure of office had no limit and on his election as Surgeon Abernethy tried to get one by a petition to the Court. All he got was the thanks of the Court for his very able and eloquent address, and he did not return to the attack until the time came for his own retirement. He had always felt that either surgeons should retire at sixty or that the office of assistant surgeon should be abolished. In July, 1825, he circulated his printed memorandum to the governors and asked leave to resign. He noted that when he first came to the hospital each of the three surgeons was over seventy years old, and that the assistant surgeons of those days had, in their turn, continued in office for just as long. His application to resign was refused. Two years later he pleaded incompetence; he was a sick man of sixty-three, and now his resignation was accepted. But alas, no term was set, and his own apprentice, William Lawrence, concerned in so many of his master's tribulations, appointed Assistant Surgeon in 1813, did not resign until the age of eighty-two.

The Hospital students' fees were the perquisite of the full surgeons, with no emolument for the assistant surgeons. Abernethy seems to have understood from Sir James Earle that when the latter inherited some property he would resign. Sir James denied ever giving such an undertaking. After a somewhat acrimonious interview Abernethy's parting words are reported by MacIlwain: "Well, Sir James, it comes to this: you say that you did not promise to resign the surgeoncy of the hospital; I, on the contrary, affirm that you did: now all I have to add is —— the liar!"

Abernethy's resignation was accompanied by the customary gift of one hundred guineas for the Hospital, entitling him to election as governor. The Court accepted the gift but found that he could not become a governor while he remained lecturer. The resulting discussions and letters revealed that the medical school had some sort of independence from the hospital proper. The minutes next year (25th June, 1828) confirm that the nomination of lecturers rested with the medical officers subject to the approval of the governors. The demonstrators were to be nominated by the teachers of anatomy subject to the approval of the physicians and surgeons.

No records remain of staff meetings but some machinery must have existed for these nominations and approbations to be made. From the early days of the eighteenth century at the latest, letters and requests reached the Court from the physicians and surgeons of the Hospital. The first formal meeting of teachers was not held until 17th September, 1834, and only in June, 1843, did the Treasurer and Almoners propose the formation of an efficient medical council to which all matters relating to the medical part of the establishment and to the school might be referred. Abernethy had to deal on his own with the administrators, and had quite a struggle to persuade the Court to make him a governor, an uneasy and unworthy end to his labours for hospital and school.

Hospital staffs at this time resembled a little the Chorus in *H.M.S. Pinafore*. Sir Astley Cooper, praised by *The Lancet* for criticising in a lecture the excessive use of mercury in the Borough hospitals, said in surprise, "Who are these men, gentlemen, whom I could possibly feel disposed to injure? Mr. Travers was my apprentice, Mr. Green is my godson, Mr. Tyrell is my nephew, Mr. Key is my nephew and Mr. Morgan was my apprentice."

The old methods of appointing medical staff were due for a change. In the seventeenth century the College of Physicians certainly canvassed candidates but not alway with success, being overshadowed by recommendations from the Sovereign or the principal officers of the State. Royal intervention ceased with James II. Norman Moore writes that only one College appointee, Dr. Salisbury Cade (1708), was ever elected, and this was because Baldwin Hamey had left money to the Hospital on condition that the College nominee for a vacancy was accepted. An earlier nominee, Dr. Henry Wootton, accepted by the Court, was passed over when the time came in favour of Dr. Timothe Bright, who was supported by Elizabeth's Lord Treasurer, Sir Francis Walsingham. Dr. Wootton was recompensed with £10. William Harvey secured the reversion of the office of Physician at the request of King Charles. In the eighteenth century there are a good many instances in which marrying the incumbent's daughter seems to have determined succession.

On the surgical side during the eighteenth century an apprenticeship was purchased, the master doing his best to get a good place for his pupil when the time came. Succession remained to a limited extent in the gift of the departing man. The climate of opinion in the nineteenth century did not encourage the system. Nevertheless, Abernethy, his feet planted in the good, solid, eighteenth century, tried to secure a future for his son. A legal document was drawn up to bind the Hospital teachers, Mr. Wormald, Mr. Key and Mr. Stanley "not to interfere in any manner which might prevent the son of Mr. Abernethy from becoming a lecturer at this Hospital." The refusal of these men so to bind themselves was supported by a special committee in 1827 as "against the plan on which this charity depends, namely that of electing its medical officers upon the ground of professional merit alone." In a rider, selection committees were recommended to consider only "ability, humanity and steadiness with strict attention." Stanley's refusal to sign the document proposed by Abernethy may explain the coldness that later existed between them.

These bothers with Sir James Earle, Edward Stanley and the Court pale into insignificance when compared with two much more serious tribulations, first at the hands of his apprentice and colleague William Lawrence and secondly through Thomas Wakley and his "most scandalous periodical pamphlet called *The Lancet*." And the two of them in a powerful partnership led the revolt of the Members at the Royal College of Surgeons when Abernethy was President.

(To be continued).

JOHN ABERNETHY 1764-1831

By John L. Thornton, Librarian

Since there is no fixed date for the foundation of the Medical College, it is fitting that its virtual founder should be commemorated at regular intervals, and the bicentenary of his birth presents an appropriate occasion. Buildings, events and dates are stressed in most historical studies, and the persons responsible are too often neglected. Their careers may be recorded in brief details of place of birth, education, appointments held, major achievements, and publications, but we have insufficient information with which to clothe these bare bones, and to re-create the man. Speaking of John Abernethy in this Hospital in 1931, Sir Arthur Keith said: "But there is one side of a man's nature which can never grow old—never pass out of date or fashion. That is his character. Abernethy as a man will never be out of date."

Abernethy is mainly remembered today as a rude, eccentric individual, a mediocre surgeon, but a great teacher. Stories of his eccentricity abound, and many of them are no doubt true, but this aspect of his character has been greatly overemphasized. Some years ago, in an attempt to re-create the whole man, I brought together all the available material—letters, the opinions of his pupils and contemporaries, his writings, extracts from minutes and registers, his Will and that of his wife, and spent a considerable time building up a picture of Abernethy the pupil, the teacher, the surgeon, the family man, and one of the most remarkable characters of his period.

The Abernethy family originated in Scotland, but a John Abernethy went as a dissenting minister to Scottish settlers in Northern Ireland. His son, another John Abernethy (1680-1740), was educated at Glasgow and Edinburgh, but also returned to Ireland as a minister at Antrim and Dublin. The son of this John Abernethy bore the same forename, but followed a different profession and went to London, where he prospered as a wealthy merchant trading under the name Abernethy and Donaldson in Rood Lane, Fenchurch Street. He married Elizabeth Weir of Antrim, and had two sons and three daughters, our John Abernethy being the younger son. April 3, 1764 was observed by his family as the date of John Abernethy's

birth, but the register of the Church of St. Stephen, Coleman Street indicates that he was not baptised until April 24, 1765.

John Abernethy attended the Grammar School at Wolverhampton from 1773 to 1778 and acquired a "fair knowledge of both Greek and Latin". A letter from a fellow pupil suggests that he was usually head of the class, was keen on sport, but was also "rather hasty and impetuous in his manner." Apparently it was Abernethy's ambition to become a lawyer, but his father apprenticed him at the age of fifteen to Sir Charles Blicke (1745-1815) for seven years. Blicke had a large practice and made a great deal of money. Sir Norman Moore has suggested that his chief claim to fame is that Abernethy was his apprentice! Abernethy also attended the anatomical lectures delivered by Sir William Blizard (1743-1835) and Dr. Maclaurin at the London Hospital, and the surgical lectures by Percivall Pott (1714-1788) at Bart's. When Pott resigned from Bart's Blicke succeeded him, and John Abernethy was elected assistant surgeon on July 17, 1787. This office carried no salary, and he was to hold the position for twenty-eight years before becoming full surgeon.

Abernethy had attended the lectures of some of the best-known teachers in London, but he was still anxious to increase his knowledge. He now attended the anatomical lectures given by Andrew Marshall at his house in Bartletts Buildings, Holborn, and also signed up for the lectures delivered by John Hunter (1728-1793), later to become his greatest admirer. Abernethy had decided to teach anatomy, and took premises at 17 Bartholomew Close (now demolished), advertising in *The Times, or Daily Universal Register of Tuesday, January* 1, 1788, that the course would begin "at One o'Clock on Saturday the 19th of January". Later the same year *The World* of Wednesday, September 17 carried an advertisement for lectures by Percivall Pott, Dr. Austin and Dr. Krohn, as well as John Abernethy, under the heading "St. Bartholomew's Hospital", but there was insufficient accommodation within the Hospital. However, in 1791 plans were drawn up for a lecture theatre to be erected in Windmill Court, and this was certainly in use at the beginning of 1795, when five teachers were lecturing there. Early in 1821 Abernethy was agitating for a larger theatre, but the House Committee were not only reluctant to pay for this from Hospital funds, but also investigated the circumstances in which the existing theatre had been erected. However, John Abernethy personally attended a meeting of the Committee and presented a statement which was ordered to be entered into the Minutes. The subject was referred to a special meeting, but meanwhile the Treasurer and Almoners were requested to investigate the possible improvement of the theatre. Former objections were withdrawn, the enlargement of the theatre was commenced and the Trustees of the Radcliffe Estate were asked for pecuniary aid, which eventually resulted in the donation of £500 towards the estimated £1,460 required. John Abernethy had triumphed, the future of the Medical School within the Hospital was assured, and on October 1, 1822 Abernethy delivered his first lecture in the new theatre before an audience of 406 persons.

On January 9, 1800 John Abernethy married Anne Threlfall, following a written proposal which is fascinating as a mirror of his personal character. In speaking of himself he wrote: "I wish you to be assured, that I am incapable of uttering anything false or deceitful, and that consequently you may rely on my word. I have pursued every object in life with an avidity which has appeared to many disproportionate to its value; but surely, if an object be worth attaining, neither diligence should be spared nor time lost in its attainment." The wedding took place at All Saints, Edmonton, and they had a total of nine children between 1801 and 1814, several of them dying in infancy. The first child, Anne, married Dr. John Warburton; the last child, Elinor, married (Sir) George Burrows (1801-1887); of the two sons, John died before his fourth birthday, and James, born in 1808, died aged thirty-two. Obviously John Abernethy had his share of family troubles, but was very happily married, playing games with the children, telling them stories, and writing interesting letters when away from home. His wife survived him by twenty-three years, dying in July, 1854, cared for by the surviving daughters.

Abernethy allowed nothing to interfere with his lectures at Bart's. Private patients, even dukes, had to wait, and on his own wedding day he still came to Bart's, as he later recalled on the day one of his daughters was married, when he was seen wearing a white waistcoat in the Hospital. He was still assistant surgeon to the Hospital, although Sir James Earle had given him to understand that he would resign upon a certain event, but failed to do so. Eventually Sir James did resign, and on July 31, 1815, John Abernethy was elected surgeon to the Hospital. He promptly attempted to ensure that future members of the staff should not have to wait indefinitely for seniors to resign, there being no retirement age, but his petition to a special meeting of the General Court was merely "received with thanks". He later printed this petition just before his own retirement.

The superiority of Abernethy as a lecturer has never been challenged, and he attracted numerous students to Bart's. In 1820 there were several hundred surgical students, but only three medical pupils. Some of his students have left their impressions of Abernethy as a teacher. Sir Benjamin Brodie (1783-1862) wrote: "Like most of his pupils, I was led to look up to him as being of a superior order, and I could conceive nothing better than to follow in his footsteps"; Peter Mere Latham (1789-1875), following a vivid description of Abernethy's lectures, wrote: "We never left his lecture-room without thinking him the prince of pathologists, and ourselves only just one degree below him"; John Flint South (1797-1882) expressed himself thus regarding Abernethy: "His style of lecturing was very attractive; there was an orginality, a quaintness, and sometimes even a drollery which fixed the attention, and impressed what he said upon the hearer's memory in a manner I have scarcely ever known any other teacher to possess; and I can well remember that, after leaving the lecture, I could often run through the whole of it almost word for word."

Abernethy was ill-adapted for the life of a surgeon in the pre-anaesthetic period. He was opposed to vivisection, and was sometimes seen in tears after carrying out a major operation. Operation was the last resort, and he favoured complete rest instead of amputation in cases of fracture. Sir Robert Christison stated: "He was a good operator when driven to operate; but he disliked it." In 1796 he carried out the first successful ligation of the external artery for aneurysm, and had previously described his researches on the respiratory function of the skin. He suggested filling the lungs completely with air, and discharging it into a glass bottle inverted in water, pointing out its possible significance in disease of the lungs. Abernethy was convinced that the upper classes ate and drank too much, and took too little exercise. These resulted in digestive disturbances and were the origin of many surgical disorders. His theories were advanced in *Surgical observations. On the constitutional origin and treatment of local diseases*, 1809, which he constantly referred to as "My Book", and hence he became known as "Dr. My Book". He quoted the book to his pupils and to his patients, giving the latter a slip of paper bearing details of the volume, and advising them to read page 72 or 73. This was instead of writing a prescription; the book went into at least eleven editions! He devised a classification of tumours, and all his writings are fascinating, many being based on his lectures, and going into several editions.

Abernethy was closely connected with the Royal College of Surgeons. He was a member of the Court of Assistants (1810-1830), Hunterian Professor of Surgery and Arris and Gale Lecturer (1814-1817), Hunterian Orator (1819), Examiner (1821-1829), and President (1826-27). At the College he became particularly friendly with William Clift (1775-1849), whom he had probably met at John Hunter's house, and who was curator of the Hunterian Collection at the College of Surgeons. Clift revered everything appertaining to John Hunter, and Abernethy became his new mentor. The two men had much in common, and Clift often visited Abernethy's country house at Enfield;

SURGICAL

OBSERVATIONS,

CONTAINING

A CLASSIFICATION OF TUMOURS, WITH CASES TO ILLUSTRATE THE HISTORY OF EACH SPECIES;—AN ACCOUNT OF DISEASES WHICH STRIKINGLY RESEMBLE THE VENEREAL DISEASE;—AND VARIOUS CASES ILLUSTRATIVE OF DIFFERENT SURGICAL SUBJECTS.

By JOHN ABERNETHY, F.R.S,

HONORARY MEMBER OF THE ROYAL MEDICAL SOCIETY OF EDINBURGH, AND OF THE MEDICAL SOCIETIES OF PARIS, PHILADELPHIA, &c.
ASSISTANT SURGEON TO ST. BARTHOLOMEW'S HOSPITAL, AND TEACHER OF ANATOMY AND SURGERY.

LONDON:

PRINTED FOR T. N. LONGMAN AND O. REES, PATERNOSTER-ROW.

1804.

Facsimile of the title-page of John Abernethy's work containing his classification of tumours.

they went on several holidays together. For most of his life John Abernethy lived at No. 14 Bedford Row, but frequently visited Field Manor, Enfield, riding out on his favourite mare Jenny. There in the country the family and Clift occupied themselves in gardening and other activities. The house was demolished about 1935 and the estate is now covered by houses.

Edward Jenner (1749-1823) was another friend of Abernethy, the two having probably been introduced through John Hunter. Our Library contains two books inscribed to Abernethy by Jenner. Many of Abernethy's pupils subsequently led distinguished careers. (Sir) Richard Owen (1804-1892), whom Abernethy introduced to the Royal College of Surgeons, and who eventually became Superintendent of the British Museum (Natural History): (Sir) William Lawrence, who succeeded Abernethy at the School, and was a brilliant surgeon, but who attempted to further his career at the expense of others, but lived to appreciate his youthful impatience; and Edward Stanley (1793-1862), who acquired an extensive knowledge of bone disease, some of his experimental work on this subject being still preserved in our Museum. This Museum was based on specimens given by John Abernethy and Edward Stanley for the use of the Medical School in 1828, and Stanley catalogued the collection, his manuscript being preserved in the Hospital Archives. The catalogue was printed in 1831, and was later brought up to date by James Paget.

The Medical and Philosophical Society was founded in 1795, with John Abernethy as one of the chief instigators. He was one of the presidents as long as he was connected with the Hospital, and rarely missed a meeting, being relied upon to present a case or to join in the discussion. One of the aims of the Society was the establishment of a library, and in 1800 John Abernethy was asked to approach members of the staff personally for financial support. This was immediately forthcoming, and the present Library dates from that period. The Society declined after Abernethy's withdrawal from the Hospital, and no meetings were held from 1830 to 1832. At the end of that year it was revived as the Abernethian Society, and continues as yet another reminder of the multiple activities of its founder. Abernethy was also one of the founders of the Royal Medical and Chirurgical Society, and acted as President in 1823.

Honours were not sought by John Abernethy, and about the year 1816 he declined the offer of a baronetcy. He was elected F.R.S. in 1796, and was an honorary member of various medical societies in Edinburgh, Paris and Philadelphia. The Royal College of Surgeons in Ireland elected him an Honorary Member in 1820, in company with Astley Cooper, John Pearson, S. T. Soemmerring and Antonio Scarpa. Abernethy probably appreciated more the piece of plate presented to him by his pupils of 1812-13 "as a token of respect and gratitude". Consisting of a cup and cover by the famous silversmith, Paul Storr, it was given to the Hospital by Mr. H. B. Willett, and Abernethy's Loving Cup was used at the annual dinner for medical officers and lecturers until recent years. His pupils also subscribed for Abernethy's portrait by Sir Thomas Lawrence, now displayed in the Great Hall.

One cannot write about John Abernethy without recounting some of the stories told about him. In 1834 William Lawrence wrote: "A great many anecdotes are still current in the profession, founded on curious dialogues, sharp sallies, and lively repartees, which occurred in his consultation room, or in other intercourse with his patients. The authority of some may be dubious; but I can assert that he is justly entitled to the credit of all the best." The following are some of these anecdotes:

A Lincolnshire farmer came to Abernethy complaining of discomfort in the head. Abernethy asked: "How much ale do you take?" "Oh, I taake my yale pretty well." Abernethy (with great patience and gentleness): "Now then, to begin the day, breakfast; what time?" "Oh, at haafe past seven." "Ale then, how much?" "I taakes my quart." "Luncheon?" "At eleven o'clock I gets another smack." "Ale then?" "Oh, yees, my pint and a haafe." "Dinner?" "At haafe past one." "Any ale then?" "Yees, yees, another quart then." "Tea?" "My tea is at haafe past five." "Ale then?" "Yees, yees, I taakes my fill then, I goes to sleep arterwards." Like a lion aroused, Abernethy was up, opened the street door, shoved the farmer out, and shouted after him, "Go home sir, and let me never see your face again. Go home, drink your ale, and be damned." The farmer rushed out aghast, Abernethy pursuing him down the whole length of Bedford Row with shouts of, "Go home, sir, go home and be damned."

A lady, the wife of a distinguished musician, consulted Abernethy, and taking exception to his attitude said: "I had heard of your rudeness before I came, sir; but I did not expect this." When Abernethy gave her the prescription, she said, "What am I to do with this?" "Anything you like. Put it in the fire, if you please." The lady took him at his word—laid his fee on the table, and threw the prescription into the fire, and hastily left the room. Abernethy followed her into the hall, pressing her to take back her fee, or to let him give her another prescription; but the lady was inexorable, and left the house.

The following song chanted by Mephistophiles also features Abernethy:

"The devil he sat on his garden gate,
A picking his teeth with the point of his tail;
And because he'd been doing so much work
of late,
He grew sick and his appetite often would fail;
When a toad, who came by in a carriage
and six,
Walk'd up to the idler so grave and so
ghastly,
Felt his pulse, viewed his tongue, and did
other wise tricks
That are practiced on earth by Sir Charles
and Sir Astley.

'Oh, Oh!' says the doctor, 'your majesty's ill!
You must take night and morning a draught
and a pill!
But the devil the toad 'neath his hoof
quickly jamm'd,
And said, 'I take your stuff! if I do I'll be
damn'd!'
Then his lordship grew worse—in vain had
he tried
A draught of the Styx and a bath in the
Lethe;
Till, worn by his torments, one morning
he cried,
'Must I die like a dog?—No: go fetch
Abernethy.'

The doctor he came, looking surly and sage,
One hand in his pocket, one stuck in his
waist,
Said he, 'Read my book;' and he mentioned
the page:
'Take blue pill every night. Where's my
fee? I'm in haste.'
Then said Lucifer fiercely, 'This can't be
endured!
You cure my disease without wishing to
learn it?—
I've got indigestion!'—'Well, that's to be
cured,'
Replied John:—'Live on sixpence a week,
friend, and earn it!"

There are other stories about John Abernethy that are seldom recounted, those recalling his kindness and sympathy towards the sick:

A woman entered the Hospital for an operation, and John Abernethy, as was his custom, kept her waiting for some time while her health was somewhat restored, in order to prepare her for the ordeal. When the appointed time for the operation approached, the dresser told Abernethy that she was preparing to leave the Hospital: "Why, my good woman," said Abernethy, "what a fool you must be to come here to have an operation performed; and now just as you are in a fit state for it, to go out again." Somebody here whispered to him that her father in the country was dying. With a burst of indignation, his eyes flashing fire, he turned to the dresser and said: "You fool, why did you not tell me this before?" Then, after a moment or two looking at the patient, he went from the foot of the bed up to the side of the bed, and said in the kindest of tone possible: "Yes, my good woman, you shall go out immediately; you may come back again when you please, and I will take all the care I can of you." Now there was nothing in all this, perhaps, but his manner gave it immense force. And I remember one of the old pupils saying to me: "How kind he was to that woman; upon my soul, I could hardly help crying."

The widow of an officer of limited income brought her child some distance from the country to consult Abernethy. After a few weeks' attendance, the lady having asked Abernethy when she might return home, was told that she must remain some weeks longer, or he could not answer for the well-doing of the case. In the meantime, having learned how the widow was situated, he continued to take fees, folding them up in paper. When he finally took his leave, he returned home, enclosed the fees which he had received, with the addition of a cheque for £50, with a kind note, saying that as he understood her income was limited, he had returned the fees with an addition which would enable her to give the child, who could not walk, a daily ride in the fresh air, which was important to her recovery.

A Mr. Wood, of Rochdale, one of Abernethy's pupils, told the following story of his teacher:

"It was on his first going through the wards after a visit to Bath that, passing up between the rows of beds with an immense crowd of pupils after him—myself among the rest—that the apparition of a poor Irishman with the scantiest shirt I ever saw, jumping out of bed, and literally throwing himself on his knees at Abernethy's feet, presented itself. For some moments, everybody was bewildered; but the poor fellow, with all his country's eloquence, poured out such a torrent of thanks, prayers and blessings, and made such pantomimic displays of his leg, that we were not long left in doubt. "That's the leg, yer honner! Glory be to God! Yer honner's the boy to do it!

May the heavens be your bed! Long life to your honner! To the divole with the spalpeens that said your honner would cut it off!" etc. The man had come into the hospital about three months before with a diseased ankle, and it had been at once condemned to amputation. Something, however, induced Abernethy to try what *rest* and constitutional treatment would do for it, and with the happiest result.

With some difficulty the patient was got into bed, and Abernethy took the opportunity of giving us a clinical lecture about diseases and their constitutional treatment. And now comments (*sic*) the fun. Every sentence Abernethy uttered, Pat confirmed. "Thruc, yer honner, divole a lie in it. His honner's the grate dochter entirely!" While, at the slightest allusion to his case, off went the bedclothes, and up went his leg as if he were taking aim at the ceiling with it. "That's it, by gorra! and a bitther leg than the villins that wanted to cut it off." This was soon after I went to London, and I was much struck by Abernethy's manner; in the midst of the laughter, stooping down to the patient he said with much earnestness: "I am glad your leg is doing well; but never kneel, except to your Maker."

This appears to have been the rule followed by Abernethy himself. Unimpressed by rank and riches he refused to give priority even to royalty.

Abernethy was attending a poor man whose case required assistance at a given time of the day. One morning, when he was to see his patient, the Duke of York called to say that the Prince of Wales wished him to visit him immediately. "That I cannot do," said Mr. Abernethy, "as I have an appointment at twelve o'clock"—the time he promised to visit the poor man. "But," said the Duke, "you will not refuse the Prince; if so, I must proceed to . . . ." "Ah," said Abernethy, "he will suit the Prince better than I should." He was, however, again sent for a few hours later, when he of course visited the Prince.

Abernethy was always kind to hospital patients; he once said: "Private patients if they do not like me can go elsewhere; but the poor devils in the hospital I am bound to take care of." In fact, he does not appear to have intended rudeness, but wrote in one of his letters to George Kerr: "I fear I might have offended you; a fault which I often unintentionally commit." When a patient complained that he had received no sympathy from Abernethy, the latter wrote him a letter:

"Dear Sir,

I am sorry to have said anything that has offended you. I may have felt annoyed that I could not suggest any plan of treatment more directly curative of your malady, and expressed myself pettishly when you did not seem to understand my meaning, for I am a fellow sufferer, and had tried what are considered to be appropriate remedies, unavailingly. I assure you that I did not mean to hurt your feelings, and that I earnestly hope the state of your health will gradually improve, and that your local maladies will decline in proportion.

I am, dear Sir,
Your obedient servant,
John Abernethy."

Bedford Row.
October 25.

Despite his instructions to patients, Abernethy took little care of his own health, and he often walked to the Hospital in the rain without an overcoat, then stood with his back to the fire, drying his clothes. As early as 1805 he mentioned his illness in a letter, and he obviously suffered from chronic rheumatism. He periodically had a sore throat, terminating in an abscess; his heart caused him anxiety and a dissection wound troubled him for years. In 1825 he sent in his resignation as Surgeon to the Hospital. This was in keeping with his views expressed upon his appointment, that surgeons should retire at the age of sixty, but he was requested to continue in office for a further year, and his letter of resignation was returned to him. Abernethy finally resigned on July 25, 1827, and he presented the Hospital with a draft for 100 guineas. This generally led to the appointment of the donor as a Governor, but it was decided that this could not be done while he was still a lecturer. Abernethy immediately sent a circular to the Governors, pointing out that he had lectured for nearly forty years independently of the Governors, and had received no charge or salary. Certain of the Governors proposed to bring up the matter at the next meeting of the General Court, but the House Committee recommended that he be made a Governor, and the General Court accepted this unanimously. A burst of applause greeted this statement, and when Abernethy was called in to take his charge he was stunned by his reception. He continued to take a keen interest in the affairs

of the School, but gradually he resigned his various offices at the Royal College of Surgeons, his final resignation being accepted on August 12, 1830. A memorial was entered in the Minutes and a copy inscribed on vellum, framed and glazed, was sent to John Abernethy.

He was now hopelessly crippled with rheumatism and spent most of his time at Enfield. William Clift visited him regularly there, recording the fact in his remarkable diary preserved at the Royal College of Surgeons. He noted that on Sunday, March 20, 1831, Abernethy was too ill to be seen, and the entry for Wednesday, April 20, is enclosed within a black border and reads: "Mr. Abernethy died this day at half past 5 p.m. at Enfield, Middlesex, aged 66?" This should read 67, his birthday having occurred earlier that month.

A month later Mrs. Abernethy wrote a letter to John Haddy James, one of John Abernethy's former pupils, deploring "the loss of my kind, my excellent Husband. . . . I know of no one who could justly write his life, he seldom spoke of the past & it seemed to be his particular wish that *after* death he might *only* live in the remembrance of his Friends." George Macilwain, 1797-1882), a former pupil, did prepare a biography which was published in 1853, 1854 and 1856, but he does not appear to have known the Abernethy family well, and it is difficult to find John Abernethy in a biography interspersed with philosophical discourses. We have no diaries or collections of personal letters appertaining to Abernethy, but an attempt was made some years ago to bring together every scrap of information and to present it as a record, albeit imperfect, of the life of this remarkable man. It was published in 1953 as *John Abernethy: a biography*, by the present writer, and the material in this article is derived from that book. Unfortunately, it is impossible to live for long in the remembrance of friends, for these follow their erstwhile companion, and unless recorded, one's good deeds tend to be overlooked, while one's failings are recounted from generation to generation. Such has been the fate of John Abernethy, the founder of the Medical College, of its Library and Museum, of the Abernethian Society, and the greatest teacher in the history of the College.

THE BRIGHTON STROLL

By R. E. Atkinson

The stroll this year was held on Friday and Saturday May 8th-9th. The start from the Tower of London was rather disorganised, but a herd of 1,800 students eventually set off twenty minutes late, looking like a cross between a tramps rally and a rush hour underground station.

Although Bart's did not do very well in the individual ratings (which do not count anyway!) the Hospital as a whole put up its best performance since the walk was thrown open to all teaching colleges—we in fact came 5th out of the 13 competing, and in so doing were the first of the five large hospitals. A very creditable effort by a large band of walkers, and our congratulations to them all.

The ladies came 9th out of the 13 in their section which is again a good effort on their rather low entry this year.

The Bart's depot and First Aid post, as in the past years, were at the flyover near Handcross on the A23. Our arrangements there went very smoothly and our thanks to all who came down and helped right through the night. We provided hot cocoa and hot dogs, and cold orange and biscuits. We are indebted to the many pharmaceutical firms for the support they gave in equipping our post, and to CIBA laboratories of Horsham in particular for providing and stocking a van which they loaned to us as a foot clinic. This saved a considerable amount of money which we were able to put towards extra food.

The finish this year was in Preston Park, Brighton, and although not quite such a good crowd pull as the front, it gave considerable amusement to many, and also provided much more room for the weary and the dying to lie out in the sun.

PROFESSIONAL WOMEN

By Mrs. J. F. Frears

From time to time there have appeared in this Journal remarks about the inadequacies of women in the medical profession. While the letters from male students have been too silly to merit a response, it was distressing to read recently that the retiring Sub-Dean considers that his female students add little to the hospital except decoration. Thus, although it must be apparent to the most conservative practitioner that women can never again be excluded from professional life, I think the moment has come to put forward a defence of our position.

The criticisms seem to be based on two assumptions; firstly, that women are 'temperamentally unsuited' to the profession, and secondly that they will waste the time and money spent on them by giving up medicine when they marry.

As regards the feminine temperament, I think it is fair to say that women in every age and culture have been roughly what men wanted them to be. How should a girl behave when she wishes to make a good impression on a new male aquaintance? Bring out the intellectual battery and baffle him with metaphysics? Alas, clever women soon realise that any display of intellectual strength is taken as an affront to male vanity, and that in the majority of cases a man would prefer her to be helpless, inarticulate, illogical and engagingly simple-minded. The temptation to defer to this image is overwhelming and it is a trap into which we all fall; the tragedy is that many professional men, particularly of the older generation, cannot think of us in any other light.

Some women, like some men, could not possibly make good doctors. The difficulties facing a selection committee must be enormous, but perhaps it should be recognised that the rather vague reasons which encourage most of us to take up medicine, and are sufficient to carry a man through studentship till he has gained a foothold in the profession, may not be adequate to induce a woman to go on working when an early opportunity for comfortable retirement into matrimony arises. Some degree of dedication appears to be necessary from the start, and should be included as a qualification for entry.

As for the rest of us, I would strongly deny that we hold in common any peculiarly feminine characteristic that would preclude us from practising good medicine. In Russia the proportion of women in medicine is much higher than that of men, and there is no reason to suspect that standards are generally lower in that country. The favourite male argument, that all women base their thinking on sentiment rather than reason, is after all nothing more than a favourite male argument.

The second criticism levelled at women in the profession, namely, that they tend to abandon medicine or at most work on a very part-time basis, must be given far more serious consideration.

The most obvious impediment to full-time professional life is childbearing. The women in the profession who are not encumbered with a family probably do better, at least on paper, than their male colleagues. I think most people will agree with me when I claim that the women medical students are harder working and more conscientious on the whole than the men. In the preclinical school they certainly appear higher on the lists of examination results. How do they get on after qualification? Dr. Robb-Smith in his survey of the Fate of Oxford Medical Women, (The Lancet, Dec. 1st, 1962), reported that of the forty women in his census who had remained unmarried, nearly 50% were consultants. The three who were not in practice had retired for reasons of ill health. I think these figures must compare very favourably with those of the general medical population, and are particularly commendable when one considers that there is a great deal of prejudice against the selection of women for higher posts.

Marriage alone, as I know from personal experience, is no hindrance to the working woman. It is, in fact, an advantage, since it leads to greater emotional stability and a more balanced outlook in both partners. However, an increasingly larger majority of women wish both to marry and to have children, and it is here that the conflict lies.

Dr. Robb-Smith shows that of 138 women who qualified between 1922 and 1950, 99 were, or had been, married. Those who were widowed or divorced had a clinical activity of virtually 100%, as did the unmarried group. Of the group which has married, with husbands and families, only about 15% had reached consultant status, and 40% were not working at all.

It would appear, on the face of it, that the critics are right, and that the enormous wastage of qualified women once they start raising families does not justify the expense of their training.

However, careful assessment shows that the majority of those who had given up did so with great regret and would dearly have liked to continue, while many of those in part-time jobs would have liked more work. The reasons given for retirement fell into three categories: (a) the difficulty of looking after a young family while continuing work; (b) the lack of suitable work and difficulty in specialising, and (c) discouragement by the husband.

Whether husbands like it or not, the age of the working wife has come to stay. To be fair to medical men, to whome this article is directed, the survey shows that they at least do not discourage their medical wives from working. However, the organisation of professional life, and indeed of modern society in Britain, is such that there is no provision for a woman with a young family to continue her job without neglecting the children. While this situation remains, trained women who are needed by the country, particularly in medicine and teaching, will continue to disappear from active life.

Obviously, a woman must take time off work to have a baby, but why is it that many young mothers do not return to the profession after a suitable interval? One reason, which calls for urgent social reform, is the acute shortage of state-organised daily supervision for young children. The recent scandal over 'pirate' Day Nurseries underlines this need among working women generally.

It can be argued that it is not in the best interests of a young child to be parted from its mother during the day even if she is quite satisfied that it is being well treated. On the other hand, it is only comparatively recently that the children of the professional classes have been looked after by their parents, and a registered Daily Guardian is likely to be just as amiable as Nanny (and probably better trained in child management than Mother). The wives who remain behind to wash nappies are liable to cause far more disruption in the home through their boredom and frustration than they would by their absence.

But this is not the whole problem. An absence of say, two years, from medical practice, particularly if it occurs shortly after qualification, makes it almost impossibly difficult to specialise. Under present conditions few women are able to obtain really interesting jobs after they have started a family, even if they are prepared to work full-time. The majority, of course, would like part-time work, and here there is very little available of real interest, and virtually no opportunity for advancement. Thus a woman who wants to work part-time is usually condemned to routine clinics or blood-letting, not because of any inherent difficulty in providing something more attractive but because of an increasing tendency to make all the responsible jobs full time.

While things remain as they are, it is inevitable that the drain on qualified women will continue. If the medical profession would only accept that the working day of a mother with young children must end in the early afternoon, and allow for her to take a job of some interest, or offer part-time junior posts

with prospects, there would be far less wastage. Unfortunately, the people who are in a position to change things commonly feel, with Dr. Balme, that one should not 'race a horse that is being used for breeding', and while this attitude persists married women are unlikely to get a better deal.

In conclusion, while I have dismissed the argument that women are 'temperamentally unsuited' to medicine, as untenable, the criticism that a large majority of us give up the work for which we have been expensively trained, is justified. Women do not often retire because they wish to, however, but because of the difficulty of continuing work and the dead-end nature of the part-time jobs available. Acceptance of the limitations of married women by the government and the profession is desirable, and might lead to the reforms necessary to amend the situation.

CHRISTIAN VIEWPOINT

The subject of conversion is always one which attracts much comment. D. Martin Lloyd-Jones M.D., M.R.C.P. in his booklet "Conversions—Psychological and Spiritual" (I.V.F. 1959) has reviewed this interesting subject.

Dr. Martyn Lloyd-Jones felt it his duty to review "Battle for the Mind"* with critical care because of the wide impression given that Dr. Sargant has more or less explained away spiritual conversion.

Dr. Sargant's arguments are based largely on Pavlov's experiments and the concept of "conditioned reflex". Pavlov suggested that these experiments may provide a key to the understanding of man and his reactions and response to various ideas.

Early in the last War Dr. Sargant observed that often the reproducing of terror, alarm and excitement in patients under hypnosis led to a cure. Sometimes *fear* of a terrifying experience was removed by making a man go through such under hypnosis.

After completing much of this work he was introduced to the report of the later work of Pavlov and concluded that it verified his own findings on abreaction.

Later, Dr. Sargant read of emotional disturbances brought about by the preaching of John Wesley. Dr. Sargant compares the technique of soul-saving (with choice of salvation or damnation) with that of suggesting to a patient under hypnosis that he is in danger and must fight his way out.

Dr. Sargant wishes to show that beliefs can be forcibly implanted in the human brain and people can be switched to new beliefs. He implies that all conversions, spiritual or political, are essentially the same and are really psychological processes. Dr. Sargant quotes Wesley's methods to support his theory that converts could only be secured by overwhelming the emotions. Although he decries the use of such methods in the religious field for modern educated man, he has already shown that this modern man is as susceptible.

Dr. Sargant admits that he is only discussing the conversions which are produced by physical and psychological stimuli. He would seem to allow "a purely intellectual conversion".

Dr. Lloyd-Jones asks: "Are these phenomena the true explanation of what happens at conversion?"

The first general criticism is "Is the comparison of animals and men strictly legitimate?" Dr. Lloyd-Jones believes that the comparison is only valid when through stress, that which differentiates man from dog has been temporarily eliminated.

Dr. Lloyd-Jones second general criticism is that according to Dr. Sargant, basically there is no such thing as real mental conviction about anything, but accepting or rejecting are simply physiological processes.

Evidence is certainly produced of the working of the brain under certain conditions but Dr. Lloyd-Jones submits that Dr. Sargant's book can be entirely dismissed by Christians as having no religious application at all. It is no more a criticism of Christianity than it is of any philosophy or political teaching.

Dr. Sargant explains the events at Pentecost as the result of shock tactics followed by acceptance (stimulus and response). He does not include, let alone consider, the complete change in the men themselves: the ability of Peter to preach; the source of the gift of tongues. The crowd had no Pavlovian stimuli. If the data is taken from the Bible, *all* the facts must be included.

Dr. Sargant finds that the conversion of Saul fits in with his thesis that anger like fear can bring about sudden conversion. In this case he says that a state of "transmarginal inhibition" followed his acute nervous excitement, and later indoctrination was imposed. Here is an extraordinary contradiction. Dr. Sargant has said that obsessive belief is a safeguard *against* conversion, but it did not render Saul immune! What is more important is that Dr. Sargant does not show what the tremendous stimulus was which led to increased suggestibility, neither are we told why Ananias went to Saul. *All* the facts must be included.

Dr. Sargant's central trouble is that he forgets that Christianity is an historical religion solidly based on such great facts as Christ's resurrection and subsequent appearances, and not a form of moral and ethical teaching to be applied and lived.

Wesley's conversion is explained along the lines of his theory and yet this event seems to have happened in circumstances that are almost opposite to those postulated by Dr. Sargant. No explanation is given as to why Wesley's ministry suddenly became so effective.

The doctrine of the Holy Spirit is also entirely ignored although there is ample evidence of its prediction. This is rather different from the inference that a number of psychological conditions were being fulfilled. The idea of Peter deliberately applying stimuli and then, at the right moment, suggestions, is quite laughable!

Dr. Sargant quotes past revivals as proof that the originators deliberately employed "techniques" which have now been dropped. Dr. Lloyd-Jones suggests that what has really happened is that there is widespread departure from the faith of the early leaders and the Church's work is therefore not being honoured by the Holy Spirit.

Before a revival the Church has generally been in a low state, and then suddenly one man or a group became disturbed and concerned. Where did this stimulus come from? The history of revivals shows clearly that that they do not result from techniques, methods or organisation. The persistence of the Church is proof that the power of God is behind its origin and continuance, and not the applied psychology of man.

Dr. Lloyd-Jones agrees that it is possible to influence the human mind by various means and methods, and that religious, political and other movements do so. It is also admitted that wrong tendencies can develop and spread even amongst those who are sincerely desirous of spreading the true gospel.

There are lessons to be learned and dangers to be avoided. Methods and message must not be divorced, and it is emphasised that techniques will only produce psychological results. If we really believe in the work of the Holy Spirit we present the truth and trust Him to apply it. It is an important principle that in presenting the Gospel a direct approach to the mind and not the will or emotions should be made. We are to "plead", to "beseech" but never to bring pressure.

If we really believe in the doctrine of the Holy Spirit, techniques and methods are unnecessary.

We can be grateful to Dr. Sargant for focussing attention on questionable methods in religious evangelism, and making us face the radical question of our need to concentrate on praying and learning. Even in this twentieth century the Bible rule still is "Not by might, nor by power, but by my Spirit, saith the Lord."

*Reference:—*Battle for the Mind* (William Heineman Ltd., 1957).

C.J.D.

THREE MONTHS IN INDIA

By D. S. Tunstall Pedoe

Part II—Travel

In my last article I described some aspects of life at the All India Institute of Medical Sciences in Delhi. St. Bartholomew's Hospital has been given an annual three monthly scholarship for a Bart's student to stay there and study medicine in India.

However the Scholarship is called "The Nuffield Travelling Scholarship in Tropical Medicine" and one is encouraged to see something of the rest of India of which Delhi and the All India Institute (A.I.I.M.S.) are far from typical.

If one lives in a hostel at A.I.I.M.S., the £60 per month grant from the Nuffield Foundation is far more than adequate and I spent more than half of my total grant and some of my own money on travel.

Kashmir

Everyone says that one must visit Kashmir, whose beauty is the pride of all India (This, plus its religious shrines, explains her reluctance to part with it). Snow falls quite early there, so October is the last possible tourist month. I wanted to see the Himalayas and so went to Kashmir a fortnight after getting to India and spent nine days on a houseboat in Srinagar.

The Dakota of India Air Lines winds its way up a mountain pass at 10,000 feet with its wings apparently just missing tree covered mountains towering above them on each side, and then dips down to land in the Vale of Kashmir at 6,000 feet.

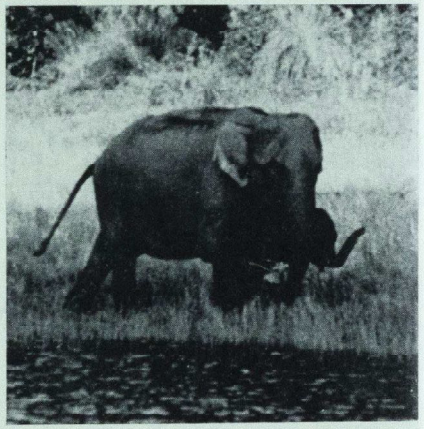
The really dramatic scenery—glaciers and lakes at 15,000 feet is unapproachable by public transport at this time of year and requires several days trekking over high passes, but a trip to Gulmarg with a wonderful view of Nanga Parbat climbing out of the murky dust laden lower atmosphere to a shining white brilliance of 26,660 feet seventy miles away really does convince one that there are some deities dotted around the Himalayas. However, even this requires a coach journey and three hours ride on a mountain pony, and to get to the snowline at 12,000 feet requires another hour of riding and scrambling.

There is a mission hospital at Srinagar with about 50 beds run by an Indian doctor and his doctor wife which is well worth a visit. The doctors have to be jacks of all trades and have to be as conversant with the maintenance of autoclaves and making their own premature baby incubators as with medicine as such.

Southern India

Before coming back I decided to blow all my Indian money on a trip to the South. I enjoyed this trip far more than Kashmir since I mostly stayed with Indian families and I liked the people more than the Kashmiris who are very tourist orientated and only seemed to be interested in the money they could unload from them. (Not really true, they are also interested in gaining their independence).

In my 14 day southern tour I travelled 3,000 miles by plane, 1,500 by train and 400 by public coach service, and the only European I met (except at Vellore) was a Russian lady professor of Anthropology from Moscow who was investigating some of the polyandrous aboriginal tribes of Southern India. We both stayed in the same 2nd class resthouse accommodation at the Tekkade game reserve in Kerala. (Bed in private room with fan, mosquito net and bedding 5/-, dinner 1/6d.—1st class tourist accommodation was £2 15s. 0d. for the night). We shared a boat to take us around the game reserve. She was interesting company and amused me by insisting on English food when I was eating Brahmin vegetarian food with my hands, to the delight of the Southern Indians. She advised me on places of interest in Madras —Clive's house, the British Fort, etc., and seemed a little perplexed by my lack of patriotic fervour when I was not particularly keen to make a pilgrimage to where the British had first landed in Madras.



Tekkade Game Reserve, Kerala.

Agriculture

I spent most of my time in Kerala, first with the family of a student at the A.I.I.M.S., in Trivandrum, the capital. I wanted to see something of the farming and so I was taken around an estate where they grow pepper, bananas, tapioca, jack fruit, citrus fruit, coffee and the omnipresent coconut which seems to be the basis of the whole Kerala way of life. It is used to thatch all the non-European houses. It is used at some stage in cooking most of the vegetarian dishes in Kerala and is one of the chief exports. Coming in to land at Trivandrum, I could hardly see the houses of the city for coconut palms which in Kerala number several million. In fact, the most important disease I saw in Kerala was the fungus disease afflicting the coconut trees, which has become a fatal epidemic.

Trivandrum

I called in at the Trivandrum Medical School as Diphtheria was out of season in Delhi and I wanted to see some better cases. I saw two relatively fresh cases of faucial diphtheria with its grey adherent membrane and a rather nasty cutaneous form which seems common there and attacks debilitated young children causing multiple punched out ulcers from which the K.L. bugs can be cultured. They had six cases to show me, most of whom had been ill for several months without any neurological manifestations but were healing rapidly with antitoxin and antibiotics.

From Trivandrum I went by coach through some tea and rubber estates with occasional glimpses of elephants and their mahouts to the game reserve at Tekkade, and from there to the port of Cochin where I bought some coconut brandy with which to celebrate Christmas and did some sightseeing.

On the plane from Cochin back to Madras I spoke with an Indian family and within two minutes they were insisting that I stayed with them in Madras which, after a day in Vellore, I was happy to do.

Vellore

Vellore Christian Medical College is a three hour coach ride from Madras. There are a large number of dedicated Christians from America and England working there, and I found the proselytising atmosphere much stronger than at any other mission hospital that I had visited.

Leprosy

I particularly wanted to see their work with "lepers" (a term of which they quite rightly disapprove since in no other disease is the sufferer stigmatised with the name of the disease for perpetuity, whether he is infectious or not. One does not hear of a "smallpocker" or "syphiler"). They treat the majority of the sufferers from Hansen's disease (i.e. leprosy) as out-patients as soon as they are non-infectious and see them along with the other patients in the orthopaedic department, and are achieving marvellous results by shielding their anaesthetic feet in special shoes and teaching them the importance of avoiding trauma to their hands. Indeed they have proved at Vellore that many of the classical deformities of the disease are only sequelae of persistent trauma to anaesthetic limbs and can be avoided with physiotherapy and education. They have also devised several tendon transplant operations since leprosy tends to pick off individual peripheral nerves where they lie near the surface of the body—possibly a predilection for tissues at low temperatures since it also attacks the testes and must be one of the commonest causes of gynaecomastia (large breasts in men) in the world.

The infectious cases are isolated at a special unit about 12 miles from Vellore, so I hired a taxi to take me there and saw Mycobacterium leprae defying attempts at chemotherapy. Although leprosy is usually a chronic disease and if untreated only slowly progressive, it can flare up into an acute exacerbation in which multiple skin lesions or complete nerve palsies can develop in hours and these reactions (some

known as Lepra reactions) are often provoked by therapy with sulphones. These reactions are not like the Herxheimer reaction in syphilis, since in many cases the exacerbation is accompanied by rapid multiplication of the Mycobacteria in the tissues. The variety of manifestations of lepromatous and tuberculoid leprosy, the lepra reactions and the allergic phenomena of the disease and its treatment are frightening. I saw many of them in the 30 or more patients that I examined—from sterile blisters to nodules teeming with bacteria and even exfoliative dermatitis. Steroids have been used for many of the allergic phenomena but are now used as a last resort since some patients became completely dependent on them and any attempt at weaning them off the steroids provoked a reaction.

Madras

My hosts in Madras made me very welcome, showed me around Madras and put a car and the chauffeur at my disposal when I wanted to visit the Madras Infectious Diseases Hospital.

I had previously found that writing ahead to hospitals confused people and caused them anxiety, whereas if you arrive unheralded and say who you are and what you would like to see you are always made very welcome. Also you will not then be palmed off on to a public relations officer who knows little medicine and shows you the buildings and the electron microscope when you want to see the patients. (Obviously if you want a bed for the night you have to write ahead with a letter of introduction).

Dr. Rao, the Director of the Infectious Diseases Hospital, made me welcome and demonstrated patients to me himself for more than an hour.

Smallpox

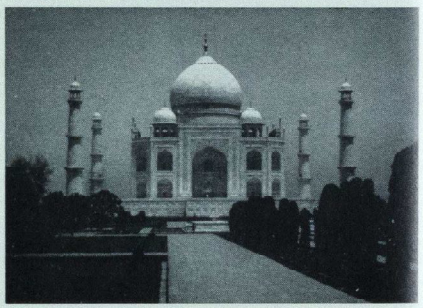
He showed me nearly 60 patients with smallpox ranging from the unmistakable confluent variety to the contacts with just one or two lesions (the type that gets missed in England as Dr. Rao said with a grin).

Confluent smallpox really is a terrible disease. The patients lie very still because movement is painful, and when Dr. Rao or I moved one of their limbs to examine the distribution of the rash or look for axillary sparing they let out an inarticulate moan, proper phonation being discouraged by the numerous lesions on the mucous membranes of the mouth. Over 10% of the Madras cases of smallpox develop a severe destructive arthritis the nature of which is unknown.

Dr. Rao showed me by comparing the cases with chickenpox patients in another ward how poor a criterion in the differential diagnosis was the centrifugal and centripetal distribution of the rash in smallpox and chickenpox. He said that centrifugal distribution was more typical of modified smallpox (patient previously vaccinated) and that the best criteria were the severity of the prodromal symptoms in smallpox, (if you haven't had to go to bed, you haven't got smallpox), the deeper situation of smallpox vesicles and their synchronous development and staging as opposed to the crops of chickenpox vesicles and their superficial nature.

The Madras Infectious Diseases Hospital is much cleaner and better run than its Delhi counterpart, but even so birds fly in and out of the wards and settle on the ends of the beds. (The birds and squirrels in India are very tame and will be quite unconcerned until you get within a few feet of them).

We then went to the laboratories and saw smallpox virus growing on the chorio-allantoic membrane of eggs. An American student was working there. I was then shown the cholera vibrio and we went to the wards again to see where it came from. The patient was grossly dehydrated and had a very feeble pulse that took a lot of finding and he had a drip going full blast with isotonic fluids. They are not keen in Madras on hypertonic saline since its effect is rather transient. The convalescent patients drink fresh cocoanut juice as it contains a lot of potassium. If a cholera patient reaches a hospital alive he now has a very good chance of surviving owing to better understanding of electrolyte replacement.



Taj Mahal by moonlight.

After a long chat with Dr. Rao I went off to dine with my hosts on Tandoori chicken and spent the afternoon at Mahabalipuram, 30 miles from Madras, swam in the Indian Ocean, ate and drank fresh cocoanuts, photographed Madrasi girls in their beautiful silk saris, and explored the 6th century B.C. temples and rock carvings which include larger than life elephants, holy cows, dancing girls and a 20 foot high rock face whose whole surface has been carved into an elaborate freize of elephants, cobras, mongooses and other animals.

The following morning I left for Delhi with a parting present from my hosts of a hollow seed not much bigger than an orange pip with an ivory bung and containing a herd of 200 ivory elephants which are just visible to the unaided eye and under a lens are remarkably accurate.

Three days later I was on my way to London with a wonderful collection of memories—the Taj Mahal by moonlight—eating off banana leaves instead of plates, gliding over Delhi in a sailplane, brain curry and Nan, two hours in an art dealer's shop looking at antique paintings with 5 rupees in my pocket and politely refusing paintings worth 15,000 Rupees, three hour Indian dance recitals which completely mesmerised me, but above all the kindness, grace and hospitality of the Indian people.

For all this, an education in the widest sense of the word, I will always be grateful to the Nuffield Foundation, and who knows, if the fortune tellers are right I will be returning to India sometime.

BATTERSEA DRAMA FESTIVAL

By M. P. Stewardson

"Barnstaple" by James Saunders. Bart's Drama Society Production

"Barnstaple" is an "un-play". Futility claims precedence over the audience's involvement with individuals and comedy is the mainspring of the play. I looked for a fast, tight marionette-like production. We almost got it. We had the production and presentation from outside the situations; the mindless counterpoint was essentially there. We also had pace. However tightness we did not have, because of inexperience and under rehearsal and because the brisker the pace the more rigorously you must trim the ship.

Inexperience applies more in respect of festival acting than anything else. "One-night standing" is a harrowing trade, for the atmosphere of strange theatres militates against controlled performances—the winning first shot of fourth place in twelve is remarkable.

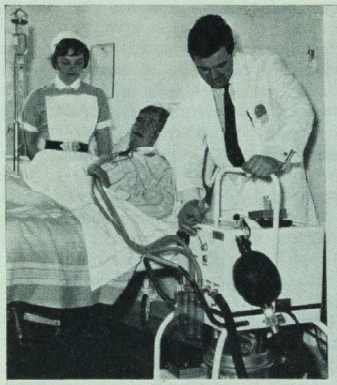
But under-rehearsed it was (though casting changes because of illness were largely responsible) and the producer's handling showed a peripheral laxness which failed to control the centrifugality of this type of play, especially as comedy had the whip-hand. Moves must be decisive, entrances, exits and demarcations of episodes of metronomic clarity and your actors must be subjugated to the play.

John Graham Pole (Charles Carboy) in the lead gave an exuberant performance—full of dash and invention which earned him the Most Promising Actor Award. A splendid tour de force but he needs someone who can tailor his imagination to the fit of the play. Nick Wagner (Rev. Wandsworth Teeter) made him an excellent if slightly ponderous foil. Sue Macdonald's maid (Sandra) was an excellently funny performance spun from practically nothing in the script, a taste of this experienced actress's talent.

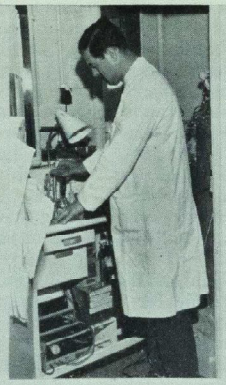
Vivian Onians as Mrs. Carboy seemed unsettled in a difficult middle-aged part which for a young company needed twice the work time available. A very exacting part not quite resolved. More straightforward is Helen Carboy, played in neurotic extravagance by Rosemary Sturgess, a comparatively untried actress of good and flexible voice. She needs further opportunity to explore and to come to terms with her physical stage presence, when she will find herself much in demand.

Bryan Lask produced this very funny play very wittily and with the Society's Secretary Bruno Kasteliz is to be applauded for carrying Bart's acting to an outside audience. Dick Cooper was Stage Manager, responsible for reducing foreign chaos to manageable proportions.

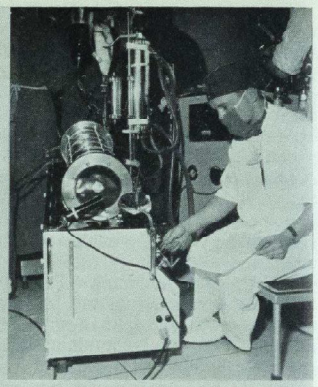
The competition was by and large stiff, including several professionally produced companies of regular competitors and we can be pleased with fourth place. This was an experiment and a success, a further achievement in the progress of a society which caters for an increasing proportion of the Student body.



Therapist

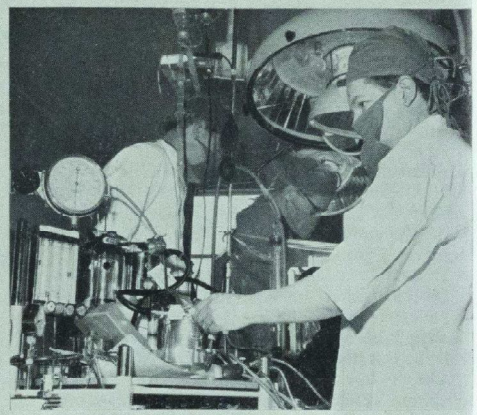


Biometrist

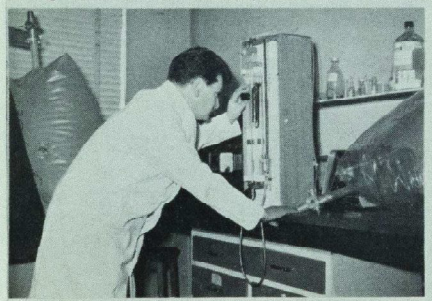


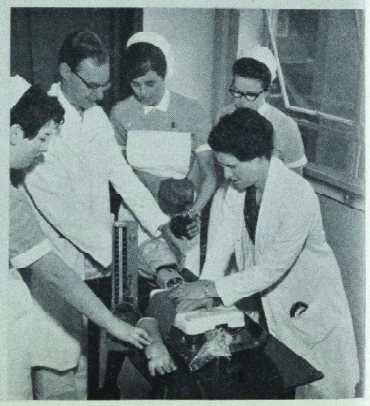
Perfusionist

The Anæsthetist 1964



Physiologist





Revivalist

SPECIAL DEPARTMENTS: VII

THE DEPARTMENT OF ANÆSTHESIA

By T. B. Boulton

The mighty edifice of present-day operative surgery rests upon the foundation of good anæsthesia; like the foundations of a building the works of the anæsthetist are often hidden from public and professional view; indeed, in many instances, the better his task is accomplished the less the anæsthetist should be noticed by patient or surgeon. Sir Norman Moore[1], in a rather quaint and touching tribute to the anæsthetists of the Hospital of his day, wrote: "The anæsthetist is a man apart . . . The ease and perfection of the operation largely depends upon his skill in giving the anæsthetic. . . . The anæsthetist becomes a sort of prologue to the operation, his influence pervading the whole action, having an important but silent part in it and in the end vanishing strangely." The doctor who embraces the discipline of Anæsthesia can expect a life of great variety which can give him much personal satisfaction but he must leave the limelight for those who practise other specialities.

History

At the time of the first successful demonstration of anæsthesia by Morton in October, 1846, the surgeon was merely scratching the surface or performing feats of manual dexterity amongst scenes of indescribable carnage and agony[2]. The discovery of anæsthesia was the starting point of this great era of surgical progress which, facilitated by the establishment of nursing as a profession and by the successive discoveries of antisepsis, asepsis and antibiotics, has led up to the present time when surgeons are able to operate on the vital organs—brain, heart and lung—with impunity.

British Anæsthesia enjoys its high status because, almost from the start, it became an independent medical speciality instead of a mere subdivision of Surgery. St. Bartholomew's has a tradition which reaches back to the very dawn of the anæsthetic era. We know that ether was administered for operations at the Hospital shortly after the news of Morton's discovery reached the United Kingdom[3]. The anæsthetist was the dentist Samuel John Tracy[4]. By July, 1850, upwards of 7,000 anæsthetics had been administered at the Hospital[5]. Chloroform was popularised by James Young Simpson of Edinburgh in November 1847, but there now seems little doubt that Mr. Holmes Coote used the anæsthetic in its impure form under the name of "chloric ether" at Bart's several months earlier[6]. Its use was recommended to him by one Michael Furnell, a medical student who later became Surgeon to the Indian Army and Professor of Physiology at Madras. Samuel Tracy, who had continued to be chiefly responsible for the administration of anæsthetics at the Hospital was elevated to the Staff as Surgeon Dentist in 1849 and ceased to administer them personally. There followed three years in which dressers gave the anæsthetics with rather unfortunate results[7] and in 1852 Patrick Black[8], Warden of the Medical College and Assistant Physician to the Hospital, was appointed Administrator of Chloroform. Since 1852 the office of Administrator of Chloroform (later "of Anæsthetics") has been in continuous existence[9]; at first it was held as a sideline by physicians and later by surgeons, but in 1875, Joseph Mills, the first member of the Staff to devote himself exclusively to the practice of anæsthesia was appointed. With the appointment of Mills the Department of Anæsthesia can be said to have been born as an Assistant Administrator of Chloroform was also appointed. As far as can be ascertained the only other special departments which can be said to have been in existence at that time were those of Dentistry (1837), Diseases of Women (1848), Opthalmology (1849), and Orthopædics (1870)[10]. By the time he retired in 1893 Mills had—in the words of Sir D'Arcy Power—[11], "raised the administration of chloroform to a fine art and left a tradition which placed the anæsthetic department foremost amongst those in the hospital".

The next half-century saw slow but steady development in the art of anæsthesia. A number of famous men occupied the posts of Chief and Assistant Administrators of Anæsthetics, perhaps the most well known name is that of Henry Gaskin Boyle. Progress was slow chiefly because the low financial rewards forced the majority of Anæsthetists to practice the speciality as a side-line to general practice.

The coming of the National Health Service in 1948 raised anæsthesia to financial parity with other specialities and enabled real progress to be made. Dramatic expansion took place in the immediate post-war years; academic anæsthesia developed, professorial chairs were created, the Conjoint Board Diploma in Anæsthesia, the Faculty of Anæsthetists in the Royal College of Surgeons and its Fellowship by examination were established and the anæsthetist's developing knowledge of respiratory physiology and pathology enabled him to extend his activities outside the theatre. It is interesting to reflect that in Great Britain in 1938 there were only 86 consultants and 140 trainees devoting their professional life entirely to anæsthesia, in 1962 there were 870 consultants and 918 junior staff[12]; in 1938 there was but one chair of Anæsthesia—at Oxford—at the present time there are eight, though London University has been behind the provincial schools in this respect, waiting until 1964 to appoint its first professor—at the Postgraduate Hospital.

The Department at Barts has undergone a similar expansion; just before the Second World War there were five Visiting Anæsthetists and three Residents[13], at the present time there are four part-time consultants, two full-time consultants and eleven Junior Staff. As in the rest of London the academic side has developed more slowly and is represented by a single combined appointment with the Department of Physiology at Senior Registrar—Lecturer level. The holder of this college appointment has the subsidiary title of "Tutor in Anæsthesia".

The Temperament of the Anæsthetist.

The author has often thought that a study of the psychological characteristics of the various specialities would make an interesting subject for M.D. thesis. The introvert wisdom of the physician, the extrovert individualism of the surgeon, the fastidious elegance of the opthalmologist and the hearty confidence of the obstetrician are a few of the type-characteristics which come to mind. The good anæsthetist must be born with the gifts of tolerance, patience and a sense of humour and must possess more than a modicum of intuition and mechanical ability. There is no place in anæsthesia for irascibility or exhibitionism.

The Theatre personnel are a team but the focus must always be on the surgeon—he is the captain and leader and *he* is operating on *his* patient[14]. The anæsthetist is the surgeon's chief-of-staff and must devote himself to ensuring that the best possible conditions in the widest sense, are created so that the surgeon can adequately complete his task with the minimum of interruption.

The duties of the anæsthetist will often extend beyond the administration of the anæsthetic and the actual physical care of the patient. Subject always to eternal vigilance the adjustment of the light or table, treating the fainting nurse or student or even surreptitiously advising the new theatre sister on the assembly of some intricate piece of apparatus, are all functions which may well properly concern the anæsthetist in aiding the surgeon in his task of treating the patient. On very rare occasions, if the surgeon is very junior and the anæsthetist is very senior, a word of quiet advice from the head of the table may be appreciated and may even avoid a tragedy.

Sir Norman Moore wrote "the art of the anæsthetist is mute". Except on carefully selected occasions he should never initiate conversation but he must be prepared to play "straight-man" to the surgical "wit" if this is required to relieve tension—at the end of a long and tedious operation for example.

The British anæsthetist has earned the confidence and respect of his surgeons; they trust him to administer the best anæsthetic which circumstances allow in his own way. There is more tolerance than in the past for necessary delay in the anæsthetic room.[15] The British surgeon respects the rights of his anæsthetist to be king in his own domain. There are fortunately few surgeons these days who are bad mannered enough to peer angrily through the windows, burst noisily into the anæsthetic room, or even shout through the key-hole, but this sort of behaviour was by no means uncommon in the not so distant past.

Outside the theatre in the treatment of respiratory failure and other conditions the anæsthetist often has to take a lead in suggesting therapy but he does well to remember that, in most cases, the patient is under the care of some other consultant and that his function is advisory.

Clinical Practice.

The Department of Anæsthesia at this Hospital has a strong clinical tradition. The Anæsthetists are now concerned with a number of aspects of patient care both inside and outside the theatre.

The Administration of Anæsthetics. This is the primary task of the anæsthetist. Much has already been said about the roll of the anæsthetist in the Theatre but it is perhaps as well to draw attention to the fact that many recent developments are directed towards providing better conditions for the actual operation; induced hypotension and the use of muscle relaxants are examples of such techniques. Better conditions for the surgeon usually mean a better chance for the patient, but this is by no means invariably true. The anæsthetist must be careful that the drugs which he uses do not have side-effects which endanger life in a particular case; safety must not be sacrificed for expediency. In this new and developing speciality the Department is constantly, trying, assessing and accepting or discarding new techniques, drugs and apparatus, this is, and should remain, one of the functions of a teaching hospital department.

Perfusion for Open Heart Surgery. The introduction of profound hypothermia and cardio-pulmonary perfusion technique provide fresh interests and responsibilities for the anæsthetist. At Barts, after initial development by the Department of Thoracic Surgery[16] perfusion has become an anæsthetic commitment. This a logical development as perfusion can be regarded as a natural extension of anæsthesia.

Pre- and Post-operative Care. The opinion of the anæsthetist on questions of fitness for anæsthesia and of post-operative care is being sought increasingly and the routine pre-operative visit is becoming more frequent. The Department endeavours to ensure continuity and satisfactory liason with firms and units by assigning junior staff to specific lists for quarterly periods. The question of allowing sessional time to part-time consultant anæsthetists for ward work is a problem which is being considered at national level.

The Treatment of Respiratory Disease. Since the Copenhagen poliomyelitis epidemic in 1952[17] the anæsthetist, because of his special knowledge of positive pressure ventilators, has found himself in increasing demand in the treatment of Respiratory failure. The speciality has contributed much to the treatment of these cases. In some hospitals Respiratory Units have been set up; in Barts such cases are usually treated in the general wards but the post of Resuscitation Registrar has been created to assist individual firms with the treatment. The appointment of Resuscitation Registrar is held in rotation by the registrars of the Department for periods of one month at a time. During his tour of duty the Resuscitation Registrar is on call for ward work and consequently does not undertake the administration of anæsthetics.

Resuscitation. The possibility of saving life by external cardiac massage and external defibrillation has made it necessary to have a medical officer immediately available. The Resuscitation Registrar undertakes this duty and is available to render assistance in any other circulatory or respiratory emergency which may occur in the Hospital.

Biometry. As a natural corollary to its work in resuscitation and perfusion the Department undertakes the measurement of acid-base and respiratory function with the aid of the Astrup pH meter in the Thoracic Theatre and other apparatus.

Teaching and Training.

Undergraduate Teaching. St. Bartholomew's is one of the few schools which devotes a whole month of its curriculum to the teaching of anæsthesia. This training has often proved invaluable to housemen in jobs in smaller hospitals and obstetrical departments. It is not possible to train an anæsthetist in a month for it must be acknowledged that anæsthesia has become a post-graduate study. The aim of undergraduate instruction is to give the clerk an insight into the work and function of the Department of anæsthesia. The course includes a series of talks on subjects related to anæsthesia such as resuscitation and pre-operative preparation. Many clerks have expressed appreciation of the fact that the anæsthetic month not only introduces them to anæsthesia, but also provides an opportunity of revising their operative surgery in their final year, and of seeing the work of a number of specialist units such as the Neurosurgical and Thoracic Departments.

Postgraduate Training. The trainee who rises through the Department from Senior House Officer to Senior Registrar receives a comprehensive training in the clinical aspects of the subject. The theoretical side is not neglected and a recent development has been the organisation of tutorials by the "Tutor in Anæsthesia. The record of the Department in the F.F.A.R.C.S. and D.A. examinations in the past two years has been very satisfactory by any standard. The Department meets once a month, except during the holiday period, to hear an outside speaker, see a film or to debate a current problem. A number of former members of the Department and anæsthetists from other hospitals usually attend these meetings.

Research and Publication.

The Head of the Department is a well known author and editor of anæsthetic text-books.[18-21] Two other members of the consultant staff have written the recognised text-book on Neurosurgical anæsthesia[22] and others have contributed chapters to standard works.[23-25] The Editor of "Anæsthesia" is a member of the Consulting Staff and a former head of the Department and the Consultant

Staff includes an editor of the "Proceedings of the Royal Society of Medicine" and an assistant editor of "Anæsthesia."

In the past the publications of the Department have been mostly of a clinical nature but recently several true research projects have been undertaken in conjunction with the Departments of Physiology, Cardiology and Thoracic surgery. These projects include studies on oxygen tension in dogs, the effects of surgery and anæsthesia on the ischæmic E.C.G., studies on deep halothane anæsthesia and insufflation anæsthesia, and the assessment of intrapulmonary shunts after profound hypothermia.

Administration.

The author has it on good authority that the Department first requested offices and a secretary in 1928[13]! The Department has certainly pressed for proper facilities for the last fifteen years. The problems of co-ordination and communication have become acute since the special departments returned from St. Albans. The day to day organisation of duties has fallen heavily on successive Senior Registrars and it seems astonishing that the filing cabinets of the largest clinical unit in the Hospital have literally been the pockets of the Head of the Department and his colleagues.

It is a pleasure to report that the cry from the wilderness has been heard and that the Promised Land is at last in sight. Three rooms on the ground floor of the Lucas block are being prepared and the Department looks forward with eager anticipation to the appointment of its first secretary.

Conclusion.

The life of the modern anæsthetist is varied and full of interest. He has a wider circle of professional contacts in other Departments than most other specialists.

Anæsthesia in general and the Hospital Department in particular, look forward to a period of further development particularly in the academic field.

Kiplings "If" might have been written as advice to the aspiring anæsthetist:—

If you can keep your head when all about you
  Are losing theirs and blaming it on you,
If you can trust yourself when all men doubt you,
  But make allowance for their doubting too;
If you can wait and not be tired of waiting,
  and serve your turn long after they are gone,
And so hold on when there is nothing in you
  And yet don't look too good nor talk too wise:
. . . —you'll be a Man, my son.

Acknowledgements.

The author acknowledges with thanks the co-operation of Mr. Tredinnick and the Department of Medical Illustration, Mr. J. L. Thornton, the Librarian and Miss N. Kerling, the Archivist, and apologizes for transposing two lines from the third stanza of "If" into the first stanza.

References.

[1]MOORE, N., (1918), *History of St. Bartholomew's Hospital*, p. 748, Pearson, London.
[2]FURNELL, M. C., (1877), *Lancet*, **i**, 934.
[3]LAWRENCE, Sir W., (1847), *Operation performed after the inhalation of the vapour of sulphuric ether. Lond. med. Gaz., N.S.* **4**, 138.
[4]THORNTON, J. L., (1952), *Samuel John Tracy* (1813-1901), *Anæsthesia*, **7**, 72.
[5]TRACY, S. J., (1850), (*Corresp.*), *Medical Times*, **22**, 130.
[6]SYKES, W. S., (1961), *Essays on the first hundred years of Anæsthesia, Vol. II*, p. 168, *Livingstone, Edinburgh.*
[7]SNOW, J., (1852), (*Corres.*), *Med. Times & Gaz.*, **25**, 349.
[8]THORNTON, J. L., (1955), *Patrick Black* (1813-1879), *Anæsthesia*, **10**, 70.
[9]THORNTON, J. L., (1959), *Development of Department of Anæsthetics, St. Bart's. Hosp. J.*, **63**, 13.
[10]WHITTERIDGE, G., STOKES, V., (1961), *A Brief History of the Hospital of Saint Bartholomew*, p. 44 *et seq., St. Bart's. Hosp., London.*
[11]POWER, Sir D'ARCY, (1933), *Obituary R. Gill, St. Bart's. Hosp. Rep.*, **66**, 1.
[12]LODER, R. E., (1964), *Symposium Camb. Univ. Med. Sch., May 9th.*
[13]HEWER, C. LANGTON, (1964), *personal communication.*
[14]BATEMAN, D. V., (1963), *A Philosophy of Anæsthesia, Anæsthesia*, **18**, 185.
[15]HULBERT, K. F., (1960), *From Both Ends of the Table, Lancet*, **i**, 1403.
[16]HURT, R. L., (1963), *Profound Hypothermia, St. Bart's. Hosp. J., Suppl.* **4**, **i**.
[17]LASSEN, H. C. A., (1954), *The Epidemic of Poliomyelitis in Copenhagen*, 1952, *Proc. roy. Soc. Med.* **47**, 67.
[18]EVANS, F. T., (1954), *Modern Practice in Anæsthesia*, 2nd *ed., Butterworth, London.*
[19]EVANS, F. T., GRAY, T. C., (1959), *General Anæsthesia, Butterworth, London.*
[20]EVANS, F. T., GRAY, T. C., (1958), *Modern Trends in Anæsthesia, Butterworth, London.*
[21]EVANS, F. T., GRAY, T. C., (1962), *Modern Trends in Anæsthesia*, 2, *Butterworth, London.*
[22]BALLANTINE, R. I. W., JACKSON, I., (1960), *General Anæsthesia for Neurosurgery, Churchill, London.*
[23]ELLIS, G., (1954), *Modern Practice in Anæsthesia*, 2nd *edit., ed. Evans, F. T.*, p. 130, *Butterworth, London.*
[24]BALLANTINE, R. I. W., (1963), *Recent Advances in Anæsthesia, ed. Hewer, C. L.*, p. 127, *Churchill, London.*
[25]BOULTON, T. B., (1963), ibid, p. 175.

WHITHER SHALL WE WANDER?

By Jasper

In this and subsequent articles I shall be wandering around London pubs, though not five minutes from Bart's nevertheless within easy reach of the Hospital.

The first visit is to Kensington, starting in the most salubrious part and ending in the less. Start at the junction of Kensington High Street and Church Street, and walking up Church Street, take the first turning on the left, Holland Street. At the corner of this and Gordon Place sits what I have always known as the **Elephant and Castle** (but which now has two signs outside calling it **The Little Pub.**) A plush little place selling Charringtons at 2s. 2d. a pint, rather slow service and usually packed full. However it is delightful to sit outside in the early evening and watch the residents of Kensington hurry home from work. A good place to meet and start my series at, but you'll only want a pint there.

Now continue along Holland Street, and turn right up Campden Hill Road. At the top of this little hill note the water tower (which must have inspired G. K. Chesterton's "Napoleon of Notting Hill") and the **Windsor Castle**. If there's any room in the Garden you may like a pint there, but I would recommend you continue past it as far as Uxbridge Street, off to the right, where half way down stands the **Uxbridge Arms**. Here the beer is Whitbreads at 1s. 9d. a pint and there is an excellent dart's board in the public bar, but don't be surprised if you are charged a deposit on the darts, you'll get it back! The saloon bar is pleasant and comfortable, and not often crowded. A word of warning—mind the lavatory steps.

If you can drag yourself away from the darts, continue along Uxbridge Street and turn left into Notting Hill Gate. Cross over and go down Pembridge Road and into the **Prince Albert**. This is in grand Edwardian style, it even has a stained glass window, and sells many brands of beer, including Watneys at 1s. 10d. a pint. Apart from the cold buffet available, though quite expensive, its chief asset is the bar-billiard table. If you feel up to a game and people are playing already, book your turn by placing a sixpence on the cloth I have seen people sitting by the table for hours never getting a game simply because no one knew they wanted one.

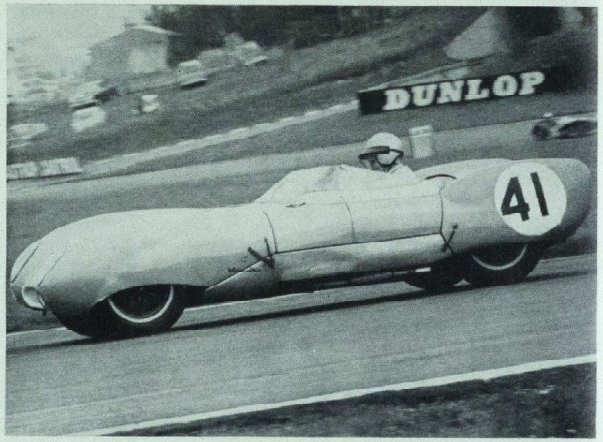
If you don't feel like a game continue along Kensington Park Road, and turn right at Westbourne Grove, and where it meets Portobello Road we find an old friend, **Hennekeys**. Although primarily a wine house it sells Bass at 2s. a pint. The pub is at its best in the winter when it sells mulled wines, at very reasonable prices. Excellent after a cold Saturday morning in the market, but don't dress up to go there, it's pretty shabby.

"The Uxbridge Arms"

OTHER PEOPLE'S CARS: TEAM BART'S

By J. M. Robinson

Originally I was asked to write about a few of the cars at Bart's that I thought were of interest. However, every time I decided on a car to write about some snag arose, until I was left with only my own to choose from. This is a pity, as up till now I think only a few people at Bart's have seen my car.



The Lotus XI Le Mans with the author at the wheel. Photograph by courtesy of Evan Selwyn-Smith.

The car is a 1957 Lotus XI Le Mans sports racing car. These cars had a considerable success in their day but when I bought it in 1963 it was considered very out of date and thus was comparatively cheap.

From the technical point of view the car has a space frame and stressed panel chassis with independent wishbone suspension in front with a de Dion suspension system at the rear. The wheels are of magnesium alloy and there are 9½ in. disc brakes all round being mounted inboard at the back. The car is powered by an 1100 c.c. Coventry Climax engine developing about 95 b.h.p. at 7,500 r.p.m. The body is of duralumin and fully aerodynamic. The car weighs about 8 cwt. and is 3 ft. high with a ground clearance of 6 inches.

Theoretical maximum speed is about 125 m.p.h. with the present set up. Fastest yet seen on the circuit is 118 at Goodwood. Fuel consumption is 15-18 m.p.g. racing; on the road it is said to be about 40-45. I wouldn't know—I can't afford the insurance.

It is easier to get into the car by climbing over the door. It does open but it is so low it is not worth it. The first impression is that the car is very low and that there is miles of bonnet in front, the first two or three feet of which is not visible from the cockpit. The seat is narrow—13 in., specially tailored to fit me—and slightly reclining. The steering wheel is leather covered, very comfortable and small. The pedals are well placed, if a bit close together. The clutch requires a very strong left leg and the accelerator is well arranged for 'heel and toe' gear changes. The gear lever is well to hand and requires very little movement from gear to gear, but a bit of concentration to do it just right.

The engine usually starts easily and after allowing the oil pressure to rise can soon be revved up, the exhaust producing a beautifully crisp note, there being no silencer.

To get the car moving, the engine is taken up to about 5,000 revs and the clutch dropped rapidly to promote wheelspin. This is necessary as 1st gear is very high and there is considerable danger of stalling. Acceleration through the gears is very rapid and the revolution counter must be carefully watched. It is safe to 8,000 r.p.m. but 7,500 r.p.m. is usually used to be quite sure.

Cornering is very flat and fast, the quick steering making any necessary corrections easy if applied fast enough. The car is very forgiving but can be quite a handful in the wet especially in low gears. There is a tendency to understeer on slow sharp corners which can be embarrassing if you arrive too fast but on faster curves it is very stable. Braking requires a firm foot and a little steering correction from time to time but there is no fade at all and the wheels can be locked at over 100 m.p.h. if excess pressure is applied. The aerodynamics are excellent and very little slipstream is felt, most of it going over the top, though I did meet a bumble bee on the straight at Silverstone which produced a fair sized bruise on my forehead. After a disappointing first season last year which culminated in a wrecked gearbox, the car has been completely rebuilt during the winter and is now going well. In our first four meetings to date we have been placed 7th, 1st, 3rd and 5th. A few further modifications are in progress at the moment and we hope to continue the season in the middle of June.

BOOK REVIEWS

A Synopsis of Respiratory Diseases, by J. Smart. 162 pp. 22s. 6d. **A Synopsis of Cardiology,** by D. Weitzman. 212 pp. 30s. Both published by John Wright and Sons Ltd., Bristol.

Both of these books originally formed separate parts of the late Sir Henry Letherby Tidy's well known "Synopsis of Medicine". The task of revising his work in the face of modern developments in the field covered by these books was felt to be too much for one author to undertake, and the publishers have therefore re-published the original volume as a series of separate monographs by experts in the subjects concerned. Both books are published in the note form that characterised the original work but unlike the usual synopses they manage to give very full coverage to the relevant subjects without sacrificing accuracy and clarity of expression. This said, Dr. Weitzman's book is undoubtebly the most readable of the two. His explanations of the *raison d'être* of various cardiological conditions could hardly be bettered. The facts are explained both clearly and simply in a style which encourages rather than discourages the reader from pressing on with the book. Dr. Weitzman has taken full advantage of recent developments in the field of cardiology to clarify some facts which many must have found difficult to understand, particularly the mechanisms behind certain physical signs. There is a useful chapter at the beginning of the book of value to the student at the outset of his clinical career, on the examination of the heart and blood vessels. One of the best features in the work is the clear explanation of electro-cardiographic changes in all the more important cardiac disorders—a subject which the average student tends to neglect and many practitioners fail fully to understand. In allotting space to various disorders Dr. Weitzman has shown a good sense of proportion and I found his chapter on the effects on the heart of systemic diseases particularly useful. The only weakness in this otherwise excellent book is the omission in the section on occlusive arterial disease of the legs of the place of thrombo-endarterectomy or by-pass operations in the treatment of this condition. The operation of Achilles tenotomy or bi-lateral lumbar sympathectomy are less often performed these days besides being of doubtful value to the patient.

Dr. Smart's book is printed on cheaper paper and is not so readable as Dr. Weitzman's but the ground to be covered is wider. A very large section of the book (50pages) is devoted to Tuberculosis including a detailed description of the more acute cases rarely seen today in Great Britain, besides dealing with the manifestations of the disease outside the respiratory system. In his Preface Dr. Smart justifies his coverage of the subject at such length on the grounds that tuberculosis is still so very common in many parts of the world and no practitioner should be ignorant of its severer manifestations. Unlike the "Synopsis of Cardiology" there is no chapter on the examination of the respiratory system nor is there a clear explanation of the nature of certain physical signs. I feel the book would have benefited by the inclusion of a section on these subjects. There is however a useful chapter on pulmonary physiology. There are no photographic reproductions of X-rays in the book but instead little diagrams showing the radiographic changes in the lung fields in postero-anterior and lateral positions. These I found more useful and easier to understand than the more elaborate diagrams in the bigger textbooks. This is particularly true of the chapter on occupational diseases, silicosis, Farmer's Lung etc.

Both these books can be confidently recommended to the student looking for information presented in a concise and at the same time easily assimilable form, particularly the "Synopsis of Cardiology" which is one of the most readable text books to emerge from the medical press for some time.

G. H.

Marriage, Sex and Happiness by Kenneth Walker. Odham's Press Ltd., 1963. 21s.

Kenneth Walker, an old Bart's man, has for long been recognised as an authority on sexual physiology and its widest implications in society in general. His very popular "Love, Marriage and the Family", is now followed by this latest volume which is mainly about marriage—particularly about marriages that are coming apart at the seams.

He deals very fully with common problems in marriage, and especially those of a sexual nature. Highly controversial topics such as A. I. D. are tackled with sincerity and conviction, and one is never left in any doubt as to the author's beliefs. He faces the question of why marriages fail, and also provides information concerning separation and divorce.

The book is well written, with a minimum of jargon (a useful glossary is provided), and the style is such that it is easy to read. It is liberally endowed with a wide range of quotations, both literary and scientific, and a small bibliography is given.

At one guinea it is good value, and can be warmly recommended. A broad cross-section of the population could benefit from reading this book, but especially, of course, all those whose work involves any aspect of 'marriage guidance'.

S. S

A Synopsis of Surgical Pathology, by Wilfred Kark. John Wright & Sons Ltd., Bristol. 422pp. 45s.

If there ever was such a thing as surgical pathology, it ceased to exist when surgeons began to intervene in such classically "medical" conditions as rheumatic carditis and hepatic cirrhosis. This is not to deny that some aspects of pathology are of special interest to surgeons. Their need would however be better filled by the study of the appropriate sections of a good textbook on general pathology than by recourse to volumes such as the one under review.

A Synopsis of Surgical Pathology consists of abundant headings and sub-headings with a terse dogmatic text illustrated by twenty-odd line drawings. All the anatomical systems are dealt with but not fluid balance, inflammation or immunology, all vital topics in contemporary surgery. Some of the text is inaccurate, some incomprehensible and some suffers from both defects, as in the account of wound healing in skin.

One may presume that nobody would recommend this book as a text for general use. It is no doubt intended for revision purposes in preparation for the final qualifying examination. The question arises: does it in fact serve this purpose? The present day examiner is for example much more interested in testing the candidate's knowledge of the general consequences of obstruction of physiological drainage tract than in eliciting from him twelve causes of lung abscess, painfully memorised the previous evening.

W. G. S.

Introduction to Electrocardiography. 2nd Edition. By L. Shamroth. Blackwell Scientific Publications. 20s.

This short book on electrocardiography makes an easily read and understood introduction to the subject. The author has taken pains to give an explanation in simple terms for the electrocardiographic abnormalities he describes, and he covers well all the routine aspects of electrocardiography. The necessary basic principles are explained quickly in the first ten pages, allowing the reader to begin the study of clinical electrocardiography long before he is bewildered by complex theoretical considerations. The chapters on Disorders of Cardiac Rhythm are particularly good, although some of the more complex electrocardiograms here are rather beyond the requirements of the non-specialist reader. This book should appeal particularly to house physicians, enabling them to study the electrocardiograms they order with new understanding.

J. S. F.

The Science of Surgery, by E. H. Storer, J. W. Pate, R. T. Sherman. Published by McGraw-Hill Book Company. 540pp. Price £3 2s.

The authors of this book are members of the teaching staff of the University of Tennessee and its content is based on lectures given to undergraduates there.

It is a soft-covered and convenient sized manual which aims to set out basic surgical facts including the application of anatomy, physiology, pathology and the principles of diagnosis and treatment, to surgical diseases. It certainly achieves its aims. Its pages are full of facts presented clearly and concisely in easy-to-read print. There is no doubt that most of the facts are up-to-date and although the book is American in origin what is described in it is in line with British teaching.

Before describing the clinical aspects of each subject matter the authors successfully link it where applicable, with its embryology, anatomy, physiology and pathology. This they do briefly and well.

There are lists and classifications which should please the undergraduate striving to concentrate his facts for examination purposes. In fact the whole book is a useful and readable revision manual.

The authors deal with most aspects of surgical disease but have over-emphasised cardio-pulmonary diseases (they form over one fifth of the book). These have been admirably dealt with but to the exclusion of any neuro-surgical or orthopædic subjects.

The illustrations are simple and clear line diagrams, though some of them are more suggestive of the 'comic-strip' type of drawing! No doubt such drawings will be very effective in pressing home the facts of surgery to some students.

At the end of each chapter is a useful short list of further suggested readings which are not limited entirely to American works. This allows the student of surgery to explore further a particular aspect of the subject of the chapter if he so desires.

Conclusion: A useful, concise and up-to-date revision manual for the undergraduate.

N. G. R.

Bonney's Gynæcological Surgery. 7th Edition, by MacLeod and Howkins. 6gns.

In the early years of the 20th century Victor Bonney was the doyen of British gynæcological surgery. His technique was second to none and was in fine contrast to that of some of the European leaders in the subject. He set a standard at the Middlesex Hospital which has been faithfully followed by many of his pupils who have themselves become eminent gynæcologists. Mr. Douglas MacLeod and Mr. John Howkins constitute the best examples of this tradition and none could be more fitted to compose a new edition of *Bonney's Gynæcological Surgery:* a book which has been acclaimed throughout the world since it was published in 1911.

This edition is made up to date by a complete revision of the old chapters with additions according to modern technique and the exclusion of some operations which are now out of date. New chapters deal with radiotherapy written by Dr. Max Hulbert, electrolyte balance by Dr. Victor Wynn, and blood transfusion by Dr. H. F. Brewer. The illustrations, old and new, are in the same style of Victor Bonney the artist, and their ease of understanding and simplicity of line reveal the great skill of the present illustrator, Mrs. Leslie MacLeod.

This volume will be invaluable to the registrar and young consultant in gynæcological surgery, and it will form an essential part of the armarmentarium of the general surgeon who is called upon to perform gynæcological operations occasionally.

It is difficult to single out any particular section of this book for comment or criticism. The text is uniformly good and the whole of gynæcological surgery is described lucidly and with a sound and conservative judgement so that the volume is highly recommended and without reserve.

J. B.

Diseases of Children, by Hugh Jolly. Blackwell, Oxford, 1964. 586pp. 47s. 6d.

It is something of an event when an author starting from scratch writes a book on Diseases of Children. If he contrives to write it in good readable English, to incorporate the results of his own experience and to bring into it a summary of contemporary knowledge, the event is one which should be greeted with enthusiam and whose success is assured. Dr. Jolly has amply fulfilled these conditions. His style is crisp and the ideas he conveys are easy to assimilate. The book reflects the current knowledge of this branch of medicine and will be of value not only to students with examinations in front of them but also to those who practise in children's medicine and whose reading of the literature has not kept pace with the times or with that of the author. There is no suggestion of a dry-as-dust presentation of current opinion for every section has been vivified by the touchstone of the author's own experience. A period in Nigeria and nine years of consultant practice in provincial England before taking over the departmental headship in a London under-graduate medical school do not leave one devoid of opinions. By good fortune and good management Dr. Jolly's pervade the book.

One cannot have everything. If the way of setting out matter is to be dogmatic and concise, the marginal bits of vagueness have to be left out. Such a statement as that under the heading Sickle Cell Disease, 'Hæmoglobin S occurs exclusively in the negro race, . . . ' p. 436, may be approximately true but it could leave the thoughtful a bit worried about the exceptions. Again one regrets that the need for brevity has largely prevented the author from speculation about causes. For instance after an account of the basic nature of mucoviscoidosis there follows the sentence 'Much therefore needs to be clarified regarding the actiology of the condition'. Of course the author has the right of it. Samuel Gee in his original article on the Cœliac affection used half his space in guessing at its causation. His ideas were soon outdated and contributed nothing to the later solution. MacCallum was once heard to say that in writing his textbook of Pathology what he had enjoyed most was not answering a single basic question. Speculation on causes would take up space and perhaps be off the mark—and yet one regrets its absence.

These are comments on, not criticism of, a fine piece of work. The illustrations are good, the index is good and the text is excellent. With reasonable assiduity the book can be read through in the evenings in less than a month. This exercise can be recommended to a great many people.

C. F. H.

Sex, by Susan Michelmore. Eyre and Spottiswoode. Price 21s.

Probably most, if not all reviewers of scientific or semi-scientific books want to know something of the background of the author. Almost without exception this is made immediately apparent, either from the professional qualifications given after the author's name or from some brief biblography. This book is an exception; all that we know is the author's name.

The title of the book immediately conjures interest, although it is apparent from the number of people who have picked it up from my desk and elsewhere and then replaced it with a polite grunt, that it tends to be ambiguous.

According to the information on the fly leaf, the book was written for the reader with little or no scientific knowledge and it explains how the mechanism of sexual reproduction works and how the process of evolution gave rise to different methods of reproduction. It also stated that one of the most interesting things in the book is the way it relates sexual behaviour in men and women to that of other animals—and in this connection bees, an odd male fish, stags and bower birds are all quoted.

There is no doubt that it is difficult to write a book under the terms of reference given above. Of particular importance is the general plan of the book and in this respect the author has shown commendable judgement. The first chapter discusses the meaning of reproduction and opens with a brief account of human pregnancy. The second chapter continues with the social implications of sex, mainly in man and other primates, and then leads on to other animals. The remaining twelve chapters follow a logical order and deal with such topics as the care of the young, sexual behaviour, advantages of sexual reproduction and breeding seasons.

One of the problems of writing for readers with little or no scientific knowledge is to know how much explanation of each new term is really necessary. There are instances when the author explains one technical term and then assumes knowledge of an even more obscure or difficult one. Thus on page 159 she writes, "Hormones are chemicals produced by the ductless glands and some other organs". A knowledge of ductless glands is assumed. A few lines further on she states that the pituitary gland, "is formed partly from ectoderm and partly from nervous tissue". Except in certain obvious cases much of the information in the book is perhaps necessarily superficial. Sometimes this rather vividly conjures up the phrase about a little knowledge. Statements like, "development can be upset by the mother taking *such* drugs as thalidomide, or in some cases by contracting a virus disease *such* as german measles", (italics mine), can be dangerous. The lay reader is not in a position to know what they mean, aspirins are drugs and the common cold is caused by a virus.

The book is well produced and reasonably priced. There are 17 line diagrams. It seems best suited to sixth-form students and those in their first year at University who have a general interest in biology and have, in fact, already some knowledge of the subject, sufficient to be able to know the meaning of some of the more common terms and are in a position to make a reasoned judgement of statements which do not profess to be too profound.

D.L.

SPORTS DAY 1964

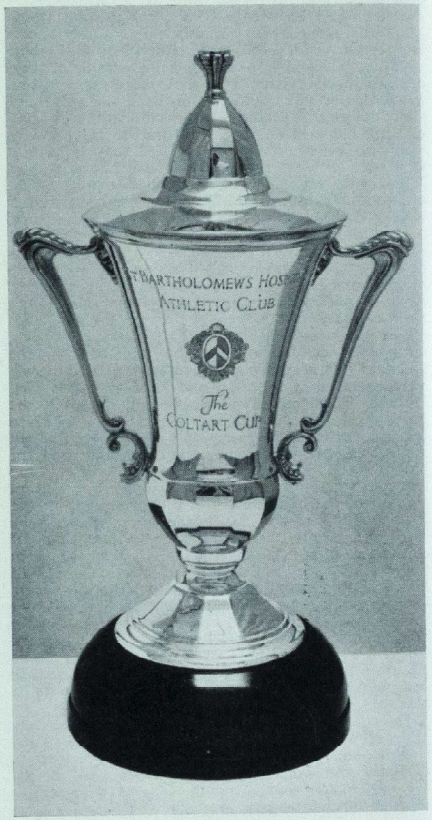
By Our Special Correspondent

A splendid English summer's afternoon greeted visitors to Chislehurst for this year's Annual Sports, and with the green turf beautifully prepared all was set for a successful occasion. There had been much talk of free beer, good food, new records—particularly in the Staff Race, a new cup and yet another chance to win a 15-1 bet against bowling out the Captain of Cricket. This indefatigable gentleman ought to go into business—or raise the odds—for nobody succeeded.

The attendance reflected mild disinterestedness rather than complete apathy and by all reports the organisers were disappointed by the crowd, or lack of it. They should not be discouraged however; both the social and sporting level of the afternoon were much improved on last year and, reading through old comments in the journals, very much improved on the last few years.

The sun made all the difference and the tennis courts full of players in white provided a fine sight. Some of the girls sported attractive summer dresses in contrast to the athletes some of whom wore a motley selection of articles to say the least. As for the actual sports there was, as ever, keen competition in all the events but of all the performances mention must be made of D. Tunstall-Pedoe's run in the mile. His time of 4 min. 21.6 secs. beat the old record held by Dr. A. E. Dormer for many years by 3.4 secs. and for this he was awarded the President's Cup. The finish of the 100 yds. was typically close but we were fortunate in having Prof. Rotblat as chief timekeeper for he was able to pin down Freeth's winning time to 10.38 secs. Niven was 0.02 secs. behind and then came a trio of Scott, Chapman and Goodall whom even Dr. Harris as President of Sports Day and Referee was unable to separate. In the 440 yds. Scott was just pipped at the post by Sutton in a very exciting finish, which defeated Prof. Rotblat, who gave them the same time of 54.1 secs. Third was T. J. Coltart in 56.0 secs.

Tea, and later supper, was arranged by Miss Parveen Kumar who had prepared a resplendant feast which was enjoyed by all except those unfortunate enough to have to stand or sit on the slightly damp grass. After the racing, the rewards, and these were presented by Mrs. Harris who kindly stood down to allow Mrs.



"The Coltart Cup"

Coltart to make the first presentation of the Coltart Cup. This went to the 2nd Year Preclinicals led by Scott. It seems that the Athletics Club will have to decide before next year who exactly belongs to which year and indeed what the years are for the purpose of this cup as well as the position of the Dental students; for it was a pity to see the poor announcer arguing with athletes not unnaturally concerned to see their own success. Perhaps this could be avoided if the task of adding up points were performed in some quiet backroom away from those with a vested interest.

Finally came relaxation—some relaxation!—to the thunderous and ceaseless roar of the Alpha Beats with a partner to the right and pint to the left.

Sports Day Results

Winners:
120 yds. Hurdles, B. Scott, 16.4 secs.
100 yds., M. Freeth, 10.4 secs.
220 yds., J. Niven, 24.0 secs.
440 yds., C. Sutton, 54.1 secs.
880 yds., T. Foxton, 2 mins. 5.2 secs.
1 mile, D. Tunstall-Pedoe, 4 mins. 21.6 secs. *New Record.*
3 miles, T. Foxton, 16 mins. 1 sec.
High Jump, K. Rawlinson, 5 ft. 6 ins.
Long Jump, J. Niven, 20 ft. 6 ins.
Triple Jump, J. Niven, 4 ft. 4 ins.
Shot Putt, T. Herbert, 35 ft. 11½ ins.
Discus, T. Bates, 99 ft. 9 ins.
Javelin, D. Pope, 131 ft. 6 ins.
Cricket Ball, D. Pope, 275 ft. 9 ins.
Relay, 2nd Year Pre-clinical.
President's Cup, D. Tunstall-Pedoe.

Inter-Year Competition

1st, 2nd Year Pre-clinical, 113 points.
2nd, Introductory Course, 93 points.
3rd, 1st Year Pre-clinical, 77 points.

SPORTS NEWS

EDITORIAL

Rather like the Michelangelo "Virgin" in the almost inaccessible boardroom of the Royal Academy, a glass case full of sports' trophies lies tucked away in isolated splendour in the gallery of the Hospital Library. The collection includes such diversities as the University Inter-Collegiate Lacrosse Cup, the 1889 Scratch Fours Cup, the Aldwych Theatre Cup (?), the U.H. and U.L.U. Diving Cups, now held for six successive years, and the Girling Ball United Hospital Boxing Trophy, not to mention innumerable cups for the less exotic but more popular sports.

That we should hide from the public eye such a worthy show-case is unduly modest. To display them all in the centre of outpatients might be too ostentatious, but surely a compromise could be reached whereby others than the more industrious students could be reminded of our achievements. It is unfortunate but inevitable that our Sports' Ground should be so inaccessible; there is no need for the gains from the playing fields to be likewise. Perhaps herein lies some clue to that "perennial argument of apathy and indifference."

JULY CALENDAR

Wednesday, July 1st
Tennis v West Heath (A).
Swimming v O. Citizen's (A).

July 1st—4th
Rowing—Henley Royal Regatta.

Saturday July 4th
Cricket v UC Old Boys 2.30 (H).
Tennis v Birkbeck.

Sunday July 5th
Cricket v Past Bart's 11.30 (H).

Tuesday July 7th—9th
Rowing—Barnes & Mortlake Regatta

Wednesday July 8th
Tennis v Royal Dental Hospital 2.30 (A).

Saturday July 11th
Rowing—Kingston Regatta.
Cricket v Incogniti 11.30 (H).
Tennis v Roehampton 2.15 (H).

Wednesday July 15th
Tennis v UCH 2.30 (H).
Golf v Bart's Society.

Saturday July 18th
Cricket v Nomads 2.30 (H).
Tennis v KCH 2.30 (A).
Rowing—Molesey Regatta.

Sunday July 19th
Cricket v Dartford.

Wednesday July 22nd
Cricket v Oxton 2.30 (H).

Saturday July 25th
Cricket v O. Ardlinetions 2.30 (H).
Rowing—Staines Regatta.
Tennis v UH Singles Comp. 2.15 at Guys.

Wednesday July 29th
Tennis v Charing Cross Hosp. 2.30 (A).

SQUASH REPORT

1st Team. Cup Final v. St. Mary's, May 27.

This was played at St. Thomas' Hospital. Unfortunately due to the late stage of the season, the team was not at peak form. J. Mitchell was a disappointment, as he can usually beat his opponent who also plays for London University and U.H. In all matches the opponents were able to dominate the games sufficiently so that although each game was close, only one game was won in the match. This is the first time the Hospital has reached this stage of the competition for many years.

Team: J. C. Mitchell, A. D. Edelsten, D. J. Delaney, D. Latham, M. A. P. S. Downham.

Result: Lost 0-4. Delaney did not play.

2nd Team

Junior Hospital Cup Semi-final v. Guy's. May 21.

This was a very close and good match. It really depended on the 1st String match. C. Edwards eventually lost in five games with a badly blistered hand: 0-9, 9-0, 3-9, 9-5, 7-9. M. Kettlewell and D. Chesney both lost, and S. Thomas and A. Chant played well to win. The second team has had a good season and done well to reach this stage of the competition.

A. D. EDELSTON.

ATHLETIC CLUB

So far this year the Club has had an enjoyable and reasonably successful season. As your correspondent is unable to draw comparison with last year, through absence on his part, he will deal with this year only.

The Club came 2nd to St. Mary's Hospital, beating Westminster Hospital in the first match of the season, the result depending upon the final relay. We won all other track events.

We then went for a short tour of Cambridge, before Whitsun, the enjoyment of which was not marred by Jesus College, who discovered they could not after all, raise a team. We lost to Queen's and Emmanuel Colleges meanwhile.

Against Goldsmiths College, who won all but one event last year, we managed a good win, many of our second strings gaining valuable points.

TENNIS REPORT

The Tennis Season has got away to an active and lively, if not perhaps too successful start. It began on April 25 at United Hospital Trials where out of 17 participants, 9 were from Bart's. This was very encouraging, and has resulted in Edelsten and Mitchenere representing U.H. on two occasions.

The first match was in the London University Intercollegiate Competition where we suffered a 1-5 defeat from College of Estate Management. This was a pleasant Sunday afternoon fixture at Wimbledon Park with plenty of distractions such as screaming kids, chattering mothers and the inevitable entwined couples. It was the C.E.M. 2nd pair which did most damage, winning three matches. Our one victory was by Fryer and Edelsten who beat their 3rd pair 6-0, 6-0.

May 2nd v. London Hospital. Lost 4-5.

It was a damp, windy day. M. Fryer and C. S. Garrard played well to win all their three matches, beating their 1st pair 2-6, 6-3, 7-5, after fighting back from 1-4 in the final set. Other two pairs were J. Pilling and S. M. Johnson: M. Nightingale and C. Roch-Berry. Unfortunately the two lower pairs did not give enough support to the top pair.

A. Edelsten and P. Mitchenere were unavailable that day, as they were playing for U.H. v. Bristol University.

Wednesday, May 13. Lost 1-5 to Guy's at Chislehurst.

This was a disappointment, and the team did not play well. Guy's are our keenest rivals in Hospital tennis, having beaten us in the Cup Final last year. Return of service seemed to be a weakness which cost us all a lot of valuable points. Guy's have a temperament more suited to the game, and this is where we must basically change if we are to make the most of our abilities.

Wednesday, May 20. Lost 3-6 to St. Mary's Hospital.

Another not too successful match. Although Edelsten and Mitchenere were missing, the team could still have done better than they did. Settling down into a rhythm seems to be a difficulty for most of the team.

Saturday, May 23 v. Imperial College. Lost 3-6 Away.

This was a fine, very windy day, and tennis was tricky. Bart's failed to master the conditions fast enough. A. Edelsten and P. Mitchenere played well to beat the first pair 4-6, 6-4, 6-4. But they spoilt their clean record by losing to the 2nd couple. M. Fryer and C. S. Garrard beat their 3rd pair only, but played some fine tennis against the 1st pair. P. Kingsley and S. M. Johnson played 3rd pair.

Thursday, May 28. Beat Bank of England 8-1.

This match was played on a very hot evening on perfect grass courts, and for the first time the team began to play some good tennis.

Only one match was lost, and the opposition was not that bad.

M. J. Nicol and E. Cantrell were playing 3rd pair, and distinguished themselves by losing less games than the first pair.

The first round of the Hospital Cup is to be played against St. Thomas' on Thursday, June 4. Our chances should be good.

2nd VI

v. Birkbeck College 1st VI. Lost 0-4.

Team: M. Nightingale, M. Bowen, M. Nicol and R. Farrow. All matches went to 3 sets, but Bart's lost them all.

v. Westminster. Won 4-2.

Team: M. Nightingale, R. Farrow, M. Nicol, I. Davies, T. Clark, R. J. Wenger.

The first pair lost narrowly to Westminster's 1st pair, but this was avenged by our 2nd pair who beat their 1st pair 6-4, 6-1.

v. U.C.H. Won 6-0.

The opposition were too weak for the 1st two couples, but the 3rd pair had narrow victories.

Team: M. Nightingale, R. Farrow, M. J. Nicol, R. J. Wenger, T. Clark, R. Browne.

There are many keen 2nd VI players who form a very useful basis for building the 1st team, as well as providing some good and entertaining tennis for many. At least 25 people have played for the Club this season.

A. D. Edelston.

SWIMMING REPORT

A.G.M.

The A.G.M. was held on May 25 with Mr. A. Badenoch presiding. Dr. G. Ellis and Mr. C. King were elected as Club Vice-Presidents, and B. Lask and D. Hanley were elected Captain and Secretary respectively for the 1964-5 season.

Annual Tour

This was the first time the Bart's Swimming Club has been on tour since before the war, and if succeeding tours prove to be only half as successful and enjoyable, then they should be well worth making. We had matches against R.N. Portsmouth Command, Northsea Swimming Club, Portsmouth, the Southampton College of Technology, and R.N. Home Air Command.

Three of these matches were held in the Royal Naval School for Instruction in Physical training, which was in fact as awesome as it sounds. We awaited the first match in fear and trembling, the atmosphere differing slightly from that of our accustomed Nurse's Pool. In fact the racing was close and exciting and Hanley surprised everyone by swimming the back-stroke 100 yards in 68 secs., but as a result he was forced to withdraw from the polo, so that he could retch violently somewhere near the Gymnasium. As the 40-minute game wore on, although no-one had any idea of the score, we felt we were improving particularly when Britton's father appeared, disguised as the referee.

Against Southampton, Knight and Quinn both swam frequently and superbly, whilst Lask was so surprised to find himself leading in the 100 yards breast-stroke, that he promptly stopped to congratulate himself, swallowed a pint of sea-water, and limped in coughing and second. Nevertheless we convincingly won the racing. In the polo, Britton excelled himself and captained the side to a good victory, whilst Blackburne who had never before touched a polo-ball, kept goal as if he had been born in it.

On the Saturday, in response to an urgent telegram, Mr. S. Clarke came down to join the team and he rather more than made his presence felt. We found him invaluable, our seven lady supporters found him irresistible, whilst our opponents found words to describe him which couldn't really be published. Anderson, Lask and Hanley, having graced the St. Thomas' Summer Ball throughout the previous night, didn't really play as well as they might

have done, but the comforting presence of Captain Britton, once more blowing his referee's whistle wildly and without inhibitions at our opponents, helped outweigh that disability.

From the social point of view, we are grateful to the Royal Navy, Mrs. Britton, the hostleries of Hampshire, *et al*, for their excellent hospitality, and we apologise to the Hayling Island Dodgem Cars Incorporated for making them stay up so late on Saturday night, and to the New Forest generally, and West Wittering Bay 'Want's Boat' for any mental trauma suffered from our euphoric presence.

The team and results: —

Triangular Match v. Portsmouth Command v. Northsea S.C.

Command 22 pts.
Bart's 19 pts.
Northsea 14 pts

Water Polo
Northsea 5, Bart's 1.
Bart's 0, Northsea 5.
Portsmouth Command 4, Bart's 1.
Bart's 2, Portsmouth Command 2.

Swimming and Polo v. Southampton College of Technology.

Swimming: —
Bart's 36, Southampton 33.

Polo: —
Bart's 5, Southampton 4.

Swimming v R.N. Home Air Command, drawn.
Polo v R.N. Home Air Command, lost 9-11.

The following were at one time or another on tour: Britton (Capt.), Lask, Hanley, King, C., Anderson, Knight, Quinn, Blackburne, O'Kane, Gibbs, Clarke, S.

LADIES TENNIS CLUB

The Ladies' Tennis Team is having a better season than last year having already played twice as many matches at Chislehurst than were played in the whole of last season.

Unfortunately the standard of play is not exceptional, and so far only one match has been won. Since this indicates obvious improvement we can hope for many more victories during the rest of the season. Those who played in the one victorious match were: E. Webb, S. Macdonald, V. Dent, E. Sykes, P. Kumar, C. Foot.

CRICKET REPORT

v. Wimbledon, Saturday, May 9. Won.

We started in the field at approximately 2.30 p.m. and with a steady opening attack, followed by good change bowling, bowled the opposition out for 115 runs. D. Husband bowled well, taking three wickets for 12 runs.

R. S. A. Thomas and D. N. Offen opened the batting, and put on 25 for the first wicket —at the present time an average performance for the first pair! R. S. A. Thomas went on to score 43. The Secretary made a useful Golden Duck and we won by 4 wickets.

v. Hampstead. Sunday, May 10. Lost.

Another fine day saw us in the field from 11.30 until 3.30 p.m. It was an indifferent day for our bowlers, and after a slow start Hampstead declared their innings at 168 for 7.

R. S. A. Thomas and D. N. Offen once again opened for Bart's and put on 51 for the first wicket. Thomas was in fine form and scored runs at a great rate—eventually after scoring 89 runs and lacking partners, he ran himself out. The secretary scored another golden duck and nobody else made double figures. We were all out for 135 runs, after a very promising start, a great shame for we have not beaten Hampstead on their home ground for a long time.

v. University College, Oxford. Tuesday, May 14, Away. Drawn.

The team travelled up to Oxford in the morning and put in a somewhat jaded appearance at University College at 2.30. As the View Day Ball claimed most of our cricketers the previous evening we did not put up a very sparkling performance. Our Senior Professional, H. Phillips, distinguished the side by not quite getting his hands round the ball, which seemed to spend most of its time in the air. University College declared at 172 for 6 leaving us just about two hours to get the runs. At the close we were 154 for 7—a moral victory? C. P. Vartan 32 not out.

v. B.N.C., Oxford. Friday, May 15. Lost

Brasenose College batted first and with difficulty put up a total of 106 runs. P. E. Savage bowled well, taking four wickets for 46 runs. The captain also bowled steadily taking two wickets for 12 runs. Bart's once again looked set for victory until the first ball of our innings when D. N. Offen was dismissed by a very fast ball. B.N.C. produced a "guest player" in the shape of a genuinely quick

bowler who has had an Oxford trial. Without knowing quite what was happening we were soon nine wickets down for only 47 runs. Our Senior Professional and P. Savage then put up a very fine last wicket stand before H. Phillips was bowled. We were all out for 74 runs, 32 short. We were very pleased to have Mr. J. Howkins as a spectator.

v. Chishall. Saturday, May 16. Won.

Having arrived back from Oxford the previous night we travelled up to Essex to play this little village cricket team. It was a charming ground, and at the start of the season they had removed the primroses from the 'square'! We bowled them out for 109, and made the runs with six wickets to spare. Amongst the runs were D. N. Offen 33, G. Major 27 and R. S. A. Thomas 32 n.o. A convivial evening was spent arranging other matches and being comprehensively beaten at darts.

v. Romany. Sunday, May 17. Drawn.

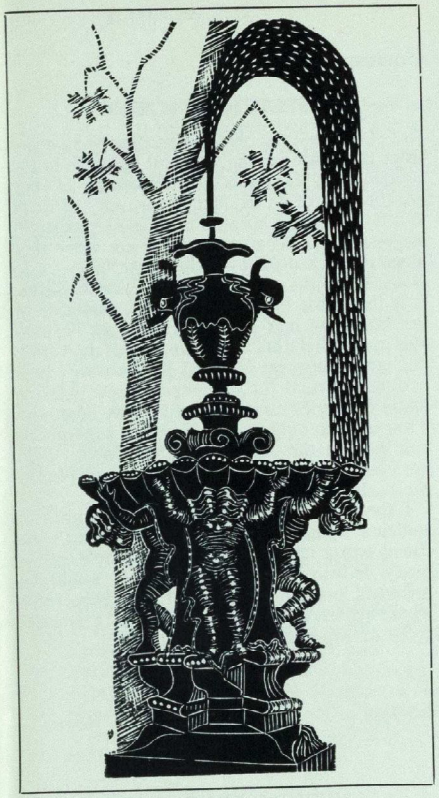
A game in a more serious vein. We put Romany in to bat and after a very hard and hot day's bowling dismissed them for 179. C. P. Vartan took four wickets for 70 runs. For a change our batting was indeed steady, and with a run-rate necessary of two per minute we were only four runs short at the close of play, with five wickets in hand. R. S. A. Thomas scored 86 not out, aided by a dashing performance by D. Husband who scored 35. It was a disappointing but thrilling finish to a strong fixture.

v. Royal Naval College, Greenwich. Wednesday, May 20. Won.

We put them in to bat and at once the Naval College were in trouble. Our captain J. R. Harrison bowled remarkably well taking seven wickets for 23 runs. P. E. Savage took the remaining three for 15 runs. We bowled them out for 88 and made the runs with five wickets in hand—a comfortable victory. N. Griffiths 29, R. Wood 24.

v. Streatham Wanderers. Saturday, May 23. Drawn.

The opponents batted first and although the run-rate was slow, our bowlers could not dismiss one of their openers who scored 100. Eventually after a laboured innings they declared at 171 for six leaving Bart's over two runs a minute for victory. Our batting was very solid, wickets falling at one for 30; two for 69; three for 99; four for 112. At the close we were 146 for 4—a dull match but well batted. R. S. A. Thomas run out 35, D. Husband not out 47.



CONTENTS

EDITORIAL

Dissatisfaction within the medical profession about the National Health Service has been growing apace and has been reflected in the policy changes passed at the annual conference of the B.M.A. at Manchester during the past month. The conference approved resolutions drawing attention to 'increasing abuse of the National Health Service'. The medical student of today faced with a choice of career after qualification is looking with increasing disfavour at the appalling conditions under which the average G.P. is forced to work. The student sees the G.P. faced with huge numbers of patients and wonders how any doctor can be asked to practise medicine conscientiously in the manner in which he has been taught. The problem is that there seem to be too few doctors with too many patients. By paying G.P.s on the present basis they are encouraged to take on far more patients than they can adequately deal with. At the same time to take on only that number with which a decent standard of care can be attained involves accepting a lower standard of living. This places an intolerable moral choice on any human being. A young man going into General Practice may altruistically intend to have on his list only that number of patients which he can adequately treat. Before very long, however, the material needs of a wife and family are surely going to weigh more heavily than his original selfless motives.

This moral black-mail employed by the Ministry of Health must be replaced. The limit to the number of patients on any G.P's list must be drastically lowered. The conditions of pay should be altered to give some incentive and so reward the industrious. The B.M.A. conference passed a motion which might well lead to a basis on which G.P's pay could be reviewed; the motion stated that charges to patients for doctors services should not be precluded. A scheme should be arranged whereby the patient would pay at least some part of a fee to the G.P. This fee need not be large and should be overlooked in the case of Old Age Pensioners and those on National Assistance. However, the fee would have the effect of discouraging unnecessary demands on G.P.s as well as contributing towards their salary and so would relieve to some extent the burden on the rest of the community. This decision along with that in favour of retaining prescription charges must have made the conference a gloomy place for any apostle of free medicine. Both these decisions show the trend of current thinking in the profession and government action will have to follow.

One obvious objection to the plan for limiting the number of a G.P's patients is that there would be a large number of people without a G.P. at all. To counteract this the scheme would have to be brought in very slowly with gradual lowering of the limit along with a tremendous drive to bring new men into the field of General Practice. The way to attract students was discovered by the Services recently when they announced attractive student cadetships and good pay and prospects on qualification. A similar scheme must be worked out by the Ministry of Health.

Although many great evils exist within the Health Service to bedevil the lives of G.P.s it is this concept of General Practice as seen by the student that is leading to a reduction in the numbers entering General Practice. Rethinking along the lines set out above may yet stop the tidal flow of doctors emigrating immediately on registration.

The views expressed in the Editorial are those of the Editor and not necessarily of the Publications Committee.

The views expressed in articles in the Journal are those of the authors and not necessarily of the Editor.

Correspondence

OBSTETRIC TEACHING

Sir,—I feel that the obstetric months spent away from Bart's are among the most valuable in the course. They are especially refreshing as they are for most of us the first opportunity to work in a non-teaching hospital and bear some slight responsibility. Because of this I am sorry that more students do not get the opportunity to do two full months of obstetrics away from Bart's. It is inevitable that with the high standards of the maternity unit here students must be content to be spectators to all but normal deliveries, but even these are few and far between. It is perfectly normal for students to score twice as many deliveries away from Bart's as here, and I am not the only one to have felt superfluous and even in the way in Elizabeth Ward. I do not consider that the limited amount of obstetric teaching here makes up for this.

I should like to suggest that the number of students doing their midwifery at Bart's be cut to two a month, so that they should get as many deliveries as elsewhere. This would be nobody's loss and would give the midwives (for whose patience I have nothing but gratitude) room to swing a cat.

Yours faithfully,

C. S. BRITTEN

4th July. Abernethian Room

MEDICAL EDUCATION?

Sir,—I once received a typewritten letter from a G.P.:

"Dear Sir,

Mrs. Smith has a sister seal. Please see and advise."

About five years later, I have thought of the obvious answer:—

Dear Dr. Jones,

I quite agree that your patient, Mrs. Smith, has a sister seal. In addition, she has a brother coming well down the vault and the grandmother of all rectoceles.

I have put the whole family on the waiting list to come in for a hitch hike operation.

Yours sincerely,

C. Rutherford Morison

88 Panalash Road

7th July. Harrogate

ABERNETHY

Sir, It is surprising to read in your editorial (July 1st) that the bicentenary of the birth of John Abernethy was not remembered by the place which benefited most by his greatness. As a loyal Bart's man I am pleased to say that the occasion was not ignored by us on April 3rd, 1964.

By the way, is there yet a rather gloomy room named after him? Or has that been forgotten also?

I am Sir your obedient servant,

David Carrick

9th July. Editor Medical News.

BARBECUE BALL

The Wine Committee are holding another Barbecue Ball at Charterhouse Square on Friday, August 28th, from 9 p.m. to 3 a.m. Double Tickets are 35s. each, obtainable from any member of the Wine Committee. Attractions include spit-roasting and a buffet supper, 3 bands, 2 Scottish Pipers, and other, as yet unfixed, activities.

PROFESSOR LEO SZILARD

We regret to report the death of Professor Leo Szilard, the world-famous nuclear physicist on 30th May. Szilard worked at Bart's in 1934 under Professor Hopgood. During his short stay at Bart's he managed to make two important discoveries. One was the photo-disintegration of beryllium (the breaking up of the beryllium nucleus by bombardment with rays), and the second was a method of separating radioactive isotopes, which has become known all over the world as the Szilard-Chalmers method.

Calendar

AUGUST

Sat., Sun., & Mon., 1st 2nd & 3rd:
Dr. G. Hayward
Mr. Badenoch
Mr. Burrows
Dr. R. A. Bowen
Mr. Fuller

Sat. & Sun., 8th & 9th:
Dr. A. W. Spence
Mr. Tuckwell
Mr. Manning
Mr. G. Ellis
Mr. Cope

Sat. & Sun., 15th & 16th:
Prof. Scowen
Prof. Taylor
Mr. Aston
Dr. R. W. Ballantine
Mr. R. F. McNab Jones

Sat. & Sun., 22nd & 23rd:
Dr. Bodley Scott
Mr. Alan Hunt
Mr. Burrows
Dr. Ian Jackson
Mr. Hogg

Sat. & Sun., 29th & 30th:
Dr. E. R. Cullinan
Mr. C. Naunton Morgan
Mr. Manning
Dr. T. B. Boulton
Mr. Fuller

Physician Accoucheur on Duty for the month of August is Mr. G. Bourne.

Obituary

G. F. ROBERTS, M.A., M.D.

Dr. George Fulton ("Tony") Roberts, who died on May 13th at the early age of 43, was a man of many parts—a research worker who was a brilliant teacher and a fluent writer, an administrator who pleased most and offended few, and a bon-vivant with a love of all things that make life worth living. He also had courage, and his indignation at what he considered unfair treatment in the Path. viva of the M.R.C.P. examination was such that he got up and walked out, and never took it again—surely a rare event in the history of the college.

Educated at Eastbourne College and Queens College, Cambridge, he trained at Bart's from 1942 to 1944, but failed to obtain the house-appointment there he had coveted. Instead he went to Charing Cross Hospital and to the North East London Blood Supply Depot at Luton before serving as a squadron-leader in the pathology laboratory at the Royal Air Force Hospital at Halton. This experience bore fruit in his first book *The Rhesus Factor* (1947), which has now reached three editions, and the later *Introduction to Human Blood Groups* (1960), and in 1948 he was appointed a demon-

strator in the university department of pathology, obtaining his M.D. in 1950 and becoming lecturer in 1953. In the last year he was appointed to a fellowship of Jesus College, Cambridge, and subsequently he became steward and bursar. He did not allow this administrative load to stop his researches, however (some of which he undertook together with Dr. R. R. Coombs), and in 1957 he published *Comparative Study of Hæmolytic Disease in the Newborn*.

Before his marriage in 1953 the other half of Tony's life had centred on music, particularly vocal music, and he ensured that this orientation continued by marrying a professional singer. Though he was an enthusiastic and catholic listener—and could be found most years at Glyndebourne or Bayreuth (and could give a fascinating account of the première in Venice of Stravinsky's *Rake's Progress*)—he was also a talented amateur musician. He sang in the Bach choir, in that splendidly named organisation Cambridge Operas Incorporated, and in small, intimate groups. Like Samuel Butler's hero he adored Handel, while one of his more engaging, and infuriating, theories was that many passages from Sullivan could be translated into Mozart (and vice versa) without the listener's noticing. When he played a record of some rare piece of either composer the truth of this had partially to be conceded, and it is sad that his projected, mock-solemn book on the subject has never materialised. To his wife, Rosemary, and their three young children, we offer our deepest sympathy.

S.P.L.

Engagements

ELLIS—GIMBLETT.—The engagement is announced between Robert Paul Ellis and Ann Dorothea Gimblett.

STEWARDSON-BELL. The engagement is announced between Michael Peter Stewardson and Judith Margaret Bell.

WELCH—MOSTYN-PHILLIPS.—The engagement is announced between David Macpherson Welch and Marylin (Anna) Mostyn-Phillips.

Marriage

BATTERHAM-FISHER. On May 30, Dr. John Batterham to Diana Fisher.

Golden Wedding

RAMSAY—DE MINIAC.—On May 7, 1914, Robert Anstruther Ramsay, F.R.C.S., to Marguerite Renée de Miniac. Present address: 9 Place des Ternes, Paris 17.

Births

BARTLETT-TURNER.—To Janet and Jeremy Bartlett-Turner, a son, David.

GRANDAGE.—On June 15, to Sybil and Dr. Christopher Grandage, a daughter.

MACDOUGAL.—On June 21, to Rachel and Dr. Iain MacDougall, a son.

Deaths

KILNER.—On July 2, Professor Thomas Pomfret Kilner, C.B.E., D.M., F.R.C.S. Qualified 1912.

PEREIRA.—On June 4, Dr. George Pereira, M.B., Ch.B.(Ed.), M.R.C.S., L.R.C.P., aged 88. Qualified 1901.

PIRIE.—On June 23, Dr. Alfred Harold Pirie, B.A., M.R.C.S., L.R.C.P., D.A. Qualified 1934.

PRACY.—On June 1, Douglas Sherrin Pracy, F.R.C.S.E. Qualified 1916.

ROBERTS.—On May 13, Dr. George Fulton Roberts, M.A., M.D., aged 43. Qualified 1944.

WHITE.—On June 3, Frederick Norman White, C.I.E., M.D., D.P.H., I.M.S. (Retd.), aged 86. Qualified 1901.

WOODFIELD.—On June 6, Thomas Harold Woodfield, D.P.H., M.D., aged 96. Qualified 1893.

Appointments, etc.

Royal College of Obstetricians and Gynæcologists.

At a meeting of Council on May 30, Mr. E. A. J. Alment was elected to it as a representative of the members.

The following were elected to Fellowship: G. L. Bourne, K. J. Franklin.

Royal College of Surgeons of Engand.

Diplomas of Fellowship were granted to the following candidates: R. J. Mitchell, J. R. Garnham, S. G. I. Hamilton, F. A. Strang, J. A. McKinna, A. C. Branfoot, D. G. Davies.

Mr. Percy H. Jayes was elected McIndoe Lecturer for 1964.

Society of Apothecuries of London.

At a soirée held on June 16, the Master, on behalf of the Court, conferred the Honorary Freedom of the Society on Sir Geoffrey Keynes.

University of Oxford.

On June 6, the degree of D.M. was conferred on G. C. R. Morris.

Birthday Honours List.

The following honours were awarded in the Birthday Honours List: K.C.V.O.—Ronald Bodley Scott, D.M., F.R.C.P., C.M.G.—Percy Cyril Claude Garnham, M.D., F.R.S.

VOX

Home

"Nothing to excess",—that was the central axiom of the Greeks' moral code, and it is rapidly becoming ours. A little of what you fancy does you good: but drink too much and you are recommended a course of Antabuse; smoke too much and your doctor starts preaching; too much sex will take you to a psychiatrist; while even if you earn too much, the Inland Revenue provides effective treatment. And now, if you are having a bad run with the horses or the pools, you can join "Gamblers Anonymous", whose function is not to give you an under-the-counter tip for the 2.30, but to cure you of your compulsive habit. An integral part of the treatment is a session for the wives on rapid methods of diverting pay packets into housekeeping.

The past month has seen some confusing developments in the melodrama of party politics, and right up to the last minute it has even been difficult to be sure of the identities of the hero and of the villain for the current episode. Act 1, scene 1 . . . **Mr. Wilson** is acclaimed as hero for his part in terminating the television strike: but next day he is blamed for messing up a "Frigates for Franco" contract worth £14 million, and the applause turns to hissing. The suspense is maintained until the end of the Commonwealth Conference, when the **Prime Minister** at last emerges as the true hero; and with the final curtain N.O.P. proclaims a drop in the Labour lead from 7 to 3.5 per cent, while the villain, still very much alive, mutters in a stage of whisper that public opinion polls are feverish in the summer.

If you find a brick in your pocket, it may well have been planted there by a policeman. But do not throw it at him—he has been under quite enough fire recently.

Abroad

More racial violence in British Guiana, and the reintroduction of good old colonial flogging; no improvement in Laos; **Mr. Smith** is threatening to base a unilateral declaration of independence for Southern Rhodesia on a referendum in which only 100,000 out of a possible 2 million would be allowed to vote; and that little enterprise in the Congo has cost the U.N. a total of £136 million. The **Old Man of Azerbaijan,** who celebrated his 157th birthday recently, must be getting rather tired of it all.

"A ministering angel shall my sister be . . .", or so **Fidel Castro** must have thought until he discovered that **Juanita** was working for the C.I.A. What great material this would have been for Hemingway.

A leak of a different kind occurred in Marseilles, where a week before the baccalauréat examination, it was possible to purchase the philosophy paper for about £100, though the price dropped steadily and was £10 one hour before the paper started; a nice exercise in when to buy.

It is amazing to what lengths **Mr. Mao Tse-Tung** will go to annoy **Mr. Kruschev.** He is now buying not one but two Rolls-Royces for his personal use.

The Arts

There is a lot of bad American modern verse, but there is going to be a lot more. In what was described as a great cybernetic breakthrough, someone has programmed a computer to produce 30 poems a minute. After all, it's the quanity that counts.

On his birthday the **Prime Minister** went to see "The Reluctant Peer", written by his brother;—a somewhat nostalgic treat?

Science and Medicine

In a survey of the views of 30,000 hospital patients, the subject of communications between doctors and patients has turned up again. One patient, frustrated by a surfeit of secrecy, asked for a telephone and by ringing his own ward sister managed to get all the information he wanted about his operation of the previous day.

Research with airborne vaccines is advancing. (ærogenic immunisation is the tick phrase); so should you receive an invitation for "cocktails, poliomyelitis and measles", remember to take some good deep breaths between drinks.

The Family Planning Association has a new problem. Now that biological pregnancy tests are being replaced by chemical methods, that good old laboratory pet the xenopus toad, whose oracular wisdom in this field was rivalled only by that of the mouse, has become redundant. The F.P.A. has 2,000; but unfortunately for those who would like to do a little business on the quiet, they want to sell them as a single lot.

THE CONTRIBUTION OF PHYSICS TO RADIOTHERAPY

by Professor J. Rotblat

Radiotherapy is nowadays mainly concerned with the treatment of malignant conditions. It is based on the well established but little understood fact that exposure of tissue to ionizing radiations results in damage to the tissue, e.g., the killing of cells. From the point of view of radiotherapy, the important effect of radiation is the arrest of the reproductive capacity of the cells so that they are unable to divide. The dependence of this effect on the dose of radiation is approximately exponential.* For example, a dose of about 100 rads (which is roughly the same as 100 roentgens in the old nomenclature) delivered to well-oxygenated tissue will reduce the number of viable cells to one half.

At first sight the problem of radiotherapy appears to be a very simple one. Suppose we want to treat a tumour containing 10^9 cells; a simple calculation will show that if we deliver to the tumour a single dose of about 3,000 rads, less than one cell will survive, and the treatment will be complete. In practice the problem is beset with difficulties, the most important perhaps being that healthy tissue is equally subject to damaging action of radiation; in fact, the malignant tissue is often hypoxic and consequently is *less* sensitive to radiation than normal tissue. Thus, in the attempt to destroy the tumour, serious damage may be caused to other organs.

It is largely for this reason that the methods of radiotherapy are extremely complex, and many variables are employed in treatment, such as the type of radiation, methods of its delivery, size and number of irradiated areas, total dose, dose per treatment, number of treatments, interval between treatments, pressure of oxygen breathed during treatment, infusion of various chemicals into the tumour, etc. All of this aims at finding the best conditions of delivering the radiation dose to the tumour. In this respect the physicist can play an important role, by suggesting the type, and method of use, of radiation which in a given case will deliver the maximum dose to the tumour with the minimum dose to the healthy tissue. To achieve this aim the physicist has to bring in the whole arsenal of modern physics and technology. It is the purpose of this article to show how much has been achieved so far and what may be expected in the foreseeable future.

*See article by Dr. P. J. Lindop in next issue.

Localisation of exposure by means of radioactive isotopes.

The ideal method of radiotherapy would be to deposit the source of radiation inside the tumour, wherever it may be in the body, and to confine the exposure to the tumour cells. This ideal has been approached only in one case, the treatment of thyroid cancer by means of radioactive iodine. Thyroid tissue has a high avidity for iodine. If, therefore, the patient is given some radioactive iodine, there will be a high concentration of it in the thyroid and very little in the rest of the body. The bulk of the radiation dose is in this case due to β-rays, which have a very short range, about 1 mm. in tissue. Thus, the exposure is practically limited to the thyroid tissue. A drink of water containing from 10 to 100 millicuries of iodine-131 is sufficient to deliver a dose large enough to obliterate the gland. Moreover, the therapeutic effect of the radiation will reach all metastases, wherever they may be, as long as they contain functioning thyroid tissue. The method of treatment is consequently extremely simple with very little discomfort to the patient. The main drawback is that only a small proportion of thyroid carcinomas take up iodine, although it is sometimes possible to stimulate the uptake of iodine in the metastases by thyroidectomy. But in those cases where there is an uptake this method has given excellent results.

Another example of the selective use of radioactive isotopes is the treatment of polycythæmia vera by means of radioactive phosphorus. This is incorporated into the rapidly dividing cells of the bone marrow, and the radiation dose arrests the proliferation of the red blood cells. A few millicuries of phosphorus-32 per year are usually sufficient to keep the disease under control.

These two examples are about the only successful applications of radioactive isotopes in radiotherapy by systemic localisation. About 20 years ago, when it became possible to produce on a large scale radioactive isotopes of any chemical element occurring in nature, there were great hopes that use could be made of metabolic processes of various substances to deposit the source of radiation selectively in the tumour. Unfortunately, these hopes have not been fulfilled so far.

In the absence of a suitable metabolic process, the local application of the radioactive isotope by placing it mechanically at the desired site can be very useful. The availability of a large number of radioactive substances, which can be made in almost any shape or size, offers many new methods of treatment not previously available to the radiotherapist. In the case of superficial tumours, radioactive isotopes which emit β-rays, but not the more penetrating γ-rays, provide simple and convenient sources of radiation. Isotopes, such as phosphorus-32, sulphur-35 or strontium-90, can be obtained in forms convenient to cover the area to be treated, thus avoiding damage to other tissue. In other cases, wires or needles containing radioactive materials, such as tantalum-182, or gold-198 can be implanted into the tumour. Other isotopes, such as sodium-24 or bromine-82, which can be obtained in liquid form, can be used for intracavitary treatment, for example by introducing a balloon with the radioactive source in it into the bladder.

Colloidal material, if injected into tissue, is removed only very slowly by lymphatic drainage. This is made use of in the treatment of malignant effusions in the pleural or peritoneal cavities, by injecting colloidal radioactive gold.

Localisation of exposure by means of nuclear reactors.

Another method of localising the effect of the radiation makes use of nuclear reactors and the very high flux of slow neutrons in them. It is known that some brain tumours, e.g., glioblastomas, take up certain substances much more rapidly than normal tissue. This is probably due to the break-down in the tumour of the blood-brain barrier, which normally prevents the entry of large molecules into the brain. One such substance is boron, which, if injected in the form of borax, shows a high concentration in the tumour during the first hour after injection. This fact, together with the high probability of a slow neutron being captured by boron, has been made use of in the treatment of glioblastoma. When a boron nucleus captures a neutron it breaks up into an α-particle and a nucleus of lithium. Both of these have a very short range in tissue and the radiation energy is, therefore, deposited in the immediate vicinity of the boron atom, producing a very highly localised therapeutic action.

After administering the borax, the patient is put with his head near the reactor, at a place where there is a very high flux of slow neutrons. The absorption of neutrons by matter other than boron is comparatively small, so that a good ratio of tumour to normal tissue dose is obtained. Some promising preliminary results have been reported in the United States where nuclear reactors were specially built for medical purposes. The limitation of the method stems from the rapid absorption of slow neutrons in tissue, which means that one cannot deliver a sufficiently big dose to deep-lying tumours. A recent modification, in which slightly faster neutrons are employed, offers better prospects for treatment by this technique.

External radiotherapy with X-rays.

For the majority of tumours the internal deposition of radioactive isotopes is not feasible, and an external source of radiation has to be used. Until recently, the conventional source was an X-ray tube working at a peak voltage between 200 and 300 kilovolts; many radiotherapy departments still employ such X-ray tubes for the treatment of cancer.

The limitation in the use of such X-rays, particularly for deep-seated tumours, arises from the rapid attenuation of the X-rays in passing through the body. Fig. 1 shows the dose as a function of depth in the body for different radiations used under the same conditions. Curve A is for 250 kV X-rays and it is seen that at a depth of 10 cm. the dose is only 40 per cent of that at the surface. This is clearly unacceptable, since a dose of radiation necessary to treat a tumour at this depth would produce a severe skin reaction and much damage to other healthy tissue.

One way to circumvent this difficulty is by means of a multi-field therapy, in which the beam of X-rays is centred at the tumour from different directions. Fig. 2 gives a typical example of planning multi-field therapy using 250 kV X-rays; in this case a carcinoma of the rectum is to be treated using ten fields. The contour lines give the total dose at different depths, and it is seen that the dose to the tumour has been greatly increased relative to that given to any part of healthy tissue,

particularly the skin. However, the total volume of healthy tissue irradiated is, of course, much greater, and although the skin reaction is much less severe the damage to healthy tissue is still the limiting factor.

The use of megavoltage X-rays

These difficulties can be significantly reduced by purely physical means, by the employment of X-rays of higher energy. Up to a certain limit, the higher the energy of the X-rays the less the attenuation in the body. Moreover, since the biological effect of the X-rays is due to the secondary electrons which they produce, and since these electrons are emitted in the forward direction, the result is that the dose delivered is considerably greater at a depth than at the surface. Curves B and C of Fig. 1 show the dose delivered at various depths in the body with X-rays of peak voltage 2.5 and 15 million volts. In the case of the latter the dose at the surface is only about one-third of that at a depth of 10 cms. This makes it possible, therefore, to deliver larger doses to the tumour with little skin reaction and much less damage to healthy tissue.

This is the chief reason for the present trend in radiotherapy to use machines producing X-rays of high energy. Another reason is that such machines have a much greater output of X-rays, about 250-500 rads per minute at one metre, which is about 10-20 times greater than with conventional X-ray tubes.

With usual X-ray tubes one cannot go up to very high energies; for this reason various accelerators, which have been developed for nuclear physics research, are now increasingly used in hospitals. In these machines electrons are accelerated to a high energy and then made to hit a target of a heavy element, in this way producing a beam of X-rays. In one type of machine, the electrostatic generator, or, as it is more commonly known, the Van de Graaff machine, acceleration is achieved directly by means of a high potential of about 2-4 million volts. In another machine, the betatron, the electrons are accelerated by making them move in circles, making use of the principle of the A.C. transformer. The machine most favoured in this country for megavoltage therapy is the linear accelerator, in which electrons are accelerated along a straight line in an electric field of very high frequency. Such a linear accelerator, producing electrons of an energy 15 million electron volts (MeV) has been in operation at Bart's for a number of years, first for research only and now for both research and therapy. Fig. 3 shows a photograph of this accelerator; the electrons are accelerated horizontally, and the beam is then bent through 90° by means of a magnet, before hitting a gold target to produce the X-ray beam. The machine is fitted with a rotating head which enables the X-ray beam to emerge in the desired direction.

A new 6 MeV accelerator has just been installed in the Radiotherapy Department at Bart's and will soon be available for therapy.

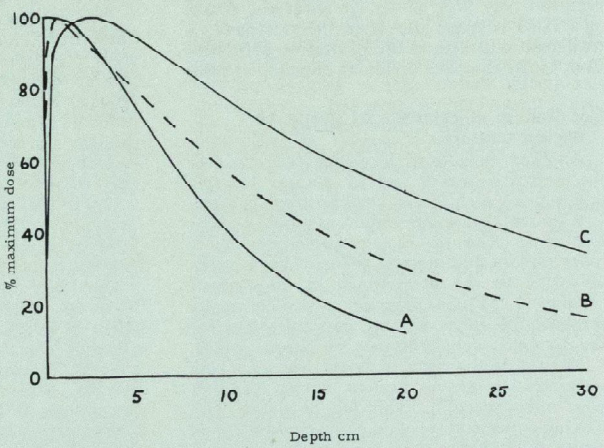


Fig. 1.—Percentage of dose absorbed at different depths in the body using X-rays of different energies; A—250 KV X-rays; B—2.5 MV (cobalt-60 γ rays); C—15 MV.

Teletherapy Units.

Instead of X-rays, one can use γ-rays emitted from a radioactive isotope. The substance most frequently used for this purpose is cobalt-60, which emits γ-rays of an average energy of 1.2 MeV, corresponding to an X-ray machine at a peak voltage of about 2.5 MV. By bombarding ordinary cobalt in a nuclear reactor very strong sources of radiation can be obtained in a small volume. Thus, a small cylinder about 2 cm. in diameter and 2 cm. high could contain as much as 3,000 curies (an activity equivalent to that of 3 kilograms of radium); this could produce a dose rate at 1 metre of about 60 rads per minute. The source is usually surrounded with a heavy shield, with only a small opening through which the beam of γ-rays can emerge.

The great advantage of such a teletherapy source is that it does not require any high voltage equipment and that it gives a steady and well defined output of radiation. Moreover, because of the smallness of the source it is very easy to rotate the whole source around the patient with the tumour at the centre of rotation. In this way one can combine the advantages of megavoltage radiation with multi-field therapy. In the teletherapy unit at Bart's the amount of cobalt-60 has recently been augmented to 3,000 curies. The half-life of cobalt-60 is 5.3 years and therefore the source has to be topped up every few years.

Another isotope used in a similar fashion is casium-137. The energy of its γ-rays (0.66 MeV) is much less than that from cobalt-60, and this makes it less advantageous. On the other hand, it has a much longer half-life, 30 years, and large quantities of it are available as a by-product of the generation of atomic energy in reactors. However, the cobalt-60 source is much more popular and many such units are now in operation in hospitals all over the world.

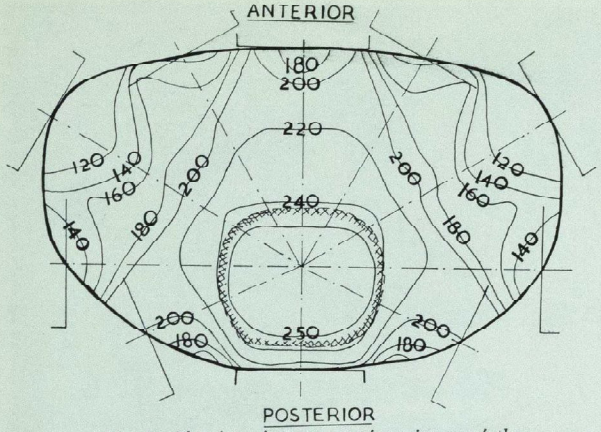


Fig. 2.—Planning of treatment of carcinoma of the rectum using 250 KV X-rays and 10 fields (by courtesy of Mr. G. S. Innes).

Electron Therapy.

There is a limit in the use of X-rays of high energy, since with increasing energy the dose at the exit from the body increases (see curve C of Fig. 1) and eventually one ends up with the same problem as with low energy X-rays, a high skin dose, this time on the exit side. Also, the volume of irradiated tissue is greatly increased. For these reasons 15 MV X-rays are about the maximum for therapy; if other considerations, such as cost of the machine, are taken into account, it is likely that a lower energy, about 6 MV, will be the optimum.

However, it is possible to reduce the volume of tissue irradiated by the direct use of high energy electrons. Unlike X-rays, electrons have a definite range of penetration. The range is roughly linearly related to energy, every 2 MeV increasing the range in tissue by 1 cm. Thus, 15 MeV electrons have a maximum range of 7.5 cm. and they cannot go beyond this. The use of electrons offers, therefore, the advantage of delivering the dose to a limited and well defined volume of tissue. For some types of cancer this method of treatment is definitely more advantageous than the use of X-rays.

The 15 MeV linear accelerator at Bart's is used for electron therapy by extracting the electron beam and directing it at the treated area. In some hospitals accelerators of higher energy, about 35 MeV, are being built for electron therapy. There would be little advantage in going to much higher energies since the total volume irradiated would become large.

The use of high energy protons.

Some of the accelerators built for nuclear physics can produce beams of charged particles such as protons (nuclei of hydrogen) of an energy of several hundred MeV. Protons of such high energy undergo very little attenuation and scattering in passing through the body. A beam of very small cross-section can be produced in a cyclotron and such a fine pencil of rays can be utilised to destroy tissue in a way somewhat similar to cautery, with the important advantage that it can be used in

areas usually inaccessible to the surgeon. The first such experiment was carried out with the cyclotron at Berkeley in California, in which a proton beam of 400 MeV was used. It was successfully employed for hypophysectomy; there are several important structures, including the optic nerve, in the vicinity of the pituitary gland which make ordinary radiotherapy very risky. Similar uses of high energy accelerators have also been reported from other centres.

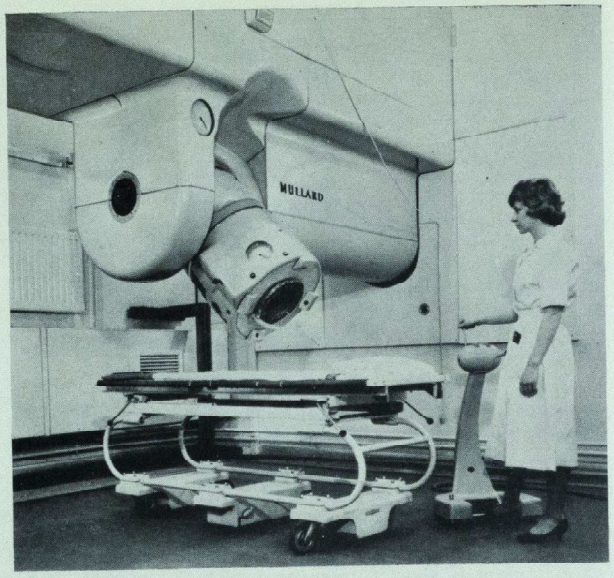


Fig. 3.—15 MeV linear accelerator at Bart's.

The use of fast neutrons

Neutrons, not carrying an electric charge do not ionize directly, but in passing through the body they collide with hydrogen atoms setting protons in motion, which in turn cause ionization; in this way neutrons can be employed as a therapeutic agent. The attenuation of fast neutrons in the body is very small and in this respect neutrons have nearly the same advantages as megavoltage X-rays. There is, however, another advantage in that neutrons apparently show a smaller oxygen effect,* which means that tumour cells which may be at a low state of oxygenization will not have the sensitivity to radiation reduced as much as with X-rays or electrons. It is this property that is responsible for the recent revival in the interest of fast neutrons for radiotherapy.

Only a few institutions, including the M.R.C. Cyclotron Unit at Hammersmith Hospital, are at present using this technique, and the results of their work must be awaited before judgment can be made about the value of fast neutrons as a therapeutic agent.

The use of π-mesons

Theoretically, much greater advantages may be expected from the use of π meson beams. -mesons are particles about 270 times heavier than the electron, and they play a very important role in nuclear structure. Beams of -mesons can be produced by the bombardment of elements with protons of very high energy (500-1,000 MeV). There are three types of π-mesons: positive, negative and neutral; of these, the negative π-mesons have therapeutic possibilities. They have a well defined range in matter, and at the end of this range they are captured, producing in the process charged particles which carry a large amount of energy, but have a very short range. Thus, most of the energy can be deposited locally at a predetermined and well defined place. Moreover, these particles should not show the oxygen effect at all, thus eliminating the difficulty of the reduced sensitivity of hypoxic tumour cells. The combination of these two factors should make -meson therapy a very powerful method.

The main snag is that to produce a sufficiently intense beam of -mesons an accelerator of very high energy is required, and the cost of such a machine is extremely high, of the order of a few million pounds. For this reason nobody has yet tried out the efficacy of π -meson beams in therapy. At present there are only a few machines in existence capable of producing intense π-meson beams, and attempts are on the way to carry out experiments with animals in one of these machines; the nearest to us is at the European Centre for Nuclear Research (CERN) in Geneva. Should these experiments be successful it is quite likely that π-meson therapy will be brought into practice, despite the very high cost of the machine.

*See article by Dr. P. J. Lindop in next issue.

Conclusions

The chances of successful treatment of cancer in any site have been greatly increased during the last 20 years, largely as a result of the introduction of megavoltage radiation and other products of nuclear physics and technology. Further improvements may be expected from the use of the newer types of particles, such as -mesons. However, a radical breakthrough in radiotherapy is dependent on a complete understanding of the mechanism of the action of radiation on living tissue; the next important step is, therefore, likely to come from radiation biology.

AROUND AND ABOUT:

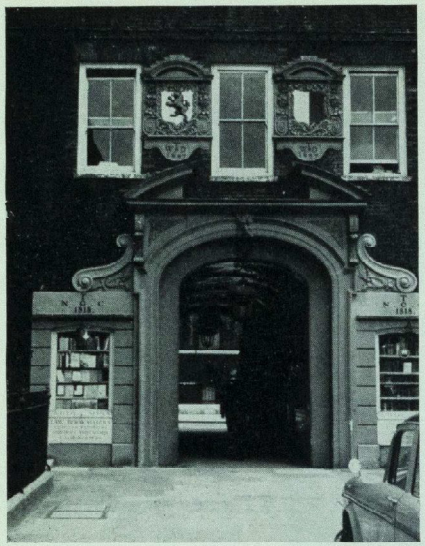
5—Inns of Court—Staple Inn and Lincoln's Inn

By "Argus"

The magnificent Tudor half-timbered and gabled front of Staple Inn in High Holborn is a familiar sight to countless Londoners, but few ever bother to turn under the arch into the main courtyard of the Inn. Here, as Dickens describes it in *Edwin Drood*, is "one of those nooks, the turning into which out of the clashing street, imparts to the relieved pedestrian the sensation of having put cotton wool in his ears and velvet soles on his boots. It is one of those nooks where a few smoky sparrows twitter in smoky trees as though they called to one another, 'Let us play at country'." On either side of the secluded cobbled courtyard are two small ranges of lawyers chambers dated 1734 and 1757-9. The initials over the doorways are those of the presidents or principals of the Inn at the time of construction. The other buildings including the Hall, originally built in 1581, were destroyed during the war and are reconstructions. The half timbered houses were erected between 1545 and 1589, the two slightly taller houses at the West end being of the latter date. The backs were encased in brick in 1826.

The origin of the name "Staple" is uncertain. It is suggested that it came from the old French word "estaple" meaning a market (usually for wool), indeed the society of Merchants of the Staple were established here in 1375. Their sign (the wool pack) is represented in the wrought iron gates of the garden behind the Inn and on the pump in the forecourt. The Inn was occupied by law students in 1415 and purchased by the benchers of Gray's Inn in 1529. Its history was otherwise uneventful but it fell out of use as a legal school during the 18th century. Part of the Inn was purchased in 1884 by the Government for an extension to the Patent Office, and the Tudor buildings and Hall sold to the Prudential Assurance Company who restored the half timbered fronts to their original glory in 1886. Further reconstruction was carried out in 1937 and little now remains of the original Tudor interiors. As you pass through the courtyard take a look at the notice under the archway which forbids "rude children from playing or old clothes men calling articles for sale" in the Inn.

A short walk down Southampton Buildings brings you to Chancery Lane. A few yards down on the left is the main gateway into Lincoln's Inn. The Inn originally stood on land belonging to the Dominicans which they sold in 1286 to Henry Lacy, Earl of Lincoln. The earl, who was a royal justice and minister of the Crown till his death in 1311, lived in a



Carey Street Gate, Lincoln's Inn.

house at the North east corner of Shoe Lane, called the Manor of Holborne. The manor was used as a residence for lawyers and for the transaction of legal business after his death and thus the Society of Lincoln's Inn probably came into being. The site of the Inn was moved to the Bishop of Chichester's mansion west of Chancery Lane about 1422 and the records of the Inn date from this time. The Gatehouse with its square angled towers was completed in 1518 and over the archway can be seen, on the left, the arms of Henry Lacy, Earl of Lincoln (founder of the Inn), in the centre of Henry VIII and on the right those of Sir Thomas Lovell, Speaker of the House of Commons and benefactor of the Inn in Henry's reign. The great oak doors are the originals of 1564 but all the old windows were replaced by the present ones in the 18th century.

Passing through the archway you enter a small quadrangle known as Old Square. Facing you is the oldest building in the Inn—Old Hall, one of the finest of the Tudor Halls of the Inns of Court, constructed in 1492. It has a rather unusual arrangement of four bay windows, two at each end. After much alteration during the 18th and early 19th centuries it was restored in 1928, when the northern archway was added. At the time an interesting relic of an even older hall was uncovered and can still be seen—a 13th century arch with characteristic dog's tooth ornamentation. For many years the Hall was used as the Court of Chancery until the opening of the new Law Courts in the Strand in 1883, and here surrounded by fog both literal and legal Jarndyce v. Jarndyce dragged out its weary length in Dicken's *Bleak House*. Unfortunately the fine interior of the Hall with its elaborately carved 17th century screen is not normally open to the public. The Hall is joined on its north side to the Chapel, a stone faced building allegedly constructed by Inigo Jones in 1623. At the opening ceremony a sermon was preached by Dr. Donne, the popular Dean of St. Paul's and so great was the congregation that several people were crushed to death. The most interesting feature of the Chapel is undoubtedly the open undercroft with its Gothic four centred arches. It was originally designed as a place for students and barristers "to walk and talk and confer for their learnings." Butler refers to it in his "Hudibras",

"Or wait for customers between
The pillared rows of Lincoln's Inn."

It was always a great place for assignments and appointments (the duel scene in the film "Tom Jones" was shot here). Here too, were buried some of the benchers of the Inn in the 17th century. The only tombstone that survives, complete with Latin inscription, is that of John Thurloe who was Oliver Cromwell's Secretary of State and who died in 1668. The interior of the Chapel is not particularly interesting but there is a fine carved 18th century pulpit and some stained glass figures of the apostles contemporary with the building. One window has a pane showing Lincoln's Inn as it must have appeared in a rural setting in the 16th century.

To the north of the Chapel is another pleasant little Quadrangle shaded by a solitary plane tree. The chambers here are rather dull Victorian neo-Elizabethan. East and South of the Chapel are brick built chambers outwardly of the late 17th century and gabled on the Chancery Lane side. They were in fact built in 1562 and rebuilt in 1607. Some indication of their real age is to be found in the polygonal stair turrets with their small windows. At No. 24 lived John Thurloe whose grave you have already seen. While he was working here one night, Cromwell came to see him with a plan to decoy Charles and his brothers, the Dukes of York and Gloucester,

from Bruges where they were in exile, to England, where they were quietly to be assassinated. While talking to Thurloe, Cromwell noticed that his clerk, Samuel Morland, appeared to be asleep in a corner of the room. Thinking that the conversation had been overheard, Cromwell drew his sword and prepared to kill Morland on the spot. Thurloe however, implored Cromwell to restrain himself as he was sure his clerk was really asleep, passing a lighted candle in front of his face to prove it. Morland was in reality awake and sent warning to Charles who thereby evaded the trap set for him. Charles subsequently rewarded the faithful Morland with a knighthood.

Passing from Old Square through a passage of 1583 with a delicate tracery ceiling, a great open space is reached. Tucked away in a quiet corner on the left is another Tudor Court of similar appearance to those mentioned previously, and built between 1524 and 1534. Turning north the most striking building is the New Hall and Library designed by Philip Hardwick (Architect of the Great Hall and Doric Portico at Euston Station) and completed in 1843. The Tudor Style of Architecture accords much better with the large size of the building than might be expected and there is variety enough in the details to delight the eye. The whole building is of red and blue diapered (i.e. diamond shaped decorative) brick, a feature that perhaps not everybody will care for, interrupted by massive bay windows. In an ornamental niche above the gable at the south end is a statue of Queen Victoria who opened the new building. The Hall seems all the more impressive for being raised on a terrace with elegant staircases leading to the various entrances. On the other side of the gardens are Stone Buildings finished in 1780. William Pitt occupied rooms here when he was treasurer of the Inn in 1794. The block is stone fronted and plain with columned pavilions at each end and an enclosed dignified court. The contrast between the two buildings separated by the gardens, "the Palladian chastity of the one set against the large scale neo-Tudor of the other" as Pevsner puts it, is visually most satisfying.

To the south of the gardens lies New Square. It is an early example of speculative building on the large scale and was completed between 1685 and 1697. It originally formed no part of Lincoln's Inn. The gardens of the square are entered by elaborate Victorian wrought iron gates (the Brewster gates) of 1863. The square itself is one of the finest in London and this is particularly true of the east side. Here, in a corner between the backs of some of the old buildings framed by a clambering vine and the passage to Chichester Rents, is a private lawn with a house (No. 15) built in 1927 but according in style with the rest of the square. This surely must be one of the most pleasantly situated houses in London—I often wish I could live there myself. The dignity of New Square, indeed all the 18th century squares in London lies in the perfectly proportioned facades and fine doorways (in this case each with an open segmental pediment). You often discover the unusual in London and in the passage to Chichester Rents, high up on the wall is an old notice about windows of houses in the square being "brocken"—no doubt a relic of the days when the window tax was in force. The south side of the square opens into Carey Street by a broad gateway of 1697 with a four centred arch and wide, delightfully scrolled pediments. The booksellers shop below dates from 1818. In Carey Street itself,

Staple Inn, High Holborn.

next to the gateway is a fine detached Georgian house of 1732—the doorway being ornamented by a pediment supported by recessed columns on each side.

The essence of London is to be found distilled in the alleyways, courts and squares of the Inns of Court, and their atmosphere changes subtly with the weather. The shadows cast by the winter sun seem to have some strange effect on the facades of the buildings—their character seems completely different when seen basking in the midsummer light. This subtle change is a particular feature of Lincoln's Inn which seems to take on new interest with each advancing season.

FIFTY YEARS AGO

From the Bart's Journal of August, 1914

ANÆSTHETIC

A DRAMATIC EPISODE (After R.B.).

To Dr. G. S. Haynes

Well, what's your choice? Here's Euthanasia's spread—
Gas, ethyl chloride, ether, A.C.E.:
The first and second mere *apéritifs*
Or appetisers for the sterner stuff;
They bring you to the borderland of dreams,
Where you shall laugh as loudly as you will,
Be on the best terms with yourself and sing,
Shout choruses, with tongue unfettered, free
(Tinging the atmosphere, as like as not,
With phrase of startlingly cerulean hue)—
The elemental man unmasked: a mild
And brief intoxication, nothing more.
If you'd be well advised, leave these alone.
. . . What's wrong with open ether, right away?
Not in a Clover: no—but given thus,
On this light mask, well mixed with Cambridge air,
The smell, you say, unpleasant?—so you've heard.
Not much in that, I fancy. So much talk.
Objection? Well, it takes a little long,
Eight minutes two, perhaps, before you lose
Full consciousness. That's all the same to you?
Good. Nurse, just edge the metal of this mask with wool—
We're going in for luxuries this morning.
That's better. Now, how's that? Quite easy? Right.
Just breathe away—so; gently, not too deep.
. . . Feeling a little muzzy now: no? Not
As if you'd had a glass too much—light-headed?
And while you breathe—if I may so suggest—
Compose a sonnet of the things you see,
And dedicate it thus—'To Dr. Haynes.'
. . . "To Dr. Haynes . . . I hear . . . a sonnet . . . yes,
That's it. Right—o! To Dr.—G.—S.—Haynes—
I must remember that—from one, from one—
Oh damn, how this stuff chokes and blinds—from one—
What shall we say?—who enters—in a wood—
A sunlit wood—where loud—loud the birds sing,
And huge, dark—drowsy—drowsy blossoms break,
Distilling dreams. . . . I heard you laugh. That's Joe.
I know it is damned funny . . . All the same,
It's not so—damn: I think this must be where . . . .
Now . . . where . . . I'm . . . really off."

D.J.F.

ADDENBROOKE'S HOSPITAL,
January 6th, 1914.

THE TRIBULATIONS OF JOHN ABERNETHY

Commemorating the bicentenary of his birth.

By Alfred White Franklin

Address to the Abernethian Society of Saint Bartholomew's Hospital, 23rd April, 1964.

PART II.

The Abernethy-Lawrence Controversy

John Hunter at his death in 1793 left a mass of manuscripts, observations, descriptions of specimens and the substance of a number of books. His ideas and his teaching about comparative anatomy, a subject developing from the need to dissect animals in the absence of the human cadaver; his attempt to make out of mechanical surgery an art based on science; his philosophical speculations about life and disease; much of this immense knowledge had been given in public lecture and in private talk to his intimates, his friends, his pupils. Very little had been published in his life time. John Abernethy who records a number of conversations with Hunter became one of the prophets of this new surgical revelation. On his appointment as Hunterian Professor of Surgery in 1814 he began, and continued until 1817, a series of lectures revealing "Mr. Hunter's theory of life and his opinions respecting diseases". The latter were regarded as valuable rather than controversial, but the former by many as controversial and incorrect.

What is life? What relationship exists between body, mind and life? Is there a subtle principle of life, something like electricity, distinct from the organization of the body, distinct from mind? Abernethy gathered Hunter into support of a vitalist theory, of a principle of life separate from the physical structure of the body.

Temkin observes that these lectures of Abernethy's "were not distinguished by clarity" and they were attacked at once by the Edinburgh Review because they were both obscure and inaccurate. Abernethy proceeded upon his course unmoved. Later in 1815 he published his accounts of Hunter's theories as expounded in the 1814 and 1815 lectures. At the beginning of 1816 the College of Surgeons had appointed a new Professor of Anatomy, William Lawrence, and he, in his Introductory lecture on comparative anatomy and physiology, propounded his belief in the importance of organization and of the dependence of function on structure. Lawrence followed the French School of Cuvier and Bichat in stressing the study of organization. Function is the purpose of organic structure, and living structure certainly possesses vital properties, both sensibility and irritability. Nevertheless no means existed of discovering the connexion between structure and function, and knowledge depended only on observing a succession of events. Anatomy and physiology taught only the facts about organization apart from which life could not be separately studied.

In later lectures Lawrence rebukes physiologists for their lack of understanding of logic, leading them to wrong thinking about cause and effect, and for their penchant for "favourite notions and speculations, which, like coloured glass, distort all things seen through their medium". An analogy between electricity and life was but a modern version of the archeus or anima of the classical philosophers.

Abernethy's vigorous reaction to Lawrence's propositions and implied criticisms came in the next Physiological Lectures at the College in 1817. Now the gloves are off. It is Hunter and Abernethy versus Lawrence, the demoralizing Frenchmen and the party of Modern Sceptics. These men disbelieved in the soul and all their philosophy was "gratifying their senses, and acting as their reason dictates, for their own advantage, independently of all other considerations". It is easy to suppose that to a man of Abernethy's temper no good thing could come out of France, the political enemy for so much of his adult life. He had visited Paris in about 1791 to see the world renowned surgeon Desault, then in the prime of surgical life, at the Hôtel Dieu. Their meeting might have been interesting to witness, our forthright Founder and this retiring Frenchman, who would state his opinion but if contradicted would drop his gaze without rejoinder. "Je suis comme les substances salines" he is reputed to have said "je ne cristallise qu'en repos". MacIlwain proudly writes that Abernethy quickly perceived the most important defects

of the Hôtel Dieu "and the influence exerted by them on his (Desault's) practice". This was before the French Revolution and the long Napoleonic Wars which would not have increased Abernethy's respect for France. He easily persuaded himself of the "pernicious tendency" of the French anatomists.

Lawrence reacted with vigour and his "reply to the charges of Mr. Abernethy" occupies half the introductory lecture in the course for 1817. In this magnificent piece of oratory Lawrence defends the rights of scientists to independence of thought. There is no party of sceptics; there are those who study science. Abernethy is unreasonable in expecting others to "rely on the workings of his fancy in preference to the evidence of their own senses". "An immaterial and spiritual being could not have been discovered amid the blood and filth of the dissecting room". The doctrine of the soul and of its separate existence rests on a species of proof altogether different, theological not physiological.

Abernethy returned to the attack in a postscript to his published Hunterian oration of 1819. That this is less vehement may be explained by his knowledge of the serious trouble which afflicted Lawrence with the publication in that year of his Lectures on Physiology, Zoology, and the Natural History of Man. Perhaps in 1967 at the centenary of Lawrence's death someone will continue this story in greater detail. Lawrence had found the biblical account of the creation and of the flood "at variance with all our knowledge of living nature". He drew the highly dangerous conclusion "that the subject is open for discussion". Retribution for his audacity followed swiftly. In April of 1819 the governors of the Royal Hospitals of Bridewell and Bethlem met for the annual election of their surgeon. Lawrence had been appointed in 1815. He was suspended in 1819 because he had published a book of which it was said that its aim is to refute the Hunterian Theory of Life, to revive the hateful and almost exploded doctrines of Materialism, to bring the sacred writings into dispute, flatly denying the truth of some parts of them, and thereby to destroy all that belongs to man beyond his prerogatives as a "human animal". Lawrence agreed to retract his opinions and to suppress his book. He was duly re-elected to the surgeoncy with what the hospital secretary called its "handsome emoluments".

Abernethy must have been severely tried by this controversy beginning as it did with an attack on his hero John Hunter and ending with the possible professional ruin of his former apprentice and most brilliant hospital colleague. Lawrence, born in Cirencester, on July 16th 1783, was the son of a leading local surgeon and of a Jenner. This is possibly why, when the boy came to London in 1749 at sixteen, he was apprenticed to Edward Jenner's friend Abernethy, then one of the leading London teachers and hospital surgeons. When in 1801 Abernethy became Lecturer in Anatomy at St. Bartholomew's, his apprentice became his demonstrator. A viper nurtured in the bosom strikes hardest.

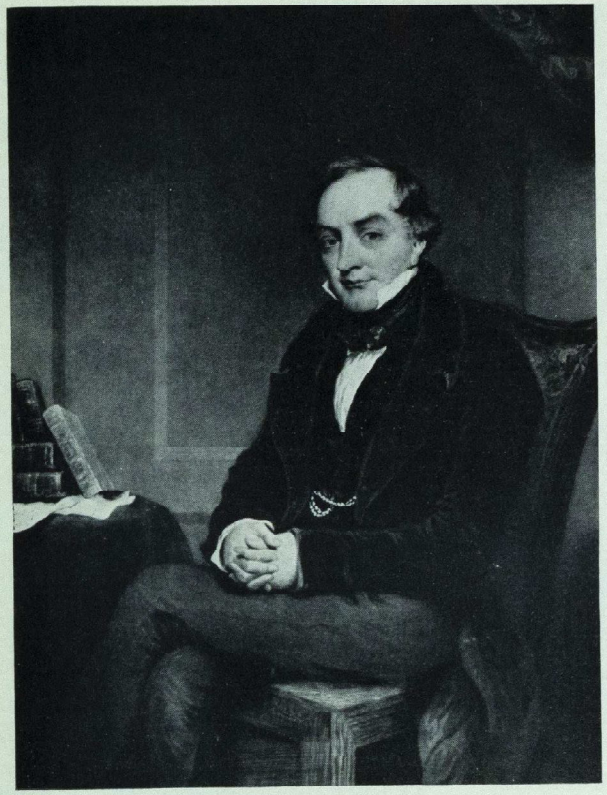
Placing these great men side by side brings to mind the contrast between Rome and Athens—"Athens", to quote J. C. Stobart "is rich in ideas, full of the spirit of enquiry, and hence fertile in invention, fond of novelty, worshipping brilliance of mind and body. Rome is stolid and conservative, devoted to tradition and law. Gravity and a sense of duty are her supreme virtues".

Lawrence, subtle, intellectual, Athenian could never have founded a medical school. Abernethy, solid Roman, could never have reached out towards a theory of an evolutionary origin of species.

Yet Abernethy claimed in his Hunterian oration that "honour is due alone to intellect, and can be paid to nothing else". Did he think of himself as an intellectual? Probably not, for in his next sentence he brings forward as alternatives for admiration, superior powers and firmness of mind. Of these he certainly possessed a generous share.

Wakley and that "Most Scandalous Periodical Pamphlet called 'The Lancet' "

Hunter told Abernethy—"my mind is like a bee-hive", and Abernethy notes approvingly that "in the midst of buz and apparent confusion, there was great order". The philosopher-hero was a thinker; all the "buz" concerned the phenomena of science and of living bodies. The thoughts, tested by observation and experiment, were new and revealing, and the thinker became, in the words of Buckle, "one of the rebels and demagogues of science". Liberation needs its chivalrous Knights in every generation. The disciples of the liberator spend their lives protecting the liberated maiden, oblivious to the protection which nature gives her through advancing age, and heedless of the



William Lawrence 1787-1867

cries of other damsels in distress. For there is a new captive maiden in every generation. But alas! the disciples of the liberator become, to change the metaphor, at once the pillars of the new establishment and the bitterest opponents of the new rebels and demagogues.

In medicine, the organisation of the profession and the place of the doctor in society, were to be the controversial matters of the first half of the eighteenth century in a community expressing its need for the closer regulation of administrators. The Apothecaries Act was passed in 1815, the Anatomy Act in 1832, the great Public Health Act in 1848 and the Medical Act in 1858. A Royal College of General Practitioners was nearly born; instead there is the British Medical Association dating from 1855. All but the first of these owed much to the influence of another "rebel and demagogue", not of science but of political medicine, Thomas Wakley, Member of Parliament for Finsbury from 1835, Coroner for West Middlesex from 1839, but in Abernethy's day founder, proprietor and editor of *The Lancet*, whose first number appeared on Sunday, October 5th, 1823.

Wakley was born in 1795 in Membury on the Devon side of the Dorset border. Educated in the West Country he was apprenticed at fifteen to a Taunton apothecary. While this was one avenue into the practice of medicine Wakley persuaded his father to apprentice him to a surgeon uncle in Beaminster, whence he moved to assist another surgeon at Henley-on-Thames. To a boy of ambition these were merely stages on the road to London and there he arrived just after Battle of Waterloo, aged twenty, to work for his membership of the Royal College of Surgeons as an enrolled pupil at the United Hospital of St. Thomas's and Guy's. In 1817 he passed his M.R.C.S. Without a University degree and a licence from the Royal College of Physicians or a costly apprenticeship to a hospital surgeon, the young doctor could climb only a step or two up the professional ladder. Charles Brook reports that during training at hospital Wakley was irritated because only favoured pupils were notified of impending operations, while a sop to Cerberus in the form of a tip to the porter was required to attend post mortem examinations. Brook, who would like Wakley as the Patron Saint of the Socialist Medical Association, stretches credulity a little by adding that "the visiting staff were irregular in their attendances". Having taken large fees

from the students they frequently delegated their duties to their demonstrators. When they did attend they were unpunctual and uninformative. None of this could be said of John Abernethy, whose consideration for patients and pupils at the Hospital was beyond reproach.

Wakley seems to have been reconciled to his modest future and returned to Devon, but finding no suitable opening there he returned in 1818 to London to practice in the City. While still a student at St. Thomas's he had been sent to Hendon to solicit a subscription from a wealthy Southwark lead merchant, receiving £100, an invitation to lunch and an introduction to the daughter of the house whom he married two years later. It was she who dissuaded him from surgical practice following a remarkable attack on him and an incendiary attack on his home. It has been suggested that he was mistaken for the hangman who decapitated Thistlewood and the other Cato Street conspirators with a skill worthy only of a surgeon. As one result of this mistaken identity, Wakley gave up practice and founded *The Lancet*.

The Lancet was frankly a reforming pamphlet, bringing into staid medical journalism the panache and the crudity that had been the features of the political pamphlets of the preceding century, with a ready welcome for libel actions and legal proceedings. On Wakley's staff were William Cobbett, James Wardrop and William Lawrence, rebels all. Cobbett buying himself out of the army ruined himself by trying to expose peculation in the army and by denouncing flogging. The Parliamentary Debates, which he started, live on as *Hansard*.

Wardrop was an invader from Edinburgh appointed surgeon-extraordinary to the Prince Regent. With no hospital appointment in London he started his own, "The West London Hospital for Surgery". William Lawrence has appeared before.

The Lancet set out to liberate medical education and the practice of hospital medicine from mystery and concealment that could protect bad teaching, poor surgical skill, negligence of duty and corrupt elections. In each of the first numbers pride of place is given to a surgical lecture by Sir Astley Cooper. The composition of quack medicines was to be a feature. Politics and a weekly Chess Problem soon drop out and a Foreign Department begins for reporting new methods of treatment and accounts of operations. Astley Cooper, whose permission to publish had not been sought, called on The Editor in the guise of a patient, discovered Wakley in the act of correcting the proofs and after good-natured argument agreed that the lectures might be published but without his name.

The next victim was John Abernethy and this time the outcome was a legal action, one of the ten to which *The Lancet* was a party in its first ten years of life. Abernethy sought an injunction to restrain the publishers and printers of *The Lancet* from issuing his lectures. The author of any literary composition has a Common Law right to prevent its publication until he has himself made it public. Until this case, the author, to preserve this right, was required to give two days notice before delivery to two justices of the peace living within five miles of the place of delivery—unless the lecture is delivered in any university, public school or college or in any public foundation or upon gift or foundation, such lectures being free. Wakley knew of Abernethy's objection but persisted in publication and in publication verbatim.

Here is a sample from a lecture on Inflammation:

"If I am wrong I shall be very happy to have my errors pointed out and corrected. I'll be hanged if erysipelas is not always a result of a disordered state of the digestive organs . . . Egad, it is a travelling disease, and, as I say, the parts are disposed to swell. . . . If it be seated in an unimportant part in the name of G—let it go on there . . . O, said the dresser, it is a case of erysipelas and he only came in last week. Good G—! said I, is it possible? . . Ho! he had his jawing-tacks on board, as a sailor would say".

Small wonder that Abernethy said of these reports, "they represent me as one of the most pert, balderdash fellows in existence". The case was heard by Lord Chancellor Eldon, the same who refused the protection of copyright law to Byron's *Don Juan* on the grounds of its immorality, to Lawrence's Lectures because they taught doctrine contrary to the Holy Scriptures, and who died worth three quarters of a million having probably made more money out of the Great Seal than any other man in English legal history. The Lord Chancellor hearing the subject of the motion put a case to himself and concluded "I shall make short work of it". On being rebuked by the Solicitor-General representing Abernethy and by Wakley's counsel that he could not decide the case without having heard it, he replied, "Let us have no more bleeding until

I have examined the patient myself and decided upon his case". Wakley's case was that it was Abernethy's public duty to deliver surgical teaching in a public place for the public good: that the colloquial style proved absence of intention to claim copyright: and that being a mere replica of John Hunter's teaching, they contained no matter in which Abernethy could claim any peculiar property. (Is this the hand of William Lawrence?) The Lord Chancellor withdrew the injunction. Despite lecturing in the dark Abernethy continued to be published in *The Lancet*. To Wakley he was "throwing new obstacles in the path of medical science". Abernethy let the matter rest until the middle of 1825 when a second application succeeded on the grounds that his lectures were delivered to persons under an implied contract not to publish them. They could not be published for profit without infringing the law. Wakley's ungenerous riposte to set Abernethy's mind at ease reads "Our pages have been already obscured with his hypothetical nonsense during six tedious months, and when we read the proof of the last paragraph we felt relieved of a most intolerable incubus".

Thomas Wakley 1795-1862

The Revolt of the Members

Abernethy stood in Wakley's mind for all the patronage, privilege and power of the purse that restricted opportunity and opposed reform. He was the Establishment and he had to be fought without mercy to divest medical education and medical practice of the remaining trappings of the eighteenth century. And it happened that he was the President of the Royal College of Surgeons when the revolt of the Members flared into the open. To Abernethy, who had hoped to improve relations by his Presidency, this was a grave disappointment.

The immediate cause was a by-law which had been passed in 1824 restricting medical teaching to the appointed professors in the University of Dublin, Edinburgh, Glasgow or Aberdeen, and to "persons teaching in a school acknowledged by the medical establishment of one of the recognised hospitals, or from persons being physicians or surgeons to any of these hospitals". The idea was to raise the standard of education, but to Wakley and his friends it looked like monopoly put into the hands and pockets of men appointed to their posts not from talent or skill but through patronage, influence and family ties, and, once appointed, serving for life. The Court of Examiners at the College who had passed the by-law would all benefit financially from its operations. *The Lancet* rallied the opposition and in 1826 was held in the Freemasons' Tavern the first public

meeting of members of the Royal College of Surgeons in the presence of twelve hundred, estimated at nine hundred members and three hundred interested spectators. The chair was taken by William Lawrence.

General dissatisfaction with the management of the College, its failure to prepare a Museum Catalogue, its method of electing its governing body was added to complaints about the offensive by-law.

Typical of an indignation meeting there was unanimous support for a complaint that members were compelled to enter the College by the back door. Secretary Belfour eventually explained that this was because the front door led straight through the museum and when this entrance was used the specimens became extremely dusty. A back door, however, remains an indignity.

The meeting voted to petition Parliament to abrogate the College Charter. A small committee reported at the next meeting of members three weeks later that they had invited the Council of the College to join in a petition to Parliament, an invitation contemptuously refused. Abernethy as President bore the brunt of the animosity of the members and the jibes of *The Lancet*. These matters slowly took their course, ceasing to concern Abernethy who was succeeded in 1827 by Sir Astley Cooper, while the next year the rebels found one of their own leaders elected to the Council. The secession of William Lawrence enabled him to exercise a moderating influence, although he was not in favour of retiring from any office and suffered his fatal stroke while climbing the main staircase at the College to take his place as an examiner at the age of 87.

Conclusion

It is easy to picture the hospital in the time of Abernethy. Many of the wards designed by James Gibbs are still in use. The Great Hall, like some gilded collecting box, reminds us by its record of benefactors, that there the money was tempted into the hospital's treasury at the Festival dinners and on state occasions. Did any of the doctors then say "Shocking extravagance spending all this on gilding for the administration"? Abernethy called it "the useless portion of the hospital". The Square contained a central pump, but no fountain, and a carriage or two instead of a car park. Then as now there was no room in which a member of the staff could sit and plan and think; into our good laboratory space Abernethy could have moved from home his vegetables grown on flannel, his glass jars and quicksilver for testing vital capacity and measuring animal heat, and perhaps the whale that he dissected, filling its absorbents (lymphatics) with quicksilver, all this experimenting that earned him his F.R.S.

Can the man be pictured on this the bicentenary of his birth?

In his younger days he charmed and fascinated his pupils by his directness of speech, his anecdotes, the dramatic quality of his lectures. He was an alive man. His kindness to real distress, his impatience with pomposity and verbosity, his common sense are the subjects of many stories. The early influence of John Hunter led him to think and to experiment, but he lacked self-criticism and having by the age of forty discovered the importance of what has later been called "bowel toxæmia" he attributed more and more illness to its effects.

McIlwain noticed declining health and lassitude leading him to resign his professorship at the College at fifty two. This was soon after the beginning of his tribulations with Lawrence. He was much troubled with throat infections and with quinsies. In his last years he was crippled with arthritis. And so to the sadness of controversy must be added the pain of illness. But the man who came to give his lecture here on his wedding day was carried through by a sense of duty.

I like to think of him in the prime of life jogging in from a taste of fresh air at his country house at Enfield on his favourite mare Jenny, reaching his home in Bedford Row or St. Bartholomew's probably in less time than it takes today, supported through his tribulations by his wife and a happy family life, a solid man, a man to be remembered, a man of character.

For help in preparing this Address I am grateful to Dr. Kerling, Mr. W. R. Le Fanu, Dr. Noel Poynter and Mr. John Thornton. The following are the writings chiefly consulted:

References

The Works of John Abernethy and William Lawrence.

BROOK, C. W. (1945), *Battling Surgeon.*

COPE, Sir Zachary (1959), *The Royal College of Surgeons of England.*

MACILWAIN, George (1856), *Memoirs of John Abernethy*, 3rd. ed.

SPRIGGE, S. Squire (1899), *The Life and Times of Thomas Wakley.*

TEMKIN, O. (1963), *Basic Science, Medicine and the Romantic Era. Bull. Hist. Med.*, **37**, 97.

THORNTON, J. L. (1953), *John Abernethy.*

GENERAL PRACTICE AS A VOCATION

On April 24th, 1964, Dr. Gerard Lang, an Edinburgh graduate, now senior partner of a firm of five in Potters Bar, came to lecture to final-year students. He owed his introduction to his life's work to a Bart's man, who initiated him into many mysteries and seemed to personify all the qualities of the ideal family doctor. Many of the techniques then so laboriously acquired had now been lost, for by National Health standards a general practitioner is not considered fit to perform work for which he is not entitled to payment: he does it as his own risk. He had noticed that young partners, though trained for practice and expected to have the D.R.C.O.G., avoided anæsthetics and all but the simplest obstetric procedures—a progressive and damaging restriction of the field of general practice which should be strongly resisted. The one inestimable advantage, which a young doctor derives from the constant observation of virtues he is unable to emulate and of ideals he can never attain, is that he has been shown a standard whereby to examine his conscience and to measure his own deviations and shortcomings. But he must not allow his own personality, the one precious thing that he alone can bring to his work, to be submerged.

Unfortunately, the G.P. is not now held in high regard by the public, even though countless individuals can be found who will praise their own personal doctor. Always the object of comment and criticism at tea parties, mothers' union meetings, in shopping and bus queues and among suburban commuters, the G.P. has now to compete with the Radio Doctor, with "Your Life in Their Hands", with "Emergency Ward Ten", with the angelic Dr. Kildare and the ape-like Ben Casey and, perhaps harder to bear because closer to real life, with the omniscient Dr. Cameron and the indefatigable Dr. Finlay of the celebrated "Casebook". Almost every day the Press regales its readers with articles and letters in which general practitioners are criticised and condemned, admonished and threatened, disparaged, patronised or damned with faint praise. By contrast, of course, the hospital doctors are beyond criticism: the only thing wrong with hospitals is that there are not enough of them, and that they are too old or too small. The glamour surrounding the names of the best-known physicians and surgeons casts a ray of reflected glory on all specialists who, from their advantageous position of assured financial superiority, maximum notional sessions, State-maintained premises, holidays with pay and locums provided, ample opportunity for private practice and immunity from criticism, are for the most part indifferent to the exclusion of general practitioners from hospitals, and tend to look upon themselves as a class apart. Small wonder, then, that among other causes for the G.P.'s depression, envy of the specialist should play an increasing part.

But envy is a poor guide to rational action —rather the reverse. If a man's chief object is to make money, not an ignoble ambition, he should seek his living in some other walk of life. If financial gain be not the primary aim of a profession, we rightly describe that profession as a *vocation*, the essence of which is that it subordinates personal enrichment, as well as ease and comfort, to the pursuit of a specialised form of knowledge and activity in the service of mankind. Just as the priest's vocation is the cure of souls, and the teacher's the training of man's intellect, so the doctor's vocation is the care of man's bodily and mental health. The general practitioner deals with the whole man, not just the organs or parts of man. His patients are always human beings, never mere cases. For them he rises from his sleep, neglects his food, interrupts his play. His responsibility continues night and day, year in and year out, throughout his working life, and he personally manages 90 per cent of his patients' ailments and illnesses. This is his vocation and, if he be faithful to it, his justification; for a man's awareness of his vocation and fidelity to its demands are, like his conscience, personal to himself, independent of outside pressures and of the vagaries of other men's judgments. It is not possible, nor is it necessary, that a man should put his sense of vocation always in the forefront of his mind; once clearly perceived and securely grasped, it dwells within the citadel of his soul, a source of comfort in despondency, of strength in adversity. Be he a Christian, a humanist or a determinist in his philosophy, this sense of vocation will sustain him in the boredom inherent in the inevitable routine work of all professions, and will give him that basic certainty of the value of his work,

which is the only prophylactic against frustration and the essential key to a really happy and contented life.

The general practitioner combines the science and the art of medicine. Respect for the personality of others will give him the imaginative sympathy and large tolerance essential to his work. He must learn to suffer fools gladly; he must not weary of the small percentage of unfortunates who cannot live without his support—those whose faces haunt his surgery and whose names constantly recur on his visiting list. He will show tenderness to young children and to their anxious mothers, reverence for the adolescent, sympathy for the middle-aged, and a particular attention to the old, whose only friend he so often is. In major illnesses and operations the patient is supported by the interest, sympathy and admiration of friends and relatives and by the sense of being the hero at the centre of the stage; but such scenes are rare in an average lifetime. It is the minor ailments and discomforts, the more chronic complaints, so uninteresting, boring and ridiculous to others, that make life miserable for a patient; and it is these that the G.P. has to learn to sift, to treat, and if possible to alleviate and cure.

"It may seem to some of you that my views have been unduly influenced by Christian standards. I make no apology for this; a doctor must have a philosophy by which to live and to exercise his profession, and in this ancient foundation of Rahere's the Christian viewpoint is not, I trust, out of place. Let me conclude by reiterating that a good doctor is not a lop-sided character, but a man of culture and wide interests, one who bases his personal and professional life on the firm belief that nothing of human interest is foreign to him. As a parting gift, permit me to set before you an ideal figure, a man of many parts; the first Christian painter, according to ancient tradition, claimed as their patron by artists the world over; the first Christian historian, whose writings reveal much of human and medical interest; the companion of St. Paul on his adventurous travels; the Patron Saint of doctors, *Luke*, the beloved physician.

A GENERATION AGO—

THE DISILLUSIONED DOCTOR

Sick of drugs and sick of diet
How to keep my patients quiet!
Serums, vaccines and syringes
Cease to ease their pangs and twinges.
Colloid states of precious metals
Now replace old roots and petals.
Macerations of the tissues
Check the flow of bloody issues,
Thin the fat, make old men younger,
Stay the diabetics hunger.
Little children when they pray,
Praise the ultra-violet ray,
Yet the world goes round and round,
Worms still fatten in the ground.

H. Muir Evans, 1931.

SOME COMMENTS ON THE RADIOLOGICAL FINDINGS IN PATIENTS WITH BACK ACHE

By G. Simon

Radiology contributes with such constancy and reliability to the diagnosis of, for instance, peptic ulcer, pulmonary tuberculosis, and cancer, renal calculi, and fractures of bones, that it is not surprisingly expected to elucidate the cause of the extremely common symptom of back ache, with or without pain in the arm or sciatica.

In an average week recently at St. Bartholomew's Hospital there were 114 requests, mainly because of back ache or sciatica, for radiographs of certain areas of the spine:

27 for the cervical spine;
26 for the thoracic spine;
61 for the lumbar spine.

This makes a formidable total of nearly 6,000 requests a year.

In the majority of these cases a vertebral or disc space abnormality is in fact found in the radiograph, but its relationship to the patient's symptoms is often very difficult to determine, and it has to be admitted that radiology often proves a broken reed in this respect.

Pain in the cervical spine

In the lower cervical spine a narrow disc space and marginal bony lipping of the adjacent vertebræ is found in some 70 per cent of patients with neck or arm pain; usually several disc spaces are affected. Unfortunately, exactly similar appearances are found in some 60 per cent of persons over 50 years of age who, in fact, have no symptoms, and the significance of the X-ray finding is therefore difficult to assess in many cases, and its influence on treatment is slight. The pain often goes, but the X-ray appearances remain unchanged.

It is often pleaded that it is necessary to exclude tuberculosis or a secondary deposit, but in fact the only unsuspected lesion seen in the cervical spine in the past 15 years in an adult was an erosive lesion of the body of C.3 due to an osteoclastoma. There was nothing in the symptoms to differentiate it from a disc lesion, except that the patient was a young adult, and she would have come to no harm had manipulation been done, or radiotherapy treatment postponed a week or two, until it was seen that rest or manipulation was not improving the pain, and a radiograph therefore indicated.

On the other hand a considerable number of unsuspected chest lesions are detected in the posterior view radiograph of the lower cervical spine, and it may be deduced that a radiograph of the chest is more useful than one of the neck in most cases of neck or arm pain. In practice, therefore, both parts are often requested as a routine.

Early radiography is, however, indicated in a patient known to have a cancer who then develops pain in the neck. Incidentally, in such a patient any local bone erosion of the vertebræ suggesting a secondary deposit is much more likely to be taken as the cause of the pain than the narrow disc spaces and bony lipping which will probably also be present.

In children with persistent neck ache a significant lesion may be found in a vertebra such as erosion of the vertebral body by an eosinophilic xanthomatous granuloma, or a narrowed disc and erosion from a tuberculous lesion, though the latter is rare nowadays.

In acute torticollis, whether in children or adults, a radiograph is not indicated unless the pain and deformity persist for some days, and in any case a radiological abnormality is rarely found.

Pain in the dorsal spine

In the dorsal spine matters are somewhat different. The number of requests for a radiograph for the elucidation of the cause of back pain in this region is far less than in the cervical or lumbar region, while requests for other purposes such as secondary deposits, osteoporosis and so on is greater in patients without back pain.

Narrowing of several disc spaces and bony marginal lipping is almost universal in adults and luckily usually ignored by the clinician. This was demonstrated when a group of students, nurses and army recruits had a routine

lateral view of the chest taken as well as the usual anterior view for a certain period. It was surprising in how many of these persons, even at this tender age, the radiograph showed disc narrowing and slight bony marginal lipping in the lower dorsal region, while some wedge-shaped deformity was also common in one or more vertebræ.

In the elderly there is also osteoporosis in many cases. In a series of (normal) persons over 75 years of age it was always present and associated with severe or moderate kyphosis in the majority, but there was not much complaint of back ache from the patients.

In a few women spinal osteoporosis may be seen at a younger age, some 20 years after the menopause, and this may be a cause of back pain, especially if there is collapse of one or more vertebræ. The vertebræ are often quite difficult to see in the radiograph because of their poor calcium content, and show no trabecular pattern, while the outer cortical line is thin. Compression collapse is common and may be wedge-shaped, while disc pressure on the central parts results in a concave indentation into the upper and lower border of the body, producing the so-called "fish-shaped deformity". Usually several vertebræ collapse but with "skip" areas, so that the collapsed ones are not adjacent to each other.

The diagnosis of the cause of the osteoporosis is not always easy, unless it is due to Cushing's Syndrome or excessive steroid therapy. Occasionally dorsal back pain is the presenting symptom of myelomatosis, and care must be taken not to diagnose the osteoporosis as due to old age, or a post menopausal condition. In myelomatosis the decalcification may be quite even, while if collapse is present, it is often confined to a single vertebra. Once the condition is suspected from the spinal radiographic appearances, confirmation is usually forthcoming either clinically or, if radiographs of the skull, major long bones or pelvis show discrete erosions.

Great difficulty, however, sometimes arises when a patient is known to have a carcinoma, in deciding whether a collapsed vertebra is the result of a general spinal osteoporosis, of which there is radiographic evidence, or whether it is due to a secondary deposit in a vertebral column already decalcified by endocrine factors or age.

Another abnormality sometimes seen is an isolated collapse of a single vertebra without evidence of general spinal osteoporosis. If there is disc narrowing and a paravertebral shadow it will suggest a tuberculous lesion. If there is no disc narrowing it will suggest, in a child, an eosinophilic xanthomatous granuloma, or in an elderly patient, a secondary deposit. Trauma will be suggested if bony lipping is more marked in the region of the collapsed vertebra, or even confined to it.

Finally osteoporosis with a collapsed vertebra and pain in the back may be caused by long term relatively high dosage steroid therapy. For this reason a lateral view of the lower dorsal spine should be taken before commencing steroid treatment, if this is likely to be prolonged as in asthma or rheumatoid arthritis, in order that the radiograph can be compared with later ones, and any osteoporosis therefore detected earlier before vertebral collapse occurs.

Back ache in the dorsal area of the spine may be the presenting symptom in ankylosing spondylitis, and if this condition is suspected, it may be confirmed by finding the typical erosions of the articular cortex of the sacroiliac joints with a wide joint space at first, but a narrow joint space later, and finally bony ankylosis.

Pain in the lumbar spine

The low back is the most common site of all back pain, and there are few elderly persons who have not experienced pain in this area at some time in their lives.

A narrow disc space in the lumbar spine with or without some bony marginal lipping is common in the elderly, and the significance of such a change is often difficult to decide, especially if several disc spaces are affected. On the other hand narrowing of a single disc space with neurological evidence of pressure on a nerve root at this level, will be important evidence of a disc protrusion.

In many patients acute lower back pain subsides on simple methods of treatment, and in the younger patients it is essential to postpone radiography of the lower spinal region at least until simple therapeutic measures have been tried and have failed because of the inevitable large gonadal radiation dose. This is perhaps one of those occasions on which it is unwise to be a medical student or nurse with acute back ache, since there is a tendency to "lay on" all methods of investigation early in such patients. As a generalisation one might say that low back ache without evidence of constitutional disturbance or a raised E.S.R. is unlikely to need early radiography to exclude tuberculosis or neoplasm, and the timing of the X-ray examination can be planned accordingly.

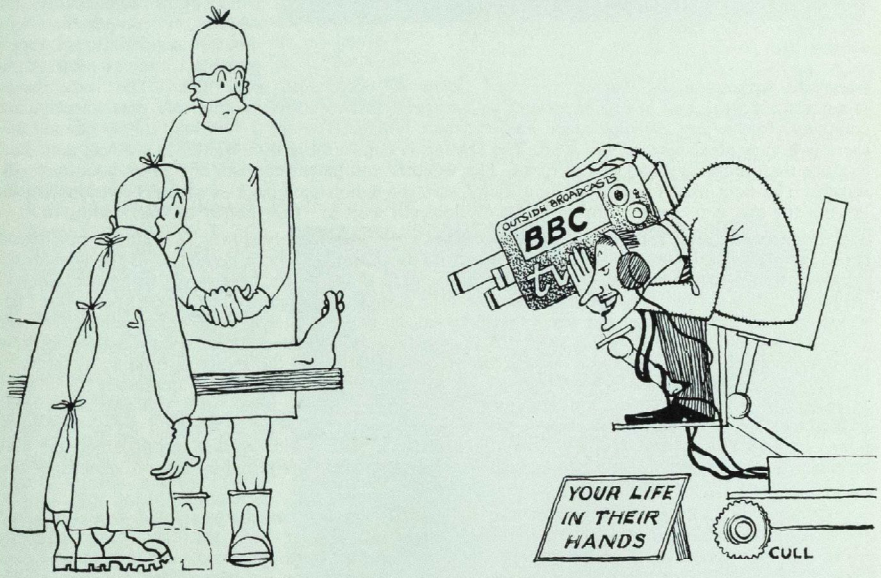
When the pain fails to subside and radiographs are taken, there is still the difficulty of correlating the findings with the symptoms. In the elderly not only may there be disc narrowing and lipping, but there may be narrowing and marginal bony lipping of the small interspinal joints, and it may be impossible to allocate the blame for the symptoms between the disc lesion and the osteoarthritis of the interspinal joints. Both changes may be present yet the pain may be due to widespread secondary deposits in the marrow spaces without sufficient trabecular absorption for their detection in the radiograph.

Another common difficulty is to assess the significance of various developmental abnormalities, such as a partly sacralised fifth lumbar vertebra on one side only, or a pedicle defect without any vertebral displacement. On the whole such changes can be ignored. On the other hand a spondylolesthesis may require special treatment, though in some cases the pain is due to an incidental disc protrusion, and not the displacement.

Occasionally a lesion is present but missed, such as the erosion by a secondary deposit of a single pedicle, and particular attention should be paid to the oval shadow of each pedicle to ensure it is clearly visible.

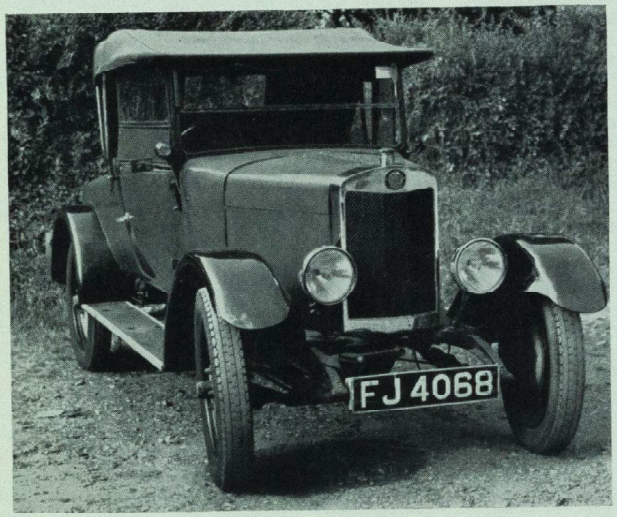
A tuberculous lesion, neoplasm or ankylosing spondylitis is occasionally an unsuspected finding, but more often the clinical picture is sufficiently different from a disc lesion to indicate the need for early radiography.

In conclusion one can say that sometimes radiographs of the spine are of great diagnostic help, but in the majority of patients, when the backache is due to an innocent condition such as a disc protrusion or degeneration, the radiographs are often indecisive. In some cases the cause may be shown by myelography, or more detailed radiography, including tomograms, but in the elderly in particular, radiography may be postponed for a short time, until simple therapeutic methods have been tried and failed, or until clinical findings such as a raised E.S.R. or constitutional upset suggest the need for immediate radiography.



"If you ask me 'Boyo' its a straightforward Hypermyotrophia of Abductor Ossis Metatarsi Digiti Quinti Pedis"

OTHER PEOPLE'S CARS: 1926 LEA FRANCIS



OWNERS of vintage cars always show great enthusiasm for their possessions. David Parr is no exception to this rule, for I am sure no car in the hospital is shown more loving care than his 'Leaf'. The car was made in 1926 by the Coventry firm of Lea Francis, now unfortunately out of production, and is powered by a 9.8 hp. 4EB engine by Meadows, a firm which was later to supply engines to such famous marques as Lagonda and Fraser Nash.

David's model is finished in blue and black with it's unusual solid disc wheels in yellow, and the polished brass lamps and radiator complete the picture. The engine compartment is remarkably uncluttered compared with today's machinery, it being possible to get at most of the essentials without really having to bend down or delve into dark holes. The transmission is notoriously weak and has to be treated with respect; just recently the near side rear wheel parted company, fortunately causing more anxiety than damage. The car is very high off the ground and there is a very good view of the road. The seating is comfortably upholstered in leather, and there is more than ample leg and elbow room. The weather equipment consists of a large hood and side screens. The boot used to incorporate a dicky seat, the upholstered back of which is contained in the lid, but the seat is no longer carried as David does not wish to stress the car by overloading it.

The engine starts easily on the starter and ticks over remarkably slowly; it is almost possible to count the individual explosions. The car must be moved off slowly in deference to the final drive; however the long stroke engine pulls very steadily, gear changing for hills rarely being necessary as manually retarding the ignition improves the hill climbing capacity. The crash gear box has 4 speeds and, being before the age of synchro-mesh, requires careful double declutching to avoid expensive noises. The lever is on the right just in front of the hand brake, which makes entry to the car from the left hand side almost obligatory, especially if the engine is running as the lever might easily be kicked into gear. The lever incorporates a catch which is depressed to engage reverse, a great improvement on modern techniques. Brakes are fitted front and rear, with large finned drums. The hand brake acts on the transmission just forward of the final drive. The dashboard is noticeably short of instruments, there being a clock (which works) and an ammeter, may be this reflects confidence in the engine, speedometers not being required by law on vehicles of this age.

In order that I might find out what the car was like on the road, I was treated to a run round the lanes near Henley in the sort of conditions that suit the car best, the open road requiring fewer gear changes and less stopping and starting. The suspension of David's car is hard and over poor roads gives the impression of leaping from bump to bump but nevertheless it is very stable in a straight line and round the corners, it has been known to leave far more modern machinery behind, may be partly due to the excellent view over the hedges of the curves in the road ahead.

At the end of my demonstration run I was of the opinion that here was a car for fine weather out of town motoring, for the city air tarnishes the brass work. David then, very bravely suggested that I might like to drive it, which I had been longing to do but had not liked to ask. I found the controls rather far away as David is somewhat taller than I, and I could only just get into first by leaning well forward. The car handled much as I had expected, all controls requiring a more forceful approach, and I hope I managed the gears without causing the owner too much heartache. The greatest surprise was the accelerator pedal which moved no more than half an inch from fully closed to fully open, however this gave very little trouble as the mechanism is very firm.

The uninterrupted view over the hedges, the hard springing, and total lack of body roll on the corners, brought back memories of the 1926 14/40 Vauxhall I had learnt to drive on. Vintage cars make few concessions to comfort, but they offer an entirely different side to motoring. The idiosyncrasies of an old car, the lack of modern luxuries, the concentration required to manage a crash gear box and the cheers from the crowds outside the pubs, all add up to an experience far removed from modern motoring.

WHITHER SHALL WE WANDER?

By Jasper

This month I'm afraid you'll have to wander rather a long way to visit all three pubs in the same evening, as we start in Hyde Park and finish in the East End.

The first place is situated at the junction of The Ring and Serpentine Road in Hyde Park and overlooks the Serpentine. It is called **The Serpentine Restaurant** and is quite a recent edifice (you'll see what I mean by edifice when you visit it). It's in two halves, one mainly a restaurant (rump steak 11s. 6d. exclusive of vegetables—I haven't tried it but I should be pleased to hear from people that have) and the other a bar. The beer is draught (chilled) Double Diamond at 2s. 6d. a pint. It's a circular bar, best on a hot summer evening, and you can sit on a balcony overlooking the water. The clientele is fascinating!

For a drink in the West End before or after a show, I recommend a visit to the **Lamb and Flag.** This is a period pub in an alleyway off Garrick Street (near Leicester Square) just opposite Moss Bros. When you've got used to all the notices about the famous people that have visited there over the past 'n' centuries I expect you'll enjoy it. The notices and people are fewer in the public bar where Courage is 1s. 10d. a pint. There's a nice little joke on the wall of the other bar but you may need a Latin dictionary to understand it. Or something anyway. One word of warning it's a little close to Charing Cross Hospital.

The final visit this month is, to some of us, to an old friend. The pub, **The Victoria,** is at the East End of Wick Road, Hackney, on the corner of Eastway. Of the landlord our Drinking Correspondent wrote in October, 1963: ". . . an affable and generous landlord who was good for a free pint now and again and would even extend limited credit." He now owns this pub in the East End and is still affable and generous, but a wiser and a better man. All Bart's people will receive a welcome from him, and he has a room which might well be used for firm parties (it's on a No. 6 bus route). Whitbread ordinary is 1s. 10d. a pint, and they also sell Tankard at 2s. 4d a pint. Van, the landlord, assures me that the menu at midday is West End standard, but I've not tried it.

The Serpentine Restaurant

THE WINE COMMITTEE TOUR DE FRANCE 1964

There is a surprising dedication in the Wine Committee's attempts to dispose of Bar profits by subsidising social events in the Hospital. Their efforts over the last year have included a Barbecue Ball, a Smoking Concert and a mystery tour to Southend. Their latest event, which proved to be the most ambitious yet, was the trip to Rheims to visit the champagne cellars of Moët and Chandon at Epernay.

Vive La Compagnie

Thirty members of the male student body, an alleged cross-section of the more well-known customers of the bar, set off on June 24th at 6.45 a.m. Despite a bus arriving half an hour late and a French air traffic controllers strike, the party flew by chartered flight to Rheims where in brilliant sunshine a bus whisked us to Epernay along avenues lined with vineyards. There we were welcomed in the English garden of the Moët and Chandon headquarters with ice-cold champagne served in the original nineteenth century conical glasses. This was a new experience for many of us—not the cosy sordidity of an English pub but rather the restrained almost measured elegance of a noble French chateau.

If this was delightful it was a mere prelude to what followed. After crossing to the Orangery through the French classical garden, almost perfect in its organisation, we sat down to what proved to be a gastronomic marathon lasting three and a half hours. This meal was the high spot of the trip and was conducted at a leisured pace, starting with Turbot and continuing with Coq au Vin Rouge de Bouzy, Salade de Saison, Fromage, Supreme des Fruits Ananas, and finishing with coffee. The champagnes we drank throughout the meal were all memorable, Brut Imperial 1952, 1959, and after a suitable speech of dedication an unobtainable 1911 vintage, stronger than its present day descendents but still clear and sparkling.

After a liqueur and a short speech from our host Comte Raoul Chandon-Moët, we emerged into the afternoon very mellow and walked around the cellars of the house seeing almost incredible quantities of champagne and the final processes of dégorgement and corking. Our host answered a continual barrage of questions with characteristic charm. On the way back to Rheims we stopped to pay a short pilgrimage to the village of Hautvilles where champagne was discovered by a monk, Dom Perignon, and where the House of Moët and Chandon was founded in 1743.

On the way back we spent a short time in relaxation at Rheims where some of us visited the Cathedral and saw its magnificent stained glass. The party flew back and reached London again after midnight. Our thanks for this memorable occasion go to our host Comte Raoul Chandon-Moët, to Mr. Manwaring-White of the M.I.A. and to Mr. Davies for organising the trip.

J.R.S.

NEW PENGUIN BOOKS

Men at Arms. Officers and Gentleman. Unconditional Surrender. Penguin trilogy, by Evelyn Waugh Price 3s. 6d. each.

The above three books, first published in 1951, 1955 and 1964 respectively, form a welcome addition to the already long list of Waugh novels in the Penguin form. *Sword of Honour*, as the trilogy is called, is a story of the '39-'45 war (the pun is bad but inevitable) which has as central character Guy Croutchback, an English Roman Catholic. After a happy childhood, he married and was briefly happy with Virginia, a gay society butterfly, who soon deserted him; taken completely by surprise Guy returned to Italy where he spent eight numbed, purposeless years. At the opening of *Men at Arms* he is 35, a thoughtful, diffident and devout man, who feels as though something has been stunted in him, "all his spiritual faculties were just perceptibly impaired". He greets England's declaration of war almost with joy. "The enemy was at last plain in view, huge and hateful, all disguise cast off. It was the Modern Age in arms", and he sets off innocently and hopefully to offer his services to his country.

Men at Arms is pure farce, dominated by large, pompous and mysterious Apthorpe, with his boot obsession, his hairy and silent friend Chatty, and his magnificient thunderbox which he conceals in the grounds of the barracks for his personal use, and over which he fights with the one-eyed "biffing" brigadier Ritchie-Hook. Like most of Waugh's "good" characters, Guy is continually unlucky; his regiment is shunted from place to place but he does not reach the front until the end of book, and when he does he is sent back in disgrace.

Officers and Gentlemen is slightly more serious, as Guy's efforts to do some fighting are thwarted again and again. It starts with pure humour: Guy, now a Commando is sent to the island of Mugg, where Waugh's imagination runs riot, as he produces such characteristics as the dynamite-obsessed Laird with his mad Nazi niece, and the sea-weed eating Dr. Glendenning Rees. It ends in the depressing spiritless retreat from Crete, the only time Guy comes into real contact with the war. This is reality, made more harsh by the vicious humour with which Waugh describes men under stress. By the end of the book Guy, "was back after less than two years pilgrimage in a Holy Land of illusion in the old ambiguous world".

In *Unconditional Surrender* the gloom is even deeper, as Guy grows more depressed in his search for something of positive value which he can do. Finally two chances come, and he takes them resignedly if not eagerly; the end is totally unexpected: a common occurence in Waughs books.

Sword of Honour has been much praised, and rightly so, by the critics. It presents an observant and accurate picture of the futilities and wastes of war, and a wickedly funny one of Army life with its many amateur, temporary officers and realistic men, and a sensitive portrait of a thoughtful and upright man, who lose many things in the war, but not his integrity. Admirers of Evelyn Waugh will find all his customary merciless wit and brilliant conversation, coupled with a depth of compassion he does not usually allow his readers to see. Definitely a must for his fans.

Phyllis Pennington

Three Singles to Adventure, by Gerald Durrell. Penguin. Price 3s. 6d.

A Zoo in My Luggage, by Gerald Durrell. Penguin. Price 3s. 6d.

Gerald Durrell's adventurous spirit has led him into a great many unusual and intriguing situations, and he derives the maximum enjoyment from them. Since in addition he is a master of clear and humorous narrative, it is small wonder that his books are best-sellers. These two are old favourites, now republished in Penguins, together with a third, *The Whispering Land*.

The prospect of starting his 1950 expedition to British Guiana in a place called Adventure was irresistible, but finding that he and his companions could get there by the mere act of taking three Singles (first class) by train and steamer from Georgetown, he began to have misgivings as to its suitability as a base from which to collect wild animals. His fears were amply allayed. They were to have many hair-raising (and often wildly funny) experiences in that wet, remote and overgrown land, and securing the animals proved an easier problem than keeping them safe and well once caught.

If you are acting as father, mother, food provider and danger eradicator to an animal half a year is enough to build up a very real friendship with it. He found that the hardest part of his expeditions was handing the animals over to the various zoos at the finish, at a time when they had begun to behave naturally in his presence and when he would have been in a unique position to study their habits. So he decided to found his own zoo of small rare animals which he could observe at leisure. Undeterred by the foreseeable embarrassment of having nowhere to put a zoo when they had one, he and his wife set off for the British Cameroons to collect its founder members. This is how they came to have a zoo in their luggage.

The book is a lively account of their expedition and of the great characters, animal and human, whom they met, including their host, the illustrious Fon of Bafut. Back at home they faced a formidable housing problem!

Both these entertaining books are beautifully illustrated with drawings by Ralph Thompson.

Catherine Stockton

The Pumpkin Eater, by Penelope Mortimer. Penguin. Price 3s. 6d.

In an entertaining book, Mrs. Mortimer takes us into the life of a woman, whose fourth marriage is beginning to break up. The stresses through which this woman passes are simply and clearly described. Sudden wealth and other women, combine to take her many children and husband from her, leaving her in a state of complete uselessness. All her fears and resultant feelings of inadequacy, are admirably presented. I enjoyed this book very much. A successful film of the story has been made by Columbia, starring Anne Bancroft, Peter Finch, and James Mason.

R.L.Cooper.

Sex in Society, by Alex Comfort. Pelican. Price 3s. 6d.

When this book first appeared over a decade ago it must have caused a stir. A bold and progressive attitude is still disconcertingly apparent in the present edition. The author is an ardent 'anti' thinker, and right from the start he proceeds to attack successively the attitudes of the Church, the Law, and most unforgiveable of all, the idea of monogamous marriage. He believes that the rather unsatisfactory state of sex in modern society is initiated by the Church, nurtured by society, and enforced by the Law. Monogamy is wholly unsatisfactory for a large number of individuals: one should either keep a mistress, or indulge in the services of ladies of easy virtue. Chastity and abstinence likewise are of no benefit whatever, and everyone should have a taste of promiscuous honey. Finally, in tune with this materialistic attitude, the author suggests that the answer to all these problems is the 'perfect contraceptive'; not only could one then indulge in premarital sexual practice, but there would be no need to face the consequences of an unwanted pregnancy.

In all fairness, one must respect the author's unorthodox ideas, which he may have overstressed in trying to convince the reader. His liberal outlook would either give support to those who are already promiscuous, or leave others who choose to remain chaste cold; meanwhile those already in doubt would continue to remain in agonising uncertainty.

B.L.

An American Romance, by Hans Koningsberger. Penguin. Price 3s. 6d.

A Long and Happy Life, by Reynolds Price. Penguin, Price 3s. 6d.

If sex, illicit love-making or abortion is what one looks for in a novel, *An American Romance* is certain to provide it. The story begins when Philip and Ann meet in New York and proceed immediately to bed. They both have affairs with people whom they meet in parties, and the climax is reached when Ann has to have a therapeutic abortion. The story is rather lacking in humour although the English is readable. The author is obviously familiar with Laclos's *Les Liaisons Dangereuses;* but whereas in the French book there is a complete understanding between husband and wife, and they treat the idea of having affairs as a bit of a joke the two characters in this book seem to have little notion of what they are up to. Being confined to the bedroom all the time makes the atmosphere rather stifling, and one is constantly screaming out for something interesting to happen. Surely one does not have to cross the Atlantic to find this kind of romance.

A Long and Happy Life by another American author, is claimed to be the first novel of a major novelist. There are signs that this may be true. The story concerns the innocent love of two country youths and develops in the course of the book into a deep understanding between two mature adults. Within this framework the author paints a sympathetic account of country life in North Carolina during the Great Depression; parts of this are very amusing. The material is rather thin, but certainly the book is not too long. The author uses a lot of slang, but it may be flattering to know that he wrote this novel during his stay in Oxford, and this may have some influence on the fluency of his writing. One hopes the author will widen his scope in his future novels.

B.L.

Position at Noon, by Eric Linklater. Penguin. Price 4s. 6d.

Position at Noon tells a series of stories about the successive male members of the Vanbrugh family. The episodes are narrated in reverse order, and are linked by the device of having each Vanbrugh blame his father for his own shortcomings. Mr. Linklater is obviously not interested in exploring the implications of determinism. The stories must stand or fall on their capacity to entertain, but they seemed to me to be using up leftover ideas mixed with rather obvious historical events and personages. The First World War, Darwinism, and the American War of Independence all appear: so do Messrs Coleridge, Wordsworth, and William Pitt! The characters are rather obviously contrasted and only one or two seemed alive. Of course, there is plenty of Mr. Linklater's "irreverent fun," and if you like hearing the most recent member of the family contemplating his wife about to "Litter ..... pups that will be Vanbrugh's" then you may enjoy Mr. Linklater's approach.

J.B.

OTHER REVIEWS

The Scientific Basis of Medicine Reviews 1964 British Postgraduate Medical Federation. Athlone Press. Price 40s.

The first M.B. drives out the causes of the Indian Mutiny, clinical studies drive out the formulæ of Physics, and the maintenance of a general practice drives out the classification of cerebral tumours. All this is acceptable if Sherlock Holmes was right, as one suspects he probably was, in likening human memory to an attic of finite size. Less acceptable is a frequent accompanying process of active rejection. The general practitioner refuses to be interested in pathology, the specialist yawns to contemplate other specialties, the medical scientist doesn't know where the operating theatre is. Prison house shades close exceeding fast and the attic is shrunk before symptoms commence. It soon fails to hold its proper complement and the doctor can't think what the world is coming to.

Prophylaxis though a bit of a bore—all those injections and things—is reputedly superior to therapy. Reading books like this will certainly keep your attic sound and prevent shrinkage. The reviewer, a clinician, prefers therapy, prophylaxis representing to him a sort of trade boycott; reading this book proved highly therapeutic to him, intellectual sloth being speedily destroyed.

It consists of twenty essays based on lectures given during 1962 under the auspices of the Postgraduate Medical Federation, and these deal with many things; phosphates, molecules, isoenzymes, neurophysiology, thrombosis, high altitude, adrenal cortex, thymus, immunology, viruses, penicillin, genes, new tracer methods, body fluids, bone, cabbages and kings. Try it. It is good.

H.W.B.

A Practical Introduction to Psychiatry, by C. M. B. Pare, M.D., M.R.C.P., D.P.M. J. & A. Churchill Ltd. Price 25s.

This is a brisk, readable and clear-cut summary of the most prevalent ideas in this country on its subject. It is written very much from the standpoint of the Maudsley school, which is all to the good for students contemplating finals in which they will no doubt encounter examiners of the same persuasion. From its chosen limits of description, classification, scientific evaluation of mental illnesses in terms of genetics, heredity, biochemistry and other suitably quantitative methods of assessment, Dr. Pare does not stray. It is very much to be hoped that the students for whom he writes will be a little more venturesome in the reading with which he acknowledges they should supplement the rather arid pastures on which he leads them to graze. Most of all, if they intend to go into general practice, they will lack any feeling for the mental patient as a human being. The neurotic who frequents their surgery will have her history punctiliously taken, even an hour (!) being devoted to this task, but she will then be expected to benefit from explanations and the tricky task of selecting the various pills that allay her symptoms. Brief insight-therapy is fleetingly mentioned, less deprecatingly than psycho-analysis, but how shall the doctor give insight to his patient, lacking it himself?

There is a sad emptiness in the chapters on the personality disorders, the affective psychoses, schizophrenia, and child psychiatry. Something is missing, or rather someone: the patient seen as a person and not as an awkward conglomeration of genes and personality factors. The framework that Dr. Pare presents is firmly outlined, it deserves a more worthy tenant to dwell in it.

F.R.C.C.

Psychiatric Education, by D. L. Davies and M. Shepherd. London: Pitman Medical Publishing Co. 1964. 129pp.

This book is a report of a symposium held in March, 1963 at the Maudsley Hospital and attended by some eighty persons, mainly psychiatrists but also general physicians, general practitioners, educationists and others.

The subject matter of the symposium was extensive and comprehensive. An excellent survey of the background and history of psychiatric education was given by Sir Aubrey Lewis and informative accounts given of undergraduate preclinical and clinical education, postgraduate education of the newly qualified doctor, the trainee specialist in psychiatry and the general practitioner.

Regarding undergraduate training there was general agreement,

(1) that psychology should be taught in the preclinical period and that more was needed,

(2) that there should be compulsory clinical clerkship in psychiatry,

(3) that there should be professional psychiatric units in all undergraduate schools,

(4) that there should be more association between psychiatry, general medicine, pædiatrics and neurology,

(5) that psychiatry should be represented in medical examinations.

The final chapter of the book is an excellent general review with an assessment of future needs by Shepherd.

This book can be recommended to everyone interested in undergraduate or postgraduate psychiatric education.

W.L.R.

Diseases of the Liver and Biliary System, by Sheila Sherlock, 3rd edition, 1963. 714 pp. Blackwell Scientific Publications, Oxford. Price 70s.

In the preface to the first edition, 1955, of this remarkable and brilliant book, the authoress said that her aim was to present a comprehensive and up-to-date account of diseases of the liver and biliary system which was designed for physicians, surgeons and pathologists and also a reference book for the clinical student. Not only did she succeed in this aim then, but has done so again eight years later. This third edition remains in the spearhead of advance of its subject. Yet, in spite of its clarity and complete coverage of the subject it has not increased in size. New facts, as the authoress remarks, usually clarify a situation and make previously obscure points redundant. This is true if most careful pruning of the text is done. It has been here and, in spite of the addition of so much new knowledge, the third edition instead of being longer is a few pages shorter than the second edition. It contains 30 chapters illustrated by 235 pictures and diagrams, 83 of which are new to the present edition and 35 tables which clearly set out classifications, differential points in diagnosis and summaries of treatment. It should also be remarked that out of just over 1,900 references on various aspects approximately 1,000 of these are important new references from the world's literature in this third edition.

Among the newer aspects considered the following are some examples. Serum enzymes which are replacing serum flocculation tests as aids to diagnosis and prognosis are described. The diagnosis of space occupying lesions of the liver by radio-isotopic scintillation scanning is discussed. The indications for such tests as percutaneous cholangiography and aspiration liver biopsy are clearly given. The great value to research of electron microscopy is shown. Modern views on the formation of bile and the mechanisms leading to jaundice are set out. Because an increasing number of drugs are known to be toxic to the liver, a new chapter on liver damage induced by drugs has been written and the various types of cholestasis are considered. The enzyme deficiencies causing neonatal jaundice and the active cirrhosis of young people and its relation to disturbed immunity and to virus hepatitis are discussed. Important new views on hæmochromatosis are given and advances in knowledge of portal cirrhosis including the newly recognised complications of portocaval anastamosis are described.

This book, written by one who has international fame in her knowledge of hepatic disease is completely up-to-date. This most readable work, which contains such a mass of facts is a model of precision. For example, treatment, though considered in detail, is clearly and concisely set forth. This wonderful book is a *sine qua non* for those interested in diseases of the liver and biliary system.

E.R.C.

Pathology, by J. L. Pinniger, M.A., D.M.F.R.C.P. Concise Medical Textbooks. Baillière, Tindall & Cox. 262pp. 15s.

This book is a welcome addition to the New Concise Medical Text books series. Dr. Pinniger provides a book which is extremely easy to read, clearly written and well laid out. The amount of pathology however is barely enough even for an introduction to the subject, considering the amount of pathology it is now necessary for the medical student to assimilate. This is especially the case in the second part of the book, which deals with systemic pathology. Only the most important diseases in each system are dealt with and even then rather meagrely. The first part, however, provides an excellent introduction to the subject and can be recommended to the student at the outset of his clinical career. Finalists too, reading the book will find that it brings pathology together as a whole besides being useful for revision.

In summary, this book does not set out to do any more than it claims to. In this way it provides a readable, completely concise and yet inexpensive book for the pocket. It can be recommended as an excellent introduction and a quick revision of pathology for the medical student.

I.E.C.

A Synopsis of Surgery, edited by L. T. Cotton, M.A., M.Ch., F.R.C.S. John Wright & Sons Ltd., Bristol.

With ever increasing knowledge and the rapid dating of books, sometimes only shortly after publication, few students have either the time or the inclination to read through big textbooks. The synopsis has tended as a result to come into its own. "A Synopsis of Surgery" was one of the earliest of such books to come from the medical publishers, the first edition appearing in 1908. The latest edition, the sixteenth, has been revised and sixteen chapters completely rewritten.

The book is filled from beginning to end with facts in the form of short paragraphs and headings. As such it is not particularly easy reading. However the qualities of the book lie precisely in its short and concise method of dealing with each subject. Topics are all treated in a like manner with enough information concerning symptoms, signs, surgical technique and where necessary anatomy and pathology, to suit even the most critical of readers. This book is one which is of particular appeal to the student for quick reference purposes and when facts are required prior to examinations.

P.M.

The Deaf Child, by Edith Whetnall, M.S., F.R.C.S. and D. B. Fry, Ph.D. 237pp. Published by William Heinemann Medical Books Limited, London. Price 42s.

This Monograph by Miss Edith Whetnall, Director of the Unit, and Professor Fry, Professor of Experimental Phonetics in London University, is based on the principles and practice of the Audiology Unit of the Royal National Throat, Nose and Ear Hospital. Few will cavil with the stress laid upon the importance of early diagnosis, and upon the auditory approach to the training of deaf children. In addition, the necessity for close and continued team-work between Otologist, Pædiatrician, Teacher of the Deaf and, above all, the mother is wisely emphasized if the ultimate aim of admitting the deaf Child to a normal school is to be achieved. All these points are soundly made, albeit at the cost of considerable repetition, and the text is well-illustrated and backed by an extensive bibliography.

Inevitably, this book must be of limited appeal. It could be read with profit by anyone taking up Audiology for the reasons adumbrated above, but for those already in this field it postulates little that is fresh either in ideas or research. Admittedly, two chapters concerning the mechanism and reception of speech make fascinating reading, but much of the writing is dogmatic and insufficiently objective. For example, in the light of recent prospective studies not everyone will agree with the statement that:— "When a woman develops rubella during the first three months of pregnancy there appears to be no reasonable alternative to abortion". Whilst to classify glandular fever and beri-beri as cause of deafness on the strength of two cases and one case, respectively, is sadly unscientific.

In the preface, the authors express the hope that:— "Even medical students may find the time in their crowded curriculum to learn about that frequently neglected patient—the Deaf Child."

The urgent needs of the Deaf Child—his isolation and frustration—should be an integral part of undergraduate teaching; but it will be the exceptional student who finds the time and summons the energy to finish this book, for it lacks the readability of, say, Ballantyne's "Deafness".

G. S. U.

SPORTS NEWS

AUGUST CALENDAR

CRICKET—SUSSEX TOUR

Sunday August 2nd
Cricket v Ferring 2.30
Monday August 3rd
Cricket v St. Andrews 11.30
Tuesday August 4th
Cricket v Rottingdean 11.30
Wednesday August 5th
Cricket v Ditchling 2.30
Thursday August 6th
Cricket v Barcomb 11.30
Friday August 7th
Cricket v Seaford Seagulls 2.00

ESSEX TOUR

Saturday August 15th
Cricket v Claverine 2.30
Sunday August 16th
Cricket v Arkesden 2.30
Sunday August 23rd
Cricket v Hill End 2.30
Thursday August 13th
Swimming—Triangular Match v O. Fulverious and O.M.T. Watford 7.30

BOAT CLUB REPORT

The United Hospitals Bumping Races were early this year, on May 5th, 6th and 7th. This gave us basically three rowing days in which to select and prepare crews. Changes were made to the 1st, 2nd and Novice eights of the previous term and the crews did not have enough time to settle down properly before racing. The 1st eight had its first practice outing on April 23rd, and from then on went out nearly every day. However, the crew was not fixed until April 29th, and Chris Hudson, who coached us during this period, had the task of producing a racing crew in a very short time. The 2nd and Novice eights also started training but were unable to fit in many outings before the Bumps. The Rugger eight practiced twice.

The U.H. Bumps

We entered six eights. The 1st and 2nd eights, two Gentlemen's eights, the Novice eight and the Rugger eight, in that order. The Gentlemen's eight did not practice beforehand.

1st VIII—On the first day we had a poor start aggravated by the wash of a pleasure steamer and a gun which went off three seconds early. From the start St. Mary's went away from us, but not for long, and soon we began slowly to gain on them. Then at about half way we received the signal that we were only one length away from them. At this the rowing took new life and we began to gain rapidly on them; we continued to do so right to the finish and when we crossed the line we were only three feet short of them. This was, and regrettably still is, the nearest we have been to them for some years. The rowing over the second half of the course was the best we had done, and we had high hopes for the second day, but the pattern of the first day's race was repeated and we were one-third of a length short at the finish. On the third day we had expected to come to grips with St. Mary's in the second half as before, but to our surprise, helped by a perfect push out, we went up on them fast from the start. We closed the gap to one-third of a length in the first minute and a half, so we went for a quick bump, rather than trying to settle to a stride, but we failed to bump them and after about two minutes St. Mary's went away from us again and went up on St. Thomas'. We were never troubled by Guy's who were behind us.

2nd VIII On the first day the 2nd VIII were also caught by the wash of the pleasure steamer, which they had to pass on the opposite side of the river to the crew ahead of them. They did not make a bump, and on the second day they were bumped by the Royal Vet. College who are working their way steadily up to their rightful position in the top few crews. On the third day the 2nd VIII again rowed over having held off St. Thomas' 2nd with some determined rowing and skilful coxing.

Of the other crews the 3rd VIII bumped Westminster while the 5th VIII bumped the 4th VIII, having bumped St. Thomas' 4th. The Rugger VIII bumped St. Thomas' 5th.

Overall Barts did quite satisfactorily. We entered more boats than any other hospital; most proved themselves to be superior to their opposite numbers, and we are now the only hospital to have three eights in the 1st division.

We are grateful to the coaches and to the team of Pushers out, some of whom now have some years of experience, who came down daily and waded waist deep in the Thames.

Crews

1st VIII—Bow M. Simmons, 2 M. Keighley, 3 J. K. Anderson, 4 W. P. Garson, 5 D. C. Parr, 6 A. N. Crowther, 7 H. C. C. Coleridge, Stroke A. B. Ayers, Cox D. A. Robinson.

2nd VIII—Bow R. Clayton, 2 J. Tricker, 3 J. Wright, 4 J. Merrill, 5 R. Boston, 6 O. J. A. Gilmore, 7 C. Sykes, Stroke C. R. S. Anderson, Cox J. Tudor.

3rd VIII—Bow A. Nicola, 2 C. Clarke, 3 A. Kirby, 4 P. Needham, 5 R. Husband, 6 D. V. Jones, 7 D. A. Lloyd, Stroke D. Macfarlane, Cox R. Weller.

4th VIII Bow K. Gilsenan, 2 C. Church, 3 J. R. Swain, 4 R. Morris, 5 P. B. Hoole, 6 P. J. Dady, 7 G. D. Bell, Stroke M. Hinds-Howell, Cox P. S. Crawley.

5th VIII—Bow C. R. Tait, 2 D. Fairbank, 3 R. Whitelocke, 4 A. H. Roderick, 5 J. G. D. Baker, 6 J. S. Lilleyman, 7 P. Cheetham, Stroke R. Franks, Cox J. Tudor.

6th VIII—Bow N. Griffiths, 2 P. Savage, 3 D. Chesney, 4 D. Goodall, 5 C. J. Smart, 6 J. A. Gibson, 7 S. Harris, Stroke T. M. Bucknill, Cox B. Watson.

Pushers out—M. Whittaker, I. R. Gibbs, I. Nicolson, C. Bartlett, I. Matheson, S. Phillips, M. E. Rimmer, G. R. Hamilton.

CRICKET CLUB

v. Queens' College, Cambridge. Won by 5 wkts.

We fielded first on a very wet wicket, the bowling in the main was steady, and we managed to keep the runs down so that Queens' were all out for 174. Our batting got away to a poor start and we were soon 10 for 2. However J. Gately batted well, if slowly, to steady the situation while N. Griffiths and D. Delaney both batted admirably and we finished 176 for 5.

N. Griffiths 2 for 11, J. R. Harrison 5 for 69. D. Delaney 71, N. Griffiths 54, J. Gately 24,

v. Parkfield. Abandoned.

Bart's batted quite well, but slowly to start the game. Thomas and Jeffries scored the majority of the runs and we eventually declared at 138 for 8 leaving Parkfield an even number of minutes for the runs. Before the rains came down 35 minutes before the close Parkfield were in dire straits at 30 for 5!

C. P. Vartan 3 for 3. R. S. A. Thomas 38, R. Jeffries 48.

Hospital Cup Match v. London Hospital. Lost by 45 runs.

Bart's elected to field first on a wicket which had the promise of early life and justified this for the London were soon struggling with the score 33 for 3. Then Bart's quietly began to throw the match away by dropping catches, some of them difficult, some easy. We dropped Wilkinson—who scored 93, twice and Dunn escaped three times during his 47. Despite this we bowled them out for 207.

Our batting was disappointing because nobody showed their capabilities. Although the earlier batsmen all looked to be settling down, they made mistakes and never got away with them as the fielding was commendable.

Bowling	Overs	Mdns.	Runs	Wkts.	Avg.
P. E. Savage ...	18	3	50	4	12.5
C. P. Vartan ...	19	3	48	2	24
J. R. Harrison ...	18	5	49	3	16.3
N. Griffiths ...	14	2	49	1	49

Batting

N. Offen, b McPhearson	8
J. Gately, c Keating, b Wilkinson ...	14
R. S. A. Thomas, b McPhearson	13
N. Griffiths, c & b Cosgrove	17
R. Jeffries, c & b Cosgrove	17
D. Delaney, c Bourke, b Cosgrove ...	28
C. P. Vartan, c Smith, b Cosgrove ...	6
R. Wood, b McClure	22
R. Higgs, c McPhearson, b Cosgrove	18
P. E. Savage, b Smith	5
J. R. Harrison, not out	4
Extras	10
Total	162

v. Horlick's. Won by 144 runs.

Bart's batted first, and as if mourning the cup match, declared at 216 for 2. R. Higgs 36, J. Gately 50, D. Husband 96 n.o., H. Phillips 29 n.o. We bowled them out for 72, D. Husband doing most of the damage by taking 4 for 15, N. Griffiths 3 for 22. It was a good spinner's day—underlining in fact the need for more spinners to strengthen our bowling.

v. Jester's C.C. Drawn.

Bart's batted first again, and soon settled into an easy scoring rate, the opening partnership of Gately and Offen taking the score to 51 before Offen was run out. Almost immediately we were 51 for 2, then 66 for 6! Nobody shone at all until J. R. Harrison came in at No. 9 and smote 24 off one over, including a 6. He finished with a score of 26 and Barts were all out for 128.

The Jesters had plenty of time to make the runs but they started too slowly and we kept them suppressed so that after an exciting finish they were left at 118 for 6, just 10 runs short. However, Bart's could have turned this into victory when the score stood at 60 for 6, by again holding their catches.

v. Old Roans. Drawn.

The Old Roans elected to bat first, and although very slow before lunch they speeded up a little afterwards, eventually declaring at 203 for 7. Our bowling was rather ineffectual although P. Savage rejoiced in the hard wicket and took 4 for 38.

We batted badly to start off with, wickets falling at 1 for 2, 2 for 3, 3 for 8, 4 for 35, 5 for 39, 6 for 85. W. Pagan steadied the batting scoring 28 and C.P. Vartan 58 not out and H. Phillips 30 not out, played out the remaining time. We were 150 for 6 at the close of play.

6-a-Sides.

Once again a very good day was had by all, with a record number of entrants—fourteen in all including two nurses teams and a baseball team from the colonies, who did not do too well by throwing their bats away after striking!

The logical team to win, by reason of the greatest number of cricket players, managed to do so, a retention of the title by the Introductory Course. They beat the first time Clerks and Dressers in the final at about 8.30 p.m.

In the evening there was a very good hop and quite possibly a record number of nurses arrived to be entertained. After the band had been persuaded to play for a little longer, and the coach driver had been pacified the hop ended at midnight.

TENNIS CLUB

Oxford Tour. May 30-31.

The tennis was rather spoiled by the weather on this weekend. Saturday's match against St. Edmund's Hall was a 5-2 victory for Bart's but it was ended prematurely in a soaking thunderstorm. As usual the team dined well in the evening. Sunday the rain just came down in buckets, but the disappointment at missing out on the tennis was more than adequately replaced by some fine hospitality in a superbly well-equipped teacher's training college. Culham College challenged us to six-a-side basket ball and after 45 minutes of effort they won by 44-40. This and some antics on a large trampolin did us much more good than any game of tennis.

Cambridge Tour June 10-13

This year seven people were able to enjoy some tennis on the best College courts in Cambridge under brilliant sunshine. The weather was really fine until the Saturday when Queen's match had to be cancelled on account of rain.

The tour began at Pembroke, a new fixture, where we beat the opposition by five matches to four. The courts were exposed to strong winds but the pairs did well to master conditions and Farrow and Nicoll distinguished themselves. Against Clare we lost 6-3. This has always been the most enjoyable match as their courts are perfection. Their team had three even, fairly strong pairs, who were too good for the second and third couples and thus it was the day of the first pair, Edelston and Fryer who came through unscathed. As usual, Clare entertained us well in their crypt bar and later we adjourned to the Turks Head to complete the day.

Caius' match started well with all the first round matches in our favour. The day was the hottest of the summer and with golf that morning we all felt sun-soaked by the end. The final result was 6-3 to Bart's.

The team is through to the semi-final of the Cup Match after a walk over against St. Thomas'.

GOLF CLUB

v. Middlesex Hospital. Lost 2-3. Chislehurst.

This was played on a sunny afternoon at the end of April. All the matches were close and it was pleasing to see J. Saddler win in his first match.

Team: Atkinson, Bowen, Weston-Burt, Begent, Saddler.

v. Staff. Lost 11-7. Denham.

Our annual fixture at Denham against the staff team, organised by Dr. Hayward, was a great success. The weather was good but many balls were lost in the rough just off the fairways.

The staff won overall despite being beaten in the evening foursomes, as their victory in the afternoon singles had given them an impregnable lead.

v. Mr. Hankey's Team. Won 5-3. Tandridge.

This is a 36 hole foursomes match, to which Mr. Hankey invites a team of six Bart's students

plus Mr. Robinson and Dr. Borrie, to play a team from his club. In the morning, under brilliant sunshine, the four matches finished 2-2. A thunderstorm broke out in the afternoon and play was very wet to say the least. Bart's won 3-1 in the afternoon. Our very grateful thanks go to Mr. Henkey for an excellent day's entertainment.

Team: Mr. Robinson and Dr. Borrie, Atkinson and Bowen, Stephenson and Thomas, Vartan and Weston-Burt.

v. Chislehurst G.C. Won 6-4. Chislehurst.

This is a new fixture instituted by our home club and they entertained us excellently. The Bart's winners were Atkinson, Bowen, Dr. Bevan-Jones and Harrison. Our thanks to Dr. Kellsey Fry for organising the evening.

Team: Dr. Bevan-Jones, Atkinson, Bowen, Stephenson, Vartan, Saddler, Hares, Weston-Burt, Downham, Harrison.

Cup Match v. London Hospital. Won 4-1 Blackheath.

This match was played in brilliant sunshine over Royal Blackheath. London put us out of the cup last year and it was pleasing to take revenge and go through to the semi-final. Winners were Bowen, Thomas, Weston-Burt and Miss Carol Cupitt. The other member was Atkinson.

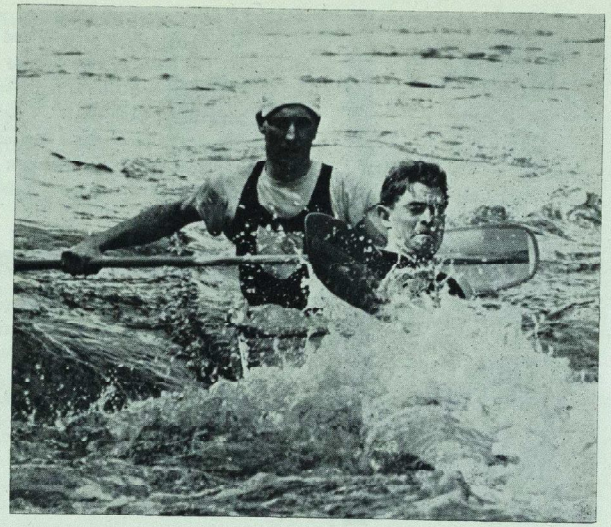
CANOE CLUB

Bedford Race.

This is over seventeen miles of winding river with six portages, three of which can be avoided by shooting through locks where the gates have degenerated. The Bart's pair had an easy race and won in a new record time of 1 hour 59 minutes.

Welsh Harp.

This is the last sprint regatta of the season, 1,000 metres, paddled this year into a stiff headwind. C. Evans and B. Watkins paddled badly in the paired event to take third place. In the singles race C. Evans disappointed his supporters by coming second after having a good lead.



C. Evans and B. Watkins in trouble.
Photo by Aqua Photo Publicity

National Championships.

The singles 10,000 metre race was paddled this year at Worcester. C. Evans was hardly in peak condition and under the circumstances did well to take second place.

In the long distance race the next day C. Evans and B. Watkins went off at the start at a fast rate and paddled through a heavy and spectacular thunderstorm to cover the 19 miles and two perilous portages in 2 hours 2 minutes 12 seconds, to come first in a new course record time.

International Long Distance Race.

This was held at Bradford upon Avon and the Bart's pair were divided up. C. Evans with his partner came second overall whilst B. Watkins was first in his own class.

Chelmsford Long Distance Race.

In this race C. Evans and B. Watkins were together again and succeeded in winning the race in a time eleven minutes quicker than last year under similar conditions.

It is pleasing to report that C. Evans and B. Watkins have been selected to represent Britain in the 28th Descensio Internationale del Sella, which takes place in the Asturias, North Spain on the 8th August. Last year they were the second string crew and came 30th out of 140 and hope this year to do better. No British crew has ever won this exciting race so success would be all the sweeter.

SWIMMING CLUB

King's College Hospital. Water polo Knock-out. Runners up.

This was a very pleasant competition which Bart's thought they had wrapped up when they beat Charing Cross 4-0 and Westminster 5-0. Unfortunately King's produced a very strong team in the final and we never recovered from the shock, losing 4-0. Britton scored five of the nine goals which surprised him more than anyone and the Bart's tactics were very commendable until the final when they went to pieces.

Team: Britton (Capt.), Lask, Clarke, Hanley, Blackburne, Gibbs.

v. Old Citizens and St. Mary's. Lost.

As most of our first string team were away doing midwifery we invited some newcomers to swim in this match and despite some good individual efforts we never made any impression on the much superior St. Mary's or our hosts the Old Citizens.

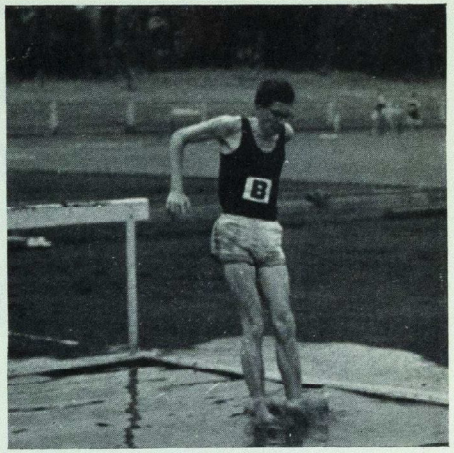
Team: Britton (Capt.), Shorey, Quinn, Blackburne, Boston, Rimmer, Castleden.

ATHLETIC CLUB

End of Season Report

The last two meetings of the Athletic Club were against the Westminster Bank and the United Hospitals Championships.

Against Westminster Bank, we were narrowly beaten on the track, but, due to a good turn out in the field events we won the match.



Terry Foxton taking the plunge.

In the United Hospitals Championships we retained third position which was the same as last year. Many of our points were won by T. Foxton, who came second in three events, and D. Tunstall-Pedoe, who came first in the one mile, and second in the half-mile.

Brian Scott, our London University Hurdler, was unfortunately in Hospital for the Championships and thus unable to lift us up into second place over St. Mary's Hospital.

Dr. Dormer performed valiantly in the Consultant 100 yards event, despite a cruel handicap, which left him back marker by not a few yards.

In retrospect, this season has been very enjoyable, and, atheletically, fairly successful since we beat Goldsmith's College and Westminster Bank, both of whom are usually fairly strong. We had our first tour to Cambridge, which was, I hope, enjoyed by all those who went and well worth repeating. Sports Day went very well, with wonderful weather, but poor attendance. The U.H. Championships were a slight disappointment, as we had hoped for better results from our sprinters.

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 .....shillings .....pence (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.

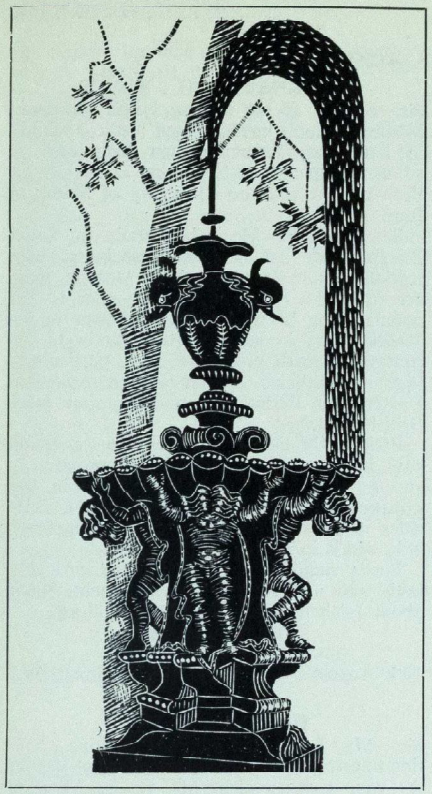
..... (name and qualifications)
(BLOCK CAPITALS)

....
(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.



CONTENTS

EDITORIAL

The untroubled peace of midsummer life at Bart's has been disturbed recently by news from an unexpected quarter. This news concerned the wife of one of the clinical students at this Hospital. This lady had an appointment at an Out Patient Clinic at Bart's. She arrived in good time for the appointment and was taken to the clinic by her husband who introduced her to the sister in charge. The patient then waited two and a half hours before being seen. When finally she was seen she was examined by a student.

If we examine this case critically we can see that two principles are involved. The first is that no patient who has an appointment for a definite time at a clinic should be kept waiting for anything approaching two and a half hours. The second matter is whether or not the wife of a student ought to be examined by another student.

As to the first point, it has long been evident that the present Out Patient system is in need of an overhaul. Any monopoly system has the consumer at its mercy and is inclined to ignore to too great an extent, the convenience of any besides itself. An arrangement, such as the present one, which is capable of producing an error of two and a half hours must be revised. A system involving exact appointment times would be well nigh impossible to keep to strictly at a busy hospital; however, at the