in April. This team has already put in many hours of hard training.

The fixtures are well planned, building up in competitive strength to the United Hospital Championships in early June. Apart from the regular fixtures, new ground will be broken, as well as records we hope, against Eton College, Metropolitan Police and Pearl Assurance.

The shadow of Tokio has led to the organisation of an Inter-Hospital relay meeting. The Bart's 4 x 440 team should produce a good performance in this much glamourised event, thanks to Brightwell et al.

Any freshers keen in athletics, no matter what standard will be most welcome, and female students and nurses are needed since some meetings have been arranged for female athletes. All those interested should contact the Secretary.

D. J. Coltart.

SOCCER

During February the Soccer Club has suffered badly from injuries, postponement of matches and 2nd M.B. At the beginning of the month Bart's lost to **West Ham College,** the University League leaders. Playing with a very strong wind in the first half West Ham soon had the advantage and eventually won **4-1,** a goal by Thew being the only consolation in a miserable game. This game contrasted sharply with the match the following week v. **St. George's.** In this match a much-weakened Bart's team with Rawlinson injured in the first-half managed to hold St. George's to a **0-0 draw.** Bart's not only defended excellently but also attacked with energy and even had the ball in the George's net only to be given off-side. Substitutes Jeffries and Pemberton played far beyond themselves, and everyone enjoyed the game.

The Oxford Tour

This tour was a success socially and on the field, though the injuries incurred (on the field) were phenomenal. In the first game against **Worcester College** Bart's eventually **won 5-4,** this was remarkable since Higgs in goal was injured in the first 30 minutes and Rawlinson was off the field for the last 20 minutes. Offen and Herbert scored two goals each and Vartan added one more.

The other game **v. Lincoln College,** an **8-1 win** for Bart's, was not distinguished except for the unbelievably bad pitch and ball. Jeffries and Pemberton again played extremely well and "Fireman" Vartan netted four goals. But this tour will be remembered for its potted plants, fire extinguishers and "the little man in the strange hat."

Meanwhile, back in the University League a ten-man Bart's team beat the **Institute of Education 3-0** at home. Two unbelievable goals by Vartan and one from Herbert brought promotion a little nearer. Bart's are now lying second to West Ham College and it seems that only 2nd M.B. can come between us and a higher standard of football next season.

Players: Layton-Smith, Higgs, Rawlinson, McGechie, Offen (Capt.), Raine, Turner, Fryer, Pemberton, Sutton, Herbert, Vartan, Thew, Dorritt, Mumford, Jeffries, Mitchell.

D. McG.

GOLF

The season opened this year with a new fixture on **February 10th** against **Bristol University** who came to Chislehurst.

Teams of six played singles in the afternoon and Bristol showed their superiority by beating us 4-2. Our winners were Saddler and Booth.

Team: Atkinson, Bowen, Vartan, Weston-Burt, Saddler, Booth.

R.E.A.

WATER POLO

This term has been one of the more successful of recent seasons and certainly the most enjoyable, the reason being that for the first time in years we have been able to 'field' regularly the same team, all the members of which are extremely enthusiastic.

At present we are **second** in the **University Second Division** and after eight matches have lost only to the College of Estate Management, having scored an average of six goals per match. There are only two experienced players in the side, Britton, who consistently works harder than anyone, and Lask, whilst Coburn and Jolly, both new this year, are well worth their places in any Hospital team. Patterson, on loan from Canada for an indefinite period, has proved invaluable, and Blackburne in goal is completely dependable, the more so when it is realised that he played two matches with an undiagnosed fractured fibula!

The new-found team spirit, which in part is due to our success, must also stem from our strong and regular support for which we are very grateful. The strong colonial flavour in both the team and its supporters makes us look forward to the Annual Tour which this year will be during May, and, it is hoped, will include some matches.

B.D.L.

CONTENTS

EDITORIAL

A new clinical teaching programme is planned for 1967. This will aim, it is said, at supplementing our meagre experience of acute medicine with visits to other hospitals, and at integrating into a rational unit a course which at present is artificially divided into unrelated chunks (Pathology for example will be taught in relation to Medicine and Surgery). That rare specimen the bird of Change, which spends all too long away from our walls, is really on the wing again, and before the winter of tradition drives it away once more, we might try to fasten to its back some even more radical improvements to our teaching system.

There are two ways in particular in which the academic climate of this Hospital could be invigorated. It is an old story to say that small groups or classes are infinitely more profitable than large ones, but has anyone given serious thought to the possibility of an individual tutorial system? The purely academic advantages of a regular meeting with a member of the staff, whether the time be used for essay practice, informal discussion, or prepared topics, are difficult to deny. Furthermore such a system would go a long way to solving the problem of communication between staff and students which was stressed recently in these columns. The only cogent argument against tutorials is the shortage of tutors, and the expense of valuable time on a moronic pupil. But a quick calculation shows that if all members of the staff from consultants to senior housemen were prepared to give just one hour a week, every clinical student could have a tutorial once a fortnight.

There is another benefit which would derive from a tutorial system. At the moment there is nobody to whom a student who wants advice about his career or examinations can go. This is no slight on the Dean and the Sub-Dean: it is quite impracticable for two men to act as general mentors to 300 students. Shall I take Conjoint? How valuable is a house-job at Bart's if I am going into General Practice? What is my best route to a career in Public Health? If I want to increase the breadth of my medical experience shall I do a job in the Bahamas or in Bethnal Green? All these are questions which can be answered only by somebody with some personal knowledge of the questioner. Even if stumped for a straight answer, a tutor would be invaluable as a sounding board.

The second thing which badly needs doing when we change our teaching system is to restrict compulsory attendances to a minimum. It sometimes seems that the primary purpose of the course is to teach us to sign our names (and other people's). Compulsion at this stage

of academic life is not only irritating and unnecessary; it can kill genuine interest in a subject, and it has produced a race of students who brand their fellows as sycophants if they ask intelligent questions and who are ashamed to discuss medical topics amongst themselves. Surely multiple examinations are incentive enough.

A secondary advantage of a mainly voluntary course is that the relative popularity of different teachers soon becomes apparent. A consultant recently said that nobody on the staff at Bart's really knows how much his teaching is appreciated, and that if communications were better in this respect, it would be possible to adjust the teaching programme so as to give more time to the good teacher and less to the bad, who probably hates doing it anyway. Perhaps the Teaching Committee, like all of us, has been too polite. It would be misguided (not just impolite) to mention specific names here, but the standard of teaching in some departments is widely accepted amongst students as being outstanding, and of these the departments of Cardiology, Neurology, Pædiatrics, and Radiology are probably the most popular. The teaching in these departments is good because they aim at teaching not facts but a method of thinking, and the emphasis is on intellectual honesty rather than knowledge.

A high proportion of bad teaching is found in any good academic establishment. People of high academic ability do not usually make the best teachers, and in a teaching hospital the problem is exacerbated since the versatility of the staff must embrace not only academic and teaching ability but also clinical application. Nevertheless much of the bad teaching could be considerably improved by attention to the technique of teaching. Often it is simply a matter of presentation: some people have a way of talking which is enough to send anyone to sleep (even the parish pump—see Dr. George Graham's letter below). And then there is a large group, mostly senior consultants, whose rounds are enormous fun, but contain a minimum of useful teaching. Like Gratiano they speak "an infinite deal of nothing, more than any man in all Venice. His reasons are as two grains of wheat, hid in two bushels of chaff: you shall seek all day ere you find them; and when you have found them, they are not worth the search." Their personality and individuality would hardly suffer from the application of a small amount of teaching method.

LETTERS TO THE EDITOR

G.P.s ARE NOT FOOLS

Sir,—I cannot allow the following sentence in your Editorial of March 1st to go unchallenged.

"There are certainly very few students at this hospital who are still fool enough to want to enter General Practice".

There is no speciality in the whole of medicine which is more satisfying than general practice. To live in a community however big or small and be loved and welcomed into every house in which you enter day after day, year after year is the most rewarding experience anyone can possibly have.

I extend an invitation to the writer of this Editorial to visit Ely, and see a General Practice at first hand. I will gladly pay his fare to prove that one would NOT be a fool to enter General Practice.

Yours etc.,
J. B. Bamford,
24 St. Mary's Street,
8th March. Ely, Cambs.

(The Editor has gratefully accepted the invitation, and will publish an account of his visit. As it happens he himself is 'fool enough' anyway.)

PRIVATE WING AT BART'S

Sir,—There is an increasing demand by patients for care in the Private Wing of a teaching hospital. The cost of this can be covered by an insurance costing less than many of us spend on cigarettes each week.

Time and again I cannot refer to Bart's Consultants as I should prefer, because these facilities do not exist. As a student I thought I was proud that the Hospital had never taken a private patient—I now wonder why.

It is time that the changing face of medicine is recognised and future building planned accordingly.

Yours sincerely,
R. J. Blow,
Rochdale,
17th March. Broomfield Avenue, N.13.

HYPNOTIC LECTURERS

Sir,—Sir Wilmot Herringham—who was Senior Physician—wrote a letter to you in 1919 about Postgraduate Education. He described the lectures at the German and French universities and said, "Both Germans and French, especially the latter, take great pains to learn to lecture. The French certainly have a greater gift of speech than we. But I should like to know how many English have really practised themselves in speaking fluently and with expression. I have heard lecturers in our own School who were not fit to talk to the parish pump. Even it would have gone to sleep—as I always did."

Herringham himself was a very good speaker and lecturer. He had a rich deep voice and always seemed to speak to the men in the back row of the theatre. He had a bad 'needle' beforehand—so he told me—but outwardly always seemed completely at ease. I have slept in innumerable lectures but I never did in his. If I had he might not have appointed me his house physician.

I remain yours sincerely,
George Graham,
49a Acacia Road,
28th March. N.W.8.

UNITED HOSPITALS CHOIR

Sir,—I would be grateful if you could give some publicity to the activities of the United Hospitals Choir.

The Choir is run under the auspices of the L.C.C. Evening Institutes and has a professional conductor and accompanist. Subscription is 32s. 6d. per annum but new members are welcome at any time. There are no auditions, and rehearsals are at St. James's and St. Peter's School, Great Windmill Street, W.1., on Thursdays at 7.30 p.m. Further details may be obtained from the Choir Secretary, Miss F. J. Allatt, 61 Cromwell Road, S.W.7.

Yours faithfully,
Lewis Braithwaite.
15th March. (Publicity Secretary).

Engagements

WATSON—WELLS.—The engagement is announced between Dr. John U. Watson and Maureen Wells.

Births

VISICK.—On March 21, to Joan (née Lister) and Dr. Robert Visick, a son (Howard) brother for Sarah.

Deaths

BOLTON.—On March 8, Alfred O. Bolton, M.R.C.S., L.R.C.P. Qualified 1917.

CONE.—On February 24, Cedric Robson Cone, M.A., B.M., B.Ch. Qualified 1936.

COVENTON.—On February 28, Albert William Duncan Coventon, M.D., F.R.C.S., aged 86. Qualified 1904.

DONELAN.—On March 9, Conor John Donelan, M.B., B.S., M.R.C.S., L.R.C.P., aged 66. Qualified 1922.

HOSKYN.—On March 3, Charles Reginald Hoskyn, O.B.E., A.M., M.D. Qualified 1907.

WAY.—On March 16, Flora Mabel Way, formerly Sister Colston.

Awards

Prof. K. J. FRANKLIN, F.R.S., has been awarded the Osler Medal for 1965 by the University of Oxford.

May Duty Calendar

Sat. & Sun., 1st & 2nd May.
Dr. Black
Mr. Naunton Morgan
Mr. Aston
Dr. Jackson
Mr. Hogg

Sat. & Sun., 8th & 9th May.
Dr. Hayward
Mr. Badenoch
Mr. Manning
Dr. Bowen
Mr. Fuller

Sat. & Sun., 16th & 17th May.
Dr. Spence
Mr. Tuckwell
Mr. Aston
Dr. Ellis
Mr. Cope

Sat. & Sun., 22nd & 23rd May.
Prof. Scowen
Prof. Taylor
Mr. Burrows
Dr. Ballantine
Mr. McNab Jones

Sat. & Sun., 29th & 30th May.
Sir R. Bodley Scott
Mr. Hunt
Mr. Aston
Dr. Jackson
Mr. Hogg

Physician Accoucheur for May is Mr. Beattie.

Obituaries

DR. E. R. CULLINAN

Dr. Edward Revill Cullinan died on 16th March at the age of 63. He was Senior Physician to our hospital for seven years and Physician to the Gordon Hospital and King Edward VII Hospital for Officers: he was also Consulting Physician to the Woolwich Memorial, the Luton & Dunstable and Leatherhead Hospitals. Cullinan was born in 1901 and educated at Downside School, Epsom College and St. Bartholomew's Hospital, from where he qualified M.R.C.S., L.R.C.P. and M.B., B.S. (London) in 1924. Two years later he passed the M.D. and M.R.C.P. (London) and in 1934 was elected F.R.C.P. He was created C.B.E. in 1964. In 1924 he became house-physician to Lord (then Sir Thomas) Horder, later house-surgeon to the Skin and Venereal Disease Deartments, in 1927 chief assistant to Lord Horder and in 1929 Casualty Physician and Senior Demonstrator of Morbid Anatomy. He was elected Assistant Physician to the hospital in 1932. In the same year the Rose research team was formed, with Cullinan as a member, to investigate lymphadenoma under the direction of Dr. Mervyn Gordon, F.R.S., and in 1933 he was awarded the Cattlin Research Fellowship to pursue this work. He became a senior physician in 1946 and was elected to the Board of Governors in 1950.

In 1941 he joined the R.A.M.C. and was sent to Egypt, and later Syria, to be Officer in charge of the Medical Division of a military hospital with the rank of lieutenant-colonel: later he was promoted to Consulting Physician to the East Africa Command with the rank of brigadier. After demobilisation he continued his interest in the Army Medical Services: he was Honorary Consultant in Gastro-enterology to the Army, Consultant Physician to the Royal Hospital, Chelsea, examiner in medicine to the Royal Army Medical College and a member of the Military Advisory Committee of the Army Council. Because of his experience of Africa the Colonial Office on several occasions sent him to make surveys of their medical services there.

He took a great interest in the Royal College of Physicians and was successively Councillor, Bradshaw Lecturer and Senior Censor. At the Royal Society of Medicine he had been President of the Section of Medicine, Editor of the *Proceedings* and a member of Council and of the Finance Committee. He was Lettsomian Lecturer of the Medical Society of London and later its President. He maintained a wide interest in general medicine, but made a special study of gastroenterology, his most important publications having been on hæmatemesis, subacute necrosis of the liver, ulcerative colitis and on an enormous follow up study of infectious hepatitis. He achieved a high reputation as a clinical teacher.

Cullinan's interests apart from medicine were diverse. He was a conjurer of great skill, which gained for him membership of the Magic Circle, a collector of glass and in his younger days a mountaineer and rock-climber. After the war he acquired the ruined lighthouse on Beachy Head and repaired it with the help of his family. He was indeed a most genial and kindly person and a good companion, possessing a lively sense of humour and an almost inexhaustible fund of amusing anecdotes. He will be sadly missed by many.

We extend our deepest sympathy to his wife and family.

A.W.S.

DR. J. V. FIDDIAN

Dr. J. V. Fiddian died in hospital in Lancaster on 16th February, 1965, aged 77. In his active years in Ashton-Under-Lyne he had been a distinguished and widely respected example of that vanished breed, the general practitioner surgeon.

James Victor Fiddian was born in India, where his father was a judge in the Indian Civil Service. For a time he was at school at Wesley College in Melbourne, his mother being Australian, and then he returned to England, where he attended The Leys School. After briefly studying architecture, he proceeded to Emmanuel College, Cambridge, where he completed his preclinical studies and obtained his blue for rugby and for water polo. In both these sports he distinguished himself, being one of the first to introduce the Australian crawl to English swimming, and as a line-out specialist on the rugby field his one-handed grab and his height of six feet four inches brought him a trial for England.

Clinical studies at St. Bartholomew's Hospital were followed by qualification, after which he became House Surgeon to d'Arcy Power. Later he took a trip around the world as a ship's surgeon. The First World War started while he was away and he returned to join the R.A.M.C., in which he served from 1914 to 1919, most of the time in France. He was Regimental Medical Officer to the 11th Battalion of the Suffolk Regiment and later joined a Mobile Surgery Unit. He was in the Battle of the Somme and at Passchendaele.

In 1919 he entered general practice in Ashton-Under-Lyne, Lancashire, and became honorary surgeon to the Infirmary. He was a general surgeon in the old, wider sense and was much respected and admired by his patients and his colleagues. In addition to his hospital work and a busy single-handed practice (until his eldest daughter joined him), he found time to get his golf handicap down to 7 and to become a skilled bridge player.

In 1930 he submitted a thesis on the biology of the cancer cell and proceeded to M.D. His surgical prowess became widely known, and in earlier days he often gave his own spinal or local anaesthetics. On one occasion he successfully carried out a fore-quarter amputation under local and brachial plexus block. He was one of the first surgeons in this country to restart, by massage, a patient's heart after cardiac arrest during operation. The patient made a perfect recovery and the newspapers gave a lot

of space to his account of his meetings with the angels.

His interest in his patients and in his work were maintained at a high level throughout his career and as late as 1949 he published an account of a case in which he performed bilateral embolectomy for simultaneous occlusion of the main arteries in both upper limbs.

He was a man who brought great energy to his work and his leisure. He had a very lively sense of humour.

He leaves a widow, two sons (both in medicine), and three daughters.

R.V.F.

Retirements

CHARLES FELIX HARRIS

Bart's 1918-1965

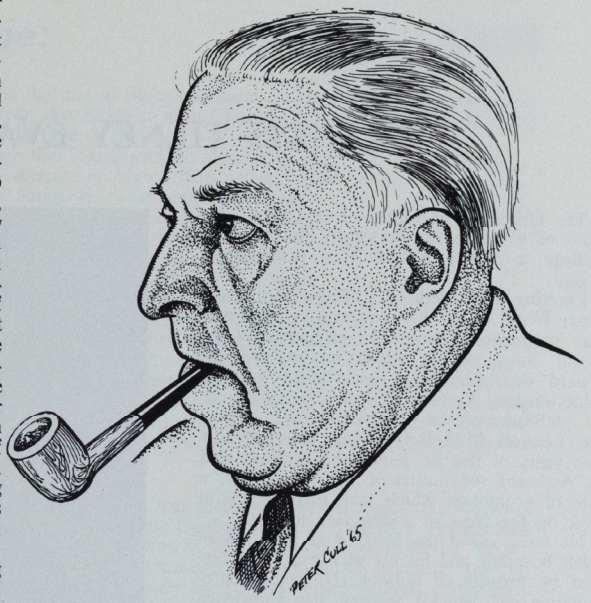
Charles Harris leaves us with a record of service to the Hospital, Medical College and the University of London which is likely to remain unrivalled for a long time to come.

Born in New York, where his father was in shipping, he spent his childhood in Australia and returned to school in England at Epsom College in 1914. He came to Bart's in 1918, having been head prefect for his final year and gained several prizes. Those were the years of the first Great War, and the post-war entry at the Medical School in 1918 was very big, of mixed character and of all ages. Among them Harris soon made his mark, qualifying both Conjoint and University in five years and gaining the Kirkes Gold Medal and scholarship in 1922. He was house physician to Dr. (later Sir Percival) Horton Smith Hartley (H.S.Co.,) from 1923 to 1924 and in 1925 was awarded the Lawrence Research Scholarship and Gold Medal. In this year also he acquired his M.D. London and the M.R.C.P. Apart from six months as a house physician at The Hospital for Sick Children, Great Ormond Street, and a period in America with a Rockefeller Fellowship as Assistant in the Paediatric Department of John Hopkins University Medical School, Baltimore, his association with our hospital has been unbroken. He came back as Chief Assistant to the Children's Department and was made assistant physician in 1928. The department, which had out-patients but no beds, was in the care of general physicians, Drs. Morley Fletcher and Hugh Thursfield. On the latter's retirement in 1929 Charles Harris became the first physician in charge of an autonomous Children's Department with a ward of its own, and will have completed thirty-six years in the post, quite a record! The first Children's Ward was at the top of the east wing, where Elisabeth Ward now stands. It is recorded that on entering the wards for his rounds it was Charles Harris's custom to greet his charges with "Hullo, you little horrors". This continued until one day before he could utter a word he was greeted by a chorus of piping voices saying "Hullo, you little horror!" Nevertheless, caught unawares and without an audience his shy and somewhat abrupt manner might be found to be very much less dignified with his little patients.

He was Editor of the Archives of Diseases in Childhood from 1934 to 1938, became a physician to the Westminster Hospital for Children, Vincent Square, and a consultant paediatrician to the L.C.C. He was President of the British Paediatric Association in 1962-1963.

In 1936 he became Warden of the Medical College and he and his wife were the first incumbents of the Warden's House in the new pre-clinical Medical School set up in Charterhouse in 1935. This, the former site of the Charterhouse and Merchant Taylors Schools, had been acquired by the energy and foresight of the then Dean, Sir Girling Ball, and these two men were closely associated in its inauguration and development.

Hardly, however, was everything in running order when Munich and then the holocaust was upon us. The year between these events was occupied in extensive planning, both for the College and the Hospital Emergency Medical Service. Sir Girling Ball became Sector Hospital Officer for the Bart's Sector and Charles Harris remained in London continuing his work as Warden to the clinical students in the hospital, directing their activities and



duties, and adding the appointment of Medical Superintendent of the much reduced but vitally important casualty hospital which was left behind when the main work was transferred out to Friern Barnet, Hill End, Cell Barnes and Mill Hill. The pre-clinical school was transferred with their teachers to Queen's College, Cambridge, where they were given a very happy home. Charles and Nadejda continued to live in the Warden's House throughout the many vicissitudes of war on the City. They slept in the body store (!) of the neighbouring Anatomy Department, took their full share in fire-watching and other chores and became keen market gardeners on part of the dug up central lawn. Their imperturbability along with that of many colleagues on the staff and administration led to an esprit de corps which ensured the continued working and efficiency of the hospital under all conditions, and not a single life was lost within the hospital. When the blitz had slackened Harris found time to be the Hon. Secretary of the Royal Society of Medicine from 1941 to 1946 and on the death of Sir Girling Ball in 1945 he inevitably became Dean as well as Warden and it was then that we appreciated his phenomenal memory for things past. Many of the College documents, minute books, etc., had been destroyed and nobody had had the confidence of the late Dean and the knowledge of College matters that he had. He was relieved of the Wardenship after a year or so, but remained Dean until 1952, by which time he had seen through nearly two-thirds of the reconstruction of Charterhouse and the erection of the first post-war Hall of residence for Medical Students. All this was greatly facilitated by his close association with the University of London. He became a member of the Senate in 1950, the Court in 1951, was Dean of the Medical Faculty from 1952 to 1956, Vice-Chancellor from 1958 to 1961 and Chairman of Convocation from then on. It was his crowning triumph, as the then Vice-President of the Medical College, to welcome the Chancellor of the University, Her Majesty Queen Elizabeth the Queen Mother, to the opening of the completed pre-clinical buildings.

He became one of the first medical representatives on the new Board of Governors of the Hospital with the advent of the National Health Service, and was soon elected one of the two medical representatives on the Executive and Finance Committee. To the end it has been impossible to defeat Charles Harris on points of accuracy dating back years rather than months, and where confirmation if still possible was to be found, but in spite of his pertinacity he could always acquiesce with that characteristic slow smile and a mumbling grumble when defeated by a majority verdict.

He is an officer of the Orde Van Oranje Nassaue, but I am ashamed to say that I am ignorant of the citation.

A great servant of St. Bartholomew's in all its fields, he will be greatly missed, but he has well earned a happy retirement to his country home in Hampshire, with his shooting and gardening and the companionship of a devoted wife.

F.C.W.C.

FRANKIS TILNEY EVANS

The retirement of Frankis Evans marks the close of 41 years of service to Hospital and College, a record impossible of achievement to-day.

Entering the Medical College during the First World War, his undergraduate course was interrupted by a period of Service in the Royal Navy, during which he enjoyed life aboard destroyers on Convoy duty, and on minesweepers. Returning to the clinical course, he qualified with the Conjoint in 1921, gaining the London M.B., B.S. a year later. Within two years of this he joined the hospital staff as Assistant Administrator of Anæsthetics, a rate of promotion which may leave a wistful look on the faces of young men to-day.

He later joined the Staff of at least eleven other hospitals and his life was ever characterized by breadth of outlook. No trade representative left Frankis without the knowledge that his new product would be given a fair trial, and he welcomed all new ideas in relation to anæsthetic apparatus and technique.

An early love of anatomy (he gained a Junior Scholarship in the pre-clinical years) persisted throughout his career, and he gave excellent demonstrations of block analgesia in all its forms. As one of the foremost experts on spinal analgesia he quickly became a master at extra-dural block when the former lost favour.

He is editor and co-editor of three standard textbooks of Anæsthesia, and a contributor to each. He was one of the first to use a continuous adrenaline drip as a pressor agent in major surgery. The needle-cannula bearing his name has enjoyed a lasting popularity and is still in daily use despite the threat of supersession by a disposable pattern.

He was a Fellow of the Association of Anæsthetists from its early days, and President of the Anæsthetic Section of the Royal Society of Medicine in 1944. A founder member of the Board of the Faculty of Anæsthetists, he became its third Dean during the years 1955-1957. In recognition of his many services to the specialty he was made a Fellow of the Royal College of Surgeons in 1960.

Clubbable, pubbable, it was inevitable that this most gregarious of men should be the member of countless outside associations. An ardent Freemason, he belongs to six Lodges and is honorary member of four others. His love of the sea and ships is reflected in membership of the Royal Thames Yacht Club and the Royal Cruising Club. Life membership of the Savage Club has led to his occupying the Chair this year and at the same time he is Master of the Worshipful Company of Tallow Chandlers.

He now plans to live near his yacht at Birdham. In wishing him every happiness in his retirement it is hoped he will not forget to visit his old Hospital. We look forward to such occasions with pleasure.

R.A.B.

Retroscope: ARIES

Aries, the Ram, is the first of the constellations of the zodiac, and spring is a suitable start to the year. According to Dan Chaucer in the *Prologue* to his *Tales of Caunterbury*, this is the time:

Whan that Aprill with his shoures soote
The droghte of March hath perced to the roote
And bathed every veyne in swich licour
Of which vertu engendred is the flour,
Whan Zephirus eek with his sweete breeth
Inspired hath in every holt and heeth
The tendre croppes, and the yonge sonne
Hath in the Ram his halve cours y-ronne . . . . .
Thanne longen folk to goon on pilgrimages.

Meanwhile that inveterate pilgrim, the Archbishop of Caunterbury, was consecrating the chapel of a new theological college in Perth, Western Australia. According to ancient custom Dr. Ramsey sought admission to the chapel by knocking stoutly on the door with the 30-pound cross of Western Australia. But the Primate, clearly no botanist, misjudged gum for the solid oak of England and hammered too hard. The door shuddered and splintered and the unfortunate prelate discovered he had knocked two holes in it.

Saigon to Selma

The bewildering state of Vietnam and those virulent pathogens, the Ku Klux Klan, make life thorny for the enigmatic Lyndon Johnson. The Klan was founded after the Civil War by a Confederate general, its purpose to keep down the "uppity niggers" newly freed from slavery. It succeeded well enough to sicken its founder, who resigned the Imperial Wizardry early on. Its means and its ends consistently despicable, the Klan has long been America's dustbin for racists, reactionaries, cowards, and lunatics. Klansmen invariably escape successful prosecution, for the Southern States judiciary is riddled with their *confrères*. Suppression of the Klan could only be brought about by the substitution of a federal pattern of justice for the present state system.

Not Cricket

A decree *nisi* was awarded against a dentist who betrayed himself unawares. He fondled his wife Sylvia when asleep one night, murmuring at the same time the name "Carole"—that of his 18-year old nurse, and the judge decided that this lapse provided excuse enough for the wife's subsequent lack of affection. To quote the gaoler from *Cymbeline*:

"He that sleeps feels not the toothache."

After Leeds beat Manchester United in the replay Cup semi-final, the unfortunate referee was poleaxed by an enraged Lancastrian spectator. A police constable who appears, like William Webb Ellis, to have temporarily forgotten the rules of the game, felled the assailant with a low rugger tackle. Though down for the count, the gallant referee managed to get out of the ring under his own steam.

Dean or Pope

Hot on scandal's dusty trail, the *Sunday Telegraph* published an article ("Hospital Sacks Lecturer") on Dr. Moody's dismissal, quoting the bearded man himself:

". . . . . he doubted whether Professor Eric Cook, the Departmental Professor, had had the right to sack him, although the decision was backed by the Dean, Dr. John Pope. (*sic*).

Dr. Moody admitted that he made life 'exceedingly unpleasant' for the authorities."

Obviously a difficult man to pope with.

The Academic Training of the Family Doctor

by G. N. MARSH

General Practitioner, Stockton-on-Tees

Introduction

For the specialist it is comparatively easy. There are well worn routes to the consultant posts; there are hard and fast regulations stipulating the necessary experience before taking the higher examinations; as a student there is constant contact with those who can advise on the appropriate path.

But whither the future general practitioner? How does one train to become a good G.P.—a successful family doctor? There are few concrete ideas about this—and whilst still young enough to remember student days through not too rose-tinted spectacles, yet sufficiently experienced to know a little of the nature of general practice. I shall make some suggestions for those who are interested in entering this difficult medical sphere.

Principles

My remarks will concern themselves with academics. for a first class academic training and a sound knowledge of clinical medicine are essential in general practice. Family doctoring is no longer "mumbo-jumbo". The days of "the bottle" and "the bedside manner" have passed. Patients are becoming more discerning in their attitude—they now expect to get better!—if they fail to improve they will wish to know why. Only a thorough academic and clinical training can prepare the student and young doctor for general practice. The family doctor is the first person to see the ill patient. As a result, he frequently stands at the crossroads marked "life", "death", "health", "morbidity". He will initiate the direction of his patient. Only with a well-disciplined academic knowledge will he direct his patients aright; mistakes may be irrevocable; the responsibility is great.

In addition, as medical progress takes place, there are more academics for the family doctor to grasp, and the need for staying in the rigorous academic atmosphere of hospital longer and longer increases as time goes by.

A planned approach to general practice is now essential. No longer the "two house-jobs and into G.P." or the "can always fall back on G.P." attitude. If you are intending to enter general practice then you should have a definite path of pre- and post-qualification training in mind.

Training as a Student

Everything one is taught becomes important in general practice. It is quite astonishing how one finds oneself reminded, for example, of one's early dissections, one's physiology experiments, a sentence in a lecture in forensic medicine, the small print in the pharmacology text book, the rare case on the Professorial Unit; everything, in time, seems to crop up. It is advisable, therefore, to take a broad and avid interest in the entire course, for none of the knowledge will be wasted and all of it ultimately may be required.

The major specialities are usually allocated sufficient time and are well taught, possibly because they are very adequately tested in the final examination. But spare some time and thought for the minor specialities, for dermatology is by no means "minor" to the practising G.P. (and if his knowledge were adequate he could well be his own dermatologist, so rarely has in-patient hospital treatment anything to offer); E.N.T. conditions present far more frequently than, for example, neurological problems; and neglected eye conditions can have serious and ever-lasting sequelae.

Obstetrics is vital. This should be the speciality above all to receive one's attention. Good obstetrics is the rock upon which many successful practices are built and this is one of the most rewarding aspects of general practice.

Geriatrics and psychological medicine—not popular subjects with many students—are the "bread and butter" of general practice. Longevity increases as medical progress takes place, and the care of old people is a major task in general practice. Psychiatric illness and psychiatric overlay on other disease are becoming

ever more prominent problems with which the family doctor must contend.

General practitioner attachment schemes are essential, and fortunately the more enlightened medical schools are approaching this problem with increasing vigour. Any opportunity to study good general practice whilst still a student should be accepted with alacrity.

Finally, whilst a student, there is no better way of broadening one's outlook on the contentious problems of academic medicine than to visit other medical schools and teaching hospitals for clinical meetings. It is mentally stimulating to discuss the differing approach of other schools to identical problems. One's own school is by no means always right.

As a Houseman

A minimum of two years should be spent in junior hospital posts before entering practice. A good general medical job is essential. A teaching hospital medical unit which does not pre-select its cases, and which takes its turn on the general emergency reception, provides the best job of all. However, if one's teaching hospital medical units are full of ?phaeochromocytoma or ? Charcot-Marie-Tooth disease, then one would learn more in the medical wards of a large peripheral hospital where the cases are the run-of-the-mill medical problems, the turnover is quick, and the pressure on beds (and housemen) is considerable.

Teaching hospital surgery is of doubtful value for the intending general practitioner. Long hours on the end of the professorial retractor bring small academic reward. An active reception (casualty) unit with a thriving "minor ops" list has much more to offer; failing this, a house-surgeon's job in a peripheral hospital where the major surgery can be seen at close quarters and the minor surgery will probably be done by oneself. Specialist surgical jobs (e.g. orthopaedic, plastic surgery, neurosurgery) have little value.

Six months pure obstetrics (or one year combined obstetrics and gynaecology) is essential—do *not* go into general practice without this. Take the D.Obst., R.C.O.G., a straightforward examination which entails only reading up the theory whilst doing the practical work, and which guarantees automatic inclusion on the obstetric list. An obstetric post where one is merely third or fourth in line for the forceps is no use. Accordingly, peripheral obstetric units probably have more to offer than teaching hospital posts, since the cases will be seen at closer quarters. Ideally, one is seeking a post where one can do a large amount of practical work yet be expertly supervised at the same time.

Six months paediatrics is also essential, and teaching hospital units probably have more to offer here in a somewhat high-powered field. More especially if the teaching hospital paediatric unit is a "general" one admitting medical, surgical, orthopaedic, burns and other cases under one roof. If during the paediatric appointment one aims for the Diploma in Child Health, this will necessitate attendance at child welfare clinics and schools for handicapped children, and adequate reading of the journals and text books.

Fortunate is the young doctor who, after this basic two-year training, can find himself a rotating house-job in the minor specialities—two months eyes, two months skins, two months E.N.T., etc.

Other Training

In the immediate post-war years, by virtue of doing his National Service, every young doctor had the opportunity of some free foreign travel and doing some medicine outside the United Kingdom. Unfortunately, this obligatory opportunity is no longer available. However, it is easy to get a job on a ship, or in the Commonwealth, or on foreign relief work for a short time (a year or two), and young doctors fortunate enough to be unmarried when these opportunities occur should grasp them eagerly. Such broadening experience is probably not repeatable in later life and yet in primitive or backward communities, or in situations where facilities are limited, all one's medical knowledge and resources will be taxed. It would be advisable to do this "backwoods" medicine after eighteen months or two years in junior hospital posts, and on returning to the United Kingdom do one more job (e.g. the rotating job) by way of a refresher course prior to entering practice.

Conclusion

I have completely ignored the financial problems. There is little money to be made in the course I have suggested. But I would say that the gaining of broad-spectrum knowledge and experience in one's twenties is of far greater import than financial reward. This time spent on training for general practice will be more than adequately rewarded in later life.

What is General Practice?

A Report of a lecture given by Dr. Frank Bevan

On February 25th Dr. Frank Bevan, an old Bart's man and now the senior of four partners just outside Oxford, came to talk on this subject. He deliberately avoided the political situation to concentrate on clinical affairs.

A student in hospital sees something of the life of the specialist, but nothing of the life of the family doctor, though he will occasionally see his mistakes. Unless he has been a member of a general practitioner's family, he can have no idea of the difficulties and would be well advised to spend a week or two attached to a G.P. to see the type of work done. Later, after registration, he should certainly fill in time by doing locums.

Dr. Bevan defined the G.P. as a "personal physician giving individual care to his patients from conception to the grave within the family setting", which, of course, includes school and work. He needs to understand the familial and social background and the patient's mental and physical characteristics; after a few years this becomes instinctive, the product of day by day experience, but can never be acquired in hospital. Hence the ideal is to select a reasonably static community for one's life's work, and he would advise those about to enter thereon to find out whether the relations with the local hospital are good, and whether the family doctor has direct access to various departments—X-ray, electrocardiograph, pathology—for essential investigations. Where there is no such access, the practice can hardly be a first choice; nor can the hospital.

The most remarkable feature is the enormous variety of clinical material. This was elaborated under four headings: first, the early and accurate diagnosis of *all* disease, so as to pick out the vitally important early symptoms of serious illness; next, the active treatment of much acute illness, e.g. pneumonia and cardiac infarction; third, the care of a multitude of trivialities, always remembering that what seems trivial to the doctor may be a great anxiety to the patient. Here there may be a disadvantage in too rigid an appointment system, for many a man, having screwed up his courage to go and see his doctor, will be glad of the excuse to change his mind if he finds he has to wait a week. It is very necessary that the patient should be able to see his doctor easily and promptly. Lastly, there is the continuous care of those suffering from chronic incurable disease—bronchitis, rheumatism, heart failure—and from the minor ailments of old age. One of the best ways of judging whether a practitioner is good or less good is by observing what care is bestowed upon those in the terminal stages of cancer. Added to all this is the need for psychological understanding, for in a large number of patients psychological factors influence the illness. Some training in this is essential, though the major psychiatric disorders are not difficult to recognize.

Which house-appointments are likely to be most worth while? "Certainly obstetrics, if you are that way inclined; paediatrics and dermatology are always useful; surgery provides experience in the early diagnosis of the acute abdomen, but familiarity with highly specialised techniques will not be required. On the whole, Medicine is probably the best for, in the long run, we are all physicians."

It is perfectly possible to do useful and satisfying research in general practice. One man alone may not see enough of the more interesting conditions, but if he is one of a group of fifty or a hundred, as in the College of General Practitioners' research organisation, he can do good work and will find co-operation with his colleagues stimulating and productive.

Apart from knowledge and experience, the G.P. must have two qualities; one is the ability to work hard, for the modern tendency to limit hours of work is certainly bad; the other is a liking for human beings. "If you haven't got that, if people don't interest you or you can't get on with them, there are plenty of other openings in medicine, e.g. in pathology or biochemistry where the actual contact with patients is not so personal, which will suit you better and where you will be happier".

He ended with a quotation from Lord Brain.* "The general practitioner is above all the doctor who sees his patient as a whole. He must be an expert in diagnosis over a far wider range than is necessary or possible for any other kind of doctor . . . No team of experts can ever take his place in the life of the patient".

**LANCET*—May 16, 1953. Pages 959-964.

A Glance at the Past

5. PER VINUM SANITAS

by Gervase Kerrigan

Before the unfortunate exposure of Tom Jones with Molly Seagrim there is a short passage which deals so accurately with the effects of alcohol that a present Bart's student had it memorised for a pharmacology viva. With the typical perversity of examiners, they never asked him, and as much to remedy this it is worth quoting: "Alcohol heightens and inflames our passions (generally indeed that passion which is uppermost in our mind) so that the angry temper, the amorous, the good humoured, the avaricious and all other dispositions of men are in their cups heightened and exposed."

That period in England was one of great drunkenness, not confined to any particular class. Ale reigned supreme among the lower classes until cheap spirit-drinking became a serious rival, to reach the extremes of Hogarth's Gin Lane. The Tory toasts in Claret and the Whiggish Port did the same for the upper classes, and as Trevelyan puts it "Magistrates often appeared on the bench heated with wine; courts martial by a prudent provision of the Mutiny Act might only take place before dinner."

Medicine had long given qualified approval to wines both for internal and external application. Indeed, doctors on the whole have never been backward with the glass, and as John Ward put in his Diary: "There is a report of Hyppocrates, as if hee should say this in charge with physitians, that they should cure others with simples and compounds, and themselves with sack and claret."

Robert Burton writing in the seventeenth century was well aware of the virtues of alcohol and its dangers on which he discoursed at pedantic length. Following his 'satyrical preface', he classifies the various causes of melancholy, and with all black wines he includes Malmsey, Brownbastard and Metheglin as inclining to head melancholy in those of hot or sanguine choleric disposition. Indulgence in ale leads to "tremor, swollen jugulars and pimpled red faces," and in the younger sort of love-melancholy, wine must be altogether avoided. He manages however to put up a good case for moderate indulgence, which dissipates all thick vapours and fuliginous humours.

In 'Drinke and Welcome' by John Taylor there is apparently no ailment on which drink excercises other than a beneficial effect. "Maladies of the spleene, iliaco passio, stone in the bladder or Reines," all came within its scope. It seemed superfluous to add that it "provoked Vrin wonderfully." Indeed the only thing for which it is not recommended is Vertigo with which Pepys writing on April 23rd, 1661 might well have agreed.

The Anglo Saxons knew of the medicinal values of ale long before Taylor. For one possessed of a devil or friend-sick a remedy was: "a number of herbs having been worked up in clean ale, prayers having been said, add garlic and holy water, and let him drink out of a church bell." After this, the cure suggested for a less severe form of lunacy seems harsh. "Take a skin of a mere-swine (porpoise) work it into a whip, swinge the man therewith, soon he will be well, Amen."

A cure for hiccups seems relevant and the sixteenth century recipe from "The Book of Notable Things" suggests: "take the root of jarrow, pound it and put it into good ale and sup lukewarm." Spirit distillation was a major domestic art in those times, commemorated by the name of still-room for the housekeeper's domain where previously she used to concoct her strong and cordial waters. Before the reign of Charles I, there does not appear to have been any control over the distillation of spirits in England. To remedy this, Charles I granted the first charter of the Distiller's Company in 1638, but the Charter was made ineffective for many years by his successors who encouraged distillation from home-grown grain to encourage agricultural interests.

One physician gave his name to a particular drink, and was in addition a noted practitioner of his day, attending James I. This man, William Butler, invented the ale known as Dr. Butler's Ale which until the end of the eighteenth century was sold at those houses having the Butler's Head for a sign. One story concerning him was "when lying at the Savoy in London, next the water side, where was a balcony look't into the Thames, a patient came to him that was tormented by an ague." The Doctor ordered a boat to be in readiness under his window, when on a signal given, three lusty fellows came behind the patient and threw him a matter of twenty feet into the Thames. The surprise absolutely cured him.

Wine was often applied externally, either as a cosmetic or a tonic, and baths in wine were not infrequent. The Earl of Shrewsbury, who had charge of Mary Queen of Scots in 1569 complained that his regular allowance of duty free wine was not enough, as his Royal prisoner's requirements for baths were large. This was at least a more fitting end for an Haut-Brion than that devised by the Master of Horse to Charles the Seventh of France, who used to rub down the legs of his horses with it. It was probably from this usage that the remark on bad wine was derived, "One would not wash a horse's hoof in it."

"..... YES MADAM, EVEN ON VIEW DAY....."

The Management of Open Neck Injuries Involving the Air and Food Passages

THIS article is aimed at the future Casualty House Officer in whom feelings of dismay and confusion are almost inevitably found when faced with a case of this type.

Open neck injuries may be suicidal, homicidal, or accidental. The suicidal and accidental types are most commonly transverse, and usually affect the most prominent structures. The homicidal type is usually of the stab variety and may be anywhere in the neck.

An increasingly common injury today, is that inflicted in high speed road traffic accidents, in which the body pivots from the pelvis. The head strikes and breaks the windscreen and the neck is forced down on to the jagged lower edge of the hole thus formed.

Of those cases reaching surgical aid, the very large majority, obviously, have escaped serious injury to the great vessels, partly due to the protective bulk of the sterno-mastoid which is instinctively tensed, and partly to their ability to slide a considerable distance posteriorly. This also applies to the important nerves except in penetrating wounds.

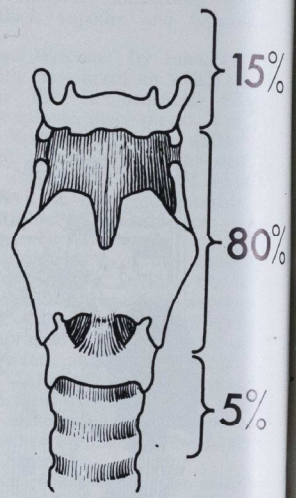
In those cases not immediately succumbing to torrential hæmorrhage, the possible modes of death are: (1) due to obstruction of the air passages by (a) traumatic oedema, (b) aspiration of blood, (2) air embolus, (3) shock; which is very rapid and profound in this type of injury.

The air passages sustain the brunt of most severe injuries—the portion below the hyoid and above the cricoid receiving over 75%. Perforation of the floor of the mouth, above the hyoid bone is the next most frequently found and the thyroid gland and trachea least of all.

Injury to the œsophagus is commonest in the post cricoid region, but only occurs in a small percentage of cases.

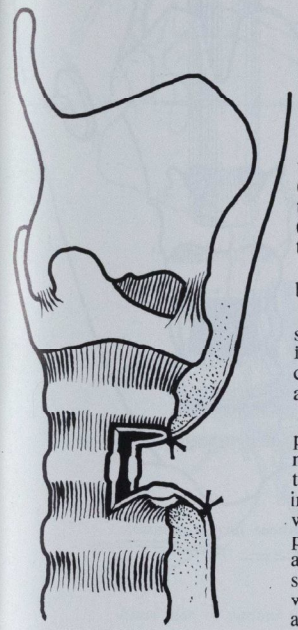
Immediate treatment is aimed at firstly, establishment of a blood tight airway. This is best achieved by dilating the laceration (rapidly spraying the air passage with 10% cocaine or 4% lignocaine in the conscious patient), and inserting a large (10-12, F guage) cuffed flexometallic tube. Once the cuff is blown up the trachea and bronchi may be aspirated with a catheter sucker, and the lungs thereafter are safe from any further bleeding or vomiting.

The next step is to combat shock by the use of intravenous



Frequency of injury by areas.

by L. N. Dowie



Tracheal flap.

dextran (first removing 10 ml. of blood for grouping and cross matching), and relief of pain. 1/8-1/6 gr. of morphia diluted in normal saline given intravenously, achieves a satisfactory pre-operative level of analgesia without depressing respiration drastically, and 1/150-1/100 gr. of atrophine by a similar route will control the increased secretions caused by the trauma and the presence of the endotracheal tube. Bleeding is controlled by suitable pressure or the application of artery forceps.

At this stage the patient may be removed to theatre on a trolley equipped with transfusion stands and an oxygen cylinder. The oxygen may be allowed to play over the end of the endotracheal tube or in cases of concomitant head injury it may be advisable to assist respiration with a breathing bag attachment.

In the anæsthetic room the patient, after induction, should be stripped, and a preliminary cleansing of blood, broken glass, oil, clothing, and other foreign materials made from all injured parts. At this stage also X-rays of skull, vertebra and suspected limb injuries may be made.

In theatre, routine preliminary surgical toilet is performed on the skin, skin edges, and wound.

A tracheostomy is now performed, preferably avoiding the wound, and using a fresh collar incision. A flap of trachea (Bjork flap) is turned down and sutured to the lower margin of the incision. This ensures easy use of a large, 39-42, cuffed rubber (Morrant Baker) tracheostomy tube and facilitates the changing of the tube at a later date.

The extent of the injury to the air and food passages may now be thoroughly explored.

Loose or ragged portions of muscle, cartilage and mucosa, should be removed, leaving clean, suturable edges whose viability is in no doubt. A rapid, clean healing process is essential, if complications such as laryngeal and oesophageal fistulæ and stenosis are to be avoided.

Commencing with the deepest structures reconstruction now takes place. The insertion of the large polythene feeding tube via the nose is essential, even if the oesophagus has not been injured, as the integrity of the protective laryngeal sphincter is severely impaired by post traumatic œdema, and contamination (spillover) will inevitably occur if oral feeding is permitted. The tube also permits easy repair of the injured oesophagus around it, and acts as a splint during swallowing of saliva. The oesophagus and pharynx should be repaired with at least two layers of plain catgut, one of which should be continuous, if a saliva tight union is to be achieved. The tissues of this area are fortunately quick healing owing to their extensive blood supply, and the use of chromic gut is unnecessary and, indeed, unwise.

The soft portions of the larynx and floor of the mouth may now be sutured into place again, using plain catgut. The epiglottis if "unshipped" or severely lacerated may be sacrificed without any resultant hardship to the patient.

Before closure of the laryngeal skeleton a 2-2½″ portion of large bore (½″) soft polythene tube is inserted. Its upper edge should be level with the aryepiglottic folds, and the lower one extending a few millimetres below the cricoid. This makes the reconstruction of the glottic aperture relatively simple, prevents adhesion between opposing parts of the glottis, and splints the soft tissues during swallowing and coughing.

The tube should be held in place by a single stainless steel wire inserted with a straight needle through skin, soft tissues, thyroid cartilage, and tube, and emerging in a similar fashion on the other side of the neck.

It should be anchored on the skin surface by button and bead.

The laryngeal skeleton is now closed.

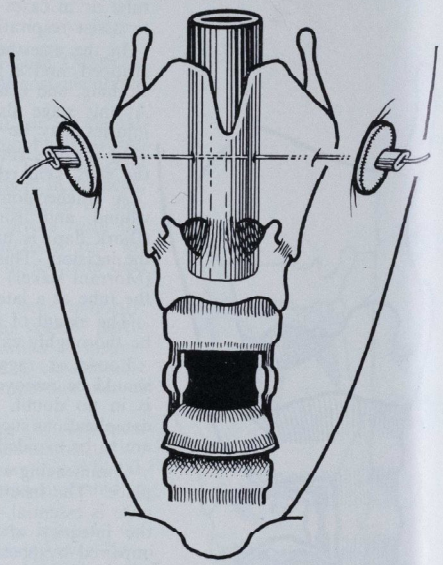
It is preferable, if possible to suture only the perichondrial layer using chromic catgut. If this layer has been damaged, however, the cartilage itself may be sutured using (35G) stainless steel. Sutures penetrating cartilage should be avoided owing to the difficulty (due to its poor blood supply) of preventing and eradicating infection.

Fine polythene suction drains should now be introduced through low stab incisions and laid in appropriate strategic positions.

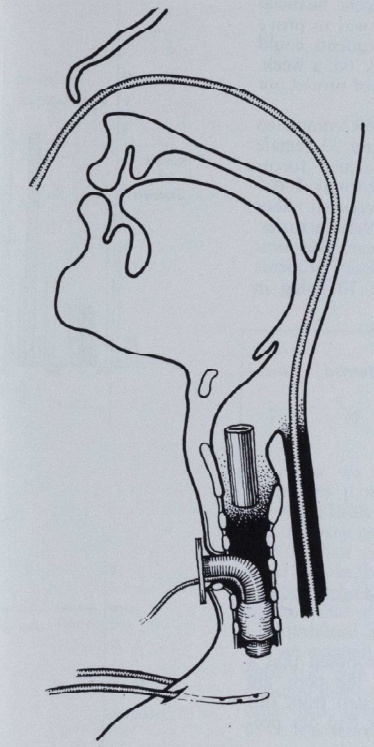
The strap muscles, subcutaneous tissues and skin are now closed after spraying the wound with polybactrin. The drainage tubes are connected to a Sterivac apparatus or to a Robert's sucker. This opposes the superficial structures to the deep ones by vacuum, completely avoids dead spaces, applies a mild hæmostatic pressure, and eliminates the use of any but the lightest of dressings, thereby reducing the work of the nursing staff and the disturbance of the patient.

These tubes are withdrawn after 36-48 hours or sooner if they become blocked.

Protection in the form of tetanus prophylaxis, and intramuscular penicillin in doses of the order of 1,000,000 units soluble, 6 hourly, should be maintained for at least 4 days, when preliminary healing should have taken place. The antibiotic may be reduced to twice daily procaine penicillin after this period and steroid



Polythene former in situ.



Final plan of various tubes.

cover commenced in moderate dosage, e.g., 30 mgms. prednisolone daily, to avoid cicatricial stenosis of the glottis and œsophagus. These are maintained until complete healing has occurred when antibiotics may be discontinued and the steroids reduced and stopped.

The patient should be nursed in a propped up position to reduce venous congestion in the neck and careful aspiration of the tracheostomy tube performed every 15 minutes. Humidification of the air entering the tracheostome may be achieved by a humidifier in order to prevent crusting and tenacity of the sputum and the consequent chest complications.

The patient is tube fed with a fluid diet to give an adequate balance for at least 7 days when fluids by mouth may be started. If this is satisfactory the feeding tube may be removed and soft diet commenced.

In approximately 10 days from the injury a direct laryngoscopy under General Anæsthetic should be performed. If this reveals union of the laryngeal tissues, the polythene former may be removed via the laryngoscope by snipping the steel wire at the skin surface.

24 hours after laryngoscopy, if respiration is easy with the tracheostomy tube occluded for some hours, the tube may be removed and the wound allowed to close without suturing. This usually occurs within 48 hours.

Rehabilitation in the form of speech therapy should now be commenced, and progress checked at regular follow-up intervals, when any tendency to dysphagia through stenosis may be dealt with, by bouginage.

The results are surprisingly satisfactory despite severity of injury, and although gross injury may require more heroic measures, such as laryngectomy, replacement of œsophagus with colon, and extensive plastic surgery to make good loss of skin, these fortunately are the exception rather than the rule.

I am indebted to Mr. J. C. Hogg for his help and encouragement in preparing this article and to Mr. P. G. Cull of the Department of Medical Illustration, St. Bartholomew's Hospital.

Social Chapter

ON STUDENTS AND STIPENDS

Because of the dearth of Social Events to report for this Journal, Social Chapter turns its attention to the recent financial form sent round to students to complete. Its purpose was to prove to the University Grants Commission that medical students could not afford to live in College Hall at the rate of £5 10s. 0d. a week, and therefore the Hall should be subsidised: this proof turned out difficult to arrange.

Of all the Clinical Students at the hospital 153 completed and returned their forms, of these 120 were male and 33 female (roughly the right proportion). Ten were in the armed forces (6.5%). Eighteen were married (11.8%), and surprisingly forty-nine owned cars (32.0%). Of those in the armed forces all either owned a car, or were married, or indulged in both of these luxuries.

Assume that everyone in the forces owns a car, and thus exclude them; and it can be taken that of the 51 'ordinary' students abiding in College Hall 18 own cars, whereas the 70 living in

Percentage	*Domicile*	*Number of Students*	*Car Owners*	*Married*	*Armed Forces*
46%	Flats	70	23	16	7
33%	College Hall	51	21	—	3
10%	Lodgings	15	2	1	—
7%	At Home	11	3	1	—
4%	Other Halls	6	—	—	—

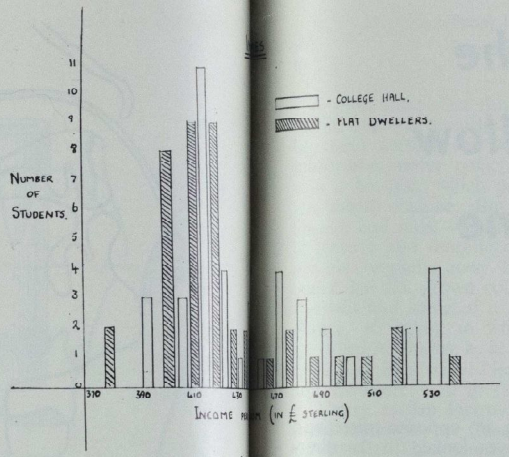
TABLE 1

flats possess 16 (Table 1). It could therefore be proposed that a richer type of student lives in College Hall, and the poor are excluded from its heavenly comfort. The obvious step from this point is to turn to the question of incomes, and we find our proposal borne out to a limited extent, (Table 2).

Over eighty per cent of the completed forms showed incomes between £350 and £550 per annum, but on these figures further assumptions must be made:

(a). People naturally tend to magnify their financial plight, so it would probably be fair to add a further £50 to everyone's estimated income.

(b). There is a danger that many of the forms were sent in by students with an axe to grind, and therefore it should be assumed that there are a considerable number of students who are better off. From Table 2 it will be seen that the average income of a flat-dweller is £425 while that of the average College Hall exister is £445 per annum.



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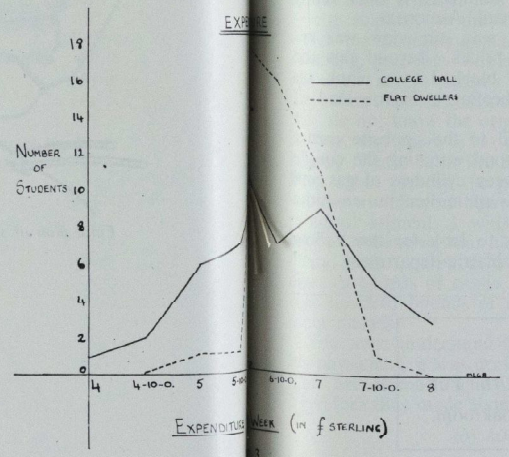

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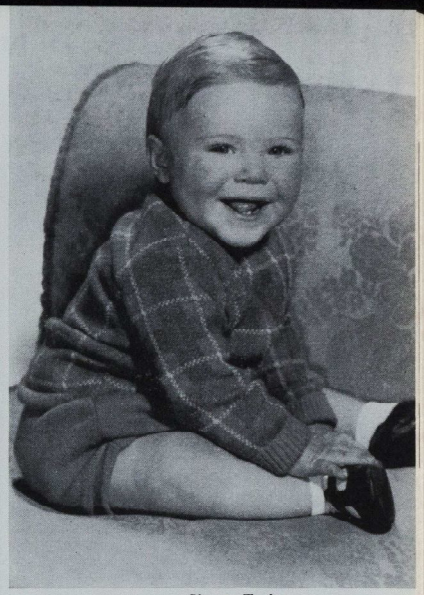
bart's babies



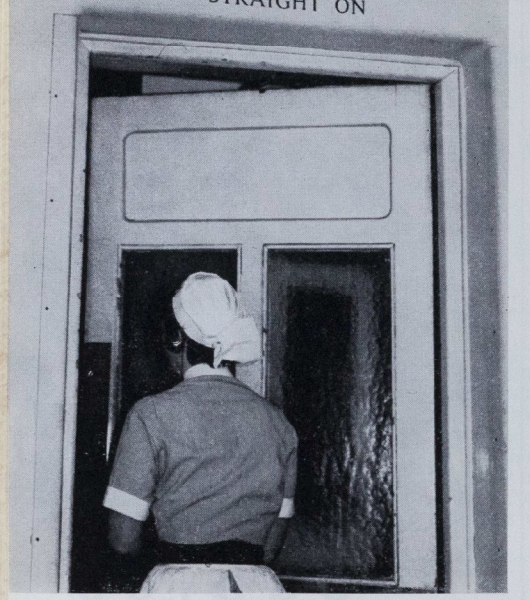
Simon Tatler

Now we must examine expenditure per week on rent and necessities (laundry, heating, services, and food), not included in the rent (Table 3).

It turns out that the flat keepers spend perhaps 15s. per week less on their basic living, and thus over a year they may save up to £35 more than someone in College Hall. Therefore we, in Social Chapter, who know that a student's life is not all gall and grindstone, suggest that if students wish to live within the pearly gates of Charterhouse Square in order to *WORK*, £5 10s. 0d. per week is not an excessive rent. If they want to live there for pure convenience (i.e. lack of travelling, use of their own private little cells, constant hot water, clean sheets, proximity of a bar, and all the other little luxuries of life), they would be far better off learning to be less selfish and more interesting living in a flat.

OTHER FEATURES OF THE SURVEY

1. No less than 7% of the completed forms showed parents or private sources contributing over £600 a year, and these people tended to live in more luxurious flats than the average.
2. Student marriage is not all milk and honey; nearly all the wives have to go out to work, and many of the husbands have joined one of the armed forces.
3. Student cars cost anything between £1 10s. 0d. and £4 10s. 0d. a week to run; depending on accident rate?
4. Far too high a proportion of students are utterly dependent on their parents for finance.



follow the yellow line

FIRM parties excepted social life in the summer months is centred on the Fountain. Thus it was at the first hint of spring our photographer stationed himself behind a tree in an attempt to capture the birds-and-bees atmosphere of this vicinity. He continues . . . .

'I made my way back towards the dispensary steps and noticed an aged couple standing there talking earnestly. "But George" the woman exclaimed, "she told us to follow the yellow line, and that's what we've done." Resisting the urge to trace this yellow line I offered to direct them towards the Physiotherapy department,—their apparent destination.

Extremely slowly, by reason of the man's disability, we made our way along the passage, over metal grills, manhole covers and other hazards. At the far end I appreciated the dilemma facing these unfortunate folk.

A notice listing four names, interspersed with arrows pointing in opposite directions, confronted us. Our eyes looked in the directions indicated, first one way then the other. To the left there was a door into a partially demolished building. An overseas gentleman was engaged in hitting what was left of one of the walls with a sledge hammer. It was funny because the notice read Almoners.

Glancing the other way our view was restricted by a pile of bricks. Beyond this the pavement was further blocked by a plank, up which a man was wheeling a barrow-load of cement.

Frustrated I pointed to the opposite corner of the square, then stood watching the couple thread their way between cylinders of gas and two massive cauldrons of molten tar en route to the physiotherapists.

I retraced my steps to look for the Yellow line. It led to the Psychiatric department . . . .'

View Day Photographic Exhibition

Entries should be handed to the Librarian by May 7th. For further details please consult the notice in the Students' Cloakroom.

medicine in literature

HOW PANTAGRUEL FELL ILL AND THE METHOD OF HIS CURE

From **'The Histories of Gargantua and Pantagruel'** by François Rabelais, Doctor of Medicine, translated by J. M. Cohen.

A short time after this the good Pantagruel fell ill, and was so afflicted in his stomach that he could neither eat nor drink. Also, since misfortunes never come singly, he was taken with a hot-piss, which pained him more than you might imagine. But his doctors came to his aid, and most successfully. For with plenty of lenitive and diuretic drugs they made him piss his complaint away. But his piss was so hot that it has not grown cold since that day, and you will find some of it in different places, in France, according to where it flowed. These are called hot baths, as at Cauterets, at Limons, at Dax, at Balaruc, at Néris, at Bourbon-Lancy and elsewhere; and in Italy at Monte Grotto, at Abano, at San Pietro Montagnone, at Sant' Elena Battaglia, at Casanova, at San Bartolommeo, at La Porretta, in the province of Bologna, and in a thousand other places.

And I am greatly astonished at the crowd of foolish philosophers and doctors who waste time disputing where the heat of these waters comes from, whether it is because of the borax, or the sulphur, or the alum, or the saltpetre which the minerals contain. For they are only rambling, and they would do better to go and rub their rumps against a thistle than waste their time like this, disputing about something they do not know the origin of. For the answer is easy, and there is no need to make further inquiry. These baths are hot because they arose from a hot piss by the good Pantagruel.

Now to tell you how he was cured of his principal ailment, I will record here how he took as a laxative, four hundredweight of scammony from Colophon, a hundred and thirty-eight cart-loads of cassia, and eleven thousand nine hundred pounds of rhubarb, not to count other messes.

You must understand that, on the advice of his physicians, it was decided that what caused him his stomach-ache should be removed. Therefore they made sixteen great copper balls, larger than the one on Virgil's needle at Rome, and so contrived that they opened in the middle and closed with a spring. Into one of them climbed one of his men, carrying a lantern with a lighted wick; and Pantagruel swallowed him in this way like a little pill. Into five others went other stout fellows, each carrying a pick at his neck; into three more went three peasants, each carrying at his neck a shovel, and into seven others went seven faggot-porters, each with a basket on his shoulders. And thus they were all swallowed as pills.

When they were in the stomach each released his spring, and they came out of their cabins, the man who carried the lantern first. Thereupon they tumbled more than half a league into a horrible gulf, fouler and more stinking than Mephitis, or the marsh of Camarina, or the fetid Sorbonian lake of which Strabo writes; and had it not been that they were well protected in the heart, stomach, and wine-pot (which is called the cranium), they would have been suffocated and destroyed by these abominable vapours. Oh what a perfume, what effluvia to soil the dainty masks of young and elegant maidens!

Afterwards, by groping and sniffing, they drew near to the fecal matter and the corrupted humours; and finally they found a mound of ordure. Then the pioneers picked at it to break it down, and others piled it into their baskets with their shovels. Then, when it was all cleared away, each one retired into his ball. This done, Pantagruel forced himself to vomit, and easily threw them up; they were no more considerable in his throat than a gurk in yours. Then they came out of their pills most joyfully—I was reminded of the Greeks emerging from the Trojan Horse—and in this way Pantagruel was cured, and restored to his former good health.

And of these brazen pills you have one at Orléans, on the steeple of the Church of the Holy Cross.

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Weekend à Paris

Robin Williamson

Only a few days before our weekend trip, I had written off in best schoolboy French to reserve two rooms in what appeared on the list to be the cheapest hotel in central Paris. I never really expected an answer and certainly none was forthcoming, but as it was the middle of February we all three felt sure, *avec le phlegm anglais*, that somebody somewhere would have the odd free room. And so we arrived by Comet in the middle of a Thursday night at Le Bourget—surely one of the most depressing airports in Europe—and were whisked in by bus to the Invalides. Inquiries proved, amazingly, that rooms had been reserved exactly as requested (a tribute this, I felt, to the French master), and off we set by taxi, somewhat alarmed that the driver had heard neither of the hotel nor even of the street it was in. After recourse to a map and several false alarms he found it at last with evident pride "dans un petit trou", halfway between the Opéra and the Louvre. Considering it was nearly three o'clock in the morning, we found the *Patron* extremely civil.

This was certainly the best concealed hotel I have yet encountered, and almost every time we went out we got lost coming back, so that we were nearly reduced to notching the trees. Our rooms gave directly onto the Rue St. Anne, a busy narrow street, *sens unique*, which seemed to be used as a shortcut at all hours by most of the lorries in Paris. The first night we left the windows open, a mistake we were careful to avoid thereafter. In fact it was a very comfortable little hotel and certainly cheap by Parisian standards, although of course, as the *Patron* explained, the prices in our brochure were slightly out of date. A large notice by the door forbade guests to bring anyone else into their room without managerial permission, but one got the impression that the tariff might have been stretched to include that sort of item. Luckily one of us had remembered to bring some soap, and although it took me a long time to discover how to turn the lavatory light on, it was, considering the impossible hours we kept, a most admirable hotel.

The weather was cold but clear for most of our weekend, and the freshly-cleaned buildings of Paris gleamed in the February sun. The waterfronts of the Seine, unobscured by leaves afforded magnificent prospects from the opposite banks, with the cathedral of Notre Dame and the Louvre imposing in the foreground, and Sacré Coeur, away on the hill of Montmartre, etched against the skyline. One afternoon, just one, we devoted to the Palais du Louvre; much of the time was spent in tracing first *La Joconde* (the Mona Lisa), and then the elusive Gents, for which alas none of us knew the correct French euphemism.

Le Commune Libre du Vieux Montmartre stands above and distinct from the rest of Paris. It has always taken pride in this distinction and cultivated the atmosphere of a village, with its own byelaws, its own cemetery, and even its own small vineyard. The centre of Montmartre is the bare Place du Tertre, the haunt of the artists and, on a summer's evening, crowded with tourists who pay exorbitantly for indifferent (but flattering) profile sketches of themselves and, inevitably, their ubiquitous children. In winter the people are fewer and the paintings, typically of *les gamins* (with ragged clothes but appealing expressions), somewhat better. We spent a superb evening in Montmartre, dining at first *Chez Ginette* where we were welcomed in local custom with a Gallic kiss on each cheek from the portly Ginette herself. We ate cous-cous, a Moroccan dish of meat based on a sort of dry semolina. Thence we repaired to the celebrated *Au Lapin Agile* to enjoy the cabaret of Aristide Bruant—French poetry and songs.

It was something of a descent from the esoteric *Au Lapin Agile* to the more prosaic *Au Clair de la Lune* in Pigalle, where we spent the following evening. We were disgusted to find our second drink costing just as much as the first, but having been fleeced we were determined to stay and get our money's worth. Pigalle is brash and noisy and crowded and brightly neon-lit; hot-dogs and crêpes are for sale on the corners, *les poules* in the doorways. The strip-clubs and revue bars are concentrated on a short stretch of the Boulevard de Clichy, between the Moulin Rouge (Place Blanche) and Place Pigalle.

The London Underground is greatly flattered by comparison to the Métro, for the tube in Paris is noisy, slow and uncomfortable. Usually there are two green 2nd class coaches on either side of a single red 1st class car, which is identical but slightly less crowded. There seems to have been no attempt to keep the track level or straight in construction, and sharp corners and steep inclines greatly reduce the maximum speed. However the stops are very close together, and it certainly proved easy to find the way. The newest trains, moreover, run on rubber wheels, allowing a much smoother ride.

No English paper can hold a candle to *France Dimanche* for scandal. In one edition of this splendid weekly we learnt, to our surprise, that Princess Margaret was about to leave the court because Lord Snowdon had had an offer from Hollywood—and the English preferred Angus Ogilvy anyway. Journal readers may also be interested to hear from the same source that King Olaf of Norway recently gave a sharp snub to Queen Frederika of Greece by failing to land at Athens airport on his journey to a state visit in Iran; and why?—"il n'a pas oublié qu'elle a refusé de l'épouser". After such news, it was mere banality to learn of further trouble among the Dutch Royal Family, and sheer bathos to read that Charles Aznavour's first wife sold tickets at a Paris cinema.

Of course we climbed the Eiffel Tower, though the top was closed for the winter and like good tourists, we drank coffee at the *Café de la Paix*. We even visited the Arc de Triomphe, modelled on Constantine's Arch at Rome, and eyed the copies of *Kama Sutra* etc., snugly bound in polythene, on the stalls of *les bouquinistes* beside the Seine. We made the usual mistakes; a request for 20 Gauloises received the horrified reply that there weren't that many packets in the shop. At La Concorde, where the statue of the town of Brest marks the position formerly held by the guillotine, we asked a stocky dapper man the way to the Métro station. Unluckily he turned out to be a former colonel in the French Resistance. Warmly shaking our hands he told us that he had watched Churchill's funeral on television with tears in his eyes; as far as the Métro was concerned, however, it was a lovely day and we would do much better to walk. So we took his advice and strolled up the Champs Elysées, past those depressing little sheds, each armed by a fierce uniformed Amazon, where it costs you 22 centimes (a most curious sum) to spend a penny. Lastly we were pursued down the Avenue de l'Opéra by a seedy little man with a grin trying to sell dirty pictures.

But the finest memory is of Sunday evening at the lovely left-bank church of St. Germain de Prés. Leaving the bitter cold outside, we came in to the darkened church towards the end of the Evening Mass. And at the end of the celebration and after the blessing, there was a short but exquisite plainsong chant, and then the huge congregation sweeping out past us, and the altar most beautifully lit.

CANCER CHEMOTHERAPY

THEORETICAL CONSIDERATIONS AND PRESENT PRACTICE

By John Matthias

Physician, The Royal Marsden Hospital

The term chemotherapy was introduced by Ehrlich to describe the specific and effective treatment of infectious disease by chemical substances. It is currently also applied to the treatment of malignant disease. Unfortunately no aspect of tumour metabolism has been discovered which has allowed the development of drugs capable of acting specifically upon the malignant cell, so that cytotoxic drugs also affect normal cells to a greater or lesser degree. The most susceptible or sensitive of the normal tissues are those with the highest rates of cell turnover and include the hæmopoietic and lympho-reticular tissues, the gastro-intestinal epithelium, the ovary, the testis and the hair follicles.

The introduction of nitrogen mustard into medicine in 1946 as a direct result of chemical warfare research may be said to have heralded the era of cancer chemotherapy, although the inhibitory effect of colchicine on cell mitosis had been recognised since the latter part of the nineteenth century. Subsequently many thousands of naturally-occurring and laboratory-synthesized substances have been examined for anti-tumour potentiality. Of these only a limited number have proved effective in clinical practice. Those in common use are listed below.

A. *Chemotherapeutic agents, the actions of which are at least in part understood.*

1. Alkylating Agents

The alkylating agents are synthetic substances of known chemical composition. They react avidly with inorganic radicles by a process known as alkylation, in which negatively charged intra-cellular radicles combine with the positively charged alkyl (CH_2) radicles of the agent.

(a) The nitrogen mustards: mustine (HN2 'nitrogen mustard', mechlorethamine, mustargen), trimustine (*Trillekamin* HN3), chlorambucil (*Leukeran*, phenyl butyric mustard), melphalan (*Alkeran*, phenyl alanine mustard), uramustine (*Uracil mustard*), cyclophosphamide (*Endoxan* or *Cytoxan*), mannomustine (*Degranol*).

(b) The ethylenimines: tretamine (triethanomelamine, triethylene melamine, TEM), thiotepa (triethylene thiophosphoramide), triaziquone (*Trenimon*).

(c) The sulphonic acid esters: busulphan (*Myleran*).

2. The Antimetabolites

The antimetabolites are substances of known chemical composition which closely resemble known naturally-occurring metabolites. Such a substance enters a particular metabolic pathway and interferes with subsequent biosynthetic steps by a process of competitive inhibition.

(a) Purine analogues. 6 mercaptopurine (*Puri-nethol*).

(b) Folic acid antagonists, methotrexate (amethopterin).

(c) Pyrimidine analogues, 5 fluorouracil, 5 fluorodeoxyuridine.

(d) Glutamine antagonists, azaserine, diazo-oxo-norleucine (DON).

B. *Chemotherapeutic agents with obscure biochemical actions.*

1. Anti-mitotic substances extracted from plants, colchicine and its derivative demecolcine (*Colcemid*), vinblastine (*Velbe*), vincristine (*Oncovin*).

2. Antibiotics or agents synthesized by living organisms such as fungi and bacteria, actinomycin C (*Sanamycin*), actinomycin D, mitomycin C.

3. Miscellaneous cytotoxic chemicals, urethane, methylhydrazine.

4. Hormones

Chemical compounds with actions similar to those of natural hormones may be properly regarded as chemotherapeutic agents. This is particularly so when they are used in therapeutic rather than physiological or replacement dosage. Apart from the lympholytic action of the corticosteroids, it is doubtful whether any of the hormones used in cancer chemotherapy affect the malignant cells directly. In the main, tumour cells seem to be inhibited by the withdrawal of certain natural hormones, for example following ovariectomy or orchidectomy. Alternatively, the production of such hormones may be reduced by the suppression of internal secretions responsible for their control. So that the mode of action of many, if not all, hormonal chemotherapeutic agents is possibly by means of a "medical" hypophysectomy, adrenalectomy, ovariectomy or orchidectomy.

(a) Oestrogens, stilboestrol, ethinyloestradiol.

(b) Androgens, testosterone and esters, nandrolone (*Deca-Durabolin*).

(c) Corticosteroids, prednisolone, prednisone.

(d) Thyroid hormones, thyroxine, triiodothyronine.

(e) Progesterone, medroxyprogesterone (*Provera*).

General Aspects

Chemotherapeutic agents are most commonly used in cancer to treat disseminated disease unsuitable for surgery or radiotherapy. Radiotherapy remains the most effective means of reducing the volume of a tumour mass and relieving localised bone pain, nerve pressure or superior vena caval obstruction.

Chemotherapeutic drugs may be administered systemically or locally. They may be given by mouth or injected into a vein or muscle. Alternatively an agent may be instilled into an artery or a body cavity or may be injected directly into a tumour mass or applied to its surface. The development of agents which are effective by mouth has greatly simplified the management of patients, many of whom may now be treated as out-patients.

Substantial but temporary palliation has been achieved in acute leukæmia in children, chronic leukæmias, Hodgkin's disease and other malignant reticulosis, carcinoma of the ovary, uterus, prostate and breast, plasma-cell myeloma, testicular tumours, melanoma and epithelioma. It is of interest that tumours arising from tissues normally most susceptible to chemotherapeutic agents are among those most sensitive to treatment.

Following a remission, most authorities recommend continuing the drug in reduced dosage as maintenance therapy. It has been shown in acute leukæmia and in Hodgkin's disease that the duration of a remission may be lengthened in this way. There is no indication that prolonged use of a low dose hastens the appearance of resistance but the long term administration of potentially very toxic drugs may prove unnecessary in very slowly growing tumours. In these cases it would be reasonable to discontinue the drug and await events.

There is little doubt that treatment with chemotherapeutic drugs may prolong life. This has been amply demonstrated in acute leukæmia where life expectancy is short (Bernard and Boiron, 1962). However, when the untreated patient survives three, four or more years, it is more difficult to prove and the usefulness of a particular drug must rest on other criteria such as its ability to bring about subjective and objective improvement. Where improvement is marginal or equivocal or when two drugs of similar potential are to be compared, carefully conducted clinical trials are required.

Hodgkin's disease and other reticuloses unsuitable for radiotherapy by virtue of the degree of dissemination may commonly be controlled for considerable periods by alkylating agents, of which chlorambucil, cyclophosphamide and melphalan are among those most widely used. Possibly the most rapid response is achieved by intravenous administration although oral therapy is usually effective. Methylhydrazine (Mathé *et al* 1963) may be useful when the disease is resistant to the alkylating agents and relapses often respond to vinblastine (Frost, Goldwein and Bryan 1962, Smart *et al* 1964) or vincristine (Bohannon, Millar and Diamond 1963, Whitelaw *et al* 1963). Methylhydrazine therapy tends to cause troublesome nausea and vomiting, and the administration of vincristine is complicated by a high incidence of neurotoxicity. Cyclophosphamide, vinblastine and vincristine possess a relatively high therapeutic ratio as far as the marrow is concerned and in particular may be more safely employed in patients with thrombocytopenia. As a rule maintenance therapy is indicated in Hodgkin's disease, particularly as the remissions induced by single courses of mustine, methylhydrazine, vinblastine and vincristine, are not uncommonly only of four to eight weeks duration.

Progressive lymphoproliferative disorders such as lymphosarcoma and chronic lymphatic leukæmia are generally relatively more sensitive than Hodgkin's disease to the alkylating agents so that smaller doses should be used initially. Corticosteroids may be used alone or in conjunction with cytotoxic drugs. However, they are usually less effective in reducing the lymphocyte count and the volume of tumour masses but are often preferred in the face of a significant thrombocytopenia because of their effect in reducing capillary permeability. Nevertheless if the deficiency of platelets is due to interference with the megakaryocytes in the

marrow by tumour cells, a case may be made for their cautious use.

The frequency of troublesome side effects due to long-term therapy, such as osteoporosis, vertebral collapse, myopathy, diabetes mellitus and steroid obesity, suggests that corticosteroids should not be used too readily in patients with a relatively good outlook.

Corticosteroids are also of value for treating the anæmia of cancer. This common complication is in part hæmolytic and the incidence of both anæmia and undue hæmolysis increases as the disease progresses. Prednisone or prednisolone in therapeutic doses will often reduce the rate of fall, and sometimes increases the hæmoglobin level. The explanation for this effect is almost certainly complex but in part may be due to a reduction of losses of red cells from the circulation (Matthias, 1964).

There seems little value in using doses of prednisolone or prednisone larger than 40-60 mg. a day in the treatment of malignant disease. Indeed it has been shown that doses in the range of 250 mg. a day in acute leukæmia are associated with an increased risk of overwhelming infection (Medical Research Council Working Party 1963).

The most successful drugs in plasma-cell myeloma are cyclophosphamide (Rivers, Whittington and Patno 1963, Matthias 1963) and melphalan (Bergsagel 1962, Brook, Bateman and Steinfeld 1964). This is possibly explained in part by the fact that either is well tolerated and may be persevered with for considerable periods, rather than for any other reason. Some 50-60% of patients will improve objectively and one third may be returned to gainful occupation.

Busulphan induces consistent and worthwhile remissions in chronic myelocytic leukæmia. It is more easily controlled and more effective than mercaptopurine and should be continued in maintenance doses. Prednisolone (or prednisone) is the drug of choice in acute leukæmia. 70-80% of children and 10-20% of adults will remit. If a remission is not achieved, mercaptopurine or methotrexate should be added and on occasion intravenous cyclophosphamide or vincristine may be effective. Corticosteroid remissions may be extended by the addition of mercaptopurine in maintenance doses.

In general the response of the solid tumours to cytotoxic drugs is disappointing. Ovarian carcinoma responds with reasonable regularity to alkylating agents and worthwhile responses occur from time to time in a number of other conditions including mammary and lung carcinomata. Adenocarcinoma of the alimentary system has proved extremely resistant to therapy, although it is claimed that successful palliation may be achieved in 20-30% with 5-fluorouracil or related compounds (Ansfield and Curreri 1963, Wilson 1960). 5-fluorouracil is toxic and must be used with particular care. 5-fluorodeoxyuridine has a more flavourable therapeutic index but it is expensive and not generally available.

Cytotoxic drugs and radiation usually produce additive effects but there is some indication that actinomycin D and 5-fluorodeoxyuridine may potentiate the effects of radiotherapy in synergistic fashion. Such combinations may prove useful in resistant solid tumours. However, it is doubtful whether tumour cells are sensitised in preference to normal cells.

The best results in breast cancer developing before the menopause or in the subsequent five or ten years, are achieved by measures which reduce the output of natural oestrogens, such as ablative surgery and the administration of androgens and corticosteroids. When the disease arises ten or more years after the menopause, oestrogen therapy is usually preferred. The controlling factor in the choice of therapy is the degree of natural oestrogen activity present at the time. On occasion hormonal therapy may stimulate rather than suppress tumour growth so that the patients should be followed carefully. Recently some separation of the anabolic and virilising activities of androgens has been achieved and it has been found that relatively non-virilising preparations may retain their ability to arrest breast cancer. It is often said that hormonal measures are most effective in the control of metastases in bone but it should be remembered that whereas a relatively minor reduction in the volume of a bone secondary may be associated with the relief of pain, a comparable effect on metastases in soft tissues and organs may pass unnoticed. Chemotherapeutic agents are usually advocated for this type of disease and some success may be expected from thiotepa, methotrexate or 5-fluorouracil in 15-30% of patients.

Measures designed to reduce the output of natural androgens (castration and oestrogen therapy) continue to be the treatment of choice in disseminated carcinoma of the prostate. It has been known for many years that a small percentage of patients with well differentiated tumours of the thyroid respond to the administration of thyroid hormones, the limiting factor being the general metabolic effects. There is hope that the antithyroid and metabolic effects may be eventually successfully divorced. This has to some extent already been achieved in the proprionic and acetic derivatives of thyroxine and triiodothyronine. Progesterone derivatives have been claimed to bring about objective remissions in one third of patients with disseminated carcinoma of the body of the uterus, and also to be useful on occasion in carcinoma of the kidney.

The concept of 'cure' by chemotherapy

Until the advent of radiotherapy, surgery offered the only possibility of 'cure' in cancer. Already radiotherapy has replaced surgery in the treatment of some malignant conditions (e.g., basal cell carcinoma). In others it has produced comparable results and cases unsuitable for surgery show increasing numbers surviving five, ten or even twenty years without recurrence after treatment. In particular, conditions previously considered of multifocal origin and therefore 'incurable', such as the reticuloses, are showing impressive survival figures when treated as if they were of unicentric origin. Large doses of radiation are given to the site of disease and the adjacent regions of lymphatic drainage are also treated. Using this principle Peters and Middlemiss claim a 71% five year survival, a 58% ten year survival and a 33% twenty year survival in Hodgkin's disease confined clinically to one lymphatic region at the time of presentation and treatment (Peters, 1950; Peters and Middlemiss, 1958). The Manchester results are equally impressive (Eason and Russell, 1963).

Wide dissemination however may occur before local control can be achieved. It is logical therefore to attempt the elimination of such cells even when the disease is localised clinically and apparently amenable to curative surgery or radiotherapy. In practice it has proved difficult to demonstrate that a combination of chemotherapy and curative surgery (Curreri, 1962; Higgins *et al.*, 1962; Holden and Dixon, 1962; Longmire, 1962) or radiotherapy improves the patient's chances of survival. However, the published series suggest that "adjuvant" chemotherapy (Shapiro and Fugmann, 1957) may be of value in particular instances; for example, the use of thiotepa with radical mastectomy in carcinoma of the breast (Noer, 1962), thiotepa and surgery in ovarian carcinoma (Masterton, 1962), actinomycin D and radiation in Wilm's tumour (Farber *et al.*, 1960; Altman, 1961), and tretamine (TEM) and radiation in retinoblastoma (Reese *et al.*, 1958; Hyman, Elsworth and Reese, 1962).

However, in general it has not been shown clearly to be of use and in view of the hazards accompanying the administration of such agents it should be considered an experimental procedure and restricted to carefully conducted clinical trials. The injudicious use of chemotherapeutic agents at the time of surgery may increase the morbidity and mortality of the procedure and there is some suggestion that on occasion the natural immunological defence of the body against the tumour may be impaired. Further, with particular regard to radiotherapy, the effects of the systemic agent on the bone marrow may severely limit the amount of radiation that can be given to the tumour.

Some forms of malignant disease in animals may be cured by chemotherapeutic agents alone. In patients, survival in good health without evidence of recurrence for five years or more has been achieved in choriocarcinoma and allied conditions (Hertz *et al.*, 1961, 1963). These tumours arise from homologous foetal tissue and are almost certainly less securely established and more easily influenced than autologous tumours. Large doses of methotrexate are required. 20 or 30 mg. are given intramuscularly on each of five consecutive days. In some resistant cases as many as ten or fifteen courses have been given. Despite a complete clinical response the gonadotrophin output may remain elevated. In some of these patients it has fallen to normal after hysterectomy and residual tumour has been found in the resected specimen. The particular sensitivity of this tumour to chemotherapeutic agents is evidenced by the high percentage of subsequent remissions (about 40%) which can be obtained by the use of other agents such as actinomycin D, chlorambucil, vinblastine or DON (Hertz, Lipsett and May, 1960; Ross, Stolbach and Hertz, 1962). In contradistinction gonadotrophin producing tumours in the male are usually resistant to treatment.

It has been suggested that the judicious use of currently available drugs may be able to eliminate malignant cells in other cancers. Experimental work, however, suggests that tumours contain a spectrum of cells of varying sensitivity and that it becomes progressively more difficult to destroy all the neoplastic cells (Hauschka, 1957). There is evidence that the higher the dose the more effective the treatment (Skipper, Schabel and Wilcox, 1964) but systemic use of large doses of cytotoxic drugs is extremely hazardous, requiring the provision

of adequate supportive measures such as red cell and platelet transfusions, electrolyte replacement and protection against infection by pathogens (reversed-barrier nursing) and commensals. The usefulness of marrow transplantation is controversial (Mathé, 1960; Kurnick, 1962). It seems that ultimate recovery is little improved even following the use of autologous marrow although the rate of recovery may be accelerated (Sprague, 1960). The administration of testosterone may allow larger doses of chemotherapeutic drugs to be given with less than the expected degree of depression of the peripheral count (Brodsky, Dennis and Kahn, 1964).

The volume of tumour present has been shown to have a considerable effect on the cure rates achieved by chemotherapeutic agents in animals. When the tumours are small and of recent origin, the greater the chance of cure. In patients the principle may be exploited by the earlier treatment of a recurrence or metastasis and by the excision of tumour masses. Further, the effect of a drug may be greatly modified by varying the intervals between doses quite apart from any consideration of the total dosage employed. For example, in the case of mitomycin, correct spacing of the doses prolongs the survival time of animals even when the total dosage is reduced.

A combination of chemotherapeutic drugs may be more likely to succeed than a single agent. Some workers are using as many as five drugs simultaneously in the treatment of acute leukæmia, and some success has been reported with a combination of chlorambucil, actinomycin D and methotrexate in resistant testicular (Li and others, 1960) and ovarian tumours.

Nevertheless, it may be possible by such measures to reduce the number of malignant cells to such a degree that there may be a chance of eliminating residual cells by other means. Animal experiments have shown that anti-tumour antibodies enhance the effectiveness of chemotherapy but little has been achieved to date in patients (Graham and Graham, 1959; Buinaskos and others, 1959). However, the circumstances are complex and it may well be necessary to prepare a specific antiserum for each tumour. Further, the antigenic determinants of a tumour may change during the course of the disease.

Regional Chemotherapy

High concentrations of chemotherapeutic agents in the region of the tumour may be more safely achieved by introducing the drug directly into the arterial supply. Drugs given in this way are more likely to be effective than when used systemically, so the techniques are to be recommended for inoperable but relatively localised tumours. Two methods are used. The first is known as infusion when the drug is instilled into the arterial supply of the tumour without recirculation. A single injection may be given, or alternatively an indwelling catheter may be introduced and a continuous infusion or repeated injections given over a period of time. (Freckman, 1963; Oettgen, Clifford and Candler, 1963; Sullivan and others, 1963; Sullivan and Zurek, 1964). Systemic effects are restricted by dilution in the general circulation and inactivation of a proportion of the drug during its passage through the tumour—thus drugs with a short action are favoured. Alternatively, antidotes may be given systemically to inhibit the general effects, for example, folinic acid may be given when using methotrexate (Sullivan, Miller and Sykes, 1959), thymidine with 5-fluorodeoxyuridine and thiosulphate or cysteine when using radiomimetic drugs. Protection of the body may also be attempted by hypothermia.

The second method is that of perfusion (Creech 1959 a and b). The tumour vasculature is isolated as completely as possible and the drug is circulated mechanically in a closed circuit by means of a pump in association with an oxygenator. When the region can be isolated completely, the tolerance of normal tissues proves the limiting factor to the amount of drug that can be used. However, except with peripherally situated limb lesions, considerable leakage into the general circulation cannot be avoided. The advantages of the perfusion technique lie in the relative isolation and the possibility of some control over the local environment. For example, the anti-tumour effects of some agents may be enhanced by increasing the temperature, oxygen tension or glucose concentration or by lowering the pH (Krementz, Harlin and Knudsen, 1960).

Many ingenious methods have been introduced for the infusion and perfusion of the limbs, the head and neck including the brain, the liver, the pelvis and the lungs: the most commonly employed techniques are the intermittent or continuous infusion of cancers of the head and neck with methotrexate or 5-fluorouracil and the perfusion of malignant melanoma of the limbs with melphalan.

Regional chemotherapy is usually a palliative procedure. It is consistently successful in relieving pain and obstruction. It may prove a valuable means of improving the results of surgery and perhaps may eventually become the curative treatment of choice for some tumours (for example, peripherally situated melanomata, see Stehlin, Smith and Clark, 1960).

However, the crux of the problem lies in the development of drugs with a specific action on malignant tissue. It has already been shown that it is possible to separate to some degree the cytotoxic effects of such drugs on tumour and normal tissue. In animals, if the minimum dose which effectively prolongs life (MED) or cures (MCD) is compared with the minimum lethal dose (MLD), the figures for mustine, chlorambucil and melphalan in μ moles per kg. are respectively, MCD/MLD, 16/15, 50/174 and 50/140 and MED/MLD, 5.2/15, 1.7/174 and 19/140 (Jones et al. 1960), showing the superiority of chorambucil and melphalan over mustine.

It must be emphasised that to date no patient with malignant disease may be said to have been cured by chemotherapeutic drugs. There is, nevertheless, high hope that success will eventually be realised. Already the elimination of malignant trophoblastic disease may have been achieved and regional chemotherapy has been advocated as the definitive treatment for malignant melanoma of the extremities.

Undoubtedly at the present time, in those situations in which surgery or radiotherapy offer a reasonable chance of cure, such treatment should be advised. However, it seems likely that the cure rates of both surgery and radiotherapy may be improved in certain circumstances by the judicious use of adjuvant chemotherapy designed to destroy undetected disseminated disease, to prevent the dissemination of viable malignant cells at operation and to reduce the size of the tumour to facilitate the technical aspects of operation. Possibly the preoperative administration of chemotherapeutic drugs will allow the more extensive and mutilative forms of surgery to be replaced by lesser procedures without prejudicing the patient's chances of survival.

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do you do this?

5. TEAM EVANGELISM

by DEREK GRAVATT

AT one of the Christmas Services at our Church in 1963, five of us sang a carol accompanied by a guitar. Shortly afterwards my mother was booked to take the morning service at an old ladies' home in Bermondsey, where her sister is warden. She suggested that we came along, chaired the meeting and sang that carol and maybe another item with the guitar. We readily agreed and after due preparation set out on January 12th to take this service. The old ladies were delighted to meet us. After the service we went round and chatted to them all. There are 28 ladies in this house and a few of them are Christians. Before we left we booked to return the next month, by ourselves.

That is how we began. Now there are eight team members and we handle one or two meetings every month. Six of us usually go on each engagement. We are all members of our local Church and take active part in the work there. Our occupations range from computer engineer to librarian.

Our prime purpose is to tell people about Jesus Christ and we tackle this in what we believe is a vigorous and varied way. We often use short sketches to illustrate Bible teaching. The Bible itself contains many parables and we find that these modern, acted parables are just the thing to set people thinking. They are easy to remember and effectively bring out the deeper meaning. They are good ice-breakers too, and help to win over the audience.

When we use the guitar, it is for accompaniment only. We sing a variety of songs, from Negro Spirituals to one or two of our own composition. We enjoy our singing—and it shows! We feel that this is very important, especially when meeting folk who are house-bound most of the time.

The work is divided into two parts—the regular and the special.

The regular work involves visits to the old ladies at Bermondsey and also the Sunday evening service for the girls (15-25 years) at John Groom's Crippleage, Edgware. We visit the old ladies and the Crippleage about once every two months. Both of these meetings are held in large sitting rooms and there is a very friendly atmosphere. We have had many happy times with these people.

Some of the old ladies are very funny. One old dear of ninety-five has a keen wit and keeps us in fits of laughter. On one occasion she thought she could cure her friend's baldness by anointing her with a jar of Brylcreem!

Some of the girls at John Groom's are quite badly crippled, yet "Rule number 1" is, Never give a helping hand. They much prefer to tackle a job and fail before

calling for help. They have great fun with their wheelchairs and often challenge outsiders to beat them. I haven't tried yet!

From this you can see that we take time to talk to these folk after the service. We think that this is very valuable. They then know that you are really interested in them and what they think and do, and friendships are formed. We like to do this at every place we visit.

The special work involves those places which we only visit once, or once in a while. Obviously there is not the same opportunity to get to know people. However we have had some interesting and exciting times. Like the evening service in a Bermondsey Mission Hall, where the sermon was preached to the tune of stones rattling on the windows and screaming kids. These children are very difficult to handle and yet often very needy. They live in the flats surrounding this Church and are always attracted by something new or unusual. And the school, near Reigate, where a large number of the 400 pupils come from broken homes. Some very tragic stories lie behind the eager faces as we tell them of the love of God. They are a lively crowd and the school is a little understaffed—two factors which don't go well together! They have compulsory Sunday morning Church and so they hate religion. However, over 50 came that afternoon to listen to us.

I hope that this has given you some insight, albeit small, into the management and activities of a group of this kind. There are many similar groups throughout the country, who work in coffee bars and pubs as well as Homes and Churches.

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Research Reviews, 1963-64, edited by Dr. J. E. L. Carrick, London. Medical News Ltd. Stiff paper back volume, illustrated.

This paper backed volume of 227 pages is a collection of research articles which have appeared in *Medical News*. The print is clear and the illustrations are well done.

This collection brings the latest knowledge with a minimum of burdensome technicalities, under fourteen main headings, contributed by many of the foremost names in the Profession.

Being intended as a gift to subscribers to *Medical News* no charge is made to them but when extra copies of the previous edition were requested this led to undesirable rationing of the volume. To obviate a recurrence of this non-subscribers may now obtain *Research Reviews* for £1 1s.

W.H.M.

Essential Anatomy, by J. S. P. Lumley, M.B., B.S., J. L. Craven, B.Sc., M.B., Ch.B. and J. T. Aitken, M.D. Published by E. & S. Livingstone Ltd., Edinburgh and London. 30s.

This short synopsis of anatomy, intended for preclinical medical (and dental) students, differs little in content and approach from several similar works on the market. It is essentially a catalogue of those facts of topographical anatomy considered by the authors to be most important. The text is organized on a rather formal basis: descriptions follow a stereotyped pattern and the key to this is printed on a bookmark. The treatment is regional and, where appropriate, very brief notes on relevant histology and embryology are included. The last six chapters are devoted to a brief account of the central nervous system. The book is sparsely illustrated with simple line drawings, often of sections through the region being considered. Within its limitations it is accurate, although there are a few rather unfortunate lapses.

Such books, of course, are a temptation to wearisome rote-learning. Anatomy can be fragmented into a mass of facts which, when abstracted from their three-dimensional context, have little significance. This type of book, then, would seem to have its only valid use in revision, by those already fairly familiar with dissected material; in this way it could prove useful—at least for passing the 2nd M.B. examination.

O.J.L.

Handbook of Obstetrics & Gynaecology, by Benson. Published by Blackwell Scientific Publications Ltd. Price 37s. 6d.

This book is a "handbook" in the sense that it can be held in the hand or carried in a poacher's pocket. This is achieved by small print on 600 pages of thin paper.

The material of the book is much more extensive than we would expect in a handbook. It compares very favourably with any British standard work on gynaecology and obstetrics written for senior students or house officers. It contains many beautifully drawn illustrations which are highly instructive in themselves and cleverly complement the text.

The chapters with a psychological flavour are particularly attractive. Those concerning the emotional aspects of pregnancy and psycho-somatic gynaecology are recommended. An unusual feature is an excellent chapter on medical genetics. One Americanism—routine appendicectomy at Caesarean section—will attract no disciples here. There are other differences of current practice, but to concentrate on these will only distract the would-be reader from a valuable book.

The intern, who supplements his daily experience in out-patients and the wards by nightly reading of this book of conditions personally encountered by him, will emerge in six months with a defensive knowledge of the subject as a whole and academically he will be more than half way towards his higher degree.

D.B.F.

Catalogue of Lewis's Medical, Scientific and Technical Lending Library: New edition, revised to December 31, 1963. Part 1. Authors and titles. London, Lewis. 30s. to subscribers; 55s. to others.

This new edition of *Lewis's Library Catalogue* will be welcomed by all subscribers to the Library, and by all librarians. It takes the place of the previous edition published in 1957, the supplement covering 1957-59, and the bi-monthly lists published up to the end of 1963. Part one lists authors alphabetically giving short-titles (not title entries as suggested), edition, size, price and date. A useful addition would be names of publishers, but perhaps one can hardly expect a bookseller to provide these.

This catalogue of about 33,000 titles lists the current editions of books in English available in the Lending Library, and includes many out-of-print books for which there is still a demand. It also records certain annuals and reports, the last five years' issues of which are available in the Library.

Lewis's Lending Library has performed an invaluable service to subscribers since 1848, and its printed catalogue assists those in the provinces and abroad to take full advantage of the facilities provided. Terms of subscription are given, but special rates for undergraduates at medical schools are only available on application.

J.L.T.

Structure & Function of the Heart, by Alan F. Toronto, M.D. Published by Heath-Harrap. Price 10s. 6d.

This paper-back book, written by a physiologist from the Latter-Day Saints Hospital at Salt Lake City, is intended for High School students interested in studying the heart in more depth than their 'hygeine texts allow', but without the complicated detail of medical textbooks.

The depth at which Dr. Toronto attacks the subject is somewhat uneven. For example, there is a whole chapter on the embryology of the heart (complete with a diagram of the foetal circulation straight out of Gray), whilst in an earlier chapter there is a half-page photograph showing how to take the pulse. Most of the text is clearly, if somewhat dully written, and should be comprehensible to sixth-formers, but the same cannot be said of all the diagrams, some of which are intensely confusing and complex. The book is of no direct interest or value to the student of medicine, but would be useful in a school library.

M.E.S.

Urology for Nurses, by J. P. Mitchell, T.D., M.S., (Lond.), F.R.C.S., Published by John Wright & Sons Ltd. 1965. Price 19s. 6d.

Mr. Mitchell appears from this small book a practical surgeon with well-formulated views and the ability to express these unambiguously. The comfort and happiness of patients with incontinence, temporary or permanent, or with bladder drainage after surgery, depends on attention to minute details of management. It is on his knowledge and thought about such mundane matters that nurses and patients judge a surgeon, and Mr. Mitchell would rate highly in this respect.

His accounts of surgical operations and of radiological investigations are good, and there is a full description of dialysis in the treatment of anuria. There are some very good diagrams, but the photographer must have been disappointed to see his pictures reduced to a size at which detail is invisible.

The book handles well, though if it was printed by a conventional process it would have looked better had the text been aligned by the right as well as by the left margins.

W.E.H.

How to Interpret Renal Function Tests
by Dr. Jean F. Porge.
Translated by Peter Holmes, F.R.C.S. Published by John Wright & Sons Ltd. Price 8s. 6d.

This book is one of a series of Belgian pocket manuals written for practitioners and students, and is intended to clarify and evaluate current tests of renal function. The book has little to commend it. Its principle failing stems from an over-zealous attempt to summarise the information presented. For example, the brief reference to the counter-current theory of urine concentration and dilution is too short to serve a useful purpose. Perhaps a more serious criticism is that there are several errors of fact. Few would agree that aldosterone has an important action on the proximal tubule, and such statements as "acidification of the urine . . . is due in part to secretion of potassium" can only confuse the reader.

The author fails to emphasise various practical points in the performance of clearance tests; a lack of reproducibility in the results of urea clearances most commonly results from errors in timing, and cannot be accepted as a "good sign". The treatment of the subject is superficial, incomplete and confused. The book cannot be recommended for students interested in understanding the basis for rational renal investigations.

W.R.C.

NEW PENGUINS

"Wolf Solent", by John Cowper Powys. Penguin. 10s. 6d.

This rather depressing bucolic tale is based upon the upland country on the borders of Dorset and Somerset where our hero was born and now returns in his mid-thirties to seek a new life. He is the child of ill-assorted parents, his father now dead, a soft philandering failure, his mother who follows him to Dorset, a hard possessive woman, egocentric but capable. Young Wolf unfortunately seems to have inherited the lust without the capability, and the egocentricity without the toughness. He hides from the reality of life by escaping like Walter Mitty into his inner world, his so-called "mythology". He is employed by the local squire, an ageing and malicious pervert, to help in writing a salacious account of past local scandals, and in so doing his self-respect is destroyed, his "mythology" ablated.

More than 600 pages are devoted to the delayed maturity of this one man, whose character therefore becomes of primary and central importance. In the opinion of this reviewer, this is exactly where the book fails, because Wolf Solent is essentially a dull and lethargic sort of fellow, and it is difficult to sympathise with the thoughts and actions of a bore. According to the blurb on the back, *"Wolf Solent"* has been described as one of the few great apocalyptic novels of our time, but the only revelation here disclosed is that Thomas Hardy describes the West Country with an immeasurably greater sense of beauty and of poetry. John Cowper Powys, a descendant of the poet William Cowper, allows his narrative style which is sometimes both exciting and full of insight to lapse all too frequently into sentiment and precious language. The author appears hypnotised by the beauty of his own fictitious names, such as Ramsgard (Sherborne), Blacksod (Yeovil), Lenty Pond, the River Lunt, Melbury Bub, the Gwent Lanes, for he drags them into nearly every page with tedious repetition.

Shortly after his arrival in Dorset, our hero, acting with rare decision, seduces and marries the beautiful but brainless Gerda Torp, daughter of the local monumental mason, while losing his heart to the cerebral but chilly Christie Malakite, daughter of an incestuous old bookseller. Thereafter he potters about, musing bitterly on his fate, like Hamlet without the ability to determine a solution to his troubles. Christie, upset by his stop-go tactics, decamps to Weymouth with her niece (the fruit of her father's incest with her sister), while on the home front our hero, so unfaithful in spirit to his wife, is made cuckold in bare and rather sordid fact by the local grocer. In an atmosphere of growing rustic claustrophobia the book meanders on, slow as the muddy Lunt, to its overdue but unsatisfactory conclusion.

Robin Williamson.

Film World, by Ivor Montagu. Pelican Special. 6s.

Are you one of those people who go to the cinema just to be entertained, or do you derive a greater pleasure from observing the actual technique of the film, the way the director uses the camera to give us his view of life, to manipulate the characters so that they are seen with greater understanding? Whatever your attitude this book is worth glancing through—rather than reading, for the book is a not altogether successful attempt to reveal the nature and meaning of films. To approach the subject on a strictly scientific footing as Mr. Montagu does, is to risk losing some of the reader's interest right at the start. Most people know how a moving picture is made to appear on a screen by the projection of a series of images in quick succession. The technical detail is not very absorbing, but the historical aspect is. What is one to make of the revelation that no one man invented the Cinema though many claimed to have done so? Alas for poor Friese-Green! Friese-Green would have been the first to admit the possibility of the film becoming an art form and it is dealing with cinema as art that the author is at his best. Nevertheless he is biased. He throws too much emphasis on the importance of editing, this perhaps being the result of his early training with Einstein. The way the image is placed in the frame and the use of lighting and camera movement to achieve a set effect reveal a director's capabilities as much as his skill in the cutting room. It is primarily by the creative use of the camera that the modern continental directors, Antonioni, Resnais and Godard, have achieved their reputations. The longest section of the book is devoted to film as a commodity, but if you are looking for a completely satisfactory analysis of what makes or breaks a film financially you will be disappointed. On the question of the restrictions that surrounds film makers, in particular censorship, the author is on far more certain ground. He is too parochial, though, when it comes to dealing with film distribution. The conditions in this country in this aspect are rather unusual. If this book has one great virtue it is that it is free from that awful

pretentiousness that surrounds so much writing on the cinema. The author's opinions are highly individual ones. They are stimulating, but enjoyment is to some extent marred by an awkward style particularly evident in the first section of the book. Whether it shows "uncommon perception and astonishing range" as the blurb on the cover claims, is for the reader to decide.

Gervase Hamilton.

Man Meets Dog, by Konrad Lorenz. Penguin. 3s. 6d.

Konrad Lorenz is a man of some academic distinction, but his books are anything but dryly academic. He is very human and records facts not dispassionately, but with the intimacy and humour of personal involvement.

The title of this book is both representative of it and misleading. It is humorous, but the humour is woven into a framework of fact, observation and explanation. The explanations are of particular interest. With no dogmatism, the author makes suggestions, for instance of how the first man/dog relationship was established, which are fascinating and stimulating—they seem to challenge the reader to consider other explanations and ultimately to draw his own conclusions from the basic facts.

But this is academic. The book has a more practical import for anyone who may consider keeping a dog. A doctor particularly may want a dog as a companion, a house dog—perhaps to protect his wife while he's out at night; or perhaps a gun dog when things are arranged so that he has more money and more time! In whichever circumstance, it is imperative that he should read this book before he chooses. It is a gold mine of information about dogs of all origins, breeds, shapes and sizes by a, if not the, leading authority.

My only adverse criticism is that the author, perhaps inevitably from long association with animals, is clearly an anthropomorphologist, however much he may warn his readers against this science.

John Mitchell.

England In The Twentieth Century, by David Thomson. Pelican Books. Price 5s.

To explain 50 years of history to people who have lived through them (or part of them) would appear to be a formidable task, and carry a slight smell of impertinence.

This, the last in the *'Pelican History of England'* series, covers the years 1914-63—the explanation of them, alas, requires far more than the 300 pages of this book. The plot is essentially political, with rare, hurried glimpses at the passing social scene. It is heavily burdened with facts, which at times drag the narrative into dry patches, but seem to be essential in giving even a brief account of political activity. The author manages to keep any party prejudices he may have to himself, and treats all with disciplined contempt, praise and indifference in equal parts. In spite of (or because of) its crowded gravity, a reasonably lucid summary of events is the result, all tied in place by some of their causes and some of their effects.

That slight smell of impertinence was not there after all. As history passes us via the loud obscurity of politically biased newspapers, it is too easy to have only a vague idea of what is going on around us! Anyone who can explain to me events that I should have known already, earns my mumbled gratitude—the difficulty is finding someone who can.

Bob Kendrick.

SPORTS NEWS

FIXTURES FOR MAY

Sat. Ist.
U.L. Athletic Championships; Motspur Park.

Sun. 2nd.
Cricket v. Putney Eccentrics; Home.

Mon. 3rd.
Athletic Trials at Finsbury Park.

Wed. 5th.
Cricket v. Royal Vets; Home.
Athletics v. Guy's; Honor Oak.

Fri. 7th.
London to Brighton Stroll.

Sat. 8th.
Cricket v. Morphy Richards; Home.

Wed. 12th.
Golf v. College of Estate Management.
Athletics: Inter Hospital Relay Meeting; Paddington.

Thurs. 13th.
Cricket v. U.C. Oxford; Away.
Athletics v. Lloyd's Bank and Metropolitan Police; Beckenham.

Fri. 14th.
Cricket v. B.N.C. Oxford; Away.

Sat. 15th.
Cricket v. Chishall; Away.

Sun. 16th.
Cricket v. Romany; Home.

Tues. 18th.
Athletics v. Pearl Assurance, Old Whitgiftians, C.U.A.C.O., Linsprey A.C.; New Malden.

Wed. 19th.
Cricket v. R.N.C. Greenwich; Home.
Golf v. Staff; Denham.
Thurs. 20th.
Athletics v. London Hospital; Walthamstow.
Sat. 22nd.
Cricket v. Streatham Wanderers; Home.
Sun. 23rd.
Golf v. Mr. Hankey's Team; Tandridge.
Mon. 24th.
United Hospitals Bumping Races.
Wed. 26th.
Sport's Day
Sat. 29th.
Cricket v. R.N.V.R.; Home
Athletics v. Charing Cross and Cardiff Med. School; Cobham.

INTER-FIRM 7-A-SIDES

The inter-firm 7-a-Side Competition was held at Chislehurst on Saturday April 3rd in brilliant sunshine. The good weather brought an excellent turnout of players, wives, friends and fighting-fit toddlers. Eventually after scratchings and rehashing of teams, thirteen sides took to the field at various times.

With two walkovers for the first two scheduled games at 2.30 p.m., the next two were brought forward, only to find that several members were still en-route from London, having stopped at the Yacht for such essentials as lunch on the way. Kids and Specials I distinguished themselves as the first to exit, soon to be followed by Finalists, despite Smart's protestations to his team at half time that the time had come to hot the pace up.

The **second round** saw Tom Bates plus the Midder and Gynae make the semi-final past Preclinical II—even after Bates' tactic talk of: "for heaven's sake lads don't win." Kids and Specials II fell to 1st time Clerks and Dressers despite the combined efforts of a Kids referee, and the Chairman and three members of the Wine Committee and the Editor and Manager of your one and only Journal. Also Martin Waterworth's exiles VII lost to the Out-patients.

After the **semi-finals** between Midder and Gynae and Preclinical I, and 1st time Clerks and Dressers and Out-patients, there was a past versus present match which ended in a very fair 0-0 draw.

With the evening sun getting lower, the **final** was fought between Pre-clinical I and Out-patients. The former, under the leadership of the tireless MacIntyre and with "kicker" Leach, outplayed their rivals and were presented with the cup by Mrs. MacPherson at the end of an excellent afternoon's entertainment.

And so back to the beer . . . . .

R.E.A.

RUGBY CLUB

On the morning of 27th February, Bart's played **Old Haberdashers** in the type of game that it is better to forget, and **lost 6-11**. It took the side all the first half, and most of the second to wake up, by which time the old boys were leading 11-0, due to poor defence and covering. Bart's suddenly shook off their lethargy, and played good attacking rugby, but had left it too late, and could only score 6 points through McIntyre, and a Gibson penalty. Moral—Friday nights and Saturday mornings don't mix. An even worse game followed on March 13th against **Aldershot Services,** when Bart's, short of several regular men **lost 0-14** to a lively Services side. For most of the first half Bart's made all the play, but through bad finishing could not score, and crossed over 3-0 down. In the second half things went from bad to worse, the scrum started to lose the ball, the threes dropped many passes, and tackling was non-existent. The result was that Services scored two tries and a drop goal, to give them their third win of the season. The side seems to have lost the ability to score through backing-up, a move that was very successful earlier in the season.

On a very damp Wednesday afternoon we played the **Public School Wanderers,** and won

23-3, through tries by Griffiths, Fryer, Baker, Gibson and Savage. A marked improvement was seen all round, in defence, in the loose, and especially in attack, the lesson of backing-up seems to have been learnt. Especially promising were the debut of Jolly in the 2nd row, and Baker's play in the centre.

On the morning of the Calcutta Cup match, Bart's played **Cambridge City** in continuous drizzle, and **won 10-9.** The pack soon settled down, and especially in the loose gave Cambridge much worry. The line-out too went very well, Jolly and Macpherson combining well at the front of the line. Despite the following wind, Bart's crossed over 5-6 down, Griffiths having forced his way over on the blind side. The second half progressed in much the same way, mostly through foot rushes, and the Cambridge substitute scrum-half scored a fine try from a line-out. All seemed lost, until in the last minute MacIntyre forced his way over for the winning try, which Gibson converted.

7-a-sides.

On Sunday, March 21st, Bart's acted as hosts for the U-H Sevens, a most successful afternoon, for the **1st VII won the Cup,** and the 2nd VII reached the final of the Losers' Plate where they lost to St. Thomas's 1st VII.

1st VII	beat Charing Cross II	25-0
	beat London	8-3
	beat Westminster I	20-0

McIntyre and Gibson played particularly well, but the whole team seems to have at last mastered that aspect of play which has previously let down Bart's Sevens, namely defence. We hope that this result bodes well for the Middlesex Sevens.

The second Seven also played very well, in fact only losing 8-6 to Westminster in the first round. Gilmore seemed a man inspired, doubtless thinking in terms of the pin of beer given to the winner of the Losers' Plate.

Results for the Season

P	W	D	L	For	Against

On the whole the season has been successful as far as results go, but as usual, several games were lost which one would have expected the side to win. Reasons can easily be put forward for this. At the highly successful beginning of the season the side was scoring tries on the whole through excellent backing-up. As the season progressed, so the backing-up, and thought over the final pass were neglected, and the side stopped scoring, and went through a very poor phase.

The pack on the whole has played well as a unit in the tight and loose, but play in the line-out has been poor. As ever, it has suffered from lightness, a great draw-back against many of the clubs we play, who can always put out a heavy pack. The pack has tried to make up for this in mobility, and has out-played many sides in this aspect, although some games have caused disappointment.

The threes have failed to realise their attacking potential, mainly through lack of hard, direct running. The halves and centres seemed loath to make the outside break, and in many games tended to run back into the cover defence. There also seems to be a lack of imagination in attack, which with the speed which definitely is there would have given many more scores. One aspect of play has improved considerably as the season progressed, notably the defence.

When the side was playing well, it would be unfair to mention individual names, but three people played consistently well throughout the year, namely McIntyre, Smart out of position in the second row, and Davies.

The following have represented the 1st XV: J. Davies, E. D. Dorrell, M. E. Fryer, S. M. Johnson, D. S. Browne, G. Hopkins, P. Harker, A. T. Letchworth, P. E. Savage, G. Baker, N. J. Griffiths, D. C. Pope, R. Soper, C. A. Grafton, O. J. A. Gilmore, D. Grieve, A. J. S. Knox, D. Macpherson, A. D. O'Kane, M. M. Orr, C. J. Smart, R. Jolly, D. J. Delany, T. Bates, D. Goodall (Capt.), J. A. Gibson, K. McIntyre, M. Hudson, P. Moynagh.

P.E.S.

GOLF CLUB

On Wednesday, March 24th, Bart's played a team from **London Hospital** at Chislehurst. The weather was excellent and seemed to help inspire the team to a win over these constant rivals.

Bowen, playing number one, and Kerrigan playing number five, both won, whilst Atkinson and Vartan both halved. The remaining match was lost on the last green.

Team: Atkinson, Bowen, Vartan, Kerrigan, Hoare.

R.E.A.

SPORTS DAY

Bart's annual Sport's Day is **Wednesday 26th May.** In recent years the hard work of the Wine Committee, Student's Union and Athletic Club has been partly rewarded by the number of consultants, students and nurses attending. Sports Day is one of those occasions when everyone can happily indulge their own whims, whether by running a three-mile race, holding a tankard, putting the shot, or just airing a new summer frock.

The athletics will attain a high standard since Bart's boasts regular members of the United Hospital team. The sprinting events will provide keen competition and given good weather, many long standing records may be broken. The middle and long distance races will revive distant battles for the members of the all conquering Cross-Country Club. In the field events many champions may be toppled by the talented freshers.

The standard point inter-firm competition whereby every student can gain points for his particular firm, will provide tremendous interest, the clinicals being determined to beat the pre-clinicals this year.

The Dean will again show his athletic ability in the consultants race but it has been reported that a well-known surgeon has been seen secretly training for this event.

Chislehurst with its pleasant surroundings provides the ideal setting. During the afternoon the Wine Committee will be serving free beer, an excellent tea is served in a marquee and the pavilion is an admirable venue for the dance in the evening. Transport to and from Chislehurst will be provided.

The success of Sport's Day depends on the attendance, so do come and support the efforts of the organisers if you possibly can.

D.J.C.

CROSS COUNTRY CLUB

Wednesday 24th February.

Final 1st Division League match at Petersham

Because the result of the League was a foregone conclusion, this match was rather an anticlimax, and none of the Bart's runners distinguished themselves.

30th	Sanders and Thompson
61st	Wood
62nd	Coltart

out of a field of 70.

Our final league position is *eighth* out of thirteen. We will have to run hard next season to maintain our position in the 1st division, and we must hope that the new intake will produce

someone to counterbalance the loss of Terry Foxton.

Saturday 27th February

Imperial College Hyde Park Road Relay

We performed quite well to finish 30th out of 82 teams in this 6 lap by 3 mile race around the Serpentine. Richard Markham, in particular, excelled himself but was unfortunate in having to take over after such a fast lap by Terry Foxton. It must have been thoroughly demoralising to have lost eighteen places while running so well, and we must ensure that never again will we make the mistake of putting our fastest man on the first leg.

Times, with end of lap positions in parentheses.

T. Foxton	14 min. 33 sec.	(6)
R. Markham	16 min. 07 sec.	(24)
J. Coltart	16 min. 28 sec.	(35)
R. Thompson	15 min. 04 sec.	(26)
G. Hesselden	16 min. 20 sec.	(31)
R. Sanders	15 min. 32 sec.	(30)

Robert Hale ran with a team full of Doctors, including Nick Pott and Dan Tunstall-Pedoe. They finished 46th, second to us out of all hospital teams and rather close to us for comfort. Phil Wood helped out Guy's Hospital by running the 3rd lap for them.

It is interesting to note that fifteen of the teams who beat us were representing provincial Universities.

Many thanks to the Bart's people who forsook a Rugby International to come and support us.

Saturday 13th March.

Tour to Dartmouth

The club spent a thoroughly worthwhile weekend in Dartmouth. We ran against the Naval College and although we took the first three places in the race, with Peter Littlewood winning in fine form, we were unlucky to lose the match by 31 points to 30. However, we enjoyed ourselves and so, apparently, did our hosts, because they have accepted a return match in London late in March.

Saturday 20th March.

Orion Harriers 15 Mile Race

A United Hospitals team, including a nucleus of Bart's runners, entered this long, wet and muddy race, and performed very creditably.

1. D. M. Turner	(Thames H & H)	1 h. 32 m. 44 s.
16. Kenwright	(London H—UH)	1 h. 40 m. 47 s.
17. Thompson	(Bart's—UH)	1 h. 41 m. 46 s.
39. Witting	(Guy's—UH)	1 h. 50 m. 57 s.
40. Sanders	(Bart's—UH)	1 h. 51 m. 09 s.
47. Brotherhood	(Thomas's—UH)	1 h. 55 m. 01 s.
61. Mr. H. B. Lee	(Bart's—Orion)	2 h. 15 m. 34 s.

Mr. Lee, whose brainchild this race was twelve years ago ran, he tells us, better than he has done for years.

R.J.T.

LADIES HOCKEY CLUB

Annual Report

This has been a very limited season as far as the number of matches played goes. In the first half of the season we played 8 matches; won 5, lost 3. Since Christmas we have played only twice, both times being U.H. Cup matches, *Oxford Tour Oct.* 31-*Nov* 1st.

We were disappointed not to be able to arrange a fixture against any of the Men's Colleges this year.

v. Oxford University 2nd XI L. 1-3.

Team: C. Foot, E. Evans (Capt.), P. Stubbs, J. Miller, M. Newbold, S. Lee P. Dengate, S. Kolting, E. Saunders, G. Bell, P. Fogarty.

v. Headington Lost 0-6.

In this game Bart's were hampered not only by fog and leaves underfoot but by being one player short. It was a fast match but their experience and extra player tipped the scales towards victory.

Team: P. Kumar, E. Evans (Capt.), P. Stubbs, J. Miller, M. Newbold, S. Lee, P. Dengate, E. Saunders, J. Bell, G. Bell.

The **United Hospitals'** trials were held on Saturday October 10th. Elizabeth Evans as Captain of U.H. has played in their four matches and Susan Költing has played twice *U.H. Cup.*

1st. round—Bart's v. London Won 12-0.

Dec. 12th

This was a chaotic match as our opponents arrived an hour late. However, we battled on against the ever darkening sky and when the game eventually finished it was impossible to distinguish player from player as they loomed up out of the gloom.

Semi-Final. Bart's v. Middlesex. Won 6-0.

Feb. 17th

Despite the professed unfitness of our Bart's team we won this game. With more co-ordination the result might have been better.

Team: E. Neach, E. Evans (Capt.), J. W. William, J. Bell, M. Newbold, S. MacDonald, R. Stringers, R. Smiley, C. Cupitt, S. Kolting, J. Spring.

As may be remembered from the last issue of the *Journal*, Bart's lost the final of the U.H. Cup to Mary's in a very close game. E.E.

CONTENTS

EDITORIAL

A recent survey of the qualifying degrees of our medical staff shows the following figures: London (including Conjoint) 49%, Cambridge 26%, Oxford 9%, others 16% (these last—say it not aloud—cannot have trained at Bart's at all). Furthermore the latest trends in decanal policy suggest that the student intake for the clinical course is going to contain a higher proportion of Oxford and Cambridge graduates. And yet our teaching course, both in timing and in content, is tailor-made for those who do their preclinical work at Bart's, while the substantial number who come from Oxford and Cambridge (at present between a quarter and a third) are treated—not welcomed—like an insignificant minority.

The programme opens with the Introductory Course, and the keen young Cambridge graduate, thirsting for clinical experience, finds that he must sit through a General Pathology course which he covered only a few months before in considerably greater detail. The teaching of physical signs which now and then punctuates this tedium is excellent, but it could be covered in two rather than six weeks. Our graduate is beginning to wish that he had gone to the clinical introduction course at Addenbrookes, and taken six weeks extra holiday. Instead he very soon finds that he is three months behind his friends who chose other teaching hospitals, and as a result he will get no revision course before his examinations.

Mollified by six months as a Clerk and Dresser, he is soon reminded that he is a misfit again—this time by three months of Bacteriology. With all deference to the department concerned, this is hardly a subject which merits such a lusty encore.

As the day draws near, and the examiners take on a less ghostly shape, our aspirant from the Fens realises that not only is there no revision course for him, but even the 'grinds', of which Bart's is so justly proud, are either too

early or too late for his ordeal. And there is a fair chance that even if he passes his finals it will be too late to apply for a job at his own hospital.

It is perhaps no wonder that our reputation as a teaching hospital could be better at the two great Universities. This is as much due to the inconsistencies outlined above, as to any deliberate policy in the past of discouraging Oxford and Cambridge applicants—a policy that has left behind it as its aftermath a failure by Bart's, alone among the London teaching hospitals, to advertise in the Cambridge medical journal, (or is this a remarkable oversight?).

There may be worse to come. One of the possible features of the re-organisation of the teaching schedule in 1967 is a six term course at Charterhouse, with only one entry a year into the clinical course. If this single entry takes place in October, as seems most likely, it will mean that graduates from Oxford, where the preclinical course has recently been standardised to finish in April, can come to Bart's only if they take a six month holiday first. Pleasant though this sounds, their course is already two terms longer than any other, and there would be strong incentives to go elsewhere and get on with it. Oxford is in the process of increasing its medical intake by 15%, which will make its school comparable in size to that at Cambridge.

There is no doubt that in many ways we are out of line, and the question is whether we can afford to be. It is difficult to deny that at least from an academic viewpoint the supply of graduates from Oxford and Cambridge is essential if Bart's is to remain a leading teaching hospital. What they do not do themselves they catalyse, and like all good catalysts we must make sure that their quantity and quality does not decline.

There is room for tact as well as reorganisation. A recent Cambridge intake, which included three first class degrees, was told at its first meeting with Bart's authority that they were the worst intake for years, and would have to change their attitudes now that they had started the clinical course. They left modest but puzzled, to discover later that these remarks had been intended for their colleagues from Charterhouse, most of whom had needed two attempts at second M.B. Enough to make even the most tolerant Cambridge man purple (not blue) in the face.

LETTERS TO THE EDITOR

TRIUMVIRATE

Sir,—The enclosed from this week's *Lancet* must surely depict an unusual—perhaps historic—event. Three professors in London—titles conferred at the same time—and all had their basic education at Bart's. They need congratulation and surely we should do more to get them back occasionally. There are scores of Bart's professors now!

Yours etc.,

D. F. Ellison Nash.
10, Kingswood Drive,
Dulwich,
3rd April. London, S.E.19.

(The cutting referred to Professors H. H. Bentall, W. H. McMenemy, and A. G. E. Pearse. Details will be found in the Appointments column on page 219).

PRIVATE WING AT BART'S

Sir,—Dr. Blow's letter in the May number of the Journal has expressed effectively the value of a private wing for Bart's and for general practitioners, old Bart's men and others. Such private accommodation makes a teaching hospital better known at home and abroad, and it gives an opportunity for a wider section of the public to benefit from the quality of services that such a hospital offers. Moreover it affords a richer training for residents and nursing staff in handling a more varied, intelligent and independent strata of society, to whom the noise and cackle in a general ward and the public performance of all physiological events are well nigh intolerable.

Dr. Blow's comment "time and again I cannot refer to Bart's consultants, as I should prefer, because these facilities (private wards) do not exist," is an opinion often expressed by many general practitioners.

On the less important side the absence of a private ward is a financial penalty which, unlike the staffs of the other large teaching hospitals, a Bart's consultant has to accept. This loss, both real and potential, particularly to younger consultants, has been and is considerable.

The other large teaching hospitals with private wings naturally give priority to their own staffs so that it has been common to wait two months or more for the doubtful possibility of a vacant bed. This has meant passing private patients requiring emergency treatment to consultants on the staffs of other hospitals.

Like Dr. Blow I held, in my youth, the view that Bart's should be a hospital only for the sick poor. Exploitation and abuse of the gratuitous work of its honorary staff in the late 'twenties', which increased during the 'thirties' of this century, by wealthy and well-to-do patients—the relatives and friends of hospital governors, city magnates and others disillusioned me in this 'sick poor' view.

The other large teaching hospitals have over a 30 year start on Bart's in the matter of providing service for a section of the public willing to pay for the privilege of behaving like dignified animals when sick—to be alone in a quiet corner.

H. B. Stallard,
82, Harley Street,
29th April. W.1.

DIAGNOSTIC FACILITIES FOR GENERAL PRACTITIONERS

Sir,—It would appear that every individual has his own private cure for the numerous ailments which beset the National Health Service. One particular remedy, although of no news value to the vociferous national press, may go a long way to heal the rift which so readily appears between G.P.s and hospital staffs: diagnostic facilities for G.P.s. The arguments for and against the scheme have been debated from time to time, with occasional emotional cries from G.P.s of hospital prejudice, and counter charges of G.P.s' lack of knowledge to use the investigations correctly.

All in all, it seems that the idea is basically a good one, and it was pleasing to learn that Bart's has accepted the scheme in principle. The Diagnostic Radiology Department is to start a plan for restricted access for G.P.s who have patients in the City of London and Borough of Finsbury as from June 1st this year. The Department of Pathology hope to follow suit when extension building is completed.

Does this opportunity do anything for the whole Health Service, or is it merely a morale booster for G.P.s, raising possibilities of a deluge of requests upon overworked pathologists and radiologists? First, a few statistics: in a Ministry of Health Report on the Health and Welfare Services (1963), it was stated that General Practitioners demanded only 6% of all pathology investigations in the total pathology services of the country, and 9% of all the radiology examinations. Only 47% of hospitals in all regions give G.P.s full access to pathology investigations, and 36% to radiology investigations. Of the London teaching hospitals, three allow full access, three allow restricted access (that is, only certain investigations allowed), and a further five allow no access at all (H. N. Levitt, *Journal of the College of General Practitioners*, November, 1964). Although the number of investigations performed for G.P.s is rising, the proportion of G.P. to hospital requests remains static:

	1961		1962	
	Total	*G.P.s*	*Total*	*G.P.s*
Pathology	18.7 million	6%	20.5 million	6%
Radiology	22.5 million	9%	23.5 million	9%

(M.O.H.)

At the Royal Society of Medicine it was stated that at the Ashford Hospital, where access has been permitted for many years, 31% of all pathology investigations were performed at the request of G.P.s. Despite this high proportion, the total number of investigations was lower than at the neighbouring West Middlesex Hospital—allowing for relative difference in size. G.P.s requested hæmatology (66%) more frequently than their hospital colleagues (43%). Bacteriology requests were even from both sources, whilst biochemistry was more frequently requested by hospital staff. (*The Practitioner*, March, 1965.)

The inference becomes obvious. Patients no longer need to be referred via an out-patient department to have a pathology investigation or radiology examination. Indeed, in a survey carried out by G.P.s in the Thames Valley, 53% stated that they did not really need a consultant's opinion. Even if a consultant's opinion is required, with co-operation between both parties, the G.P. can save the patient's time by ordering investigations at the time he makes the appointment.

In his article Levitt concludes that "the

reports from Edinburgh, Thames Valley, and South-East London suggest that the number of new patients who attend medical out-patients could be reduced by at least 15%."

How many of us have heard in an out-patient session—"Let's do such and such an investigation—that's what his G.P. really wants?"

"It might be considered that it is every doctor's birthright, upon qualification, to be provided with the tools of his profession." (*The Practitioner*, March 1965).

Yours sincerely,
A. K. Bacon,
23rd April. Abernethian Room.

REPAID WITH INTEREST

Sir,—I entered Bart's when I was 17 in October '95 and my father "anted" up a fiver (big money in those days for a poor parson who was the father of 10 children) for me to join the Amalgamated Clubs, an amalgamation which had only just recently taken place, and to join the Abernethian Society. I seem to have received a copy of the Journal with great regularity ever since, so I enclose its modern equivalent as a donation, and a bit of a copy which, if you think too frivolous, tear up.

Yours faithfully,
V. Godsalve Ward,
The Tiled House,
West Byfleet,
23rd April. Surrey.

(We are sad to announce that since receiving this letter Dr. Ward has died. An obituary will appear in a later issue.

The 'modern equivalent' has been very gratefully accepted, and the 'bit of a copy' appears on page 241.)

LYING STATISTICS

Sir,—How gullible do you think we are! Perhaps you could disclose to me the genius who lives in College Hall on £4 per week.

The interpreters of the recent woolly student expenses survey who reported in May's Journal seem to have lost sight of one or two basic facts:

£5	10	0d.	per week	College Hall rent
£1	0	0d.	per week	Lunches
£2	0	0d.	per week	Spending money, to include laundry, toothpaste, etc.
£8	10	0d.	per week	Total
£442	0	0d.	per annum	

Is not the basic grant £420? Where do one's clothes and books come from!

I think there's been a nonsense here.

Yours faithfully,
R. J. Clayton,
College Hall,
29th April. Charterhouse Square.

MANCHESTER INFIRMARY FIT ONLY FOR A WAREHOUSE

Sir, — Criticism of Britain's old-fashioned hospitals is certainly not new. This is demonstrated in an autograph letter written by Florence Nightingale in 1861 expressing grave concern about plans to enlarge Manchester Infirmary.

The letter—to be exhibited in the 8th Antiquarian Book Fair at the National Book League, Albemarle Street, London, from 15th-19th June—was addressed to an unnamed gentleman who had asked permission to translate Miss Nightingale's book, "Notes on Nursing".

She wrote in part, "I wish you could do something at Manchester about the infirmary, which I grieve to hear they are enlarging. That ill-placed, ill-constructed, ill-ventilated Infirmary will be fatal to the sick, if its already overgrown bulk is added to. How much better to sell it for a warehouse . . ."

From:
The Antiquarian Booksellers' Association,
29 Revell Road,
Kingston, Surrey.
7th May.

PÆDIATRICS IS NOT A REST CURE

Sir,—After perusing Dr. Robinson's account of teaching in the Children's Department, one is left with the impression that he strives against the immense odds of intolerance, disinterest and extracurriculum activities in his attempt to teach the paediatric clerks. As a member of the group of students, by whom, presumably, these contentions were prompted, it seems necessary to present the other face of the coin.

No one will deny the existence of a few students who exemplify the above description, but to ascribe it to all students, is unjust.

If my personal experience is typical, the doldrums of the clinical course have been passed in the Medical Outpatients' Department, before one arrives on Lucas and Kenton, and paediatrics provide Dr. Robinson's 'gentle breezes', of themselves reviving one's clinical interest.

Interest in paediatrics and children is certainly not lacking among students. Granting a fundamental feminine interest in children, and the impending probability of parenthood among married and engaged students, the last group of paediatric clerks had a total of 52% interested parties—28% married, 20% engaged (12% of these subsequently married) and the remaining 4% female.

Furthermore between them this group of students possessed a total of six kids and one foetus, consolidating their paediatric interest with the production of two babies during the three month course.

Yours faithfully,
A. J. Walter,
7th May. (Father).

Engagements

ATKINSON—PEAT.—The engagement is announced between Dick Atkinson and Barbara Peat.

BETHELL—HEGGADON.—The engagement is announced between Dr. M. F. Bethell and Miss R. Heggadon.

GREER—FOULGER.—The engagement is announced between Dr. Alexander W. Greer and Miss Sally Foulger.

SCOTT—TATE.—The engagement is announced between Brian Scott and Pat Tate.

Births

BATTERHAM.—On April 16, to Diana (née Fisher) and Dr. John Batterham, a daughter (Rhona Mary).

HOUGHTON.—On April 20, to Belinda (Binnie) (née Brady) and Dr. Leon Houghton, a daughter (Susannah Louise).

MARK.—On April 6, in Sydney, to Elizabeth (née Sheppard) and Dr. P. C. Mark, a daughter.

NOTTIDGE.—On April 21, to Jennifer (née Lucette) and Dr. Edward Nottidge, a son (James Edward).

ROSSITER.—On March 30, in Victoria, Australia, to Jane (née Luckin) and Dr. James Rossiter, a daughter (Abigail Mary), sister for Penelope, Gage, David, Ben and Tasmin.

Deaths

CANDLER.—On April 4, Arthur Laurence Candler, M.B., F.R.C.S., aged 83. Qualified 1908.

HODGE.—On March 31, William Henry Stewart Hodge, M.R.C.S., L.R.C.P. Qualified 1913.

PRIDHAM.—On April 16, John Alexander Pridham, M.C., M.R.C.S., L.R.C.P., aged 74. Qualified 1914.

ROBINSON.—On April 8, Geoffrey Stanhope Robinson, M.B., B.Ch., aged 76. Qualified 1914.

Change of Address

COOKE.—Dr. Robert Hunt Cooke *from* 20, Brampton Grove, Hendon, *to* 38, The Street, Newnham, Kent.

Appointments

University of London.

The title of Professor of Cardiac Surgery has been conferred on Mr. H. H. Bentall, in respect of his post at the Postgraduate Medical School of London.

The title of Professor of Pathology has been conferred on Dr. W. H. McMenemey, in respect of his post at the Institute of Neurology.

The title of Professor of Histochemistry has been conferred on Dr. A. G. E. Pearse, in respect of his post at the Postgraduate Medical School of London.

Mr. J. B. Hume, M.S., F.R.C.S., has been appointed deputy Vice-Chancellor from September 1, for the University year 1965-6.

Sir Herbert Seddon, G.M.C., D.M., F.R.C.S., has been appointed to the chair of orthopaedics tenable at the Institute of Orthopaedics.

June Duty Calendar

Sat. & Sun., 5th & 6th.	
	Dr. Black
	Mr. Naunton Morgan
	Mr. Manning
	Dr. Boulton
	Mr. Fuller
Sat. & Sun., 12th & 13th.	
	Dr. Hayward
	Mr. Badenoch
	Mr. Manning
	Dr. Cole
	Mr. Cope
Sat. & Sun., 19th & 20th.	
	Dr. Spence
	Mr. Tuckwell
	Mr. Aston
	Dr. Bowen
	Mr. McNab Jones
Sat. & Sun., 26th & 27th.	
	Prof. Scowen
	Prof. Taylor
	Mr. Burrows
	Dr. Ellis
	Mr. Hogg

Physician Accoucheur for June is Mr. Fraser.

Retroscope:

TAURUS

Seven hundred and fifty years ago Magna Carta was signed at Runnymede. In his fury the King, John Lackland, gnawed the reeds on the palace floor. The loss of the crown and royal clothes in the Wash preceded a further dietary indiscretion (lampreys this time) the following year (1216). The new King, Henry III, drove the barons to distraction by his failure to observe the Charter. Simon de Montfort, Earl of Leicester, defeated the King in battle at Lewes (1264), taking prisoner the young Prince Edward. June 10th. is the 700th. anniversary of de Montfort's first parliament, held in Westminster in 1265. The Frenchman's great triumph was closely followed by his defeat and death at Evesham at the hands of Prince Edward, who had but recently eluded his captors by riding too fast.

King of the Road

Eager to create the news he is accustomed merely to report, your peripatetic correspondent exchanged his converted cupboard (*alias* the Journal Office) for the scenic Brighton Road, and joined the gallant throng on the Hospitals' Stroll. The only amusing moment of the whole ghastly escapade was to see the ramrod get stuck in the starting cannon and the Governor of the Tower narrowly avoid deposition in the nearby Thames:

"What a sight it were
To see thee in our waters yet appear,
And make those flights upon the banks of Thames." (Ben Jonson)

By Horley your correspondent had realised his terrible mistake, but comfort was at hand both spiritual and practical, in the Gatwick foot clinic which was manned by nurses from Guy's. Thus fortified considerably your correspondent pottered on to the very end, passing latterly an amazing assortment of battered wrecks, human derelicts reminiscent of William Cowper's:

"Prepost'rous sight! the legs without the man."

Brighton at last attained at the expense of foot, calf and ankle, your correspondent downed his Guinness and retired to his cobwebs for another year.
year.

Then as now

Readers might be forgiven for thinking that nearly every worthwhile pub in London boasts once to have been the snug and favourite haunt of Dickens, Pepys, or Samuel Johnson. Less well-known but certainly more valid is the literary connection between Clerkenwell and Arnold Bennett. Bennett rose to fame in Edwardian days on the crest of his 'Potteries' novels—*Clayhanger, The Card, Anna of the Five Towns;* but like Debussy, considerably shocked by the horrors of the Great War and in poor health, his later works were much less successful. Nonetheless in 1923 he achieved a remarkable comeback with the appearance of *Riceyman's Steps*. Gwynne Place is a short cul-de-sac in Clerkenwell which runs off Kings Cross Road just north of Mount Pleasant, and empties by a double flight of stone stairs into modest secluded Granville Square. At the bottom of this stairway (the Riceyman's Steps of the title), and directly over the underground railway, the author sited the second-hand bookshop which was to be the central focus of the novel. Bennett described the shop as being "strangely, even fatally, out of place in that dingy and sordid neighbourhood where the familiar and beloved landmarks were public houses, and where the immense majority of the population read nothing but sporting prognostications and results, and, on Sunday mornings, accounts of bloody crimes and juicy sexual irregularities."

—a prophetic description of life elsewhere in Clerkenwell?

The Management of Epileptic Patients

By J. W. ALDREN TURNER

Epileptic attacks may result from many types of structural disease of the brain and of biochemical disturbances affecting it, or they may occur without evidence of any such disorder, the so-called constitutional or idiopathic epilepsy. I do not intend in this article to describe the investigation of a patient suffering from epilepsy to determine the possible aetiology but to discuss the social aspects, general management and drug treatment of patients suffering from either idiopathic epilepsy or symptomatic epilepsy in whom surgical or specific treatment (other than anti-convulsants) is not indicated.

General Management

Many people associate the diagnosis of epilepsy with mental disturbance, a view which is unjustified. In the majority of patients epileptic attacks can be adequately controlled by treatment and in fact there are a number of people who have one or perhaps two or three isolated epileptic fits in the course of their lives for which no adequate cause can be found. Epilepsy and mental change can of course occur in the same patient but these are normally both the result of a common pathology rather than the epilepsy leading to the mental changes. In children epilepsy and mental deficiency may result from birth injuries or vascular or infective processes affecting the brain in early life. In adults epilepsy and mental deterioration may be the sequel of a severe head injury or result from intracranial tumours or progressive degenerative diseases involving the brain. The idea that repeated fits in themselves lead to mental deterioration is largely false and this must be explained to the patient or in the case of a child to the parents as they may have this fear but not mention it to the doctor.

Education

The majority of children suffering from epilepsy can and should be educated at ordinary schools. It is important that the headmaster or mistress should know of the child's disability. Only minor restrictions are necessary for these children; they should not be allowed to swim unless there is an adult with them who knows about the attacks and cycling should not be allowed. They can play most games but in the gymnasium they should not climb ropes or ladders as the occurrence of a fit might cause serious injury. Difficulty with education in ordinary schools arises in epileptics who have other disabilities in addition as for example mental deficiency, severe behaviour disorders or a cerebral palsy and in these cases it may be necessary for the child to go to a special school, such as an E.S.N. school or a school for the physically disabled. There are in this country six schools especially for epileptic children.

Employment

There are clearly certain types of work unsuitable for patients with epilepsy; driving a vehicle of any kind, working at heights, or working with machinery when the occurrence of a fit would be dangerous. The patient who has occasional fits or in whom the fits are nocturnal usually has no difficulty in obtaining and keeping a job suitable for his intellectual and other attainments but the position is very different for the patient whose fits are poorly controlled by treatment and is particularly difficult if there is also mental instability. Such a patient should be registered as a disabled person and will then have the help of the disablement resettlement officer (D.R.O.) in trying to find suitable employment. Some such patients may get appropriate training at an industrial rehabilitation unit. There is a small number of epileptics who cannot get or hold jobs in the open labour market but can do useful work in a sheltered environment and Remploy is doing a most useful service in employing some of these people in their factories for the disabled. Another factor in connection with employment is living accommodation. If a chronic epileptic has not got a home he may find it very difficult to get lodgings and there is a real need for the provision of residential hostel accommodation

for such patients. The epileptic colonies are of particular value for patients in whom the fits are difficult to control and who cannot keep a regular job. In a colony the patient will be under medical supervision and it may be possible to rehabilitate and train him and obtain better control of the fits so that he improves sufficiently to return home and to employment. In hospital practice the skilled advice of an almoner is of the greatest help in dealing with the problems of education and employment of epileptic patients.

Marriage

Epilepsy is not a ban to marriage in the United Kingdom and is not a ground for divorce but under the Matrimonial Causes Acts 1937 and 1950 epilepsy can be a ground for nullity. Three conditions are necessary for a nullity plea to succeed; the petitioner at the time of marriage must be ignorant of the fact that his spouse suffers from epilepsy, the proceedings must be instituted within a year of the marriage and marital intercourse must not have taken place with the petitioner's consent after discovery of the fact.

The frequency of epileptic attacks is not usually influenced to any notable extent by pregnancy, and epilepsy in itself is not an indication for termination of pregnancy or for sterilisation.

The question which is most frequently asked by patients and which is difficult to answer is the likelihood of their children suffering from epilepsy. If the epilepsy is symptomatic of intracranial disease such as a tumour or is the result of a severe head injury it seems unlikely that the risk of epilepsy in the children is higher than in the normal population, although no definite statistics on this point are available. Figures often quoted are that the chances of non-epileptic parents having an epileptic child are about 1 in 200, while if one parent is epileptic the risk increases to 1 in 40 (Cohen, 1958). It is of course difficult to apply figures gathered from a mixed group of epileptics to individual cases. Generally it seems safe to advise that if one parent suffers from epilepsy and if there is no other known history of epilepsy on either side of the family the risks of children developing the disease are little, if any, greater than with normal parents. If there are other known cases of epilepsy on one side of the family the risks of children being epileptic are definitely increased and if epilepsy is present on both sides of the family the risks are great. It must, however, be recognised that a reliable family history in respect of epilepsy may be difficult to obtain.

Driving Licences

One of the most difficult problems for a patient who has had epileptic attacks in the past is that of the issue of a driving licence. In theory there should be no problem, as under the Road Traffic Act 1930 the applicant for a driving licence must state whether he suffers from epilepsy and the Motor Vehicles (Driving Licences) Regulations 1950, No. 333, precludes anyone suffering from epilepsy from claiming a driving test (Cohen, 1958). The difficulty arises from the interpretation of the words, "suffering from epilepsy." In 1961 the Ministry of Transport sent a memorandum to the Registration and Licensing Authorities from which the following is quoted: "The Department has received advice that epilepsy should

Normal sporting activities are part of every day life at the Lingfield Hospital School for epileptic children.

be regarded as a continuing liability to recurrent epileptic attacks. It follows that a person who has, in the past, had one or more attacks of convulsions, or of disturbance of consciousness, in circumstances which are unlikely to recur need not necessarily be regarded as suffering from epilepsy. Certain people who may think that they have, or may have been regarded as having suffered from epilepsy may, therefore, in fact not be suffering from epilepsy. In order to determine whether this is so, it is appropriate to take into account such matters as the frequency of attacks in the past and the duration of freedom from attacks since any treatment ceased.

In any case of doubt as to whether an applicant for a driving licence, or the holder of a licence is debarred from holding a licence by reason that he is suffering from epilepsy, the Licensing Authority will, no doubt, consult the local County Council or County Borough Medical Officer of Health with a view to obtaining any specialist medical advice which may seem necessary in all the circumstances." (*Lancet*, 1961).

Prior to this memorandum, in 1957 the British Epilepsy Association made enquiries of the licensing authorities in England and Wales as to their practice in issuing driving licences to applicants who admitted that they "suffered from epilepsy." It was clear from the answers to this enquiry that there were marked differences between the various licensing authorities. Some implied that a licence would not be issued to a person who had a history of epilepsy at any time in the past while others were prepared to issue a licence if an applicant had been free of attacks for a period of time, usually from three to five years. Some authorities stipulated that the applicant must have stopped taking anticonvulsants during the latter part of the free period and one or two that the E.E.G. must be normal. These last two conditions seem to me unrealistic and the insistence on a normal E.E.G. absurd as it is well known that the inter-seizure E.E.G. may be normal in a patient who has fairly frequent major epileptic attacks.

It is recognised that a number of epileptic patients continue to drive and Phemister in 1961 made enquiries of 60 men and 70 women who attended a neurological out-patient department suffering from recurrent attacks of epilepsy. Of the 70 women only one drove but of the 60 men, 27 drove or held valid driving licences. Of these, 19 had filled in the licence application form falsely, 2 had started to have epilepsy after taking out a three year licence, 2 drove regularly without taking out a driving licence, while 2 said that they answered "Yes" to the question "Do you suffer from epilepsy?" in the application form and were still issued with a valid licence.

Once a diagnosis of epilepsy has been made, the doctor should tell the patient the diagnosis, explain the legal position about driving licences to him and advise him not to drive. The question of supporting an application for restoration of a driving licence or for the first application for one in the case of a patient who has had epilepsy in the past is more difficult. If the patient has had only occasional attacks in the past and has been free of them for at least five years it is reasonable to support such an application but the licensing authority will not necessarily grant it. One must, however, remember that there is no way of being sure that the patient has been free of attacks other than his own statement.

Drug Treatment of Epilepsy

If a patient has only had a single fit or if fits occur at very long intervals it may well not be worth giving anticonvulsants, for once these drugs are started they must be given with complete regularity and for a prolonged period. It is useless and indeed dangerous to give them for a few weeks at a time as the sudden stopping of anticonvulsants may precipitate a fit or even status epilepticus in an epileptic patient. This should be explained to the patient and he should also be told that it may well be a matter of trying various drugs or combinations of them before the most effective therapy is found in his case. When a suitable regime has been established and provided there are no serious side effects, this should be continued for at least two and preferably three years in which the patient is free of fits before gradual reduction of dosage is started.

Whatever anticonvulsants are used, they are most commonly given regularly two or three times a day but this may be varied in individual patients. There are many epileptics who only have fits while asleep and in these a larger dose should be given in the evening and a smaller one in the morning. In women where attacks occur with the menstrual periods the dose can well be increased for the week preceding and during the period.

Phenobarbitone. This is still the most generally effective and least toxic anticonvulsant and in many patients fits are completely controlled by 30 mg. twice or three

times a day. It is not usually advisable to increase the dose above 60 mg. three times a day. To obviate a midday dose, Phenobarbitone can be given in a spansule in the morning as this method allows for slow absorption during the day.

Phenobarbitone occasionally causes a rash but the main side effects are drowsiness, apathy, and mental slowing. These symptoms are quite common when Phenobarbitone is started but usually pass off after the drug has been taken for a week or two. In a minority of patients, however, they persist even with small doses. Sometimes amphetamine is given to counteract these symptoms but in my opinion it is preferable to change to a different anticonvulsant. If large doses are continued, ataxia and nystagmus may develop and these symptoms are an absolute indication for reduction of the dose.

Methyl-phenobarbitone (Phemitone) occasionally causes less drowsiness than phenobarbitone, the effective dosage usually being double that of phenobarbitone.

Hydantoins. Phenytoin sodium is the most valuable anti-convulsant in this group. Its main advantage over phenobarbitone is that it does not cause drowsiness or slowing of mental activity; its main disadvantage is that an effective dose and a toxic dose are often very close together. Complete control of fits can often be obtained by a dose of 100 mg. three or at most four times a day, doses larger than this frequently cause side effects. In such cases the exhibition of both phenytoin and phenobarbitone may give the best results without producing side effects, for example, 100 mg. phenytoin three times a day and 30 mg. phenobarbitone twice or three times a day is a common and often effective combination. Some patients develop an erythematous rash and as this may be accompanied by swelling of glands in the neck and even a slight rise of temperature, the clinical picture is very like that of German measles. This usually develops shortly after starting phenytoin and appears to be due to sensitivity to the drug. If this occurs the drug should be stopped. Many patients who take phenytoin for long periods develop a characteristic hypertrophy of the gums which tend to bleed easily. This is not necessarily an indication for stopping the drug. If the gum hypertrophy is severe gingivectomy may be necessary.

The most important and often overlooked toxic effect is the development of a cerebellar syndrome with ataxia, nystagmus, dysarthria and incoordination of the hands and arms. This frequently occurs if the dose is increased above 400 mg. a day, but more surprisingly it may develop gradually in patients who have been taking phenytoin for long periods and in whom the dosage has not been increased. The symptoms are reversible in the patients in whom the dose has been increased when it is reduced. In the patients who develop the syndrome insidiously without increase of dosage it is preferable to withdraw the drug gradually and substitute another anticonvulsant and recovery will gradually take place.

Methoin also has an anticonvulsant activity in a similar dosage to phenytoin but aplastic anæmia has resulted from its use and it does not seem to have any special advantages over phenytoin.

Primidone (*Mysoline*) was introduced as an anticonvulsant in 1949. It is chemically related to the barbiturates and may cause some drowsiness and apathy; for this reason it is not generally advisable to give it in combination with phenobarbitone but it can be given with phenytoin. It is a valuable anticonvulsant and may control fits which have not responded to phenobarbitone or phenytoin. The usual dosage is 250 mg. three or four times a day but some patients can tolerate and need as much as 1.5 gm. in 24 hours. Apart from drowsiness the main side effect is vertigo. If this is going to occur it usually comes after the first two or three doses and often settles down if the drug is continued. In some patients, however, primidone cannot be tolerated on account of this symptom.

Megaloblastic Anæmia Due to Anticonvulsants. A small number of patients on regular anticonvulsants develop insidiously a megaloblastic anæmia. Most cases have occurred with a combination of drugs, of which one has been phenytoin, but there have been cases in which phenytoin alone, primidone alone or phenobarbitone alone have been used. In these patients there has been normal gastric acidity and usually the serum B.12 level has been normal. The anæmia responds to folic acid in a dose of 20-30 mg. a day and if this is continued the dose of anticonvulsants need not be changed. It has been suggested that the drugs interfere with some enzymatic process normally involving folic acid as a co-factor. If this is the explanation it is strange that this form of drug induced anæmia is so uncommon when the use of these anticonvulsants is so widespread.

Acetozolamide. This carbonic anhydrase inhibitor has been used as an anticonvulsant but in the majority of patients it seems to be ineffective. In an occasional case when it is given in addition to other drugs fits may be reduced in frequency but in my experience it has very limited value in the treatment of epilepsy.

Sulthiame (*Ospolot*) is a sulphonamide which has recently been used as an anticonvulsant and it has been claimed to be of special value in temporal lobe epilepsy. It is very liable to cause side-effects, some of them serious, common ones being ataxia, confusion, headache and vertigo, and at times psychotic reactions. These side-effects usually come on shortly after the drug is started. Sulthiame has a place in the control of epilepsy which has not responded to other anticonvulsants but in view of the serious side reactions it should only be started if the patient is under observation in hospital.

The Treatment of Petit Mal

True petit mal consists of a momentary loss of consciousness, or sudden myoclonic jerks of the limbs. This type of attack, which occurs principally in childhood and which may occur many times a day, is usually accompanied by spike and wave complexes in the E.E.G. These attacks are not often controlled by the anti-convulsants already considered but if major attacks also occur these drugs will have to be used in addition to ones more effective in petit mal. Amphetamine in a dose of 5 mg. after breakfast and lunch is occasionally effective but the most useful drugs are the succinamides and the diones.

Ethosuximide (*Zarontin*) is the most useful succinamide and is effective in controlling petit mal in many cases. The usual dose is 250 mg. three or four times a day. If it is going to be effective this is usually obvious in the course of a few days but if after a fortnight or so there is no reduction in the frequency of attacks there is little point in continuing with the drug. It occasionally causes dyspepsia or hiccoughs but seems to be free of more serious side-effects.

Troxidone (*Tridione*). Before the introduction of ethosuximide, troxidone was the most useful drug for petit mal and frequently controlled the attacks in a dosage of 300 mg. three to four times a day. Its great disadvantage is the occasional side-effects, two of them serious ones. Many patients taking the drug complain of a curious "glare" of objects at which they look. This does not presage any damage to the retina or optic nerves and frequently stops if the drug is continued. A toxic erythema may occur and is an indication for stopping the drug. In many patients taking troxidone the polymorph count in the blood falls and there have been fatal cases of agranulocytosis and aplastic anæmia coming on suddenly. Troxidone may also have an effect on the kidneys causing a nephrotic syndrome and regular urine testing for albumen is indicated in patients taking it.

These rare but serious side effects always made one loath to use troxidone unless the petit mal attacks were so frequent that the child's life was greatly interfered with by them. If it was used the parents had to be warned to stop it if the child developed a fever or a sore throat which might be the first symptoms of agranulocytosis and immediately take the child to his doctor or hospital for a blood count.

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I would like to thank Miss Anne Rose, Almoner to the Neurological Department, for her advice in the preparation of this article.

general practice in ELY

It is hoped that this will be the first of a series of articles based on visits to general practitioners. The Editor would welcome any contributons along these lines.

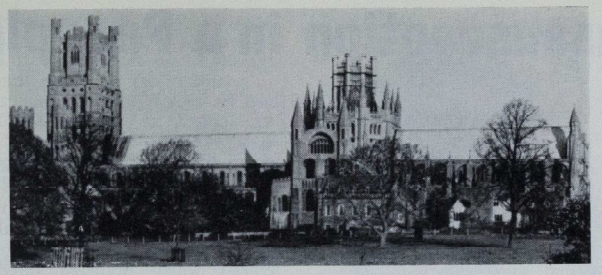
ELY has the quiet attraction of an English market town. It is compact, has no traffic problems, and amongst its jumble of houses are some fine examples of several architectural periods. The one difference from many other towns of its kind is the cathedral, whose huge and beautiful proportions make the buildings clustered at its feet seem little more than a model village. Built in the thirteenth century, it is crowned with the "Lantern",—a unique wooden canopy constructed largely out of eight enormous oaks which took twelve years to hoist into position.

The population of the town is about 10,000, and the practice which I visited looks after some 8,000 patients, a quarter of whom live in surrounding villages. This number includes about 600 private patients. There are three partners (trained at Bart's, Middlesex, and The London respectively), and they share the work equally, with no specialisation except that one of them has an expert knowledge of ophthalmology. There is a considerable attraction in working in a community of this size since the practitioner soon gets to know almost everybody, and he is in a good position to become a respected and influential adviser generally as well as medically.

The surgery is in the centre of the town adjoining two of the partners' houses and within two hundred yards of the third. There are no frills here, and no up-to-date methods of patient reception. But the two consulting rooms are compact and clean, and have a pleasantly unclinical atmosphere. They are separated by a records office-cum-dispensary which is run in turn by three part-time girls and has a hatch through into the waiting-room. When a patient arrives he can either knock on the hatch or place his medical card in one of two trays bearing the names of the two doctors on duty. By the time the doctor sees the patient he has any previous notes in front of him. There is an appointment system for antenatal cervical smears, inoculations, and for cases requiring prolonged examination or history taking.

Surgical procedures nowadays are limited in the main to "sebaceous cysts, septic fingers, and f.b.'s in the eyes." They used to inject piles, when time was less precious and hospital services less extensive, and a wicked looking guillotine in one of the instrument cases testifies to the tonsillectomies which, under a general anæsthetic of ethyl chloride, were common practice not so long ago. In another case a curious set of miniature instruments, looking like something that Gulliver might have come across on his travels, turned out to be designed for piercing ears, an operation which despite the fact that it is not covered by the N.H.S., is not infrequently requested.

The emphasis in general practice must be on a clinical diagnosis; but relations with the local hospitals are excellent and all pathological and radiological investigations are dealt with at the R.A.F. Hospital in Ely, or at Addenbrookes Hospital Cambridge. Patients requiring E.E.G., E.C.G., or physiotherapy have to be referred to a consultant at one of the hospitals, which seems an unnecessary inconvenience. Special or complex cases are referred to hospitals further afield, especially to Addenbrookes and to Bart's. Emergency and routine cases are sent to the R.A.F. Hospital. There are chest clinics at Doddington Hospital and in Cambridge, both 16 miles away, and Ely has its own geriatric hospital.



One of the attractions of general practice is that it often involves, on top of the basic work, extra duties which broaden the interest for the doctor and lead him still further into the heart of the community. This practice in Ely has many such commitments. Perhaps the most absorbing of these is the Palace School for crippled girls, founded by Lady Spens, the British Red Cross Society, and the Ministry of Education, with the co-operation of the senior partner. He is responsible for the general health of the children and he looks in on them briefly most days of the week. The school was unfortunately closed for Easter during my visit, but it is in a wonderful position right next to the cathedral, in a magnificent building which used to be the Bishop's palace, and it must be a fascinating addition to the daily routine. Another partner looks after the 300 boys at the King's School, Ely, and makes a visit there most days in term-time. Then there is the link with the sugar-beet factory, which involves emergency calls for accidents, routine examination of new employees, and general advice on health conditions in the works. The partners, together with the other general practitioners in Ely, also run a maternity home in the town, and this seemed a bright and well-equipped affair, with room for about twenty mothers. Domiciliary delivery is still popular however, and the practice is lucky to have two excellent midwives at its disposal. The total number of deliveries per month averages about fifteen.

As well as all this the partners are Police Surgeons, which means that they are called in by the police to deal with accidents, drunkenness, rape, and other emergencies; and they also carry out quite a number of examinations for insurance companies. Finally they do their own dispensing for country and private patients. It is perhaps not surprising that none of the partners does part-time hospital work, and they feel that a good general practitioner should not have time for that sort of appointment.

The senior partner and his wife, whose charm is an integral part of the practice, live in a delightful Georgian house, with one of the loveliest gardens I have seen. They have worked in Ely for thirty years and have earned the love and respect of its people. Appearances, I was told, are of fundamental importance for a general practitioner, especially for one working in a small community—"it's no good eating in the kitchen if one wants to keep the respect of one's patients." The hospitality that I received seemed to me to be rather more than was necessary to keep up appearances, and not least among my memories of a happy and enlightening day is that of a magnificent lunch, at which I met Sir Geoffrey and Lady Keynes. His house surgeon in the early thirties, the senior partner is now his general practitioner.

Intussusception in a Paraplegic

by J. J. CHURCH

Intussusception is an acute abdominal emergency and although principally a disease of infants, it does occur in all age groups. The case history below is reported as it would seem to be a typical clinical presentation of adult intussusception; some symptoms, however, were masked by the paraplegia.

Case History

The patient, a woman of 30, was quite well until eight days before admission when she became shivery, sweaty and complained of central adbominal discomfort. She had been involved in a road accident ten years previously leaving her paraplegic below the level of C6; although she had a patchy distribution of sensation to light touch the pain involved in any deep visceral lesion was masked by her paraplegia.

On the advice of her doctor, who had diagnosed an acute urinary episode, she started drinking large quantities of fluid. This resulted in a period of intense vomiting during which she vomited anything taken by mouth. At this time she had one episode of hæmatemesis which occurred three days before admission. As her thirst increased she continued taking fluids in sips and eventually could take a little bread with it. During this period she noticed her motions were black, tarry and offensive.

Over the next two days the discomfort became more marked in the right upper abdomen. Her past history revealed that she had had two previous attacks of upper abdominal discomfort occurring before food and at night. These had been relieved by food and alkalis and there had been no episodes of melæna. At the age of eighteen a slightly inflamed appendix had been removed.

Fig. 1.—Barium enema.

On examination an area of slight guarding and increased sensitivity to light touch was found to extend from the right iliac fossa up to the right lateral region of the abdomen to the right hypochondrium and across to the epigastrium. After three days in hospital her symptoms settled down and she almost stopped vomiting, but the discomfort had become more acute in the right hypochondrium. She was found to have a slight pyrexia and her constipation had to be relieved manually. At this stage the initial diagnosis of an acute exacerbation of a duodenal ulcer was contended by a suspected lesion of the gall bladder but this was not supported by a subsequent cholecystogram.

By the end of the second week she was still having bouts of intermittent discomfort and her motions were getting steadily looser. She had become febrile with a temperature of 102°F., although her white cell count was not raised. On further examination her abdomen seemed somewhat distended and the bowel sounds were greatly increased and bell-like. From these signs and the result of a plain X-ray it appeared that there was an obstruction of the large bowel. Over the next week she again settled down, her gastric suction tube was removed, the distension became less apparent and she began eating and drinking normally. A large mass, however, became palpable in the right abdomen and the bowel sounds remained bell-like The final diagnosis of intussusception was supported by a barium enema. Although there was obvious obstruction to the head of the barium, the radio-opaque material did flow between the intussusceptum and the intussuscipiens outlining the colon and the cæcum to the neck of the intussusception (Fig. 1).

At laparotomy the most obvious feature was the engorged, œdematous intussuscipiens consisting of the ascending and half the transverse colon. The head of the intussusceptum lay in the transverse colon almost at the mid-line. With the intussusception and at the neck, extensive adhesions and œdema of the intestinal wall made the defect too gross to reduce manually. It was, therefore, excised *in toto* and continuity restored by an end-to-end anastomosis between the terminal ileum and transverse colon.

The resected specimen consisted of a portion of colon 35 cm. in length into which an intussusception had been formed. This occupied the greater part of the lumen. However the lumen of the intussusceptum was still patent and obviously sufficient for the passage of a daily motion. The intussusceptum consisted of 5 cm. of terminal ileum, the cæcum and a portion of the ascending colon. A Meckel's diverticulum had intussuscepted with the ileum and lay within the inner lumen. Histologically the diverticulum was found to contain gastric mucosa and structures suggestive of Brunner's glands. The involved tissues were extremely œdematous and considerable exudate had been found in the submucosa of the involved gut and in many areas the mucosa had become ulcerated (Fig. 2).

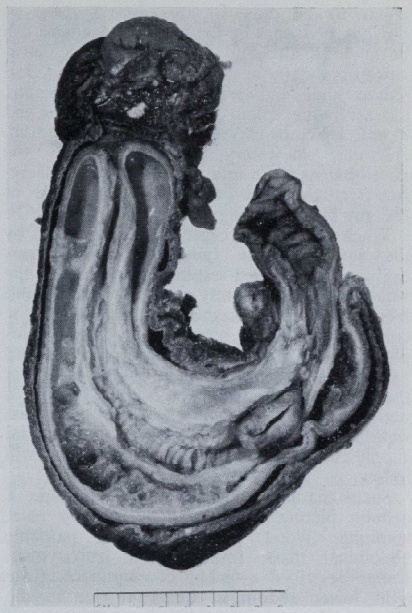


Fig. 2.—The resected specimen.

Other than a slight pyrexia the recovery was uneventful.

Discussion

In infancy intussusception is apparently spontaneous, the most generally accepted theory of causation being that between the ages of six to nine months there is a change of intestinal flora as a result of weaning the child. Such a change leads to inflammation and swelling of the lymphatic tissue, predominantly in the Pever's patches (Perrin and Lindsay 1921).

However in adults the cause is normally

apparent and only in rare cases is there no obvious predisposing factor. Any segment can be involved although the most common intussusception starts in the region of the ileo-cæcal valve initially and spreads to involve the cæcum, the ascending colon, the transverse colon and in extreme cases may even prolapse per rectum. Adequate mesentery is necessary for the development of an intussusception which therefore occurs most commonly in those regions of the gut having a long mesentery.

When the intussusceptum is firmly held by the intussuscipiens lymphatic and venous drainage is impaired resulting in œdema of the wall and consequently further obstruction: leucocytes respond to the insult and add to the congestion. At this point the process is completely reversible and reduction can be achieved by a Barium enema although this should be in the presence of a surgeon should there be a perforation of the œdematous friable intestinal wall (Kahle, 1953). If, however, the arterial supply is embarrassed irreversible necrosis will follow.

Such characteristic pathology results in a definite picture of intermittent colicky pain, vomiting, blood per rectum, a palpable abdominal mass, fever and a leucocytosis. Dance described a feeling of emptiness in the right lower abdominal quadrant due to the absence of the intussuscepted gut, but this is an unreliable sign (Goldenberg, 1954). In order to avoid the acute complications, treatment should be delayed as little as possible. Intense pain usually preceeds the complications; in this case the pain was masked and so the position did not appear so critical. If, on laparotomy, the intussusception can be reduced manually the lesion provoking the intussusception must be excised; manual reduction was not possible in the case described and in such cases resection of the whole segment is undertaken.

In adults any lesion involving the bowel may predispose to intussusception, but by far the most common cause is a tumour. This may either be benign—adenoma, lipoma or leiomyoma—or it may be malignant—lymphosarcoma, adenocarcinoma or argentaffin tumour. Adenomatous Polyposis can reveal itself as an intussusception often concurrent with melanosis of the oral mucosa and lips (Peutz 1886-1957).

That adult intussusception is extremely uncommon can be illustrated by the combined results of three surveys. The first, undertaken in the U.S.A., reported that of 430,000 patients admitted to a general hospital in five years there were fifteen cases of adult intussusception (Brown and Michels, 1952); the second survey at the Sheffield Infirmary reported that in seven years only sixteen such cases were admitted (Bond and Roberts, 1964). Finally, a survey over the period 1954 to 1963 involving 136,220 patients admitted to St. Bartholomew's Hospital reveals that there were nine cases of adult intussusception, the patients being over five years of age; four of these were caused by malignant tumours, three by benign tumours, one from the complications of a gastro-jejunal ulcer and one was idiopathic. Therefore, of a total of over a million patients admitted to hospital there were forty cases of adult intussusception yet not one of these was due to a Meckel's diverticulum as suggested in the case described. There is a strong argument here that the primary cause of the intussusception was not the inverted Meckel's diverticulum but that hyperperistalsis arising from an imbalance of parasympathetic innervation led to a trapping of the ileal wall which was itself propelled within the lumen. A similar occurrence is known to take place immediately following death. Motility of the intestinal wall continues for some hours in the complete absence of nervous control and this often results at post-mortem in numerous small intussusceptions. Although this patient maintained complete vagal control, being paraplegic, her lack of sympathetic innervation would tend to result in an autonomic imbalance; this and the fact that the diverticulum was not at the apex of the intussusception would support this argument. However, in the cases that have been ascribed to a Meckel's diverticulum the majority was due to swollen, inflamed, heterotrophic tissue at the mouth of the diverticulum resulting from irritation by the secretion from the gastric mucosa of the diverticulum (Bailey, 1962). There is no reason why this should not be the situation in this case as the diverticulum was found to contain gastric mucosa and the involved tissues were inflamed, œdematous and in many areas ulcerated.

Other ætiological factors in adult intussusception include an inverted appendix, although extremely rare and usually found in children, Hodgkin's disease, lysis of pelvic adhesions, trauma and pregnancy. In the latter it is suggested that a disturbance of alimentary peristalsis secondary to concurrent hormonal changes can result in intussusception; similar changes are known to influence the ureter (Slemens, Chaffin and Mason, 1937). Intussusception shows a seasonal incidence, the disease becoming more prevalent in warmer weather; from a series taken in Western Nigeria (Elebute and Adesole, 1964) there appears to be a marked regional variation, where the proportion of infant intussusception to that in the adult was 1:3 whereas in the United Kingdom infants are affected twenty-two times more frequently than the adult (McNab, 1948); however pathology showed a high rate of ascaris and other parasitic infestation. Idiopathic intussusception is extremely rare although the incidence is said to be high in Egypt following the Mohammedan fasting season (A. Mooro, contemp.).

I would like to thank Professor Taylor for permission to publish the case and Mr. B. N. Catchpole for his considerable advice and help in presenting it.

Summary

A case of adult intussusception in a paraplegic has been described. Although the symptoms were masked by the paraplegia the presence of a Meckel's diverticulum in the intussusception would suggest that this was the primary factor in the ætiology rather than an autonomic imbalance although the latter is likely to have contributed.

It has been stressed that although in infants intussusception is usually spontaneous, in the adult there is almost always a primary lesion of the bowel which predisposes to the disease.

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"MIGHT I SUGGEST MISS FAVERSHAM, THAT IN FUTURE YOU ADHERE TO THE ACCEPTED SETTINGS - SIX WEEKS EXPERIENCE AS A STUDENT RADIOGRAPHER DOES NOT GIVE YOU THE RIGHT TO EXPERIMENT"

recent meetings of

The Abernethian Society

PROFESSOR L. GUTTMAN, C.B.E., M.D., F.R.C.P., F.R.C.S., *'The Athletic Skill of the Paraplegic'*.

An alternative title for Professor Guttman's lecture might well have been "The adaptability of the human being". He presented a vivid picture of the ways in which the physically handicapped patient can compensate for his disabilities by developing fresh skills and finding fresh fields for hopes and enthusiasm.

The centre at Aylesbury has been in action for 20 years and it has been found that sport plays a fundamental part in the rehabilitation of all cases. Apart from the physical benefits, the competitive spirit induced is most valuable to the mental outlook of the patient, and on this his whole progress may depend.

Practically speaking, the treatment of the paraplegic is based on developing compensatory muscle and sensory abilities. Certain sports develop special groups of muscles and new patterns of postural sensibility in the sitting position are acquired.

The standard achieved in the activities is very high and paraplegic Olympic Games have taken place at Rome, Perth and Tokyo. In Japan especially, enthusiastic interest and assistance are remarkable.

SURGEON LIEUTENANT R. L. W. CLEAVE, R.N., B.M., B.Ch. *'Overland Journey to China'*.

Surgeon Lieutenant Cleave, a past president of this Society, was fortunate enough to be allowed by the Navy to come home from Singapore overland via India, in order to get experience in tropical diseases. He visited many hospitals in India and showed us some photographs of the cases he had seen, especially smallpox and leprosy.

He also showed many beautiful colour slides of the cultural and scenic aspects of the countries passed through, which included Afghanistan, Ceylon, Thailand, Syria and Turkey.

* * *

meetings in June

June 3—MR. KEITH REGAN
"Medical Insurance".

June 24—DR. G. CANTI, M.B., B.S., Cytol. M.C.Path.
"Cytological Investigations on Carcinogenesis".

at Charterhouse

Charterhouse has suffered a severe loss in the resignation of Mrs. Goldshaw last month. Known as Mrs. G. to more than ten generations of Bart's students she did far more for the welfare of both male and female students than her official position of Women's Cloakroom Attendant could ever imply. She became a mother figure to many students with problems and difficulties of all kinds. She will be sorely missed. She carried out her duties at Bart's with the same dignity and kindness as she performed those of Lady Mayoress of Finsbury last year. Her successor Mrs. Butter has a great deal to live up to.

Mrs. Goldshaw's future in Bart's as a whole is still very much in doubt. It is sincerely hoped that she will return in some capacity and it is to be regretted that a personal dispute should have led to such an unhappy loss which Bart's can ill afford.

VIEW DAY

from a Special Correspondent

This year it was a perfect day for the Saturnalia, and more than ever tea became the central focus for View Day afternoon. Taking part in the festivities as usual were the Governors, staff, nurses' parents and sundry extras quietly baking in the Square. Entertainment for the latter group was provided in accordance with ancestral tradition by the goldfish, the latest fashions and their wearers, and The Procession. From time to time the dignitaries trooped by, clad in morning dress for the most part and armed with sticks (traditionally used to silence the patients' complaints), but bearing up commendably well in the unnatural heat of the afternoon.

The guilty few as usual could be seen to time their furtive arrival on the very stroke of tea, slipping off afterwards (deplorable fact) without discharging the honourable duty of admiring the various exhibitions. Needless to say your correspondent was not among these sluggards, but toured the Royal Hospital from top to toe until thirst and exhaustion halted his noble quest for the Exhibition on Slimming (Dietetic Department) and drove him regretfully to the oasis, as it were, of Gloucester Hall.

Photography lay back to back with the missionaries in the Library. First prize in the Photographic Exhibition was claimed by the portrait of a leaf, second by a misty scene in remote Fernando Po. On the other side of the screen much work had been devoted to informing visitors of the work and locality of various medical missions manned by Bart's men. Aloft in the Gallery there lurked some fine old Bart's prints, of John Abernethy (Sir Thomas Lawrence pinxit), of the Great Hall crowded with beds during the General Strike, and of the death of Wat Tyler, slain by the Lord Mayor in Smithfield in 1381.

A long haul up the stairs towards the Pathology Museum was rewarded by a glimpse of the historic laboratory where Dr. John Watson first encountered Mr. Sherlock Holmes. A modest bronze tablet marks the spot. ". . . . we ascended the bleak stone staircase and made our way down the long corridor with its vista of whitewashed walls and dun-coloured doors. Near the farther end a low arched passage branched away from it and led to the chemical laboratory. This was a lofty chamber, lined and littered with countless bottles." (*A Study in Scarlet*)

There was time for a hurried look at the Department of Medical Photography and above where the medical artists work in their splendid sunlit studio. A quick visit to the wards was called for, where the patients, a trifle mystified by the whole business, reclined like waxworks, unwilling to disarrange those beds so neatly made. It seems a pity that the old custom of serving tea on the wards to the visitors and staff has been dropped. The modern ceremony, celebrated en masse and no doubt easier to arrange, remains a rather impersonal affair.

Your correspondent's last task was to sample the view from the top of Gloucester House. Other delights awaited him up there—the exhibition of nurses' paintings, for example. He found some interesting information on the naming of the wards, and various other titbits, notably that in 1791 the Sister and entire nursing staff of Luke Ward were sacked for drunkenness. Thus refreshed it was a return to ground level and contemplation of Bart's heraldic shield — Argent, a chevron sable, counterdemidiated paleywise?

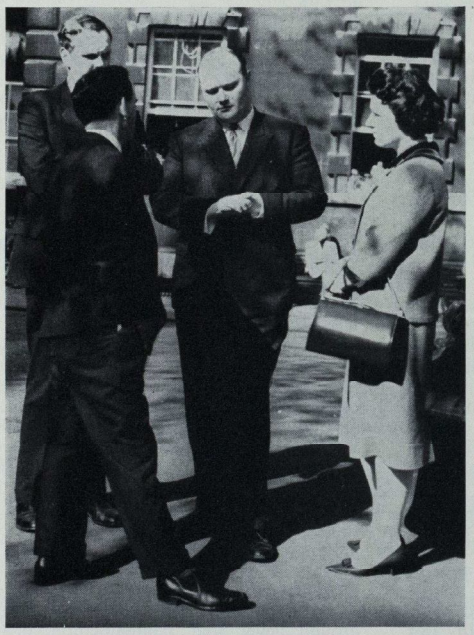
Social Chapter

VIEW DAY BALL

Approximately four hours ago I left the Criterion Rooms in Piccadilly, and have since been to Covent Garden, and Hampstead Heath to watch the sun rise, and hear the birds twitter. Now I feel lassitude and contentment seeping over me, so it follows I must have enjoyed the 1965 View Day Ball. Without any shadow of doubt many people will feel as I do, but in fact some trenchant criticism must be levelled at certain aspects of the evening.

On arrival there was a considerable queue to get in, and then four hundred guests to fight through to reach a bar served by two inept retainers. What a sad start to the proceedings! Blue language floating about, and deserted girls standing around waiting for their furious, perspiring, drinkless males.

So, up to dinner and better things: Oeuf et Jambon Norvegienne, Truit de Rivière Meunière, Suprême de Volaille Maréchale with



"Well, sir, I'm a busy man, but I think I could manage it in July."

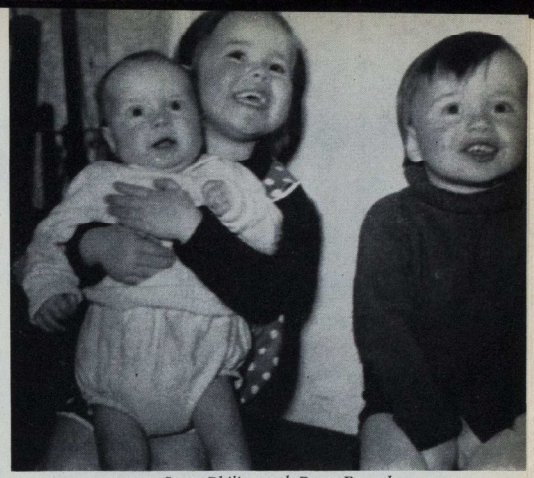
Chouxfleur à la Crème and [illegible]es Nouvelles Rissolées, then Vacherin aux Fraises and Bo[illegible]Tutti Frutti, and finally, Petits Fours and Café; the whole [illegible]well served and tasty to the palate. There was also a full re[illegible]able wine list.

By now previous frustration[illegible]eased and 11 p.m. saw in the cabaret of Terence Brady and [illegible]chael Bogdanov: sad to relate they were given "the bird" b[illegible]sier sections of the gathering; perhaps this was slightly unjus[illegible]at least half the guests could hardly hear a word, let alone s[illegible]ything, and of those who could see and hear, perhaps half ha[illegible]eady had a bellyful of satirical "Beyond the Fringe"-type ca[illegible]

Yet again the majority of th[illegible]sts were looking pained. However, praise the Lord, from [illegible]n the evening improved. Bill Savill took over the Grand H[illegible]fter the dinner tables had been cleared, and was much apprecia[illegible]as always. The Fugitives are an exceptionally fine Group, and [illegible]e given hearty support throughout the night, and the Tropicana[illegible]re streets better than the average Steel Band. The Roulette w[illegible]well patronised, though always attracting more watchers tha[illegible]amblers, and the well-stocked Tombola went as well as usua[illegible]

I must now reiterate that t[illegible]30 a.m. and close-down most guests, mellowed by music, wi[illegible]artners, and the view over Eros, were satisfied with their Ba[illegible]nd had forgotten their earlier frustrations. No real criticism [illegible]be levelled at the Committee who worked extremely hard, [illegible]blame for the disasters of the evening must fall onto the s[illegible]ders of the administration and design of the Criterion itself. I[illegible]important for future committees to realise that they will sell mo[illegible]ckets, and have an easier Ball to run if they choose a place l[illegible]e "Hilton," with a name and efficient management to attra[illegible]e type of guest who will bring a party with him.

bart's babies



Sara, Philip, and Rory Downham

also . . .

Nurses Dance

One of the best of its kind; this dance, organised by Mrs. Owen, the Social Secretary for the nurses, was an excellent 5/-'s worth, aided by dimming the arc lights, the enthusiastic performance of "The Few," (a Bart's Group), and the plentiful supply of beer. Proceeds were sent to the Churchill Memorial Fund.

Rugby Club Dinner

After sherry in the new A.R., a full sitting proceeded to Walker's Restaurant, Old Bailey, for the Dinner. More Vice-Presidents were present than usual, amongst whom were, Mr. R. F. McNab Jones, Dr. N. Oswald, Dr. R. Macpherson, and Mr. C. Morris. After dinner festivities were ably led by the President, Mr. J. W. Cope, and on leaving Walker's further beer was available in the gym at Charterhouse Square.

Soccer Club Dinner

Twenty-five members were present at the annual dinner, held this year at the Cheshire Cheese, amongst the guests were Mr. J. O. Robinson, Dr. T. Duffy, and Dr. J. Jailler.

LONDON ——————————→ BRIGHTON

STROLL

from Our Special Correspondent

THE two thousand mark has been surpassed at last! This year the thirteen participant hospitals managed to get a number very near to, or just over, two thousand strollers on to the A.23. They left the Tower of London at 6.30 p.m. on May 7th., on the fifty-three mile run, walk, stroll or limp to Preston Park in Brighton. Instead of everyone crowding through one tiny drawbridge into the precincts of the Tower, as in previous years, the start this year was from the wharf in front by means of a yacht club cannon which even managed to go off for a change.

As the mob made its way through the busy London streets, the Bart's marshalls were loading everything they could think of into and on top of four cars to go to the Depot at Handcross.

Whilst driving down it was interesting to see the stragglers still on Brixton Hill, whilst the flat-out leaders were well south of Purley.

Having organised ourselves we retired to the Red Lion until closing time. On returning to the Post we awaited the first runner, who came through at 12.40 a.m.

During the night we served over a thousand hot dogs, 15 gallons of cocoa, countless gallons of orange juice and attended to about 300 dead and dying.

Everything ran very smoothly with "King Uncle Bradley" welcoming everyone individually with a tankard of salt tablets and codeine and showing them to "feet" or food", as required.

Results are worked out for the Toucan Trophy on the percentage of the total number of medical students in the College, not just the total number entering, and as the table below shows, Charing Cross achieved the amazing feat of getting half their students there.

The Wander Trophy for the Ladies is provided by Ovaltine Ltd., and works on a similar percentage of total female students at the College. Bart's came eighth in the Toucan Trophy, with 15.87% getting there. (Second of the big Five to Guy's). The Ladies came twelfth with 4.35%, just pipping Mary's from the Wooden Spoon.

Many congratulations must go to all those who finished and in particular to Charlie Evans who passed through Bart's post 19th; but with the never-failing support of Bernard Watkins, he made up fourteen places in the last sixteen miles to finish fifth, just before the Ovaltine and Guinness breakfast vans arrived.

Anything for a change

Toucan Trophy

1st.	Charing Cross ...	44.5%
2nd.	George's	27.0%
3rd.	King's	24.6%
4th.	Westminster	23.9%

Wander Trophy

1st.	Charing Cross ...	42.3%
2nd.	Westminster	22.0%
3rd.	U.C.H.	19.7%
4th.	George's	16.5%

NEW METHODS OF TREATMENT IN CARDIAC DISEASE

by J. S. FLEMING

Senior Registrar, Department of Cardiology

New drugs and new methods of treatment are constantly being introduced throughout the hospital, and I will describe here some of the more recent additions for the management of the cardiac patient. The cardiac surgeon continues to devise more effective operations for the correction of congenital and acquired heart disease, and in this he has been aided by the manufacture of efficient artificial heart valves, whilst the electronic engineers have played a large part in the construction of machines capable of terminating abnormal cardiac rhythms or of electrically stimulating the arrested heart. The demonstration that the circulation can be maintained in a cardiac emergency by closed chest cardiac massage is a very real advance and the application of this technique has saved many lives.

Cardiac Arrest

The suddent cessation of the circulation is an emergency familiar to most medical students, and they are well aware that vigorous compression applied to the lower sternum about 60 times per minute will maintain an adequate circulation to the brain, thus preventing irreversible changes which otherwise occur within 2-3 minutes. In fact the technique is so simple that it is quite surprising to the modern student to realise that only a few years ago the usual procedure was to give intravenous or intracardiac drugs and perhaps thereafter to open the chest or the abdomen and massage the heart directly. It is important to remember that closed chest massage will circulate the blood, but that the lungs must be made to oxygenate that blood, so that artificial respiration is also necessary. At St. Bartholomew's Hospital there is now a resuscitation registrar always available who can perform artificial respiration after passing an endotracheal tube within minutes of a cardiac arrest anywhere in the hospital. Usually the electrocardiogram will show that the patient is in ventricular fibrillation, indicating that the muscle fibres of the ventricles are contracting in an irregular non-synchronous manner with insufficient strength to propel the blood. An electric current applied to the heart can cause depolarisation of all the muscle fibres together, so that the next impulse from the sino-atrial node may be conducted in the normal manner, resulting in sinus rhythm. There are two types of machine capable of giving an electric current to the chest wall sufficient to pass through the heart and stop ventricular fibrillation. One type delivers an alternating current whilst the other produces its effect by means of a direct current. The alternating current defibrillator is an easily portable box, and by applying two large electrodes to the chest wall from this, a shock of up to 850 volts lasting for 200 milli seconds (one-fifth second), can be given. The advantages of this alternating current defirillator are its portability and cheapness, but an alternating current of this strength and duration is liable to produce some cardiac damage. The direct current defibrillator consists of a large condenser which will give a direct current shock of up to 400 watt seconds when applied to the chest wall. Sixty watt seconds are usually sufficient to terminate ventricular fibrillation, and this type of shock causes much less damage to the myocardium, as well as being effective at times when the alternating current shocks have been unsuccessful.

Treatment of Other Arrhythmias by Direct Current Countershock

The first use of an electric current to depolarise the heart was naturally in the treatment of ventricular fibrillation, a hitherto fatal condition. However the success of direct current in this, encouraged much research on the effects of direct current on other abnormalities of heart rhythm. It is now known that a D.C. shock lasting 2.5 milli seconds and of under 400 watt seconds produces minimal damage to the myocardium and will not precipitate ventricular fibrillation if the shock is given at a time in the cardiac cycle avoiding the ascending limb of the T wave.

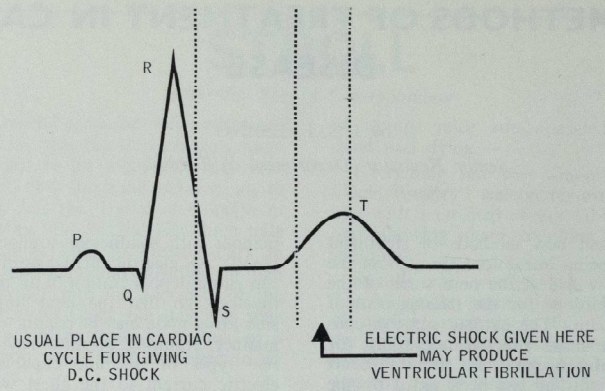


Fig. 1. The timing of the defibrillating shock within the cardiac cycle.

We now have a direct current defibrillator whose discharge is triggered automatically by the R wave of the patient's electrocardiogram (Fig. 1) thus avoiding the dangerous part of the cardiac cycle, and it has been used to restore sinus rhythm in patients with ventricular tachycardia, atrial flutter, atrial fibrillation and atrial tachycardia. Of course many of these arrhythmias can be controlled or reverted to sinus rhythm by means of digitalis, quinidine, procaine amide, prostigmine, lignocaine or other drugs, and it is not suggested that all patients should be given a direct current shock. However if the patient is very ill because of his arrhythmia, or if large doses of potentially dangerous drugs such as quinidine are being used, then D.C. countershock is probably the method of choice. The procedure is simple and causes little discomfort to the patient—electrocardiograph leads are applied in the usual way and after giving i.v. thiopentone to produce light anæsthesia, the condenser is discharged across two large area electrodes, one applied to the chest in the region of the cardiac apex, the other to the left infrascapular area. Usually only a few minutes of anæsthesia are required for the procedure and there are no unpleasant after effects.

Figure 2 illustrates a dramatic example. This man had a posterior myocardial infarct in

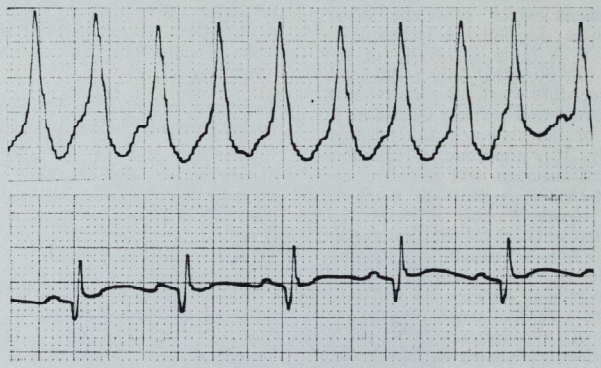


Fig. 2. Top: Ventricular tachycardia, rate 166/min. Bottom: Sinus rhythm restored with one D.C. shock.

May 1964 and was readmitted in August with a ventricular tachycardia which had been present for 4 days. He was in severe congestive cardiac failure with both pulmonary and peripheral oedema and a high blood urea (134 mg.%) due to the low cardiac output. One direct current shock synchronised on the R wave restored sinus rhythm with immediate improvement in his condition, and he was discharged ten days later free from failure and the blood urea had fallen to 79 mg.%. Table 1 gives our figures for the treatment of arrhythmias by D.C. shock:-

Arrhythmia	*No. of Patients*	*Sinus Rhythm Restored*	*Complications*
Atrial Flutter	7	7	0
Atrial Tachycardia	3	3	0
Atrial Fibrillation	9	7	0
Ventricular Tachycardia	1	1	0

TABLE 1

Although as yet the number of patients treated is small, it does appear that the success rate is high, whilst the lack of any complications makes D.C. countershock a very useful method of treating arrhythmias.

Heart Block

We have now several methods of treating patients who are in complete heart block. In many cases oral isoprenaline or ephedrine will suffice to maintain a ventricular rate compatible with a reasonably normal life. However others may suffer from repeated episodes of cardiac standstill with sudden complete loss of consciousness, or have a ventricular rate so slow that they are practically confirmed to bed. For these, electronic artificial pacing of the heart should be considered, and indeed this procedure may be life saving in patients who are in heart block after cardiac surgery, fortunately now a rare occurrence. As an emergency measure the heart can be paced with two external electrodes applied to the skin over the heart and connected to an external pacemaking machine which delivers current 70 times per minute at about 100 volts. However this is exceedingly uncomfortable to the patient who really requires to be anæsthetised, and skin burns can occur under the electrodes.

A much better method is to pass a sterile, platinum tipped wire down the external jugular vein through the tricuspid valve and impact the tip in the region of the apex of the right ventricle. (Fig. 3). This can be done fairly quickly but involves cutting down on the external jugular vein in the neck and X-ray control is necessary when placing the wire in the ventricle. The other end of the wire is connected to a box which delivers a 3 to 5 volt electric impulse at a rate of 70/min., and this makes the ventricles contract at that rate. As the patient must carry the box about with him, and as there is an ever present danger of infection getting into the blood stream along the wire leading to the heart, this method is usually only used to pace the heart for a few weeks.

For prolonged artificial pacing of the heart small units are manufactured which can be implanted in the sheath of the rectus abdominis muscle, and two wires are led from this unit through the diaphragm to be sewn onto the ventricular surfaces. (Fig. 4). For the insertion of this unit therefore the patient has to undergo a thoractomy and, of course, a further operation is necessary when the unit fails or the batteries become exhausted. Unfortunately although the manufacturers claim that the units function for over two years, they have not done so in the few patients we have treated. At present three

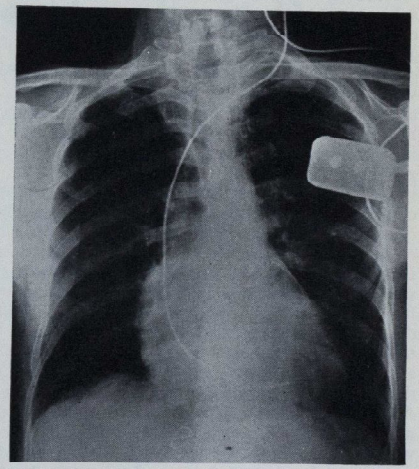


Fig. 3. Platinum tipped catheter passed from external jugular vein to apex of right ventricle.

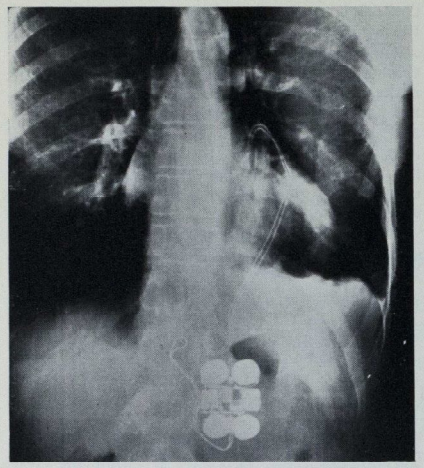


Fig. 4. Pacemaker unit in abdomen with wires leading to heart.

out of nine internal pacemakers implanted this year have failed after a variable period and have had to be either replaced or removed.

Aortic and Mitral Valve Disease

Recently our thoracic surgeons have been achieving considerable success in the surgical treatment of mitral valve incompetence and aortic valve incompetence by replacing the diseased valve with a Starr Edwards artificial valve. This consists of a metal cage containing a round ball which is attached firmly to the mitral valve ring for the correction of mitral incompetence, or to the aortic valve ring in patients with aortic incompetence. The immediate post-operative results are good, complete competence of the valve being obtained in every case. As the long term effect of these artificial valves is not known, and as there is always a danger of clot formation with subsequent embolism, this type of operation has been reserved for patients who are severely disabled. The Starr Edwards valve is also used to replace the calcified aortic valve of severe aortic stenosis when the valve is too grossly deformed and destroyed to allow simple decalcification and separation of the commissures. By means of these operations patients with chronic congestive heart failure have been discharged home free from oedema to lead a new life after years of chronic invalidism. I know that the general practitioners of these patients have been most favourably impressed by the improvement obtained. So far fifteen patients have had aortic valve replacement and seven patients mitral valve replacement.

Because of the risk of thrombus formation on the artificial valve with subsequent embolism, all the patients in whom the mitral valve has been replaced are given anticoagulants post-operatively, and they continue to take these after discharge from hospital. The dosage of the anticoagulant drug, usually phenindione, is controlled by the one stage Quick method, and this involves attending hospital only about once a month. Most hospitals use the Quick method, so that arrangements are easily made for the patients to attend their nearest local hospital and long term anticoagulant therapy does not therefore greatly disturb the patient's life. It has not been our policy to give long term anticoagulant therapy in patients with artificial aortic valves as the embolic risk is less. However recently one patient who died ten months after operation was found to have massive thrombus formation extending from the artificial aortic valve into the ascending aorta, and this suggests that probably all patients with these artificial valves should be maintained on long term anticoagulants.

Severe Angina Pectoris

Angina pectoris usually results from narrowing or complete occlusion of part of the coronary arterial system, but unfortunately the obstruction is rarely amenable to operative relief as it is rarely confined to a short segment of a coronary artery accessible to surgery. The patient with severe angina pectoris, whose pain is poorly controlled by drugs such as glyceryl trinitrate, is a real problem and several operations have been devised to make him more comfortable. Of these, bilateral cervical sympathectomy has been extensively studied and used in St. Bartholomew's Hospital, and has been of great value in suitable cases. In the selection of patients likely to benefit from cervical sympathectomy the effects of beta-adrenergic-blocking agents on the symptoms and on the exercise electrocardiogram are studied, a favourable response being good evidence for advising the operation. These beta-adrenergic-blocking agents are recently discovered drugs, usually given orally, which inhibit the action of sympathetic amines on the myocardium and in this way mimic the effect of sympathectomy, which removes the sympathetic drive from the heart.

Pulmonary Embolism

To conclude this brief survey of some new methods of treatment, I should like to discuss a new approach in the management of pulmonary embolism which is likely to be used in the near future in this hospital. Pulmonary embolism is usually caused by a blood clot, which has formed in the deep veins of the legs, breaking off from its site of formation and travelling in the blood stream to the pulmonary artery. Leg exercises for patients confined to bed, and the mobilisation of all patients just as soon as their disease or operation allows, has greatly decreased the incidence of pulmonary embolus, but occasional cases still occur. When the embolus is large and lodges in the main pulmonary artery, the circulation is greatly decreased because of this clot blocking the flow of blood to the lungs. In occasional cases the surgeon has successfully removed the clot from the pulmonary artery at an emergency operation, but the difficulties of this operation on a beating heart, and the inability to maintain an effective circulation during surgery, greatly limited the chances of success. The institution of cardio-pulmonary by pass in this emergency would obviously be of the greatest value, for, in doing this all the venous return to the right atrium is withdrawn to a machine where it is fully oxygenated and then pumped back into the arterial system. In this way an adequate circulation of oxygenated blood can be maintained despite the block in the pulmonary artery, and the surgeon can then open the pulmonary artery, remove the clot and close the incision again with no interruption of the circulation to vital organs such as the brain and kidneys.

With the usual cardio-pulmonary by pass machine many hours are required to sterilise and prepare the equipment, and many litres of cross matched blood are necessary. Recently the hospital has obtained a disposable oxygenator which is supplied sterile ready for use and which requires only a few pints of cross matched blood for its use. This has proved very effective in routine cardiac operations where cardio-pulmonary by pass is required, and it can be made ready at very short notice for emergency operations such as pulmonary embolectomy.

Give Honour Where Honour is Due

by the late V. GODSALVE WARD

(*who began his training at Bart's in* 1895)

I had occasion to see Mr. Jackson Burroughs with a painful 'antique' hip joint, and the London Temperance Hospital cropped up in conversation. He told me his father had been on the junior staff there and did some good work. I knew him quite well; I was appointed as R.M.O. at the London Temperance Hospital in 1903 and was there 3½ years. I was appointed not because I was a teetotaller—in fact, my mother used to insist on our drinking a glass of beer at bedtime directly we were 10 years old. My only surviving brother, aged 95, remembers my mother drinking beer for breakfast! An interesting clinical fact is that one brother who absolutely refused the beer suffered very badly from acne. I have always been a great believer in the mellowing effect of alcohol; in fact, I think that if a wife would meet her husband with a kiss in one hand and a double whisky in the other there would be far fewer divorces and many more pleasant evenings! And I think in these "no domestic" days she deserves one as well.

The London Temperance Hospital was built, I think, at the instance of Benjamin Richardson. There was a brass plate in the hall protesting against the amount of alcohol which was given for the cure of disease. The teetotallers were somewhat aggressive in those days; many of them wore a bit of blue ribbon in the lapel of their coats (just as the Frenchman in the Legion of Honour wears a pink ribbon) and

called themselves the "Blue Ribbon Army".

There is no doubt that lashings of brandy were poured down people's throats at Bart's in those days. Sister Darker used to insist on the House Surgeons putting 4 oz. of brandy on the diet sheet for anyone in the 50s and 6 oz. for anyone in the 60s. The over-70s were comparatively rare, but if the amount went up in arithmetical progression, being rising 88 I shudder to think how much brandy I should have poured down *my* throat!

Of the staff at the Temperance Hospital Sir Wm. Collins was the senior surgeon and some of the surgery was a bit crude. Hæmorrhoids were done by gripping a great chunk of the pile-bearing area, clamping with ivory covered forceps and then burning right off. This was done in three positions and a large bolus of wool and gauze put inside, but they seemed to do very well. He was also responsible for the eye work and I must say it was very brilliant. He used to put the Graefe knife between his lips, open the eye with one hand, put in the speculum and then cut the cornea. Here again, there never seemed to be any bother.

Soltaw Fenwick, the senior physician, was a very good teacher. I remember once he had a woman patient, an obvious neurotic, and when he uncovered her stomach there were many scars on it as if she had had every organ either removed or examined or, I was going to say, replaced. He asked her what was the matter and she said she was sick. He said, "Very, very sick?", and she said "Yes". He asked her if she had ever brought up a large round, fleshy worm, and she said, "No, sir". So he just tapped her on the shoulder and said "Not yet", and went on to the next bed! There were no "trick cyclists" in those days but I doubt if they could lay claim to such lightning therapeutics.

Whilst I was at the Temperance I had a bad attack of typhoid and perforated. Paterson, the abdominal surgeon, insisted that I should be operated on, and Hogarth, one of your illustrious predecessors, somehow got old Dr. Gee in to see me and I was told afterwards that he had said in his dry way, "I think Ward is going to die, but if you operate on him I am sure he *will* die!" Dr. Gee was well-known for his dry sayings and when Queen Alexandra, whom he was looking after, tried to make him have a title he said he would rather have a fur coat, which she gave him, and he was frightfully pleased with it and wore it on every excusable occasion. He used to attend the postmortem of every patient of his who died and he once said he had never seen an uncomplicated broncho-pneumonia in a child in a postmortem room. I feel that this should make those people who are so keen on penicillin think twice before giving it because of some of the after-effects. I personally had an attack of broncho-pneumonia at the age of 84 and I had a dozen doses of penicillin. As a consequence I have now lost all sense of taste, I have a sore tongue and a continual running nose—not that it was not very essential in my case. It seems that in these days medicine is more dangerous than surgery.

I do not know who started this racket of cigarette smoking being the specific cause of lung cancer. When the increase in lung cancer occurred I first of all thought it was a biological or a pathological phase. Over 70 years ago I was smoking more than 20 cigarettes a day. The timing is all wrong; if it is an inhalation disease it synchronises with the burning of diesel and heavy oil. Oil is the fuel of the future. All buses by their noise use diesel oil, 50% of taxis use it for economy reasons and they say that the London Power Station burns a small tanker a day.

Over the years the pattern of disease has changed. Chlorosis has disappeared; scarlet fever has practically lost its potency so that it now has to be called scarlatina, and smallpox has been divided into smallpox major and smallpox minor; and does one ever see a sarcoma at the head of the tibia these days? They used to be quite common.

Another extraordinary change has taken place in the world of anæsthetics. In my day if anyone over 50 required an operation one was asked "Would he stand the anæsthetic, doctor?" It was reported to me that at Pyrford an old lady of 103 had broken her hip, had it pinned under anæsthetic and had been able to walk out! Well, I ask you? I think they are completely upsetting the balance of nature.

It is difficult to assess the actual value of this example of giving practically no brandy in disease, but there is no doubt it is now no part of the cure and I think Mr. Benjamin Richardson deserves much honour.

medicine in literature

SURGICAL WARD

by W. H. AUDEN

They are and suffer; that is all they do;
A bandage hides the place where each is living,
His knowledge of the world restricted to
The treatment that the instruments are giving.

And lie apart like epochs from each other
—Truth in their sense is how much they can bear;
It is not talk like ours, but groans they smother—
And are remote as plants; we stand elsewhere.

For who when healthy can become a foot?
Even a scratch we can't recall when cured,
But are boist'rous in a moment and believe

In the common world of the uninjured, and cannot
Imagine isolation. Only happiness is shared,
And anger, and the idea of love.

Some Medical and Human Problems of Automation

by V. C. MEDVEI, M.D., M.R.C.P.

AUTOMATION is not new. It may be defined as the exercise of mechanical control over a system without using hands to do so. The ancient Greeks linked together the rudder and the sails of ships in a specific manner and could steer the ship on a set course, defeating the waves which attempted to deflect her. In the 15th Century the Dutch invented a device for turning windmill sails into the optimum wind force. In the 18th Century an entirely automatic mill was constructed in Philadelphia. The corn was brought in at one end and came out at the other untouched by hand, already ground and packed into sacks. This was long before the days of power. In fact, power or mechanisation are very recent when compared with the idea of automation.

Automation will change the face of human life in industrial countries within the next 10-20 years. If it is introduced into industry too quickly, without careful planning and consideration not only for the existing arrangements but for the existing manpower, it may cause great disaster and even political upheaval. The effects of haphazard introduction of automation are already to be observed in some parts of the United States.

This does not mean that the new generation of young people trained in automation, and acquainted with its use, should feel a particular strain. When the fully automatic car was introduced, drivers of the present generation used to complain that cutting out the gear lever would make driving an unskilled job, fit for morons only. Drivers, however, who have never used a car with a gear lever, do not share this opinion. Nor is the fact that a pilot can land an aircraft with the help of electronic devices proof that pilots must be less skilled in comparison with the pilots of the First World War.

From the medical point of view, we have to consider the effect of automation on the body and on the mind.

Bodily Effects

As automation is meant to cut out a number of maintenance and repetitive jobs and, as it is expensive to install in offices and in factories, it is obvious that only large firms can afford to make use of it. Computers and machinery controlled by automation are usually completely enclosed and poisonous products are out of the reach of the worker whose main task is supervision. Hence the risk of accident is much less, not only because there is less handling of the work, but also because large firms are usually well aware of the importance and hazards and of good working conditions. Much of the highly complicated apparatus function only under good conditions of temperature and humidity, and in the absence of dust. The only possible physical hazard could be, in some instances, high-pitched noise. In this country with its experience of industrial medicine and hygiene and highly developed legislation which is controlled by the Ministry of Labour, automation should not cause any adverse effects to the body of the people who are working it. There are, however, observers who are worried about the lack of muscular activity at work which results from automation and may effect especially the younger men.

Effects on the Mind

This is a much more serious problem. It is clear that in order to handle automatically controlled processes, people must be often highly skilled and of above average intelligence. On the other hand, automatic machinery may be the cause of increased boredom at times, interrupted occasionally by periods of increased activity, perhaps due to emergencies. In addition to the boredom, there will also come into play the effect of loneliness. As automation cuts down the number of people needed, there will be much less team-work or the craftsman's skill handling an exciting and perhaps dangerous machine. Increased noise and the need for shift work will make the workers' isolation even more acutely felt. These dangers will be counteracted up to a point by the fact that the worker will have a large amount of responsibility and more work of a supervisory nature. He will have to understand the whole process of manufacture going on within the orbit of the machinery he controls. Although he is not usually able to see the actual procedure, which is enclosed, he will have to visualise the process by watching the indicators and dials and, also perhaps, the sounds. Maintenance will be of greater importance and the operator will have to look out for things going wrong unless the equipment contains a built-in fault detector. No doubt, the greater intelligence needed, the greater amount of responsibility, and the possibility of higher salaries, will give that type of people a higher status. On the other hand, those people who will not be able to make the grade and find work under the conditions of automation, i.e., the less intelligent and the older people, will suffer not only from the social but also from the mental effects of automation. In the case of people who have become redundant because of the introduction of automation in offices and factories, this problem has become very acute in the United States. Good management will take care that automation is not introduced too abruptly. In an office it will mean that clerical staff under 40 or 45 may need retraining to new work. Beyond the age of 45, one cannot accept average people to be able to be retrained in entirely new jobs. In other words, clerks and skilled or unskilled workers who have given good service over the years and who are over 45 should be allowed to run their course and peter out gently.

Whereas people who are in control of automation processes, such as programmers, will enjoy enhanced prestige, many of the lower ranks, if employed at all, will face psychological problems because of loss of prestige. It is already a problem of our modern times that the unskilled or clerical worker or messenger is not made fully aware of the importance of his job well done. Automation introduced without careful planning and intelligent appreciation by management and industrial medical officers, will increase that feeling, and mental misery will be added to financial loss. Needless to say, in the case of unskilled labour, team work and companionship are even more important than for the highly skilled expert. The need for companionship and for good adjustment and intelligent team formation has been studied intensely for the last 25 years. Automation will increase therefore the need for sufficient facilities for people to have a chance to talk, relax and have the social life they need at work as much as outside. Such a need will be increased by the fact that shift work is inevitable where automation is introduced. Computing and other electronic machines are so expensive, that they have to be used day and night in order to make them pay. It has been estimated that the machines must work 168 hours a week, apart from maintenance, in order to yield profit. This means 3 shifts in 24 hours in the case of manufacturing purposes.

At this point we must be clear that the effects on the mind will be closely linked with social effects.

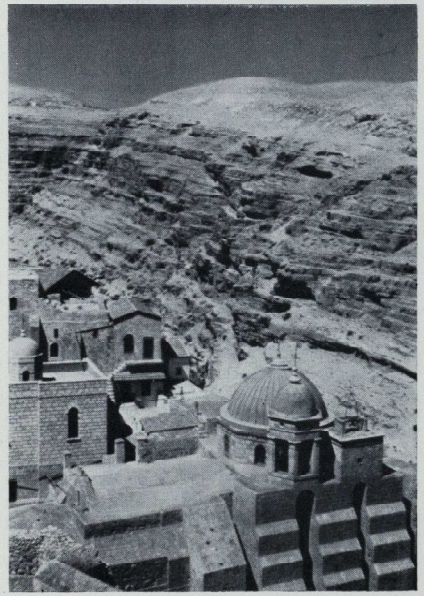
As I have already said, automation prevents group formation, which, for the psychology of work, has great importance. In this manner it increases the chances of working in isolation and loneliness. Apart from a selected group or programmers, the type of foreman craftsman and skilled labourer craftsman is bound to disappear. Whereas at present we are persuaded that, in order to maintain our output and export possibilities, we must use woman power to the full, there is likely to be such a redundancy that the majority of women will find it very hard to get work. A complete reconsideration of the relation of wages to work, output and working hours will be necessary. It will be quite impossible to link either working time or piece work to the amount of money that should be paid. As regards the increased facilities for leisure, two great problems will become imminent. The first one is to educate people how to use their leisure; the present concern with the problems of teenagers who, out of boredom, revert to mischief and violence is an example of what may happen if the time for leisure exceeds that for work. Have we got the means for such education and the manpower, and is it indeed possible to educate all people for such a purpose? The second and even greater problem appears to me that many people, by no means the less intelligent, will take up two or three jobs, partly to escape the monotony of enforced leisure and partly to increase their income so that they are able to enjoy all the facilities of modern life such as motoring, overseas travel and so forth. This trend was quite obvious when discussed at a meeting on double-jobbing and, indeed, the Trade Unions are well aware of this problem.

Automation is inevitable but, in order to make it work and make life worth living in a future world of automation, urgent and intelligent consideration will have to be given to the problems mentioned.

MAR SABA

Philip B. Wood

A CLOUD of dust billowed out behind the travel stained Volkswagon, as it lurched and bumped down the rough track under a burning and remorseless mid-morning sun. Sharply pointed rocks tore at the tyres and the dormobile skidded slightly round another ninety degree bend, sending a small boulder bouncing over the brink of the track. The trouble was that the track to Mar Saba had only been constructed for donkeys and small carts and the sandstone hills of Midbar Yehuda —the Wilderness of Judah—seemed to have resented even this insult to their privacy. We had not fancied a twenty mile walk, there and back, from Bethlehem, and horses seemed unobtainable. Obviously the Monks were not particularly keen to have visitors but we had been assured earlier, as we obtained a letter of introduction from the Greek Patriarchate in Jerusalem, that we would receive a warm welcome.



Our first view of the Monastery was rather disappointing—just a derelict old tower and the suspicion of a couple of buildings with orange tiled roofs. However, as we descended down stone cut steps to what was obviously the main entrance, we saw that the vast majority of buildings were hidden in the side of a deep dry valley that we were approaching from the side.

Our loud knocks on the door were soon answered by a rattling of chains and the smack of bolts being drawn and we were welcomed by a middle-aged monk with a long uncut beard and simple black, but rather dirty, habit —this was Stanislav. His first action was to pound a three foot metal bar, hanging by the door, with an iron rod for about thirty seconds and, our ears still ringing, we were ushered into the oldest monastery in Palestine.

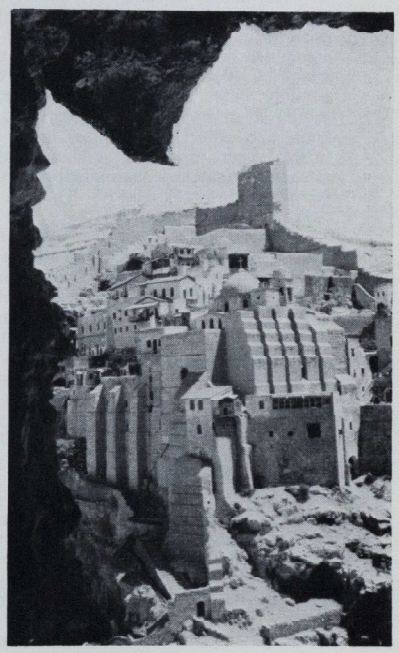
First we were taken to the chapel built over St. Saba's tomb. St. Saba came in 481 A.D., at the age of forty, to live as a hermit in a cave which is still preserved in the valley immediately opposite the present monastery. Traditionally he was told to come by an angel and a fire indicated the cave where he should live. When he died in 534 at the age of 93, he had almost 5,000 followers living in other caves along the valley. Their ambition was to lead a perfect life of constant prayer. On Saturdays some of their number trecked to Jerusalem to trade crucifixes and patera the hermits had made, for food and provisions. Combined meetings were held on Sundays and this led to the start of monastic buildings after St. Saba's death. In 614 almost 1,000 monks were martyred by the Persians and behind a grill in the chapel a number of their skulls are preserved—many with ominous holes through their frontal bones. The present chapel dates from 650 A.D. but has been extensively restored since. At first buildings consisted of a few cells but later chapels, libraries, a bakery, refectory and more cells were slowly added so that the present buildings form a maze of narrow passages and jutting buildings on several different levels.

There are twelve chapels to various saints in the monastery and services are held in them every night from 9 p.m. until 3 a.m. The most impressive are dedicated to St. Saba, St. Nicholas, and St. John of Damascus. This latter came to the monastery in 726 A.D. and wrote one of the first systematic theologies. He also formulated much Greek Orthodox liturgy and appears to have started the tradition of icons. Although many were removed by the Crusaders, several fine examples still remain in his chapel. The saints days to these three fall successively and so once a year three days of feasting are held in the monastery, to which the Greek Patriarch is invited. Spectators are naturally limited to the really interested by the inaccessibility of the monastery.

We continued our tour by descending to a small spring at the side of the valley, the main water supply, the other being rain water that falls on the monastery which is stored in cisterns on the roof. We then walked over to St. Saba's cave and on returning to the refectory a small cup of sweet black coffee was awaiting us. The monks eat only one meal a day, in silence, at ten o'clock in the morning and it always consists of vegetable soup and bread. The only supplement in their own cells is bread and water, the bread being baked once a week in the monastery.

There are now only fourteen monks in this monastery, built to hold over six hundred, and all but Stanislav were over seventy. Perhaps they are a lot of old 'cranks' but I can see some of the satisfaction they must get out of living in that sort of situation—the clear sun streaming down on whitewashed walls, beautiful sandstone bluffs and a glimpse of the Dead Sea down the Kiddron valley. 'Some of the satisfaction'—for a short time, anyway.

We soon had to say goodbye to Stanislav and after presenting him with a small tin of Nescafé, for which he was profoundly thankful, we retraced the ten dusty miles to Bethlehem.



do you do this?

6. TEACH SAILING

by CEDRIC CLARKE

If, after a few years of sailing in dinghies, you have not succeeded in drowning or maiming either yourself or somebody else, you may start having delusions that you are now capable of passing on this acquired and delicate art to others. In persisting in this fantasy, you may find yourself, as I did, taking on the job of a sailing instructor at one of the now many 'well known and approved sailing schools with expert instruction'. As long as you are free for about eight weeks, and know or appear to know how to sail a dinghy and which of the two sails go where and how, the chances are that most 'well known and approved schools with expert instruction' will sign you on.

The schools which I know operate from April till October, and speaking from experience the only month that you are likely to get anything approaching good sailing weather is August. Some say that this is because it is mid-summer, but again speaking from experience the real reason is because there are so many boats and sails on the water that there is not enough wind and rain to go round and capsize and soak everybody.

The actual teaching, or 'expert instruction', is fairly easy and done in one week courses. First morning the simple nautical knots are taught. This usually presents no problems because on the walls of the school—which is often as not a tumbled down shack in a tumbled down boatyard, or a wreck of a barge kept afloat by goodwill—there are large clear diagrams of all the knots you could possibly want: bowlines, clove hitches, sheepshanks, and a Turk's head if you should so desire. The tyro mariners, after tying the first morning up in granny knots and other horrors, now move on to the first afternoon's 'voyage'. This, to the 'expert instructor' is literally plain sailing. The three pupils you have are often too frightened, fascinated, or drunk to ask questions, fiddle with the rigging, get in your way, or mutiny. Thus all they are told is to sit in the bilges and keep their heads above water.

On the second morning, questions may be fired at you by these mariners. This is terrible, because there are no answers written on the school walls. One way out, however, when you do know the answer, is to explain it in a loud seafaring voice using the most obscure and nautical terms possible, and injecting every now and again that it's all common sense, basic and simple mechanics, or second nature. If this does not stop the questions, then it is best to announce the fact that sailing can be learnt only by careful observation. This if you are lucky grants you an escape from further questions for the rest of the week.

After another two days of showing them 'the ropes', the Rules of the Sea have to be instilled. These are baffling, complicated, but very important, so if you cannot remember any off hand, then the golden rule is pronounced to be—"Keep clear of everything, be it on land, sea, or in the air".

Now about the fourth day you let these mariners, who have got the 'feel of the deck under them', have a go—and you have to go with them. So on with warm waterproof clothing and lifebelts, for in the next few days you will be capsized and run aground a dozen times. Capsizing presents no trouble; you just tread water and tell them to take down the mainsail, stand on the centreplate to right the boat, bale it out, heave you aboard, head into the wind, put up the mainsail, back down with the jib, and then you either run aground or capsize again. When running aground you can usually get off by bringing the boat about, passing the wind across the stern, and thus gybing. This requires a careful hand on the centreplate which must be kept down on the bottom until you are about to or have begun to gybe. However if you run aground on a leeward shore, an oar, paddle, or crew has to be used to fend off, and this always means gallons of stinking black mud all over the boat.

Thus by experience the art of tacking, going about, gybing, running, reaching, bearing away and luffing up, and backing down are learnt. All being well most people have learnt enough to go out in a small big-sail boat by themselves during the last few days of the week. Those who stay for a second week form crews of two, taking turns to helm and crew, and maybe using more difficult manoeuvres and sails such as a spinnaker.

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Lecture Notes on Dermatology, by Bethel Solomons, M.A., M.D., F.R.C.P.I., Pp. VIII + 248 with 69 Figs. and 31 Plates. Oxford: Blackwell Scientific Publications. Price 21s.

Of course, it all depends what you are "in the market for," but, if you are on the look-out for a reliable text and a small book, very lavishly illustrated, this is what "Which" would classify as the "best buy."

The Author and the Publishers are to be congratulated on their ingenuity in having found four commercial firms to act as Angels in this production whereby in a book selling for only £1 1s. 0d. they have been able to include no less than 69 photographs and diagrams in black and white, and 31 plates (all extremely well chosen and well produced) in colour.

The book begins in the usual way with a short introduction concerning the anatomy and physiology of the skin and a very brief note on general pathology—it then passes to a consideration of the history, examination and diagnosis of skin cases. Thereafter there is a short section on treatment and then a consideration and description of the commoner skin diseases.

These Lecture Notes can be warmly recommended to the average medical student and will be of considerable use to the General Practitioner in this country and Eire. It contains little or no information concerning tropical diseases.

Dr. Bethel Solomons has a considerable gift of saying a lot in a limited space but his sections on treatment are too short to be helpful to the average General Practitioner.

Your reviewer hopes that this book will have the success which it deserves.

R. M. B. MacK.

Fundamentals of Current Medical Treatment, edited by C. W. H. Havard, M.A., D.M., M.R.C.P. Published by Staples Press. Price 70s.

Of the available books of medical treatment this may well become the favourite of students and housemen. It is written by a number of younger physicians (many from Bart's) who have tried to provide an up-to-date and above all practical guide to therapy. In a wise and entertaining introduction Sir Derrick Dunlop exposes some time honoured but valueless forms of treatment, and points out the ways in which medical treatment is changing. The dangers of many modern therapies are emphasised in the chapters on drug induced disease and steroid therapy.

Throughout the book the approach is essentially clinical and practical, but enough physiological, pathological and pharmacological information is provided to explain the rationale of therapy, and in many cases to summarise modern views on aetiology and mechanisms of disease. In the sections dealing with medical and psychiatric emergencies the advice is clearly stated, reliable, practical and readily found.

A minor criticism is the inclusion of proprietary names in the text. This makes certain sections less readable, and in some chapters the preferable system of tabulating proprietary drugs in an appendix is used.

In summary this is a comprehensive, up to date and practical account of modern medical treatment, which will continue to be of value to the student long after he has qualified.

J.E.S.

Handbook of Human Embryology, by Haines and Mohiuddin. E. & S. Livingstone, Ltd., Price 25s.

In order to justify a further addition to the large amount of reading to be done by a preclinical student, a new textbook must justify itself by a better presentation of knowledge than already exists in the standard works. It was to be hoped that this handbook would achieve this, but although it condenses some aspects of embryology at the expense of clarity it does not measure up to the above stated requirements. The best parts of the book are the simple reconstruction diagrams, many of which give the essential information almost at a glance.

As a book to be used in a practical course on embryology in the medical school of its origin, it probably fills a useful place. J.B.H.

NEW PENGUINS

Play With a Purpose for Under Sevens, by Elizabeth Matterson. A Penguin Handbook. Price 4s. 6d.

Those parents who watched the B.B.C. TV series "Growth and Play" probably experienced some envy at the magnificent array of toys and equipment displayed, and sensed a desire to provide something similar for their own children. However the cost may have deterred them. If so, this book is the answer. Elizabeth Matterson sets strong emphasis on improvisation and home construction of toys, with a view to minimising expenditure, conserving money for articles that can only be bought.

The object of the book is not to propound the theories behind play or to catalogue the available play material, but rather to produce "written knowledge on how to combine needs, provision, and environmental limitations". This she performs with immense success, producing a lucid and absorbing account, categorising the material to the extent of conferring order, but not to the extent of producing a rigid textbook classification.

The varying needs of play groups and families are taken into account. Before buying toys consider whether there is adequate space available; e.g., slides, whether they can be stored easily, and if money is short, whether they can be made at home or improvised. In respect of the latter, it is emphasised that the parents' ideas of ideal toys and the child's may differ widely. Parents often buy attractively finished, prestige toys, whereas the child will be content with and even prefer something improvised from cardboard and treacle tins. With this in mind, a good portion of the book is devoted to the sort of junk and materials to use for improvisation, and to guides to construction. Children enjoy making their toys, as well as playing with the finished products.

Elizabeth Matterson is a mother with two sons, and is now Chairman of the National Association of Pre-School Play Groups. Her practical experience pervades the book. Her intimate knowledge is evidenced by many small embellishments and details that make one feel that she has personally made, improvised and used all the toys and apparatus she mentions.

Parents of young children and those organising play groups will find this book extremely useful, and a sound investment.

A. J. Walter.

The Heart of the Hunter, by Laurens Van der Post. Penguin. Price 3s. 6d.

Following the success of a previous book, "The Lost World of the Kalahari", Laurens Van der Post recognized a wide spread interest in the life and culture of the most primitive of all African tribes, the Kalahari Bushmen. Here he seeks to maintain this interest, at the same time taking the opportunity to probe into problems facing the overdeveloped nations whose citizens 'move among a comfortable rubble of material possession. . . . . starved of meaning.' In the name of progress man has so constructed his environment that he has denied himself a living experience of the truly natural world. Thus divorced from its object life has lost its meaning. Here is a cri de coeur that knowledge is no substitute for experience; that we should not lightly disregard those whose lives depend on 'being' rather than 'having'.

The immediate appeal of this book lies in the author's vivid description in the first section entitled "World Lost". This relates a desert journey and subsequent encounter with a small party of bushmen right in the heart of the Kalahari. Such is the impact of the narrative that one is almost obliged to drink a glass of water before proceeding. Having made a mental readjustment into this world of sun, sand and sky, of starlit nights, of desert, where silence rather than sound convey meaning, it becomes easier to understand the beautiful picture language of the latter half of this outstanding book.

In the third section, "World Regained", he seeks to penetrate Bushman Mythology emphasising that these are the most primitive myths in the world. Man's emotions and character are pictured in the animal kingdom, reminiscent of Aesop's fables or even The Revelation of St. John. But these are more than archetypes of Winnie the Pooh and Peter Rabbit; it is the mantis rather than the lion as ruler of the beasts. Is this just a world of dreams or the product of a good imagination? I can only leave you to judge for yourself.

James Casson.

Discrimination and Popular Culture, Edited by Denys Thompson. Pelican Books. Price 4s.

This book, which deceptively is entitled a Pelican Original, consists of a series of essays on subjects covered by the general title of Popular Culture. Such topics include Advertising, Radio and Television, and Magazines. The book was compiled as a direct result of a National Union of Teachers' Conference on a similar subject, and was designed to constitute a guide to "the positive use for the good of the mass media". This somewhat sententious phrase sets the tone for the whole book and the general impression is one of a world full of intellectual sterility and moral decadence. This is hardly a revolutionary idea. This is not to say, however, that the essays are not well intentioned, but the net result is a total denigration of our society with little constructive thought that has any practical relevance. Despite the fact that mass media play a considerable part in the lives of most people, the essays are concerned with the most trivial aspects and failings of Women's magazines, Television, and three of the less distinguished British films. David Holbrook, having quoted a few ludicrous paragraphs from some popular magazines, cries out that "the need to reform the minority press and free it from the debasing influence of commercial pressures is urgent." The profit motive is almost entirely responsible for the deterioration in standards. The need to nourish the "cultural health" of man should be dominant; entertainment and enjoyment, it seems, are totally irrelevant if not abhorrent. The arguments are in general pedantic, but for a summary of all the priggish views expressed over the past decade on this subject, this book will suffice.

Jolyon Oxley.

Age of Austerity, 1945-1951, Edited by Michael Sissons and Philip French. Penguin Books. Price 5s.

There are fifteen contributors to this book, all of whom were still children during the post-war Socialist era. To those who, like this reviewer were barely yet at school, it affords a fascinating glimpse of those difficult years, when economically things were just as bad if not worse than the war and patriotic self-denial had worn extremely thin. Times were best for the children, who had no idea of the comforts of pre-war life, and worst of all for the housewife, still juggling with food points and dried egg. Spivs and the black market flourished in these conditions like aetiolated plants, and the findings of the Lynskey tribunal showed that even the politicians had forgotten the example of Caesar's wife.

"Austerity" derived from and was indeed epitomised by Sir Stafford Cripps, who followed the luckless Dalton to the Exchequer. In September of 1949, amid a storm of criticism from both parties, Cripps devalued the pound from $4.03 to $2.80—the inevitable culmination of a series of balance of payments crises. By this time the stock of the Labour party had fallen heavily from the euphoric days of 1945, when their 393 newly-elected members entertained the House with a rendering of *The Red Flag*. The Conservative Opposition, revivified by the new ideas of Butler and his boys, reorganised by the efficient Woolton, and led by the indomitable Churchill, rose like a phoenix from the ashes of its electoral humiliation. By 1951 the country was tired of nationalisation and heartily sick of the recurrent food and fuel shortages. The government was weakened by deaths and resignations. The time had come yet again for a change.

These then were the years of whalemeat and snoek (barracuda), the Stern gang in Palestine and Jinnah's Muslim League in India, of squatters and Marshall aid and Dior's New Look. On the eve of the Appointed Day of the National Health Service, Aneurin Bevan issued his notorious description of the Tories as being "lower than vermin"—an insult Laski estimated as likely to cost two million votes. Some rodent Tory wit was stung to reply by painting the words "Vermin Villa—home of a loud-mouthed rat" on the Minister's front door in Chelsea. But Bevan won his struggle with the intransigent B.M.A. under Dr. Charles (now Lord) Hill by his shrewd alliance with Lord Moran and the Presidents of the other two Royal Colleges, and by the far-reaching concessions he subsequently granted to the specialists.

This book is written for the most part in an entertaining and objective style, although it is a pity that Anthony Howard (political correspondent of the *New Statesman*) has failed to keep his own radical journalism out of his account of the Socialist triumph in 1945. The book ends fittingly with a splendid article by Michael Frayn on the Festival of Britain, which owed much of its considerable success to the late Herbert Morrison, and which proved to be a psychological watershed between the Austerity of the '40's and the Affluence of the '50's.

Robin Williamson.

SPORTS NEWS

FIXTURES FOR JUNE

1st.
Athletics v. Westminster and St. Thomas' at Cobham.
2nd.
Tennis v. Metropolitan Police; Home.
Golf: Beveridge-Eckhoff Cup at Denham.
3rd.
Athletics v. Goldsmith's College at North Cray.
5th.
Cricket v. Ducend Club; Home.
Rowing v. Walton.
6th.
Cricket v. Parnfield; Away.
7th.
Rowing v. Eton and Windsor, Evesham.
8th.
Golf v. Bart's Society; Chislehurst.
9th.
Tennis v. Caius; Away.
10th.
Tennis v. Pembroke; Away.
11th.
Tennis v. Clare; Away.
12th.
Cricket v. Tauntonians; Home.
Tennis v. Queen's; Away.
Rowing v. Reading, Putney Town.
13th.
Cricket v. Horlicks; Away.
15th.
Golf v. Chislehurst Golf Club.
Rowing v. Metropolitan.
16th.
Cricket v. Tony Salisbury's XI; Home.
Athletics v. Westminster Bank; Away.
Rowing v. Metropolitan.
17th.
Tennis v. Bank of England; Home.
Athletics v. King's College Hospital; Away.
Rowing v. Metropolitan.
19th.
Cricket 6-a-sides; Chislehurst.
Tennis v. Imperial College; Home.
Rowing v. Marlow, Horseferry.
23rd.
Tennis v. St. Mary's Hospital; Home.
Athletics v. Royal Veterinary College; Away.
26th.
Cricket v. Jesters; Home.
Tennis v. St. George's Hospital; Away.
Athletics: Westminster Bank Medley Relay.
Rowing v. Richmond.
30th.
Tennis v. U.C.H.; Away.
Athletics: U.H. Championships; Motspur Park.
30th—July 3rd.
Rowing at Henley Royal.

CRICKET CLUB

The 1965 Cricket season was opened with our match aganst U.C.H. on Saturday, April 24th at Hendon. **Won by 5 wickets.**

Having lost the toss we were put into the field. The standard of bowling left a great deal to be desired (as could be expected as the nets at Chislehurst had been too wet for play).

However our opponents were no better off with their batting and were devastated by a shrewd spell of indifferent slow bowling by J. Gately who took 5 for 28. D. Husband took 3 for 5 bowling very well. U.C.H. were thus all out for 72. After a poor start we scored the runs for the loss of 5 wickets. D. Husband 34 and C. P. Vartan 29 n.o.

We are pleased to see that there are several promising Pre-Clinical Cricketers and hope that there will be more to swell the ranks.

The first Cup match has to be played by the 18th of May, against St. George's Hospital and we will be grateful for support.

A Cricket Club tie has been introduced, the colour being a black and white stripe on a pale blue background: to be awarded on the completion of ten games for the 1st XI in one season. Treat it with reverence!

The Officers of the Club for this season are:—

President: Dr. N. C. Oswald
Captain: C. P. Vartan
Vice Captain: J. Gately
Secretary: N. Griffiths
Hon. Treasurer: R. Higgs
Hon. Social Secretary: N. Offen

C.P.V.

SOCCER CLUB

Season 1964-65

	P.	W.	D.	L.	Goals F.	A.
Match Analysis:	25	15	4	6	70	45

Since the last report only one match has been played. This was against the **Westminster Hospital** in the **University League** and resulted **3-2 win** for Bart's. Sutton, Thew and Herbert concluded a successful season's hunting with a goal each. This result confirmed Bart's position as runner-up in the U.L. 2nd Division which means promotion to the 1st Division next season.

Team: Layton-Smith, Pemberton, McGechie, Offen, Raine, Mumford, Phillips, Herbert, Sutton, Thew, Dorritt.

This must have been the most successful season for the Soccer Club for many years. The team competes in the U.L., U.H. Cup and U.H. League competitions and since players who were taking 2nd. M.B. could not play in all matches it was decided to concentrate greater effort on U.L. matches.

Under Offen's captaincy, this policy has paid dividends. Next season Bart's will be playing in a higher standard of football in the U.L. 1st. Division which should mean better results in the U.H. League and Cup.

This season's results are surprising considering that not one new soccer player was provided by the October 2nd. M.B. intake. Cambridge provided a centre-half, Raine, who immediately established himself in the Ist. XI and Bart's defence now looks solid and plays consistently. The forwards have also had a good year, especially at the start of the season when it seemed that they could not fail to score. The team can only really be faulted on its inability to play as a unit—defence and attack often being unco-ordinated. This will have to be remedied next year together with a rise in the level of fitness.

Few players are being lost next season and so the outlook is optimistic. It is hoped that more new players will be found and that a 2nd XI can be formed to play regularly. The support of non-regular players has been much appreciated, especially towards the end of the season.

1st. XI players representing Bart's this season were:

Goal: Layton-Smith, Hudson, Pope, Porcherot.

Full-backs: Rawlinson, McGechie, Pemberton, Jeffries.

Half-backs: Turner, Raine, Offen, Mumford, Fryer.

Forwards: Philips, Herbert, Sutton, Thew, Dorritt, Hugh, Savage, Barclay, Vartan, Ormerod.

D. McG.

ATHLETICS CLUB

University of London Championships

Friday, April 30th and Saturday May 1st

The championships are held at the University track at Motspur Park which is of international standard. To qualify for a final and to gain a place in the first six in the high standard of University athletics is a performance of no mean credit. Bart's therefore sent only its finest athletes to perform, and as a team achieved the remarkably good position of fourth out of the thirty-eight colleges of the University being pipped into second place in the minor college's cup.

Brian Scott must be congratulated for his fine performances in the hurdling events reaching his apogee of the afternoon by winning the 220 yards hurdle in 25.9 secs. There must only be a handful of British athletes today who could emulate this performance. He was third in both the 120 yards and 440 yards hurdles demonstrating on all occasions a text-book style of hurdling.

Chris Sutton gave of his all in gaining fourth place in the 880 yards in 2 mins. 0.1 sec. which was excellent in the poor weather conditions. An unfit Terry Foxton relied on his natural ability to gain fourth place in the mile in 4 mins. 32 secs.

John Coltart provided Bart's first runner in the 440 yards final for many years and came fifth in 53 secs.

Robert Thompson kept himself fit by recording sixth place in the one mile and seventh in the three miles. Rikk Jolley and Dave Jefferson completed the Bart's team and were unlucky not to gain points.

Bart's came second out of the hospitals to Guy's who easily won the championship with a remarkably potent team.

D.J.C.

GOLF CLUB

April was a busy month for the Golf Club as it included two inter-hospital matches and a new venture, the Golf Club tour.

On April 7th we played **Charing Cross Hospital** at Chislehurst and **won 4-1.** Atkinson, playing very indifferent golf deservedly lost his match.

Team: Atkinson, Bowen, Vartan, Weston-Burt, Edwards.

Two weeks later we met **St. Thomas' Hospital** at Chislehurst, but due to a brake failure on one of their cars, only three players arrived. Against these three, Bowen and Weston-Burt won whilst Vartan halved. Match **won 2½-½.**

Golf Club Tour.

Six players left London on Friday April 23rd for a tour which took us for two matches in Sheffield and two in Cambridge.

On the Saturday we met **Sheffield University** at Rotherham Golf Club. In the morning the foursomes were lost 2-1, Saddler and Booth pairing well in second place.

In the afternoon singles, Atkinson and Bowen played the two top matches against lower handicap men. Although both matches were close, the former lost 3 and 2 which was clinched by a 305 yard drive on the last hole; and Bowen lost to a spell of par golf. Saddler Booth, Weston-Burt and Begent all won to give an **overall 5-4 win.**

On the Sunday we played **Abbeydale Golf Club,** playing singles in the afternoon and foursomes in the evening. A strong team was put out against us and we played on handicaps. Everyone again played excellent golf on a very well kept course to give a **singles lead of 5-1,** Bowen having a tense downhill putt to win on the 18th green after having been dormy-three up.

Foursomes were a formality in which two were halved and one lost. A very social evening followed in which a syndicate got the jack pot from the fruit machine, and our hosts showed us one or two of the local hostelries finishing up at a Chinese nosh house near the fire station.

On Monday we drove down to **Cambridge** to meet **Trinity Hall** over the **'Gogs'.** An intensive weekend plus travelling showed on the team who could only manage a 2-2 draw with the top match halved. A two hole play off was eventually decided, but both Bowen and his opponent played par golf so that the match was agreed as **drawn 2½-2½.**

On the Tuesday, in a roaring gale with a very difficult wind direction we met **Pembroke College** over the 'Gogs'. We lost our only match of the tour to a team containing two 'Blues'. Our only winner was Weston-Burt who has lost only two matches in the *three* seasons he has played for us very remarkable.

This indeed was a successful first tour, and the only complaint amongst the team was that we had left a trail of wealthy fruit-machines around Britain.

Tour Party: Atkinson (Capt.), Bowen, Weston-Burt, Saddler, Booth, Begent, Vartan (Tuesday).

R.E.A.

THE RIFLE CLUB

The Smallbore Season ended with the Club having provided teams in ten league competitions. A grand total of 91 matches were shot, 57 won, 32 lost, 1 drawn, 1 no result.

Some of the team results are shown here, and it is hoped to publish some individual scores at a later date.

The most successful team was undoubtedly the **Pistol team** winning Division Two of the University of London League. The team was not without its poor days, yet managed to win 9 out of the 10 rounds, with a convincing aggregate of 4053 to 3594.

The Novices A team, normally very difficult to keep to a reasonable standard, soon gained confidence and shot pleasingly, loosing only the first of their ten matches, winning the League by 18 points to 14.

The Club 'A' team were matched against some very experienced and accurate opposition. Nevertheless, they acquitted themselves adequately, losing the inter-Hospitals Lloyd League in the final round, coming second overall. In the University of London Postal League (Div. 1) the team gained second place, and in the Engineer's Cup, in spite of some good scores the team only gained fourth place.

Results

Lloyd Cup—Shot 7, Won 6, Lost 1—2nd.

Engineer's Cup 1—Shot 10, Won 5, Lost 5—4th.

Postal League I—Shot 8, Won 6, Lost 2—2nd.

The 'B' team was handicapped by the constant procession of better shots being transferred to the 'A' team, thus came fourth in the Lloyd, Engineer's Cup II and Postal II Leagues.

Lloyd Cup—Shot 7, Won 4, Lost 3—4th.

Engineer's Cup II—Shot 8, Won 3, Lost 4, Tied 1—4th.

Postal II—Shot 8, Won 3, Lost 4, No result 1—4th.

In all, a successful season.

A.K.B.

Ladies Hockey Team, U.H. Cup Final 1965.

Back Row: J. Spring, E. Neach, M. Newbold, J. Williams, P. Stubbs.

Front Row: E. Saunders, E. Evans, S. Kolting, P. Dengate, C. Cupitt.

CONTENTS

MAGNA CARTA

In February of this year the independent Review Body advised the Prime-Minister to award a further £5½ million to the general practitioners in lieu of the £18 million they had demanded (*see March Editorial*). The "Charter for the Family Doctor Service" was the profession's indignant reply to this miserly offer—a reply that has been powerfully reinforced by the arrival of nearly 18,000 undated resignations, which have hung over the ensuing negotiations like Damocles' sword. Mr. Kenneth Robinson, Minister of Health, agreed to negotiate on all the proposals in the Charter, except for the vexed question of pay, which he insisted be left in the controversial hands of the Review Body. At length the British Medical Association agreed to this on condition that they received "four positive and unequivocal assurances" from the Minister. Dr. J. C. Cameron and five colleagues from the General Medical Services Committee of the B.M.A. were appointed to negotiate these assurances, and a Joint Report (published on 21st. May) reveals a considerable measure of agreement between the two parties on these four matters:

(1) The Government have agreed to set up an independent finance corporation to make loans for the purchase and improvement of practice premises.

(2) It is agreed that there should be direct reimbursement of much of the cost of employing ancillary help (secretaries, nurses, but not yet wives) for G.P.'s.

(3) It has been decided to reduce the number of N.H.S. certificates that doctors will need to issue each year by nearly 10 million.

(4) The negotiation of a new contract would allow the Government to abolish the current Pool system of payment, and the Review Body have indicated that they would be prepared to reconsider the situation completely.

The G.M.S. Committee accordingly recommended (a) that the negotiations should continue and (b) that the resignations should now be destroyed in view of the considerable progress made so far. Meeting on 28th May the Council of the B.M.A. accepted recommendation (a), but decided after heated discussion to postpone withdrawal of the resignations until the new financial terms were clarified.

It is ironical indeed that the medical profession, which welcomed so eagerly the independence of the Review Body when first established, should now need to seek assurances from the Minister of Health to curb this independence. The Council of the B.M.A. clearly distrusts the Review Body; it is essential for the future of the family doctor service that the Council should soon have cause to alter its opinion.

SOBER-SUITED MATRON

While sternly rebuking medical staff for attitudes of patronage and condescension, a Scottish hospital matron, Miss W. E. Prentice, made a recent appeal for a new word to describe those under their care. The term 'patient', she claimed, implied a "submissive, enduring person who takes no active part in the drama of his own condition or malady". Unfortunately Miss Prentice offered no alternative words. The term 'victim' would inject a greater sense of drama into the wards, but perhaps 'medical bed-filler' or 'hospitalised person' would in the circumstances be more appropriate. Judging by the success of the medical social workers to lose their appellation of 'almoners' (or better still 'lady almoners'), it seems likely that the matron's words are destined for stony ground. Indeed we would deplore any facile change of term. A patient is one who suffers: the word must logically encourage a sense of shared suffering, that is sympathy or compassion on the part of the medical staff. We venture to suggest that it is a substitution of attitudes not jargon that Miss Prentice really wants. And in conclusion, has she considered the unsuitability of 'matron' as a word to describe the superintendents of nursing staff—ladies who in fact are generally unmarried? "Thou sober-suited matron, all in black" writes Shakespeare (*Romeo and Juliet*), but it is night that he is describing.

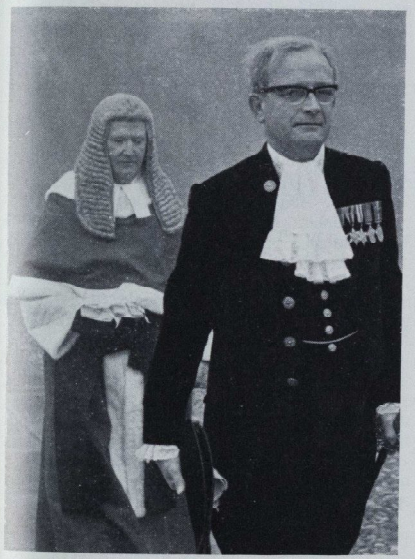
LETTERS TO THE EDITOR

HIGH SHERIFF

Sir,—In your interesting account of General Practice in Ely in your June issue you omitted to mention that the Senior Partner (Dr. J. B. Bamford—see photograph) has just completed his term as High Sheriff of the Counties of Huntingdon, Cambridge and the Isle of Ely—surely a remarkable tribute to the position he has attained in the eyes of the community for which he has worked.

Yours sincerely,
GEOFFREY KEYNES,
Brinkley, Cambs.

29th May.



DR. CHARLES HARRIS

Sir,—The very sympathetic remarks by your distinguished correspondent about Dr. Charles Harris contain a few mistakes, which should, for the sake of the record, be corrected. Harris was not one of Sir Percival Hartley's House Physicians. He clerked for Dr. Morley Fletcher and then for Professor Fraser, in the Medical Unit, and became his House Physician.

He was Second Assistant (now styled Junior Registrar) to Professor Fraser for over a year. While holding this post he was awarded a Rockefeller Fellowship and went to Baltimore for a year to work under the very able Paediatrician Dr. John Howlard in Johns Hopkins Hospital. From there he went to Great Ormond Street Hospital for six months as a House Physician. He returned to St. Bartholomew's as Assistant Physician to Dr. Hugh Thursfield in the Children's Department and succeeded him a year later.

I remain,
Yours sincerely,
GEORGE GRAHAM.
49a Acacia Road, N.W.8.

10th May.

TOFFEE-NOSED

Sir,—The reputation that students from Bart's are 'toffee-nosed', which is so wide-spread at present, seems to be derived from the small section of students whom the Hospital, in its wisdom, has seen fit to admit from the older provincial universities, or so it would appear from your June editorial.

There are certain facts in this editorial that are undoubtedly true, and I am sorry that the poor graduate from Cambridge finds the pathology and bacteriology courses tedious, but the editor is surely aware that the professors of these departments have both been intimately connected with the universities under discussion so that the solution is in their own hands.

But it's a bit much when you expect the Hospital to alter its examination and 'jobs' schedule (not that the former is controlled by the hospital) when the provincial universities don't even hold their own examinations at the same time. What is the use of the Hospital having its own preclinical technical college (which is more or less what Charterhouse is between 9 a.m. and 5 p.m.) if it is not geared to the Hospital's requirements and vice-versa?

Surely if people from Oxford and Cambridge really had found life so difficult here over the years they would have made sure there were adequate facilities for clinical training within their own universities.

Furthermore I read with interest your little anecdote in the last paragraph. I would be interested to know what authority informed you that the remarks referred to those who had failed 2nd M.B. once. Had it not occurred to you that 1st class degrees in Natural Sciences or Animal Physiology have very little to do with the makings of a good doctor and the speaker may well have been referring to the academic bias of the intake when he called it the worst for years?

Finally, to be constructive, would the solution not be for graduates from other universities to take the London M.B., B.S.? This would solve all timing problems with jobs and exams, save the student the trouble and expense of having to return to his mother university for the exam, and remove the terrible stigma of having different letters after their name from everyone else.

Yours sincerely,
A. R. BAILEY.
Abernethian Room.

1st June.

CHERCHEZ LA FEMME

Sir,—I fear "father" Walter took far too seriously my general comments about the teaching of the Children's Ward clerks. For his information, the article was written long before he or his colleagues appeared on Lucas and Kenton. Taking such general remarks as a personal indictment could easily be misconstrued as early paranoia. However, in this case it is perhaps nothing more than a manifestation of unconscious guilt.

Totalising the reproductive capacity and potential of his group is indeed revealing! Without doubt, it indicates an interest in something, but with the best will in the world I cannot ascribe it solely to the stimulus of paediatrics.

Yours faithfully,
A. ROBINSON
Children's Department

8th June.

Engagements

HIGGS—FOWLER.—The engagement is announced between Robin J. E. D. Higgs and Judith Mary Fowler.

CALDER—BOHN.—The engagement is announced between Dr. Malcolm William Calder and Miss Elizabeth Bohn.

MOYNAGH—LISTER.—The engagement is announced between Dr. Paul Digby Moynagh and Miss Imogen Mary Lister.

ORMEROD—PAYTON.—The engagement is announced between Dr. Thomas Peter Ormerod and Miss Christine Elizabeth Payton.

MITCHELL—JONES.—The engagement is announced between John Neville Mitchell, of Wallington, Surrey, and Susan Eileen Jones of Bellevue Hill, Sydney, Australia.

Marriages

COOPER—BETTS.—On April 24th, Richard Cooper to Leslie Betts.

GLOVER—ROYLE.—On May 1st, Dr. David Neill Glover to Miss Jean Gay Royle.

RICHARDS—NORTON.—On May 22nd, Nicholas Christopher Gwyn Richards to Wendy Geraldine Norton.

Births

ABELL.—On May 23, to Anna (née Webber) and Dr. I. D. Abell, a son.

BOULTON.—On May 8, to Helen (née Brown) and Dr. Tom Boulton, a son (Anthony James).

HOWES.—On May 13, to Gillian (née Prockter) and Dr. Alan Howes, a daughter.

LEMON.—On May 2, to Angela (née Jacobs) and Squadron Leader John Lemon, M.B., B.S., a daughter (Claire Elizabeth).

RIDSDILL SMITH. On April 28, to Christine (née Ward) and Dr. Robin Ridsdill Smith, a son.

WALLER.—On May 4, to Drs. Anne (née Brodribb) and James Waller, a daughter (Elizabeth Grace).

Deaths

ACKLAND.—On May 18, John Gordon Ackland, M.R.C.S., L.R.C.P. Qualified 1915.

HAMILTON.—On May 10, Arthur Francis Hamilton, Lt.-Col., I.M.S., C.I.E., F.R.C.S., F.R.C.O.G. Qualified 1903.

JUPE.—On May 23, Frances Mary Jupe, retired Sister of St. Bartholomew's, aged 72.

WARD.—On May 17, Vere Godsalve Ward, M.D., aged 87. Qualified 1902.

Appointments

Universities of Oxford and Cambridge

Sir Geoffrey Keynes, M.D., F.R.C.S., F.R.C.P., F.R.C.O.G., has been awarded an Hon. D.Litt. (Oxon) and an Hon. Litt.D. (Cantab), and in addition he has been elected an Honorary Fellow of Pembroke College, Cambridge.

Royal College of Physicians.

The following were elected to the Fellowship in April 1965: Drs. V. C. Medvei, A. E. Jones, and R. McL. Todd.

St. Bartholomew's Hospital.

The following were elected to the Hospital Board: Mr. J. O. Robinson and Mr. G. D. Fraser Steele.

Royal Photographic Society

David W. Tredennick, the Chief Photographer, Department of Medical Illustration has been awarded the Fellowship of the Royal Photographic Society, May 1965.

July Duty Calendar

Sat. & Sun., 3rd. & 4th.	Sir R. Bodley Scott Mr. Hunt Mr. Aston Dr. Ballantine Mr. Fuller
Sat. & Sun., 10th. & 11th.	Dr. Black Mr. Naunton Morgan Mr. Manning Dr. Bowen Mr. Cope
Sat. & Sun., 17th. & 18th.	Dr. Hayward Mr. Badenoch Mr. Manning Mr. Ellis Mr. McNab Jones
Sat. & Sun., 24th. & 25th.	Dr. Spence Mr. Tuckwell Mr. Aston Dr. Ballantine Mr. Hogg
Sat. & Sun., 31st. & 1st.	Prof. Scowen Prof. Taylor Mr. Burrows Mr. Jackson Mr. Fuller

Physician Accoucheur for July is Mr. Howkins.

Retirement

GEORGE TREVOR HANKEY

Bart's 1927-1965

When George Hankey retired in March he had served the Hospital for 38 years, having joined the staff of the Dental Department in October 1927 as Chief Assistant. In January 1929 he was appointed Assistant Dental Surgeon, a post of Consultant rank, and on the retirement of Mr. Atkinson Fairbank in October 1945 he became the Senior Consultant Dental Surgeon. Coincidental with his appointment at Bart's he was Consultant to the London Hospital and Dental School, to which he was appointed in December 1928.

He is a man of many parts having achieved distinction in the academic and clinical fields of his chosen profession, in the Army and in sport.

Guy's was his Alma Mater and there he received his medical and dental training, qualifying with the L.D.S. in 1922 and the Conjoint in 1925. In 1945 he was elected F.D.S., R.C.S., Eng.

Following qualification he held numerous House jobs at Guy's, both medical and dental, the one he valued most being House Physician to the famous trio, Sir Arthur Hurst, Sir John Ryle and Sir Charles Symonds.

In addition to his Consultant posts he has taken an active part in the teaching and administrative aspects of dentistry and continues in these spheres as a member of the Board of the Faculty of Dental Surgery, Royal College of Surgeons to which he was elected in 1958.

He was Lecturer in Oral Surgery and Dental Radiology at the London Hospital Dental School and a member of the Board of Governors of that institution from 1954 to 1960.

He served as a member of the N.E. Metro-

politan Regional Hospital Board from 1959 to 1962.

In his clinical work it was Oral Surgery in general and disorders of the temporo-mandibular joints in particular that had a special appeal for him, subjects on which he published many papers and in which he achieved an international reputation. He chose Temporo-mandibular Arthrosis as the subject for his Tomes Lecture at the Royal College of Surgeons in 1953.

He has been President of the Odontological Section of the Royal Society of Medicine and of the British Association of Oral Surgeons, both of which posts he filled with great distinction.

In the Army his career was equally distinguished, having had continuous Commissioned service in the R.A.M.C. (T.A.) from 1927 to 1957, receiving three clasps to the T.D. and being promoted full Colonel o/c 12 General Hospital R.A.M.C. 1945-57 and Hon. Colonel of this unit in the latter year.

He was away on active service from August 1939 as Lt. Colonel R.A.M.C., T.A. o/c 141 Field Ambulance, taking this unit to France in November 1939. In May 1940 he was captured and was a prisoner of war in Germany until June 1945. During these five years he was Senior Medical Officer of British and Allied P.O.W. camps in Poland and Germany and for the last 18 months of that period of Luft. 1. Pomerania, a mixed British and American Air Force officers' camp. For these services he was awarded "The Legion of Merit" U.S.A., Degree of Officer, the O.B.E. (Mil.) and mentioned in Dispatches.

His activities extended to the Arts for whilst at Guy's he sang all the tenor leads in Gilbert and Sullivan Operas. In Sport he excelled at

golf, being Vice-President of the Golf Societies of both Bart's and the London and Captain of Tandridge Golf Club in 1955 (holder of 1 holers' tie). His other recreations are fishing and stalking, shooting his first stag of 14 stone at 3,000 ft. on Glen Affric in 1963.

He will be missed at the Hospital but he has many memories and activities to accompany him in his retirement, in which every good wish is extended to him and his wife.

G.A.C.

FINALS RESULTS

University of London
Final M.B., B.S. Examination
April, 1965

Honours

Axon, A. T. R. (Distinguished in Medicine)
Cooke, T. J. C. (Distinguished in Surgery)
Kennedy, J. S. (Distinguished in Applied Pharmacology and Therapeutics)
McElwain, T. J. (Distinguished in Applied Pharmacology and Therapeutics)

Pass

Anderson, C. R. S.
Bennett, B. S.
Brown, M. E. A.
Cotterell, S.
Gibbs, I. R.
Hilton, A. M. B.
Labrum, A. S.
Lyons, A. J.
Matheson, I. C. C.
Phipps, C. R.
Rimmer, M. E.
Swain, J. R.
Wilkinson, J. M.
Barretto, J. H.
Britten, C. S.
Cadle, D. R.
Davies, N. J. T.
Hamilton, G. R. S. A.
Howat, I.
Linggood, R. M.
McNie, D. J. M.
Nicoll, J. M. V.
Pitt, J. M.
Robins, D. G.
Underwood, J. C. E.
Bedford Turner, J. E. B.
Britton, B. J.
Campbell-Smith, S.
Foxton, A. T.
Hardy, F. J. R.
Hudson, M. F.
Lloyd Williams, J.
Martin, C. R.
Owen, D. G.
Richards, N. C. G.
Smart, C. J.
Whittaker, M.

Supplementary Pass List
Part I

Bartlett, C. L. R.
Brooks, W. A.
Coleridge, H. C. C.
Foot, C. M. R. M.
Gilsenan, K. L.
Greenwood, N.
Lask, B. D.
Mitchenere, P.
Bishop, A. N. R.
Casewell, M. W.
Davis-Dawson, L. H.
Frears, J. F.
Goldie, D. J.
Kingsley, P. J.
Lee, B. C. P.
Page, A. J. D.
Bohn, E.
Cole, I. E.
Dorrell, E. D.
Garson, W. P.
Goodall, D.
Kuur, J. B. G.
Merrill, J. F.
Peek, I. M.
Pembrey, J. S.
Pogmore, J. R.
Robinson, D. A.
Savage, R. B. de la M.
Smith Walker, M. T.
Weller, R. M.
Wood, R. M. T.

Part II

Aveline, M. O.
Bruton, C. J.
Dutt, T. P.
Kuur, J. B. G.
Otti, B. I.
Smith Walker, M. T.

Part III

Aveline, M. O.
Birch, A.
Bubna-Kasteliz, B.
Jones, D. V.
Stockton, C. E.
Udal, L. A.

Part IV

Aveline, M. O.
Bruton, C. J.
Bubna-Kasteliz, B.
Dutt, T. P.
Garson, W. P.
Husband, P. R.
Jones, D. V.
Otti, B. I.
Smith Walker, M. T.
Stockton, C. E.
Udal, L. A.

Conjoint Board
Final Examination
April, 1965

Pathology

Coleridge, H. C. C.
Bishop, A. N. R.
Cole, I. E.
Moore, A. J.
Pembrey, J. S.
Smith Walker, M.T.
Bartlett, C. L. R.
Weller, R. M.
Bohn, E.
Dorrell, E. D.
Pogmore, J. R.
Casewell, M. W.
Hanley, D. J.
Pilling, J. B.

Medicine

McNie, D. J. M.
Otti, B. I.
Brown, M. E. A.
Bruton, C. J.
Pine, R. C.
Kuur, J. B. G.
McElwain, T. J.
Dutt, T. P.
Stockson, C. E.
Whittaker, M.
Cooke, T. J. C.
Lyons, A. J.
Matheson, I. C. C.
Rimmer, M. E.
Bedford Turner, J. E. B.
Phipps, C. R.
Axon, A. T. R.
Smith Walker, M. T.
Cotterell, S. D.
Bubna-Kasteliz, B.
McArthur, P.
Lloyd-Williams, J.
Hardy, F. J. R.
Underwood, J. C. E.
Martin, C. R.
Anderson, C. R. S.
Britton, B. .
Robins, D. G.
Foxton, A. T.
Kennedy, J. S.
Gilsenan, K. L.
Bennett, B. S.
Swain, J. R.

Surgery

Otti, B. I.
Brown, M. E. A.
Hardy, F. J. R.
Rimmer, M. E.
Bedford Turner, J. E.
Udal, L. A.
Davies, N. J. T.
Martin, C. R.
Hudson, M. F.
Wilkinson, J. M.
Linggood, R. M.
Lee, B. C. P.
Lyons, A. J.
Matheson, I. C. C.
Dutt, T. P.
B. Bateman, A. M.
Barretto, J. H.
Weston-Burt, P. M.
Kennedy, J. S.
Cotterell, S. D.
Kuur, J. B. G.
Underwood, J. C. E.

Midwifery

Gilsenan, K. L.
Bennett, B. S.
Swain, J. R.
Weller, R. M.
Nicoll, J. M. V.
Lee, B. C. P.
Bubna-Kasteliz, B.
Brown, M. E. A.
Bruton, C. J.
Husband, P. R.
Wood, T. A.
McArthur, P.
Coleridge, H. C. C.
Revill, M. G.

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

Axon, A. T. R.	Barretto, J. H.	Bedford Turner, J. E. B.
Britton, B. J.	Brown, M. E. A.	Bruton, C. J.
Cooke, T. J. C.	Cotterell, S. D.	Davies, N. JJ. T.
Dutt, T. P.	Foxton, A. T.	Hardy, F. J. R.
Hudson, M. F.	Kennedy, J. S.	Kuur, J. B. G.
Linggood, R. M.	Lyons, A. J.	McNie, D. J. M.
Martin, C. R.	Matheson, I. C. C.	Nicoll, J. M. V.
Phipps, C. R.	Rimmer, M. E.	Robins, D. G.
Swain, J. R.	Udal, L. A.	Underwood, J. C. E.
Whittaker, M.	Wilkinson, J. M.	

HOUSE APPOINTMENTS

Jun. H.P. to Dr. Spence	T. J. McElwain
Jun. H.P. to Sir Ronald Bodley Scott	J. E. McLaughlin
Jun. H.P. to Dr. Hayward	J. S. Kennedy
Jun. H.P. to Dr. Black	G. Haig
Jun. H.P. to Professor Scowen	M. F. Hudson
Casualty House Physician	M. R. Klaber
Jun. H.S. to Mr. Naunton Morgan	B. J. Britton
Jun. H.S. to Mr. Hunt	T. M. Bucknill
Jun. H.S. to Mr. Badenoch	C. J. Smart
Jun. H.S. to Mr. Tuckwell	M. Whittaker
Jun. H.S. to Professor Taylor	T. J. Powles
Casulty House Surgeon	A. J. Lyons
Jun. H.P. to Children's Dept.	R. M. Linggood
H.S. to Gynaecological & Obstetrical Dept.	R. J. Hamshere
	H. J. Kersley
H.S. to Orthopaedic Dept.	D. G. Owen
	A. J. Robertson (if qual.)
	T. P. Dutt
H.S. to E.N.T. Dept.	E. Abell
	S. G. Harris
H.S. Harold Wood Hospital	D. J. M. McNie
H.P. Rochford General	L. A. Bruton
	C. R. Martin
	M. E. Rimmer
H.S. Rochford General	C. J. Bruton
	A. T. R. Axon
H.O. Obs. Unit Southend General	J. D. Hardy
H.S. Southend General	J. M. V. Nicoll
	S. D. Cotterell
H.P. Whipps Cross	T. J. C. Cooke
H.S. Whipps Cross	I. C. C. Matheson
	S. Campbell Smith
H.S. Redhill General	M. E. A. Brown
H.S. Royal Berkshire	B. T. Anderson
	A. S. Labrum
	J. M. Wilkinson
Rotating Locums at St. Bartholomew's	I. A. Aaronson (if qual.)
	J. B. G. Kuur

At the time of going to press this list was subject to confirmation.

VETERINARY MEDICINE

by C. M. GOULD, M.A., B.Sc., M.R.C.V.S.

Veterinary Surgeon, Southampton

In the case of a pet, sentiment and sometimes sentimentality influence the cost of treatment and disease control, but on the farm, except sometimes in the case of the horse, methods of disease control and treatment have to be economic, since stock are expendable. This is so important that in many countries only recently has it become worthwhile treating pigs and sheep for an individual complaint—previously it has been cheaper to cull. It has also influenced the veterinary approach to the control and eradication of an infectious disease. The disease reservoir and the direct contacts, if necessary, can be killed—unless they happen to be wild game in Africa—and all animals within a certain area around isolated. Experience has shown us that it is almost impossible to keep a highly infectious disease restricted to one farm by isolation alone. In rinderpest, in pleuro-pneumonia, and in foot and mouth disease isolation has been tried and abandoned for a slaughter policy to stop further spread.

During the agricultural and industrial revolutions in the 1700's cheap foods were imported on a much larger scale than ever before, and with them disease. In 1714, 1745, and again in 1770 rinderpest arrived in London presumably with cattle imported from Holland. On each occasion the government promptly ordered the slaughter and burial or burning of all affected animals and paid compensation at the rate of £2 per head. On each occasion it was eradicated quickly. In 1865 it re-appeared in London. This time it was not eradicated quickly—the country had been free of the disease for 100 years and had forgotten it. Some daily papers even maintained that it was not cattle plague but poor dairy hygiene!—those were the days of antiseptics and it took time to realise that strong phenol and good hygiene were insufficient to control the disease. Ten years earlier doctors had said the same about cholera. In the end, however, when 5,000 fresh cases a week were being reported, the slaughter policy was re-introduced, compensation this time being up to a maximum of £40 per cow—inflation even then. In two years rinderpest was eradicated, having decimated the cattle population, 400,000 dead out of 4 million—in some parts of Cheshire for instance, the mortality was far higher, 100,000 dead or killed out of 140,000 (70%)—and this in the days before the transport of milk from the country to the town by train, when cows were housed in great town dairies. Some towns went very short of milk. Twice more it returned to Britain but on each occasion it was stamped out quickly. Until recently a recurrence was considered unlikely, but now the fear is voiced that air transport may bring it back. So far this has not occurred.

The 1865 epidemic demonstrated the value of veterinary advice. A Diseases of Animals Board was set up which in 1938 became the Animal Health Division of the Ministry of Agriculture. This department has the power to deal with a number of diseases scheduled for eradication, most of them virus diseases; many were eradicated before the days of vaccines, antisera and antibiotics. If any return to this country we should be justified in wiping out the pocket of infection before it spreads, unless by then we have available a rapid, reliable and economic cure. Of these diseases foot and mouth disease is probably the best known. That this disease has not appeared in this country since June 1962 is due to the efficient operation of the slaughter policy in Great Britain, the tightening up of the import regulations, especially the ban on the importation of fresh and refrigerated pork and edible pork offal originating in South America, and to the recent successful introduction of a slaughter policy in France. There can be no doubt that the success of this policy in France is very important to Britain.

Rabies, the reason for the six months' quarantine of animals, is another of these

diseases. In the 1800's generally there were about 20 human deaths per year from rabies; in 1885, a bad year, there were 60. The Muzzling of Dogs Order which reduced the incidence of the disease sharply was attacked bitterly at the time because of the 'torture' of the animals involved. This order was re-introduced when rabies returned to this country in 1918, probably with a dog illegally imported at the end of the War. It took four years to eradicate the disease again. The recent outbreak of rabies in Holland which resulted in 5 human deaths has for the time being silenced critics who were once again agitating for the removal of the 6 months' quarantine despite the fact that cases have occurred in quarantined animals.

A tuberculosis eradication scheme has just been completed successfully. Nowadays the risk of a man infecting a cow is probably as great as, if not greater than, that of a cow infecting a man. Before this scheme was introduced 30/40% of the dairy cows in the country were affected with tuberculosis. 20,000 a year were seized and killed because they showed frank clinical signs of the disease. Many 'wasters' were also slaughtered. Certainly if this disease had not been eradicated it would have been a major disease and economic hazard in the more intensive systems of husbandry recently developed.

Brucellosis is the next disease of cattle on the eradication list. A fairly efficient vaccine is available, but until the recent introduction of a free vaccination scheme all to often we saw the widespread use of the vaccine after an epidemic, and then more and more lapses over the years—probably quicker than in man because the vaccine had to be paid for—and then a new epidemic and back into favour. This disease does not come readily to the minds of the medical profession, even less so nowadays when patients are seen at the surgery rather than in their home environment, the farm, where before long the doctor would be bound to hear of the 'abortion storm' affecting the stock. Of course, he runs less danger of catching the disease himself, since he is unlikely to be offered raw milk to drink in a town.

Not all of our diseases are eliminated by a slaughter policy. Sheep scab, a parasitic skin disease, was eliminated by the strict enforcement of regulations concerning the dipping of sheep once an efficient parasiticide had been developed. A pocket of infection in Wales persisted for some time but in the end the disease was eradicated. Some pig diseases have been successfully eliminated in herds by rearing in sterile conditions piglets produced by hysterectomy followed by the slaughter of the sows. After six weeks they are returned to the farm which in the meantime has been cleaned up and disinfected.

Some diseases such as anthrax and tetanus are endemic in certain areas because the organism persists in the soil. A widespread epidemic of anthrax is more likely to be associated with the presence of infection in a food or food supplement. 'Tetanus' farms are well known to local veterinary surgeons and their warnings should be heeded by doctors practising in new housing estates so that the appropriate prophylactic measures can be instituted.

As in medicine, progress is being made in the recognition of new causes of disease, often the pre-requisite of successful treatment and prevention. For instance, since the last war 'slipped discs' have been recognised as an important cause of paraplegia in long-backed dogs. In 1926 there were 19 major diseases of sheep of which the cause was unknown. Today, in 18 of these diseases the cause has been demonstrated and probably in the 19th as well, and in 14 of them specific means for cure or prevention have been evolved. But equally, if not more important, is the recognition that changes in the pattern of farming are matched by changes in the disease pattern of farmstock, and that a high incidence of certain diseases is associated with certain husbandry practices or malpractices, generally grouped under the omnibus title of the standard of management or stockmanship. Changes of feeding practice, grazing technique, milking technique, breeding techniques, etc., have all markedly influenced the enzootic disease pattern, so much so that nowadays the pattern of disease resulting from the introduction of a new method of husbandry can be predicted fairly accurately and advice on the appropriate control measures given.

In the 1930's some cattle were housed all the year and were fed cheap Canadian hay and imported concentrates. At most the productive grazing season was fifteen weeks and the grass unlike the best we have now. Cows were milked by hand. When the war came, imports of animal feeding stuffs were cut, forcing the farmer to grow more of his own, which in effect meant to control the grazing season, and grow more grass per acre per day during the season, and to fill the 'Winter Gap' when no grass was available, tackled once before by Turnip, Townshead and Coke in the 1700's.

After the war this tendency was encouraged by the high price of imported feeding stuffs. Nowadays, thanks to new grasses and artificial fertilisers the winter gap on some farms is only from December to February, and this is filled not only with the traditional hay, but also with kale and cabbage, and with silage, a method of conserving 'grass which depends less on our notorious climate than hay. (Turnips and mangolds involve too much labour nowadays).

Several disease problems have arisen from feeding more grass longer. The composition of grass varies greatly according to its stage of growth. When fed very young it can cause three diseases, grass tetany, bloat and diarrhoea; when grazed heavily for too long, stock can become heavily infected with stomach worms or lung worms. As the veterinary surgeon sees it, the farmer has introduced a new system which has run into trouble—we have to show him how to modify his method to avoid the trouble or tell him not to use it. In nearly every case we have been able to show him how to avoid the problem. Looking at the problem from another angle we know we can't fight Nature, but we aim to show the farmer how to keep Nature on his side. For instance, we know that after worms are passed in the dung they take about a week to become infectious. In the past not enough grass was grown per acre to permit heavy stocking and the resultant heavy contamination of first the ground and then the animals. Nowadays, we find that if the land is not too wet we can control these diseases in most years by allowing the heavy contamination of the ground but removing the stock from the area by the end of the week so that the cycle of infection is not completed, and leaving it bare for a month or so for the worms to be killed by the sun and dessication. In wet areas this method of control is less likely to succeed. Here the new vaccine, the first one against a parasitic disease in either the veterinary or the medical field, has been successful. This vaccine can also be used on farms where the standard of grassland management is low—where the weather, by its effect on grass growth, determines what fields the stock shall graze next and for how long, rather than the farmer.

'Bloat' occurs when cows are turned out on to fast growing young grass, especially when the clover content is high. The first stomach of a cow is a fermentation chamber where foods are broken down by bacteria into short chain fatty acids which are then utilised by the cow. At the same time, as in brewing, carbon dioxide is produced in large quantities. This normally escapes easily, the cow belching repeatedly, but sometimes bubbles form, the gas is trapped and the cow's stomach blows up like a balloon. Unless relieved promptly this can cause death by asphyxia. First the veterinary surgeon had to learn about the froth and how to deal with it, and later to discover when the state of growth of grass in a field was likely to be dangerous, so that he could advise when not to graze bloat-prone fields, and lastly, how to utilise the grass crop in such fields and to reduce the clover content so that they were safe to graze later on—by cutting for hay and then fertilising them heavily with nitrogen which depresses clover growth. If the ground is covered in snow for a long period during the winter the clover is not eaten by the pigeons. If this is followed by a warm spring pastures are likely to be more prone to 'bloat' than usual. In such a season timely veterinary advice on the dangers and on methods of control is very welcome, as it is with other seasonal diseases.

Grass tetany is characterised by hypomagnesaemia. The story is not wholly understood yet but it is known that as the winter proceeds the serum magnesium in cows decreases, and that when first turned out on to spring grass, especially if it has been recently fertilised with a complete fertiliser, the magnesium content is reduced still further. The animal may start having fits and often dies. If magnesium is injected quickly and is supplied daily for some time afterwards, this disease may be cured. Nowadays many farmers feed magnesium to their cattle for several weeks before they turn them out to grass in the spring. On some farms the management of the grass is such that the equivalent of spring grass is fed to the cattle for a far longer period than ever before. Here it may be necessary to include magnesium in the ration for most of the year. If the soil is chalky the direct application of magnesium to the grass is of little use unless the stocks graze it within a few days, but on sandy soil this can stop the pasture from being 'hypomagnesaemia-prone' for several years.

Baling hay wet in the field often results in its heating, which is associated with the growth of certain moulds and thermophilic actinomycetes. In stock it may result in a lung condition or perhaps in abortion associated with presence of these moulds. In man it may result in Farmer's lung. This method of making hay when it is wet is spreading into Scotland because the labour involved is less than that necessary to dry hay on tripods. Presum-

ably the diseases associated with it will become more prevalent in those areas too.

The shortage of labour on the farms has resulted in many management changes. Out of fashion has gone the hand-milking of cows, 10 per hour per man. In has come the milking machine, 20/30 cows per hour—in other words a half or third of the labour required. No longer do we see thickened teat walls, the result of over-energetic hand-milking and the mastitis which resulted from it, but instead we see mastitis, the result of a faulty machine or faulty handling of it. It is relatively easy to correct a defective machine but it is still extremely difficult to get a cowman to change his ways, whether he is mis-using his thumb when hand milking or leaving the machines on too long. The eradication of Streptococcus agalactiae mastitis within a herd can be carried out relatively easily provided the management co-operate, since the organism is limited mainly to the udder. The other forms of streptococcal and staphylococcal mastitis are not so limited in distribution. At the moment no practical method of eradication has been devised and control rests on good hygiene and good milking methods. If a herd has a mastitis problem which cannot be corrected, often because the owner is the milker and is a bad milker who cannot be dismissed, the development of mastitis-causing staphylococci resistant to the antibiotics used, is a very real problem. This, and the similar problem of diarrhoea in neonatal calves and piglets associated with certain strains of coliforms, is responsible for the vast increase of laboratory facilities in many veterinary practices where sensitivity tests are regularly carried out, so that the veterinary surgeon knows the following day what antibiotic to advise if the one recommended happens to be unsuitable.

During 1964 summer mastitis was again very prevalent in the south of England. As its name suggests, it is a seasonal condition, associated with the organism Corynebacterium pyogenes, and its incidence each season depends upon the weather during the period July to September. Last year the probability that this mastitis would be prevalent was recognised by many veterinary surgeons in the south and the control methods known to be effective advised. It was recommended that cattle should be dried off with penicillin and that there should be close supervision of the dry stock, the stock most likely to be affected, so that treatment of the condition could be initiated within 12/24 hours if it occurred. Diseases such as hypomagnesaemia, bloat, milkfever (hypocalcaemia), and summer mastitis all require prompt treatment if lives are to be saved. These diseases are common and the veterinary services are organised to cope with such emergencies as routine. This is probably one of the reasons why the farmer may compare the service provided by the medical profession unfavourably with that provided by the veterinary profession. Another reason is that many common diseases of stock are caused by bacteria or parasites against which effective and spectacular methods of treatment exist, antibiotics and parasiticides, whilst the colds, influenza, backache, and diseases of old age treated by doctors respond very slowly to treatment, if at all.

On many farms natural service has been replaced by artificial insemination—about 80% of the dairy cows in the country are now inseminated. The venereal diseases spread by the communal bull used by several smallholdings are far less common, and now occur in bunches of heifers which have been run with a bull for limited period. Instead we have other troubles. Without a bull it is more difficult to tell when a cow is in oestrus and is fit to be inseminated. If the cowman is not good at this, the cows may remain 'infertile'. Very occasionally the bull's semen ceases to be fertile, perhaps temporarily, sometimes permanently. At the latest this will be spotted at the A.I. Centre when the results are analysed three to six weeks later. This requires close co-operation between the veterinary surgeon and the A.I. Centre if he is to recognise when an infertile bull is the cause of the infertility. Where natural service is used such a condition would result in all cows returning to service. With A.I. sometimes only one or two cows, those in the herd put to a particular bull, return.

The development of a better costing service to farmers has resulted in a more general recognition that generally a herd with an average calving interval of 420 days is far less profitable than one with an interval of 365 days. In large herds under average management it has been found more economic on occasions to serve cows first earlier than the optimum interval so that time is on their side if a period of temporary herd infertility occurs. If the farmer is unaware that the conception rate is lowered if such a practice is indulged in, the veterinary surgeon may be called in to be presented with this new clinical picture, and to determine whether or not an infertility problem exists at all. This problem may be complicated by either extremes in the standard of feeding, by a period of kale feeding, or by the introduction of new cows into the herd, all of which factors can affect fertility.

First in poultry and now in pigs and sheep the methods of genetic improvement of the breeds have changed. The introduction of 'Hybrid' chickens, the progeny of three or four very inbred lines of grand-parents, occasionally results in an 'outbreak' of a genetic disease involving as many as 10/15% of the flock. In cattle, the importation of the French Beef breed, the Charolais, has resulted in better carcase gains in the cross, but also in an increased incidence of dystokia because of an 'oversize' calf with its attendant higher calf mortality rate. Recently it was found that only thyroid hormone out of a large number of hormones added to the fertilised egg reduced the gestation period of a hen's egg. This may be the reason why dairy cattle generally have a shorter gestation period than beef cattle, since milk yield can be increased by giving a cow extra thyroid hormone. The practical application of the corollary of this observation if it is found to be true, may speed up the genetic improvement of both the meat and the milk industry. The pattern of oxygen consumption of the newly hatched chick has been correlated with its growth potential. This is being used to speed selection.

The development of the 'intensive' systems of husbandry have brought their own problems. The collection of animals from a large number of sources increases the risk of infectious disease. If the ventilation is not efficient an outbreak of respiratory disease can result in a high mortality rate. If the conditions are bad underfoot, foot troubles can become a herd or flock problem, just as they can out of doors in wet weather once the land becomes 'parched'. The size of an 'intensive' unit is often limited, not so much by capital, as by the size of the sources of supply, or the size of the outlet for the finished product, or nowadays a problem occurring more and more frequently—the problem of dung disposal.

Veterinary practice, of course, is concerned with treating the individual case. It is, however, becoming increasingly obvious that all too often an individual case is only a sign of some fault in the management of that farm. This field of preventive medicine is developing rapidly in certain areas of the country, the rate depending on the quality of the veterinary advice proposed and the readiness of the farmer to accept it. In the small animal field this interrelationship between disease and certain environmental factors is much more difficult to pin-point, as presumably it is in human medicine, because the size of the population at risk in any one family is generally so small, and so often the patients attend the surgery, rather than the doctor the home, where the cause may be all too evident.

Saint Bartholomew

From the *New Statesman*:

Noticing the other day that I was supporting my case without that perfect impartiality for which I am famous, I recalled a story told me some time ago by Robert Graves. It seems that Jones scored a spectacular try in the annual rugger match between Guys and Barts. He won the match for Barts just as the whistle went and always remained a hero to an admiring circle. Unhappily his pleasure was marred by a secret fear that the pass which enabled him to score was slightly forward, in fact a foul. In course of time he died and went to heaven. He presented his card to the bearded figure at the gate who, to his surprise, warmly welcomed him. 'You must be the man who scored that wonderful try for Barts?' 'Yes,' he said, 'but I did not know you were interested in such things.' 'Indeed,' said his host, 'I always follow that match with peculiar interest.' 'Then you can put my mind at rest about a matter which has always troubled me. Was the pass I accepted a legal one?' 'An absolutely perfect pass', said the bearded figure. 'Just a little backward; all as it should have been.' 'Oh, thank you, Peter, it's wonderful to know that for certain.' 'Who are you calling Peter?' said the bearded figure. 'I'm St. Bartholomew.'

(Contributed by Dr. Barbara Smith, Department of Pathology.)

aurelius

VIVISECTION

Vivisection is an unfortunately loaded word. Its literal meaning of 'cutting alive' is not a just description of most of the experiments performed on animals. The anti-vivisection societies delight in the macabre connotations of the word, dubbing animal research workers 'vivisectors', a term which makes the most benign of academics sound like some spine-chilling ogre out of a horror film. They are not likely to be overjoyed by the recent* Report on Animal Experiments. The system of control of experiments has been little altered since the Cruelty to Animals Act in 1876. In the first year of compulsory registration of animal experiments, there were some 300 such experiments performed. This figure has now risen to something in the region of 5 million, so a complete re-appraisal of the legislation and its administration is not untimely. The reporting committee of 14, formed less than two years ago under the chairmanship of Sir Sydney Littlewood, has produced a very lucid 255-page report, setting out 83 recommendations for improvement.

The 1876 Act requires that all places of animal experimentation should be registered with, and subject to inspection by the Home Office, and that all persons whose connection with the animals is more than basic feeding and cleaning duties, should hold a licence.

Special certificates are required for certain classes of experiment such as those in which curare-form drugs are used, experiments involving dogs, cats, horses, asses and mules, and those in which no anæsthetic are used or the animal is allowed to come round from the anæsthetic. At present there are 550 establishments registered, 8,746 licencees and eight Home Office inspectors.

The reporting committee were scrupulous in obtaining evidence from all interested bodies. They visited 29 research establishments, invited comment from others and from scientific societies, anti-vivisection societies, the press and members of the public. The Editor of the *Daily Mirror* said that his readers showed practically no interest in the subject; an article on vivisection would draw only a handful of letters from the anti-vivisection societies and a small fringe public. The Editor of the *Daily Telegraph* on the other hand considered that vivisection ranks with sex, religion and major political issues as a provocation for a flood of correspondence—an interesting comment on the mentality of their respective readers.

The committee found that in general the living conditions of the animals were excellent, indeed their conditions were often superior to those of their human keepers. Certainly this is in accordance with the writer's limited experience as an animal technician, where the animals had clean, light, warm pens, luxurious compared with the staff's one small, draughty room, used for everything from tea-breaks to autopsies, often simultaneously. It was reassuring that they found little wastage, and that the animals were treated with exemplary kindness by licencees and technicians. Anyone who has to deal with animals soon learns that a firm, kind handling of them is conducive to a co-operative working arrangement.

Contrary to the propaganda of the anti-vivisection societies, they found virtually no evidence of cats and dogs being stolen to sell to laboratories.

Although none of the recommendations are startling, some may be singled out as of interest.

(1) The number of inspectors should be increased from 8 to 21, enabling them to visit each establishment at least twice a year, and it should be made a more attractive career.

(2) The Advisory Committee, at present rarely called in to advise on ethical problems should play a more active rôle.

(3) The system of certification should be abolished. Instead individual licences will state specifically what procedures the holder may carry out. Whilst resulting in overall tighter control, much tedious administrative work will be obviated.

(4) Students, under supervision of licencees, should be allowed to work on fatally anæsthetised animals. If taken advantage of, this would increase the scope of Physiology and Pharmacology practical classes considerably.

It looks as if opponents of vivisection will have to write a lot more letters to the press and pester a good many more M.P.'s before anyone takes much notice of them.

(Report of the Departmental Committee on Experimental Animals. H. M. Stationary Office.* 16s.)

HOMOSEXUALITY

By giving a second reading to the Earl of Arran's Bill for Reform of the Homosexual Laws, the House of Lords showed that it is not such an outworn Victorian institution as we sometimes think. Two days later however, the House of Commons refused Mr. Leo Abse (Pontypool) leave to bring in his similar Bill by 178 votes to 159, thus successfully shelving the distasteful subject for another year.

In moving the second reading of his Bill, the Earl of Arran gave a refreshingly detached speech, stating that he did not expect his deliberately simple Bill to become law as it stood, but he hoped that it would provoke general discussion of the problem. It certainly did. In the other House, Mr. Abse was anything but detached in one of his characteristic emotionally overloaded speeches. His lament for the poor homosexual, denied the blessings of wife and children, scorned by a hostile society, and driven into homosexual ghettoes, was enough to draw crocodile tears from the hardest man. The outraged horror with which some members approached the subject shows how deeply rooted is the idea that sodomy is not just "a horrible revolting practice . . . wrong, unnatural, degrading and disgusting" (Sir Cyril Osborne), but a *crime* comparable with theft, rape or any other penal offence. The opponents of the Bill seemed to imagine that a change in the law would result in a kind of homosexual's Utopia. Students and their tutors, schoolboys and masters, police officers, prison warders, boys on their 21st. birthday are all implicated in the orgiastic sessions predicted to occur over night. This is quite enough to stomach without imagining (as Lord Montgomery asked his fellow Lords) the ensuing chaos in the 2,000 bunks on board an aircraft carrier. While he was a judge, poor Lord Goddard had been made to feel physically ill listening to stories of "buggers' Clubs", and he thought the Bill would be a Charter for these clubs, whilst the Earl of Kilmuir thought the clubs would send out armies of missionaries to convert the innocent. If the Bill were passed the public would think that the Lords "approved of homosexual conduct, or to put it vulgarly, was in favour of buggery" (Lord Brockett).

But no one proved as capable of clouding the basic issues as the Hon. Member for Louth, Sir Cyril Osborne—the Bill would offend the non-conformist conscience of the public; most spies and traitors were 'homos'; homosexuals were not inevitably so, any more than drug addicts, kleptomaniacs and drunken thugs were; Britain's friends abroad would think that the character of the English people was going wrong—to sample just a few of the Hon. Members reactionary rumblings.

What are the basic issues at stake then? As the law stands *all* acts of homosexuality are penal offences. The Bill proposes that acts between consenting male adults should be legally permissible, but corruption of minors, public display, etc., would carry the same, or heavier penalties as today. Medical science knows little enough about homosexuality. Whether the ætiology is acquired or hereditary, the fact remains that the true invert is not so because he has willed it on himself, but being so made he would have no wish to be anything else were it not for the intolerable pressure brought on him by society and the law. Estimates of the number of homosexuals in this country vary from one to ten per cent of all males, whilst a wider number have had some experience at some stage in their lives. Whatever the figures are there is no doubt that for all the homosexual offences committed, only an unfortunate minority are brought to trial, which is unjust and indicative of the ineffectiveness of the law as a deterrent.

When such a Homosexual Law Reform Bill is eventually passed, it will not mean that the Members of the Houses condone or approve of homosexuality (just as they may not approve of legal heterosexual acts outside marriage). It will simply show that they recognise homosexuality to be a 'natural' deviation from the normal, for which compassion and tolerance are required rather than the harsh brutality of the prison cell. The public is ready to accept a change in the law that will abolish this source of human misery.

general practice in WHITECHAPEL

The second of a series of articles based on visits to general practitioners.

By
Alan Bailey

THE practice that I visited was in the East End of London, 150 yards from the Whitechapel Road, run by a small elderly but well-preserved graduate of the London Hospital. He manages the practice of about 1,900 on his own, three small interconnecting rooms on the ground floor of his house serving as dispensary, waiting-room and surgery respectively. The surgery is small and contains a desk, a workbench, a couch and several oddments, leaving room for about four people. There is an air of mystery and informality about the place: the littered work-bench, scattered instruments and books, an old head-mirror hanging from a hook, and frequently patient and doctor smoke during an interview.

The East End community is a close-knit one, predominantly Jewish, but I found them friendly, and only twice did a patient object to my presence behind the doctor during the six surgeries that I attended, at which I would retire into the waiting room and read Fleming's original work on penicillin, selected at random from a case of ancient tomes. In those six sessions not one patient was referred to a consultant, about a quarter were children and about a quarter were suffering from 'nervous' troubles. We saw about 15-20 patients in the two-hour period and never did the doctor seem rushed. The phone rang at regular intervals, and a few minutes' discussion took place between each patient. Notes on patients were kept to a minimum, and often the patient carried a small card on him on which the drugs he was taking were written. Quite a proportion of the problems dealt with were social; housing, marriage difficulties, convalescence, employment and care of the old, being among the most frequently encountered. The doctor's advice was always earnestly and gratefully received, and all his patients seemed to have the greatest respect for him.

The extent to which his patients are a community is seen in this story: one of the patients has chronic kidney disease, requiring dialysis every 10 days at the Royal Free artificial kidney unit. Under the doctor's guidance the practice decided to try and raise £1,300 to buy the cheapest machine for the patient's own use at home as the hospital could not continue the treatment indefinitely. In fact well over £3,000 was raised in a remarkably short time, and a more expensive machine is to be purchased.

At least three or four of the patients seen each time were Indian; some came from as far away as Kings Cross. In order to understand them better he has troubled to learn several phrases in Bengali, and as a result the Indian new to the country, whose English is bad, can make his complaints understood to the doctor whose fame for this seems to have spread quite widely.

Apart from his practice, and although welcoming more pay the doctor is reasonably satisfied with the conditions (but he admits that if he had more than 2,000 patients things would be different). He attends the College of General Practitioners regularly and occasionally presents a paper. During holidays a neighbouring G.P. looks after his practice in return for the same favour.

Here is a practice built up over many years, probably not typical of East End practices, but an example of one G.P. who has come to terms with general practice within the N.H.S. Apart from the medicine I learnt in this Whitechapel surgery, I was most impressed by the medicine, social and organic, that I saw practised there.

Διάγνωσις

The Editor would be grateful for any accounts of interesting or unusual cases which readers may have encountered.

I.J. Female. Act. 79.
Admitted to Royal Prince Alfred Hospital, Sydney, in July 1964.

The patient who had previously been well and active presented with a six week history of recurrent epigastric pain associated initially with nausea and vomiting, and usually occurring after meals. A small meal would induce intestinal hurry. There was no history of gastro-intestinal blood loss. The diarrhoea and vomiting later subsided spontaneously, but anorexia persisted. By the time of admission the patient had lost two stones in weight over the preceding three months.

On admission physical examination was unrewarding apart from a readily palpable abdominal aorta. At one time previously a mass was thought to have been palpable in the epigastrium, but this could not be confirmed. The following investigations were carried out: —

Hb. 13.1 g.%; E.S.R. 22mm./hr. (Westergren)
W.B.C. count 6900; Neut. 67%, Lymph. 23%, Mono 10%
Blood urea 34 mg.%
Serum bilirubin 0.2 mg.%; S. alk. phosphatase 16 K. A. units
Turbidities—$ZnSO_4$ 2 units, Thymol 1 unit
Random blood glucose 134 mg.%
Gastric lavage—no carcinoma cells seen.
Stools—no occult blood.
no pathogens grown on culture.
Xylose absorption—5 hr. urinary output of xylose was 2.0 g. (normal at least 4.5 g.).
24 hr. faecal fat excretion was 9.2 g
Radio-iodine uptake was within normal limits.

The following radiological examinations were carried out: —

Chest "There is an area of increased opacity to the right of the mediastinum beneath the sterno-clavicular joint. This is probably vascular in origin, or may be due to a retrosternal thyroid. The lung fields are otherwise clear."

Thoracic inlet The opacity was revealed again. "It is still not possible to be certain about its aetiology, but I think it is probably a small retrosternal thyroid nodule."

Abdomen Advanced degenerative changes were noted in the lumbar spine. There was well-marked calcification in the abdominal aorta.

Ba enema showed some slight narrowing of the proximal sigmoid colon but the mucosal pattern appeared normal.

Ba swallow showed no lesion in the oesophagus.

Ba meal anl follow through No lesion demonstrated in stomach, duodenum or small intestine.

The patient remained anorexic and continued to lose weight. Several days after admission she complained of pain in the epigastrium (at no stage did the pain radiate to the back or anywhere else) and was tender to the left of the midline. The abdomen appeared distended and dull to percussion.

Two days later in the early morning she became hypotensive (systolic B.P. 70 mm. Hg.) and complained of severe abdominal pain. Her abdomen remained distended. Bowel sounds were not heard. Peripheral pulses were palpable. She responded for some hours to pressor agents but later that same day had a haematemesis and died in shock.

Answer P.287

R.A.M.C. (T.A.)

Neville C. Oswald, T.D.

The complexities of modern living fill the waking hours of most of us, but beyond the blare of juke boxes and the noisier means of transportation lie various voluntary services. Amongst these, the Territorial Army with its weekly drill nights, its week-end training and annual camp would seem to be an unlikely outlet for a nation which is not over-enthusiastic about martial matters in times of peace. Yet the T.A. flourishes. It is very much a civilian affair and is called upon to function only when General Mobilisation is proclaimed—it is then embodied and remains so until its disembodiment at the termination of hostilities (these terms were not, as far as is known, proposed by the R.A.M.C.). The idea of a co-ordinated part-time force under the immediate control of County Territorial Associations is of comparatively recent origin.

The Territorial Force was formed in 1907 by the passing of the Territorial and Reserve Forces Act and has continued since, its name being changed to the Territorial Army in 1921. Its original purpose was to unite the various militia, volunteer and yeomanry units which had grown up over the years. Also in 1907 a special Army Order was published announcing plans for an Expeditionary Force of 140,000 men for service overseas, in preparation for a possible conflict in Europe. This necessarily involved the formation of many field medical units, none of which existed in time of peace. Hence the newly formed Territorial Force R.A.M.C. was soon busily engaged in organising regimental staff, field ambulances and general hospitals. It did not provide for the collection and transport of the sick and wounded in base areas or the establishment of base hospitals. For these, Voluntary Aid Detachments were devised, along the lines suggested by the Geneva Convention of 1906, and were recruited through the Territorial Force County Associations from the St. John Ambulance Association, the St. Andrew's Ambulance Association and the British Red Cross Society.

The decade leading up to 1907 was an important one for the regular R.A.M.C. After many years of wrangling, the Corps was formed by Royal Warrant in 1898. The Army Medical Department at the War Office assumed its present structure, save for subsequent elaborations, in 1904, with the Director General answering to the Adjutant General. The School of Sanitation opened at Aldershot in 1906, and in 1907 the Royal Army Medical College moved to Millbank after a long and distinguished existence at Netley. The field ambulance was introduced in 1906, partly as a result of experience in the South African War, and was followed shortly by the clearing hospital, later to become the casualty clearing station. In effect, the Corps had shaken down very well during the first ten years of its existence. It had various sources of reservists who could be called upon in case of emergency, namely the Regular Army Reserves, the Supplementary Reserves and the Home Hospital Reserves, all of whom were orientated towards the regular R.A.M.C. The Territorial Force, which also bore allegiance to the County Associations, was something rather different. In retrospect, the extent to which the Territorial Force was allowed to develop seems surprising. Of roughly 150,000 men in the R.A.M.C. in World War I, no less than 50,000 were territorials, of whom about 40,000 were medical officers. The force provided 246 complete units for service overseas.

In 1919 virtually the whole of the Territorial Force was disbanded. It was reconstituted in 1920 and assumed its present name in the following year. At first a large Territorial Army was envisaged, having 101 medical units including 25 field ambulances and 23 general hospitals. No sooner had these been formed than a policy of retrenchment was adopted, in keeping with the mood of the nation. By 1927 the number of medical units had been reduced to 36 with 14 field ambulances and three general hospitals, and remained so for the next 10 years. Between 1937 and 1939 the R.A.M.C. (T.A.) expanded once again and was called upon to provide medical cover for the newly created Anti-Aircraft Command, but at the outbreak of hostilities no more than 38 field ambulances and seven general hospitals were in existence. On embodiment in 1939 all these units were brought up to full war establishment, joined their field formations and prepared to proceed overseas some three or more months later. Many supplied cadres for fresh units. The Territorial Army was absorbed into the Regular Army in 1940. The former peacetime units kept unofficially their Territorial designations but, with cross-postings, few were able to retain more than a handful of their original members throughout hostilities. At the end of the war, T.A. personnel were released in age and service groups, with the automatic dissolution of the force. The T.A. was reformed in 1948 and is now little short of its permitted peacetime establishment, being about three-quarters of the size of the Regular Army.

The R.A.M.C. (T.A.) has only one really important function and that is to provide field medical units to T.A. formations on mobilisation. Clearly, the most urgent need is to supply adequate medical cover for divisional troops, and this was well exemplified in 1939 when regimental medical officers and field ambulances were immediately available to work side by side with colleagues they had known in peacetime. Other T.A. formations such as casualty clearing stations and general hospitals are indispensable in support of divisional troops but they are less intimately associated with them and hence are less important in terms of the medical commitment of the T.A.

The aim of the R.A.M.C. (T.A.) is to provide field units which are as efficient as voluntary peacetime service permits. As a start, drill halls are established where recruits are clothed and introduced to military procedure. If the T.A. went no further than this it would have achieved something, namely the provision of a uniformed force which was immediately available for training in an emergency. Obviously it goes further, due to the enthusiasm of its members over the years. It provides as best it can instruction in a bewildering variety of subjects which are not ordinarily part of civilian life. These include first aid, the movement of casualties, map reading, the establishment of medical units in the field and the many skills which are needed for existence in isolation. In addition there are the consequences of nuclear warfare which are constantly in mind.

The reasons why men and women continue to join the R.A.M.C. (T.A.) are difficult to summarise. Some are introduced through friends who are already members. Others may feel that the T.A. offers an outlet sufficiently removed from their normal activities to be a fresh interest—an outlet in which, by virtue of their training, they can be of real service to the community. Obviously the most desirable time for a doctor to join is shortly after qualification, when he is the same age as other territorials of equal rank. Unhappily, this is rarely possible owing to the lack of continuity of house-jobs, and so in practice he usually joins later when a fixed appointment for not less than two years can be foreseen.

Fortunately there are still sufficient, or almost sufficient, doctors and nurses who are prepared to devote a considerable part of their spare time to the interests of the T.A., thus ensuring in peacetime the medical support of combatant troops who look to them for assistance in time of war.

Social Chapter

CROQUET

Bart's men for Olympics?

I have just been speaking to those two doyens of the croquet world Mr. R. Clayton and Mr. C. Watkins on the croquet court at College Hall. As we all know, they gallantly represented Barts in the recent Evening Croquet Tournament at Roehampton. Chatting frankly about their wide and varied experiences—they assured me that although unfortunately unable to participate in the second round, they had savoured many of the more subtle points of the game. When pressed further, they revealed more fully the events of the tournament.

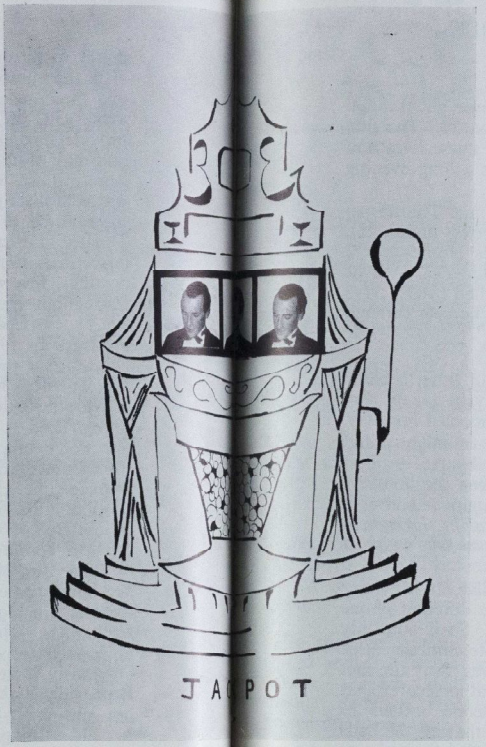
It appears that Mr. Clayton had been drawn against a Mrs. Beaver of Beecham Pills. After the first few strokes is was only too clear who had the upper hand—but as our man was rallying magnificently with two brilliant roquets followed by a timely crush stroke, the game had to be terminated with the intervention of bad light.

On the following evening Mr. Watkins engaged a Mrs. Wells, one of croquet's true veterans. "It was," Mr. Watkins said to me, while running through his wrist strengthening exercises, "a refreshing game." Before dark Mrs. Wells peeled one of her balls after a skilful continuation stroke and pegged out with a suddenness which left Mr. Watkins under the misapprehension that the game was still in progress.

I left them wielding their mallets with characteristic aplomb, in preparation for their next tournament in mid-July. Good Luck, I thought—they need it.

From Our croquet correspondent

The Mallet, Mr. Clayton and Mr. Watkins



THE 1965 BARBECUE BALL

The third Annual Barbecue Ball will be held this year on Friday, 13th August in College Hall from 9.0 p.m. until about 3.0 a.m. This is the Committee's chance to spend its profits and make really enjoyable and inexpensive evening for all. There will be three bands including the Temperance Seven, barbecue, buffet supper, cabaret and several bars. Drinks will be 1/9d. a nip and beer 1/9d. a pint. Double tickets will cost only £2, but unfortunately numbers are limited. If you want a ticket write now to James Perry, c/o College Hall, Charterhouse Square, E.C.1., enclosing remittance.

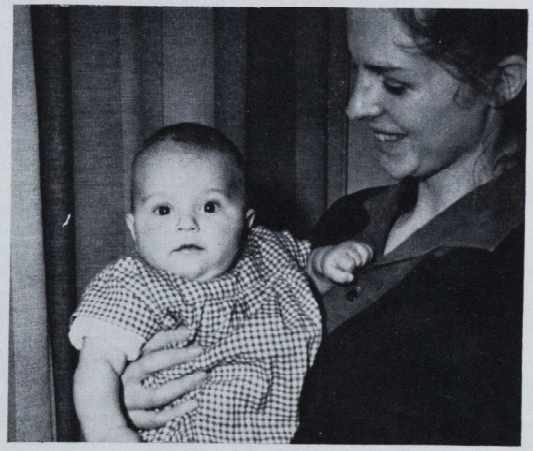
SPORTS DAY

Time to think again?

Chislehurst is a long way to go and unless the organisers are happy offering little more than a College Hall hop for your pains then it is time they did some thinking about the social side of Sports Day. There was of course the well publicised free beer, predictably absent by the evening and the barbecue, a free issue of rolls and hot sausages. Only at this stage did the party really get moving; as someone put it—you've got to give the boys time to warm up. Moving as the thought of a dozen or so men becoming progressively intoxicated may be, it should be balanced by the fifty or so girls in mute peripheral attendance. Many of them, I'm afraid, were simply waiting for the return bus.

No one can be directly blamed for this sort of situation and of course some of us were happily drinking or dancing. However, one wonders what might be done to improve the evening without changing the framework of a very informal and strictly Bart's occasion. After all this is the Athletic Club's only social event. For instance how about a short cabaret, there's plenty of talent to provide this in Bart's at the moment. The barbecue side of things is worth extending to something bigger with perhaps an entrance fee to help cover it. For a beat group with only three players "The Few" were certainly adequate for the occasion—and they are 'our men'. Finally what about keeping those barrels for the evening?

BART'S BABY OF THE MONTH



Nicholas Kettlewell

do you do this?

7. PHONE THE NURSES' HOME

by DAVID MILES

Probably most readers do, or have done, this. Whether they ever got through to the person they wanted is, of course, a completely different matter. The first problem is to discover in which of the many homes a particular nurse lives and usually the best way is to ask her, otherwise you're going to have a long evening battling with exchanges from MONarch to PADdington and back.

Let's start by phoning the grey-belt living in Queen Mary Home. The unsuspecting student picks up the S-Z telephone directory and looks under 'St. Bartholomew's Hospital'; but is there any mention of the Nurses Home—not a bit of it, and so he has to phone the main hospital switchboard (Mon 7777). If its a friendly girl on the switchboard the number can normally be elicited (MON 5118 to those not in the know!) and thus with another three-penny bit he gets through to the Q.M. home:

"Oh hello, is Miss Greybelt there please?".

"No sorry she's out" comes the reply, even before they've had time to catch the name properly. But, as a great favour, a message will usually be taken. I'm not certain whether the message ever actually reaches the nurse concerned however.

Another time perhaps you want to contact that nice girl on nights, and Bryanston must be phoned. Once you know the number this is by far the best bet for getting hold of girls quickly. Just phone PAD 7491 between the hours of 9 a.m. and noon (bit expensive on STD at that time of day though) and after a couple of words with the lady at the switchboard *you are put straight through to the room of the girl concerned*—what could be better, and what's more, *she's almost always in.*

But when the girl you fancy moves to the West End to live in Maybury Mansions difficulties arise once more. Here there appears to be a different phone on each floor, and each funnily enough with a different number. So if you only know one of the numbers, the girl answering the phone may not like climbing three or four flights of stairs to look for the girl you're after. It also gives away the fact that on some previous occasion you'd been phoning a girl living rather nearer that particular phone. This is always assuming of course that someone bothers to answer the phone at all (at least one acquaintance of mine thinks that all the bells have been removed from Maybury phones!) and even if it is answered the girl you want can rarely be found.

The other home for student nurses is Charterhouse Chambers. Now this is one which I have never phoned, I don't even know the numbers. Perhaps its the best of the lot, where the person you want can always be contacted without difficulty, but, judging by the others, this seems very unlikely.

So that's four dealt with. The rest need only be read by those wishing to phone staff (anything from blue-belts to sisters). I refer of course to Gloucester House. This, actually, isn't too bad. Dial MON 6741 and the phone is usually answered by an obliging porter who will buzz the room of the person concerned, and if she's in, connect you through to the appropriate floor phone. Quite reasonable.

Still it seems to me that unless you're phoning Bryanston its just not worth bothering. Sit back and let them try and get hold of you in College Hall—especially on a Sunday!!

BISTROS

Reporter:

Tim Wheeler

First of a series of articles on where to enjoy some more unusual or exotic meals.

Bistro is a term interpreted at will by restaurateurs. This review is deliberately confined to the cheaper ones. Such bistros are small and informal—go in anything from jeans to DJ. Candlelight is de rigueur but they are far too crowded and noisy to be called intimate. Most of the dishes come from Eastern Europe but there are always a few standards like steaks for the wary to fall back on. Eating in a bistro often becomes a protracted business—a bottle of wine should always be allowed for.

For an idea of the cost—a really basic meal such as soup, Hungarian goulash, ice cream with chocolate sauce would be 10/- to 12/- in any bistro. A more interesting but not extravagant choice such as Corn on the Cob, Boeuf Stroganoff, fresh fruit and cream would cost, in the Bistro Vino for example, 15/3. Finally you would have to start again to exceed 25/- a head.

In addition you will have to pay more for bread and any support you want for the main course—a green salad is always best with the foreign dishes. Coffee is 1/- but strong and in reasonable quantity.

It is important to appreciate which bistros are licensed and therefore charge corkage. Those which do not are:

Bistro d'Agran (Pavilion Road, S.W.1.) Popular and reasonably priced. Background music from a gramophone—occasionally audible. Interesting dishes: Kronneski, Kebab, Steak Tartar. One of the main attractions of this bistro must now be **Searcy's Wine cellar** practically next door, which opened in May this year. They have a very broad wine list with some from Yugoslavia, Hungary, Bulgaria, Rumania and Russia. For the connoisseur the manager is building up a collection of vintage wines.

Bistro Vino (Clareville St., S.W.7.) Particularly cosy seating arrangement—but the cooking makes it the best value of them all; try the Stroganoff. Best selection of sweet dishes of any bistro. Get your wine from Denmark (round the corner in the Old Brompton Road)—they have a list of fifty, standard stuff starting at 8/6d.

Luba's Bistro (Yeomans Row, S.W.1.) Just as crowded as the others but the visibility is better and the prices slightly higher. Madame Luba herself attends and keeps the menu essentially Russian—but there is also a wide selection of steaks. The Bunch of Grapes sells thirteen selected wines from 10/6.

Licenced Bistros charge 5/- or more corkage. Their wine lists tend to be expensive but a carafe of red or white is only 9/6d. On the whole they are more expensive and smoother than the bistros already described.

Bistro 42 (Crawford Street, W.1.). Clean but rather overdone with onions and chianti bottles. Noticeably hushed atmosphere. Prices are in fact reasonable but the quantity of food is less.

Bistro 17 (Moscow Road, W.2). Related to above. Same owner. Same decor. Same menu. Recommended for its intimate atmosphere.

Buzzy's Bistro (11 Kings Road, S.W.3. opposite Peter Jones). Paintings round the wall which you are meant to be able to see. The bistro element is minimal. Interesting dishes are expensive but you can pick up an omelette for 3/6. Clientele decidedly "U".

Grumbles (Churton Street, S.W.1.) Decor deliberately off-beat. Recently reviewed by Town Magazine, Grumbles can be said to have arrived. The menu is good but becoming expensive—try the Coq au vin at 9/6d.

1965 WANDSWORTH DRAMA FESTIVAL

(May 21st—24th)

After winning 2 awards at last year's Festival with James Saunders's "Barnstable", the Drama Society this year entered two plays. "Life and Carole Carter" was unplaced but it was well received by the audience and the Adjudicator commented on the wealth of talent in the cast. After seeing "The Room", the Bart's members of the audience thought it would win 1st prize; but we had all missed the Wednesday evening, when the first two prize-winning plays were put on.

Benita Wylie, who has worked as hard as anyone in the Drama Society during the last two years, despite examinations, is a mature and versatile performer. She has acted brilliantly in diverse roles from plays by Pinter, Simpson, Giradoux, and Pirandello. To say that this award was thoroughly deserved is an understatement.

The Drama Society has done 6 productions this year, all of them good, and its officials (Judy Bell and Bruno Bubna-Kastelitz) and producers (Sue Macdonald, George Dunn, Bob Kendrick and Bryan Lask) deserve praise and thanks for the talent and imagination and hard work that they have put into them. What with Smokers and the Ward Shows, as well as the Drama Society productions, the stage has become the creative centre of the hospital. May St. Genesius bless it, may St. Bartholomew back it!

Awards:
1st. Bec Players in "An Office of Profit".
2nd. Rookstone Players in "Inherit the Wind".
3rd. Bart's Drama Society in "The Room".
4th. Wendelsworth Players in "Hotel Paradiso".
Best Actor Trophy: Ronald Barry.
Best Actress Trophy: Benita Wylie.

LIFE AND CAROLE CARTER by Marian Mosely

This so-called "Modern Morality Play" does indeed have a moral, which after much thought is probably—"Mother knows best, or does she? Yes, she does! The story traces 25 years in the life of Carole Carter, who is first portrayed as an 18 year-old schoolgirl planning to marry against her parents' wishes. The playwright then depicts the ups and downs of married life in half-serious, half-comic vein, the comedy being provided by a series of characters whom one is tempted to describe as the hybrid of music-hall artists and a modern form of Greek chorus. The effect is not a success, with the result that the play is difficult to put across, particularly to a sparse but critical Festival audience.

Mary Newbold as Carole Carter still has some trouble in controlling her voice, but is gradually overcoming the other major problem for amateur actors, stance. Hers was a vivacious, sustained and touching performance, and whilst she is a good and conscientious actress, professional direction would make her even better.

Jenny Pilsbury had a trilogy of parts, each with contrasting character and accent, and she managed these quite competently; particularly amusing was her fine portrayal of the problem-solving TV personality, Martha Mason. Priscilla Fogarty as the "old school-friend" gave exactly the right touch to the part, whilst Roger Clayton, Heather Hillen and Sue Macdonald, as "Stagnation", "Resignation" and the foolish virgin, were very effective in their brief roles.

Gus Moore made a very pleasing "Happiness", though during Carole Carter's wealthier days she tended to get lost amongst the fine furniture. The remaining parts were well acted, but with the exceptions of Dick Thompson and Jon Lilleyman, the various groups lacked individual characterisation, so vital for capturing the extra points.

George Dunn's production was witty and imaginative, although the pace slowed a little in the second half. His presentation as regards many minor details was quite successful, whilst the difficult and hazardous scene-changing was the best part of the production. The drum-solo, which was both distracting and exciting, played a necessary and effective part.

The Adjudicator's summary that this was a "talented young company performing a poor play" was very fair comment. B.D.L.

THE ROOM by Harold Pinter

This production had had one previous performance—in Gloucester House last November (See January Journal).

Pinter has said, "I want to present living people to the audience, worthy of their interest primarily because they **are,** they exist, not because of any moral the author may draw from them", and Sue Macdonald directed "The Room" well because she understood where the emphasis should lie in a Pinter play. In other words, she was right on the basic issues—that the dialogue must be spoken naturalistically, not portentiously; that the perichoresis must be around the form, not around the multi-ambiguous theme; and that the first 9/10 must be played slowly, getting across the humour in every line, and the climax (the tenderness and violence and blinding) unsentimentally and very fast. Some of the footwork, however, seemed insufficiently thought-out, especially the exits—Mr. Hudd's, for example, was managed so that it appeared to be the actor, rather than Mr. Hudd, who had forgotten to put his overcoat on; and the Sands did a minor marathon across the stage before they disappeared.

The central character of the play is Mrs. Hudd (the room is behind her eyes) and Benita Wylie acted the part with wonderful naturalness and varition of mood. "The more acute the experience the less articulate its expression" (Pinter) and all Benita Wylie's remarks were both absurd and expressive of the complexities within—the fear and the longing and the conflict.

Sue Macdonald directing "The Room".

This conflict is represented by Mr. Hudd (consciousness/life/might/matter/privilege/self etc.) and Riley (the unconscious/the spirit/charity/guilt/death/Pluto etc.). It was the strongest point of the production that these two, who must suggest the power of archetypal forces, were played by actors with the theatrical gift of "presence"; Bruno-Kastelitz, for example, sour and stunned at his high tea, and rising from the table like Stonehenge; and Bryan Lask brilliantly catching the poetry of "Come home, Sal . . . So now you're here . . . Now I touch you . . . I waited to see you . . . Now I see you . . . Come home now, Sal". It is a "comedy of menace" and both these retained their duel potential (protector or menace) to the end.

The most difficult parts are Mr. and Mrs. Sands, for the form of the play is: A & B together; A exits; C and D enter, talk, and then exit; E enters; E and B together; A returns and meets E: explosion. C and D are dangerously close to irrelevance. This structural weakness set Marcus Setchell and Bridget Jack a problem. They partially solved it by excellent timing of their repartee and by using the valuable stage-prop of charm. They were also assisted here (compared to Gloucester House) by the greater freedom of movement which the larger stage allowed, and by Mrs. Sands changing her red plastic mack for a zip-up black one.

Mr. Kidd is a link-man in the play and Jolyon Oxley played him in the right modulated key. To have hammed it up would have been easy and fatal.

The whole cast found the energy and mood and rhythm of this play, so that it came to life, and even when lines went astray there was no loss of conviction. It was a fine achievement.

J.D.

medicine in literature

An extract from

Doctor Zhivago

by BORIS PASTERNAK

Everything in Yura's mind was mixed up together and misplaced and everything was sharply his own—his views, his habits and his inclinations. He was unusually impressionable and the freshness and novelty of his vision were remarkable.

Though he was greatly drawn to art and history, he scarcely hesitated over the choice of his career. He considered that art was no more a vocation than innate cheerfulness or melancholy were professions. He was interested in physics and natural science and believed that a man should do something useful in his practical life. He settled on medicine.

In the first of his four-year course he had spent a term in the dissecting room; it was deep under ground in the basement of the university. You came down the winding staircase. There was always a crowd of dishevelled students, some hard at work over their tattered textbooks and surrounded by bones, or quietly dissecting, each in his corner, others fooling about, cracking jokes and chasing the rats which scurried in swarms over the stone floors. In the half-darkness of the mortuary the naked bodies of drowned women and undentified young suicides, well preserved and untouched by decay, gleamed white as phosphorus. Injections of alum salts rejuvenated them and gave them a deceptive roundness. The corpses were cut open, dismembered and prepared, yet even in its smallest sections the human body kept its beauty, so that the wonder Yura felt in looking at the body of a girl brutally flung down upon a zinc table he also felt in gazing at her amputated arm or hand. The basement smelled of carbolic and formaldehyde and was filled with the presence of mystery, the mystery of the unknown lives of these naked dead, and the mystery of life and death itself—and death was as familiar in this place as though the underground room were its home or its headquarters.

The voice of this mystery, drowning everything else, distracted Yura at his dissecting. But then a lot of things in life distracted him. He was used to it and was not put out.

Yura thought well and wrote even better. Ever since his schooldays he had dreamed of writing a book in prose, a book of impressions of life in which he would conceal, like buried sticks of dynamite, the most striking things he had so far seen and thought about. He was too young to write such a book; instead, he wrote poetry. He was like a painter who spent his life making sketches for a big picture he had in mind.

(Printed by kind permission of the translators, Max Hayward and Manya Harari, and of the publishers, William Collins Ltd.)

A STRANGE ENCOUNTER IN THE WEST AFRICAN JUNGLE

By Derek Browne

On a hot December afternoon, two years ago during my Christmas vacation in Nigeria, James our houseboy, invited me to his village yam festival.

Yam is a staple food and is rather like potato. Every year the village celebrates the yam harvest, and thanks the spirits for guarding their crop. In a temperature of over 100 degrees I walked up the steep two mile track from our house to James' village, past the local hotel (Fig. 1), and crossed over the wooden plank bridge thrown over a muddy stream, where I saw several children washing their clothes. It was not long before I heard the sound of drums; I quickened my pace, and brushed aside the tall jungle creepers. The insects croaked and squeaked as I approached the jungle clearing. My entrance caused quite a stir amongst the people. They shouted, "Beke! Beke!" which means white man. I looked round and saw that I was the only white person present.

On my left six drummers, their bodies streaming with sweat, pounded drums which were held between their knees. On my right I saw several women and children and a few men firing dane guns precariously into the air. I assumed that they had drunk their quota of palm wine! I recognised James amongst the group of male dancers, but was surprised not to see any female dancers. A man who spoke good English answered my query, and said that at this festival women were not allowed to dance; if they did, they would be ostracised by the village.

FIG. 1. *"Excellent Hotel".*

The monotonous repetitive rhythm of the drums soon sent me into an hypnotic state. My feet tapped out the rhythm and it was not long before I was dancing. My body was not responding exactly to the rhythm but I did my best and enjoyed every minute. I looked in amazement as I watched the other dancers; their feet stayed fixed in one place but their muscles moved with the rhythm of the drums. It was like a glorified twist or shake.

The heat and dust were almost overpowering. Suddenly, all was silent, the drums stopped beating, and the children assembled together, their fingers poked in their drooped, expressionless mouths. I sensed something was imminent. A drum beat out a new rhythm, the other drums followed. A man, or was it a man, entered the clearing. A grass dress covered his body and face, two cockerels crowed from a smouldering wooden superstructure placed precariously on his head, his arms and legs were painted red and white, and round his neck were several charms and fetiches. In one hand he held a stick and in the other were some bird entrails. This was the ju-ju man, the man who had personal contact with the spirits. His entrance marked

the climax of the festival. James came across and told me that if anyone stopped the ju-ju man dancing they would be bewitched. I wanted to take a photograph, but was advised to wait for a more opportune moment. The ju-ju man pointed his stick at me. A cold sweat trickled down my back. He beckoned me to dance with him. I obeyed, hesitantly. I tried to follow his bodily movements but failed miserably. A woman screamed and was soon quietened by one of the dancers. I decided that this was a more opportune moment to take my photograph. James came across and explained to the ju-ju man what I wanted. After the exchange of a few words and some money, the ju-ju man posed for his photograph. Click! I had stopped the ju-ju man dancing. What was going to happen next? I waited in suspence . . . I was relieved when the ju-ju man waved his stick in the air and started dancing again. The other dancers followed.

After a few minutes, the dancers stopped dancing, the ju-ju man removed the two cockerels from his head. A man gave him a matchet and with two blows the ju-ju man beheaded each cockerel and poured the blood over a pile of yams. A woman pounded the mixture together and distributed portions to the dancers. The ju-ju man left the clearing followed by several children. I decided that it was time to take my leave, and James' wife gave me two yams to take home.

FIG. 2. *The witch doctor with his fetiches.*

It was not until last March that I identified the ju-ju man. James invited me to his village house for a social visit. After pushing aside several chickens and goats, I was greeted by James' family and friends. We sat down on broken chairs, and James broke a Kola nut and gave us each a piece. The breaking of the Kola nut is a very symbolic West African custom. It must be broken at the beginning of any social gathering, and represents a sign of friendship and safety. No harm will come to any person if they accept a piece. I took a small bite and put the rest surreptitiously in my pocket as I did not like the bitter taste of the nut. We went outside and walked round the village. A well dressed Nigerian stopped us and invited James and me to his house. James told me that this was the village witch-doctor. I felt a little uneasy as we walked into his house. The room was very dark and full of smoke, and it took me several minutes to get accustomed to the darkness. The witch-doctor rubbed his hands rather ghoulishly together. A young girl gave him a Kola nut, which he broke and gave each of us a small piece. I felt more relaxed now that I knew that I was welcomed as a friend, and that no harm would come to me during my stay in this house. Drinks were passed round, and James, being a well trained houseboy did not think that gin was the right drink for me, and ordered Coca-cola. The glasses looked rather dirty so James asked a little boy to clean them. He soon returned with the glasses dripping with water. I wondered where he had washed them, because I knew that there was no running

tap water in the village. I remembered passing the muddy stream! I was thirsty and stopped reminiscing and drank the refreshing drink. The witch-doctor rose from his chair and reached for a photograph on the wall. I recognised the picture of the ju-ju man which I had taken the previous year at the yam festival. The witch-doctor looked at the picture and then at himself and then nodded his head. I realised that the witch-doctor and the ju-ju man were the same person. No wonder the women kept silent in his presence at the yam festival; they knew his power... I wondered what was going to happen next. I remembered what James had said would happen to people who stopped the ju-ju man dancing. I put my hand into my pocket and felt the piece of Kola nut, and remembered its significance. The witch-doctor asked a lady standing beside him to go into the next room. She returned with a breast of chicken. "For you," the witch-doctor indicated. "What no skin?" I remarked. I was very inquisitive because I knew that all meat sold in the market had to have a piece of skin left on by law, to ensure that it was not human meat. Cannibalism is still practised in some parts of Africa. The witch-doctor understood my facial expression and asked the girl to fetch the rest of the meat. She returned with the rest of the chicken and also the skin. A banana leaf was brought to wrap the meat. Banana leaves are used as paper bags in Africa. James thought that the banana leaf was too unhygienic and asked for some paper. This was soon found and the meat wrapped in it carefully. I was satisfied.

FIG. 3. *The witch doctor with his wife and friends (including the author).*

I asked the witch-doctor several questions about how he prepared his medicines, but he would not tell me. I was very interested because I knew that several herbal plants contained pharmacologically active products, some of which are used today in modern medicines. For example; curare, the arrow poison is used as a muscle relaxant in surgical operations; reserpine, one of the Rauwolfia derivatives, is used as a sedative and for the treatment of mild hypertension. These were found in the witch-doctor's pharmacopoeia a long time ago.

As I was not getting much information about herbal medicines, I decided to take a photograph of this group. I asked James to translate. The witch-doctor understood my question and nodded his head in agreement. I went outside and set the exposure. The little boy who had washed the glasses dashed past me and soon returned with a handful of fetiches. The witch-doctor emerged from his house followed by four attractive females. James was quick to remark that these were his wives. The other men present were people who had recently paid their fees to the witch-doctor for his medicines. James told me that he had had to pay £10 and two chickens for the ritual burial of his daughter who had died the previous week with acute intestinal obstruction; she was also pregnant. The witch-doctor had had to remove the foetus and bury the two separately, because the people believe that it is wrong to return to the future life pregnant. The spirits would be angry and bring bad luck to the village.

After I had taken several photographs (Figs. 2 and 3), the witch-doctor invited me to the village chief's house. The chief broke a Kola nut, and gave me a piece. I was now quite used to this procedure and its significance and took a small bite. James translated to me, saying that I was about to be invested as a member of the secret society. I felt deeply honoured. The witch-doctor brought round a potent

mixture, I took a sip and spat the rest on the ground. What a horrible taste! The chief rose from his chair and came towards me and chalked a cross on my leg, and then sat down. That was all, a very simple ceremony. James whispered in my ear, and said that usually people had to pay £30 before they were invested as a member, but as I had the courage to stop the ju-ju man dancing at the yam festival, I was considered to be a brave person and could be invested free of charge. I shook hands with everybody, and thought it was time to leave. I did not want to attend any more ceremonies. The chief gave me a bottle of gin to take home with me, but not knowing the true nature of the gin or the chicken I gave them both to James.

As we left the chief's house, I asked James what would happen if the witch-doctor was taken ill. "He would most probably disguise himself and go to the local Mission or Government Hospital as a private patient. He can afford it," James quickly remarked. This comment surprised me.

The next day I went to the local Mission Hospital and was surprised to see the number of patients awaiting treatment. The doctor remarked that it was often very difficult to decide if their illness was due to the witch-doctor's medicines or whether it was due to their original complaint. I realised that the witch-doctor still played an important rôle in the village, and that people would go to him first for treatment, and only if his treatment failed would they go to the Mission or Government Hospital.

The doctors in these hospitals are faced with a tremendous challenge to win the confidence of their African friends. I looked around the wards, and in one of the private wards, I saw a patient who had recently had an appendiectomy operation. The doctor remarked that this was a witch-doctor. I did not recognise him as the one I had seen the previous day at James' village. I was told that this witch-doctor had come a long distance so that he would not be recognised by anybody. I do not know how the hospital doctor found his identity.

I had met a most interesting person in the West African jungle; a man who usually defies talking to white men, especially if his conversant is a medical student who disapproves of his treatment and who one day will try to take away his patients.

(The author wishes to thank the Department of Medical Photography for their assistance in processing the photographs from colour transparencies.)

Nurses' Column

As Miss Ironside has left Bart's, a new nurses' representative for the journal was needed. It was decided to appoint two, who would be able to cover all the nurses. Their main function is to extract articles etc. from the seven hundred females, a job not without hazards; and it is hoped to publish more material from nurses. Any criticisms, article, poem, review, ideas—will be warmly received. Publication cannot be guaranteed! (Please help us to make the journal more attractive to nurses!)

Social events during the past month have been over-shadowed by a sensational engagement and the View Day Ball—which was a topic of conversation for some time—both before and after the event. The usual round of block, firm and other parties were still being held in a certain flat in Hampstead. There were also several social events around the Smithfield area—not entirely confined to the medical college.

View Day came with the fine weather providing a scene in the square reminiscent of school speech days. The annual Vicarage Club sherry party and the Student Union's Cocktail party the following week were both held on the lawn at College Hall and enjoyed by most (aided admirably by Pimms No. 2 with extras).

Tickets were still forthcoming for " A Funny Thing Happened . . . " and "Chase Me Comrade." Practices were held for orchestra and choir in preparation for "Trial by Jury." Painting recommenced in the Sun Lounge and tennis flourished in the fine weather—as did the Nurses' Home roof. Inmates of Maybury woke one night to the accompainment of five fire engines, while a few interested spectators watched a puff (very small) of smoke escape from the roof of the Mansions.

Rumour again swept the dining room that internal nights were coming this Summer. The hospital and State Finals are here again—once more Portabello Road is invaded with people desperately searching for buckles.

Answer to Diagnostic Problem (Page 273)

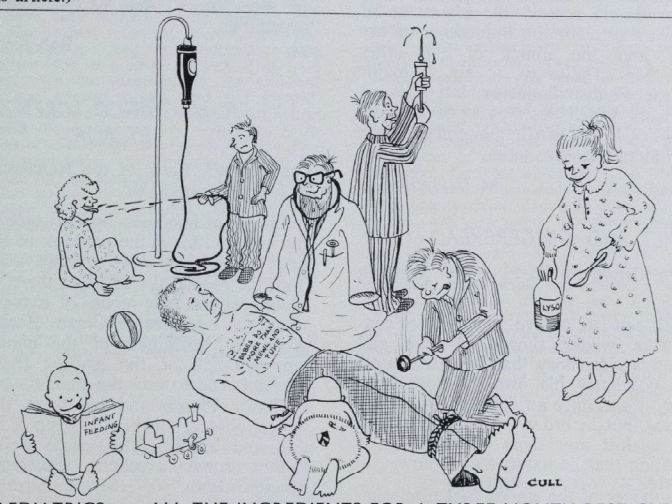
In summary, this is an elderly patient with loss of weight, anorexia, and epigastric pain dying from an acute abdominal disaster. She had steatorrhoea and an abnormal xylose absorption. Examination revealed no abnormality throughout the alimentary tract. The E.S.R. and serum alkaline phosphatase were slightly raised. Diabetic, hyperthyroid, or chronic infective causes of the weight loss are not supported by the findings.

One possible diagnosis would have been carcinoma of the pancreas, presumably in the body of the gland in view of the absence of jaundice. Weight loss, anorexia, nausea and vomiting, steatorrhoea, and decreased xylose excretion are all consistent with this; so are the epigastric pain (although not classical) and the transient diarrhoea. Carcinoma of the body of the pancreas, could cause splenic vein thrombosis and hence haematemesis from gastro-ossophageal varices, or it might erode into the jejunum; either of these possibilities could explain the terminal episode.

An alternative diagnosis, suggested by the calcification of the aorta, is mesenteric arterial disease. The weight loss, epigastric pain after meals, anorexia and steatorrhoea are classical symptoms of chronic mesenteric arterial insufficiency; the diarrhoea and low urinary xylose excretion are consistent, and so is the normal x-ray appearance. Occult blood may be found in the stools. The terminal episode would have been caused by an acute occlusion of the arterial supply leading to infarction of the bowel; the patient gives the typical history of severe generalised abdominal pain and distension, shock, and absence of bowel sounds.

Post-mortem examination revealed a serosanguineous exudate in both the peritoneum and the lumen of an extensive loop of infarcted bowel. The aortic orifices of the coeliac and mesenteric arteries were virtually obliterated by atheromatous plaques. Thrombus was found in the arteries of the infarcted loop of ileum. A diagnosis was made of acute-on-chronic mesenteric arterial insufficiency.

(The Editor would like to acknowledge the assistance of Dr. P. D. Mulcahy in preparing this article.)



'PAEDIATRICS . . . ALL THE INGREDIENTS FOR A THREE MONTH REST CURE' from The Childrens' Department by A. Robinson, St. Bartholomew's Hospital Journal, April 1965.

NEW PENGUINS

PROSE TURNER

Mrs. Dalloway by Virginia Woolf. Penguin Modern Classics. 4/6d.

When this book was first published in 1925, one reviewer wrote, "Mrs. Woolf makes great the little matter, and leaves us with that sense of the inexhaustible richness of the fabric of life, which marks the work of this truly creative artist." There can be no doubt that it is Virginia Woolf's ability to "make great the little matter," which makes her novel so essentially readable. She could perhaps be compared with another great innovator, J. M. W. Turner, who early last century finally broke from the conventional method of landscape painting and became the forerunner of the great Impressionist movement. Both he and Virginia Woolf, were great innovators, and in 'Mrs. Dalloway', Virginia Woolf finally broke from the traditional form of the English novel.

The reader lives through one day in the life of Mrs. Dalloway, the events of that day however being no more than a skeleton upon which Mrs. Woolf reveals the character of Mrs. Dalloway through the impression of her own mind and the minds of the other characters. 'Mrs. Dalloway' is not a major classic of the English language, but it is an important work which deserves to be read by a wider public. It is a worthy newcomer to the 'Penguin Modern Classics', series.

M. F. Hudson.

GILT AND GINGERBREAD

The Golden Oriole by H. E. Bates. Penguin 3/6d.

This book consists of five short stories concerning — "the wilder shores of love and loneliness . . . a territory that he (Mr. Bates) has made peculiarly his own" (Quote from back cover). I was once an appreciative reader of Mr. Bates, but in order that you may arm yourselves against any signs of prejudice, I should mention that he nauseates me now.

The bare bones of the stories (not disclosing the endings, of course) are as follows: —

"The Ring of Truth"—Young man discovers that his newly widowed mother had a lover that father knew about,—much mental torment in which he finds a sweetheart (previously father's).

"The Quiet Girl"—Unattractive girl with good figure,—discovers sex,—starts collecting lovers.

"The Golden Oriole"—Middle-aged loneliness leads to middle-aged sex.

"Mr. Featherstone Takes a Ride"—Student of philosophy (Oxford) taken for ride by lovable crooked, double-crossing rat of a lorry-driver.

"The World is Too Much With Us"—Love relationship between man and chicken disturbed by local widow woman.

But do not get excited for these stories are not as unseemly as the bare bones might suggest. Subjects such as heterosexual lust, lesbianism, man/chicken love, and fornication are created with sugary delicacy that would fail to rouse a hyperactive adolescent. They are nice stories, well written and eminently forgettable.

Bob Kendrick.

IL MAGNIFICO LORENZO ET ALIA

The Penguin Book of the Renaissance edited by J. H. Plumb. 10/6d.

An age of harshness and savagery, of beauty and civility, this is the paradox of Renaissance Italy. In a time when old ways lingered on from the Medieval Centuries, there was a birth of new values, new modes of expression. The scurrilous intrigues of Cesare Borgia and the pragmatic worldiness of the papacy are as representative of the age as the works of Michael Angelo and the builders of Florence. Professor Plumb and his team of specialist writers observe this broad sweep of history with skill and insight. They write well and have chosen some excellent illustrations. The Penguin Book of the Renaissance should appeal both to the expert and to the general reader.

Roland Morris.

MEDICAL BOOKS

Artificial feeding in early infancy. Andrew Bogdan, M.D., M.R.C.P., D.C.H. Tutorial System Publications 1964. 31 pp. Price 5s.

This new edition will be welcomed as a real aid to learning. The author is keen on commonsense, mathematical expression, regularity and late rather than early weaning on to solids. His tables and general principles are well suited to the healthy, normal baby, but might not satisfy all babies. Perhaps in a sequel he could helpfully suggest that one of the mother's (and her adviser's) duties is to discover what suits the baby, even if this leads on to demand feeding in the early days.

A.W.F.

Samson Wright's Applied Physiology. Eleventh Edition revised by Cyril A. Keele and Eric Neil. Published by Oxford University Press. Price: Paper Covers 42s., Cloth boards 60s.

Paradoxically, this textbook has a less uniform standard than others in which every chapter is contributed by a different author. Its uneveness has not decreased in the present edition. One wishes a firm editor had enforced a better overall balance, and had sorted out some of the minor, but irritating inconsistencies which abound. The chapters on circulation, respiration, CNS and ANS are very good indeed, though they can hardly be described as a text on 'applied' physiology. They take the subject to a far more advanced level than is attained elsewhere in the book. Other parts are less successful.

In most chapters of the present edition some short paragraphs have been deleted, others inserted; and a few—too few—recent references were added. The chapters on Digestion and on Endocrines were partly rewritten for the new edition. They are disappointing, with the exception of the excellent sections on the adrenal cortex and the thyroid. These contain a moderate amount of new information compared with the earlier version, (not enough on the regulation of aldosterone secretion); but the gain in clarity is tremendous. By contrast, it is to be feared that the revised sections on hormonal control of glucose and calcium metabolism will do little but make confusion worse confounded. They are not recommended. The chapters on Reproduction were among the best in the previous edition, and now contain a welcome additional section dealing with the physiology of pregnancy, and nutrition of the foetus. However, as before, contraception, surely an important topic in 'applied' reproductive physiology, is not mentioned, let alone discussed.

Some interesting illustrations present in the last edition have now vanished; many others have been reduced in size. This has done considerable harm to the electron-micrographs and other histological pictures which were outstandingly well reproduced in the earlier version.

Because it contains some excellent chapters, and despite many shortcomings, the paperback issue of 'Applied Physiology' at two guineas is probably still the 'best buy' among current elementary textbooks of physiology, provided its readers will not —as some do—regard it as physiological Holy Writ. The informed scepticism which is essential for a profitable use of this book is more likely to be found in those who study it while preparing for the 'primary' than among 2nd M.B. candidates.

E.U.

A Pocket Gynaecology, by S. G. Clayton. 5th Edition. Published by J. & A. Churchill Ltd. Price 12s. 6d.

Professor Clayton in 118 pages has successfully packed and compressed the factual knowledge that most gynaecological textbooks present in four times that space, nor has he omitted anything of importance. His style is absolutely lucid and he has avoided the odious abbreviation and the telegraphic style. This little book is not intended to be a substitute for the well worn and established classics, such as Ten Teachers and its rivals, but it will be an invaluable solace to the panic stricken on the eve of their ordeal and a useful companion to those few students who still travel by public transport, and even to those who own cars, when frustrated in traffic jams.

There are 15 illustrations which, while not pretending to be artistic masterpieces, clearly depict what they intend to illustrate. Professor Clayton is to be cordially congratulated on this edition—the fifth—and when the sixth appears in four years time he will, I hope, allow me to make a few suggestions. Does he really, himself, still use radium in the treatment of fibroids—page 60? Surely the Manchester method of radiation for cancer of the cervix has now superseded the more lengthy and tedious Stockholm method and should therefore be given pride of place—page 64. If he does induce an artificial menopause for benign lesions of the uterus he must insist on a preliminary curettage—page 108. He mentions chomiphene—page 84—as a method of inducing ovulation—this drug is not yet available, except at Chelsea Hospital for Women, for general use and is not even obtainable for hospital trial. In discussing gynaecological causes of backache he omits to mention the one that we recognise—endometriosis of the utero-sacral ligaments—page 105. Moreover, I cannot agree that it is obligatory as a routine to empty the bladder before all gynaecological operations, such as diagnostic curettage or dilatation of the cervix, to quote two simple examples—page 109.

In offering these sincere criticisms, all of them trivial, I do not intend to detract at all from the excellence of the whole and I hope Professor Clayton will consider them for the next edition to which we all look forward, and many more thereafter. Having suggested some small constructive criticism may I say that Sex and Intersex Problems— page 24—are the best review of this abstruse and bewildering subject and that now at least we have no excuse for not being genetic experts. In a word, an excellent achievement and a book to be strongly recommended.

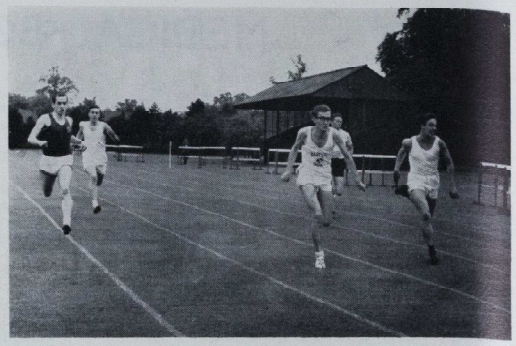
J.H.

PUBLISHER'S ANNOUNCEMENT

E. & S. Livingstone's 1965 Catalogue of current medical publications is now available from them on request.

82nd SPORTS DAY

Wednesday, May 26th



Intermittent showers and overcast skies shadowed the panorama of Chislehurst. Nevertheless a solid core of athletes and others perhaps attracted by The Wine Committee's free beer swelled the numbers at the track side.

The wet track slowed the runners and made conditions particularly difficult in the hurdles. The Long Jump and Triple Jump run up became treacherous and by the end of the afternoon and the slippery grass and wet spears limited the javelin throwers. Wet implements caused the discus and shot to fly out at some unusual angles and hardened the landing for the high jumpers. Sports Day sometimes brings to light latest athletic talent in the hospital. This was not the case this year since the proceedings were dominated by members of the Athletic Club.

In the Ladies race many kept dry by running with their umbrellas. The Consultants hundred yards ended in dead heat between Dr. Francis and Mr. Aston in the surprisingly good time of 4.6 seconds.

Mr. Aston was President of Sports Day and his wife presented the cups and prizes to the winners. After an enjoyable tea provided by a team of female medical students the evening was made successful by the popular "beat" group, the Few, with a barbecue in the interval.

Sports Day Results

120 yards hurdles. The B. N. Ash Cup.—1 B. Scott, 16.8 secs; 2. J. Coltart; 3. R. Baumber.

100 yards. The Bowley Cup.—1. M. Freeth, 10.5 secs.; 2. J. Coltart; 3. B. Scott.

220 yards. The Griffiths Cup. 1, B. Scott, 24 secs.; 2. M. Freeth; 3. J. Coltart.

440 yards. The Harrison Cripps Cup. 1. B. Scott, 52.7 secs.; 2. C. Sutton; 3. J. Coltart.

880 yards. The John Hosford Cup.—1.C. Sutton, 2 min. 4 secs.; 2. J. Coltart; 3. R. Sanders.

1 mile. The Morley Fletcher Cup.—1. R. Thompson, 4 min. 40.5 secs.; 2. R. Saunders, 3. H. Oxley.

3 miles. The Gordon-Watson Cup.—1. R. Thompson, 15 min. 23 secs.; 2. P. Littlewood; 3. D. Tunstall-Pedoe.

Long Jump. The Edgar Kettle Cup.—1. D. Jefferson, 19 ft. 10 in.; 2. K. Rawlinson; 3. C. Sutton.

Triple Jump.—1. C. Sutton, 38 ft. 11 ins.; 2. D. Jefferson; 3. K. Rawlinson.

High Jump. The Reginald Vick Cup.—1. K. Rawlinson, 5 ft. 1 in.; 2. K. McIntyre; 3. M. Redfern.

Discus. The B. N. Ash Cup.—1. J. Kenwright, 95 ft.; 2. T. Herbert; 3. P. Fairclough.

Shot. The B. N. Ash Cup.—1. J. Kenwright, 34 ft. 10 ins.; 2. P. Fairclough; 3. K. Rawlinson.

Javelin. The C. F. Harris Cup.—M. Orr, 147 ft. 1 in.; 2. K. Rawlinson; 3. T. Herbert.

Throwing the Cricket Ball.—K. McIntyre, 289 ft. 7 ins.; 2. K. Rawlinson; 3. C. Vartan.

4 x 220 yards firm relay.—1. Introductory Course; 2. M.O.P. and S.O.P.

Presidents Cup awarded to B. Scott.

The Coltart Cup awarded to the Introductory Course Firm.

SPORTS REPORTS

FIXTURES FOR JULY

3rd United Hospital Athletic Championships.
Tennis v. Roehampton; Home.
4th Cricket v. Past; Home.
7th Golf v. St. Thomas'; Worplesden.
Tennis v. R. D. H.; Home.
10th Cricket v. Incognito; Home.
11th Cricket v. Hampstead; Home.
14th Tennis v. K.C.H.; Home
17th Cricket v. Nomads; Home.
Tennis v. Westminster Hospital; Away.
18th Cricket v. Dartford; Away.
20th Tennis v. Bank of England; Away.
21st Golf v. St. Mary's Hospital; Away.
24th Cricket v. Old Cholmelians
25th Cricket v. Wimbledon; Home.
28th Tennis U H. Singles at Guy's.
Golf v. Middlesex; Hendon.

SAILING CLUB

This summer the Sailing Club has available at the Welsh Harp two Fireflies, *Rahere* and *Acolia*, the latter by kind permission of Geoff Doggett. These may be sailed by anyone, but helmsmen should show the secretary—M. Freeth or C. Clarke—some proof of their ability. Bookings can be made in the Firefly book at College Hall—ask the porter for it. The Enterprise *Percivall Pott* will be at Burnham shortly. Anyone wishing to sail her should contact C. Clarke who will arrange this.

In the first round of the **Hospitals' Knockout Team Race,** Bart's 'A' beat St. George's 'A' by the close margin of two points: 39¼ to 37¼.

Team: G. Doggett and M. Freeth, D. Garrod and R. Markham, Miss A. Yendall and C. Grafton.

M.O.F.

GOLF CLUB

In the first half of May we had two matches —one against **U.C.H.** at Chislehurst and the other against **College of Estate Management** at Malden.

In the former, U.C.H. arrived with only four men so that Atkinson and Bowen stood down to make the team Thomas, Saddler, Begent and Hares. The first three matches were won and the last halved to give a further victory to Bart's.

The Malden match was played on a very hot day against a very hot C.E.M. team, with two University first team players in it. This was our worst defeat of the season as **all four** matches were lost by the seventeenth hole.

Team: Thomas, Grieve, Atkinson, Saddler.

The remaining two matches of the month were the **Staff match** at Denham and the match against **Mr. Hankey's team** at Tandridge. As the staff had won last year, there were no bisques this year, the matches being played level. Eleven singles were played, Dr. Kemp Harper taking on two students in a three ball as there was an odd number present. In doing so, he gained the staff's only two victories in the singles, two others being halved. Foursomes were played after tea but again the result was in favour of the students, who would like to extend their grateful thanks to all the Staff concerned for the enjoyable afternoon's golf.

A team of six Bart's student's, plus Mr. I. G. Williams, played a team from Mr. Hankey's home club, Tandridge, on Sunday, May 23rd. This is 36 holes foursomes and at lunch time we found ourselves 4-0 down. A slight revival was made in the afternoon with wins from Saddler and Begent, and Weston-Burt and Booth, but three regular players, Bowen, Vartan and Thomas were sadly missed. Our thanks go to Mr. Hankey for the splendid way in which he entertained us on this occasion.

R.E.A.

ATHLETICS CLUB

A triangular match was held with **Guy's and London** on Wednesday, 5th May at Honor Oak Park in blustery conditions. Bart's strength was somewhat reduced by the aftermath of the Rugby Club Dinner and a Swimming Club Tour. Many members had therefore, to double up to provide point scoring competitions in every event.

The two individual winners were **Chris Sutton** in the 880 yards and **John Coltart** in the 440 yards, the former avenging his defeat in the University Championships. Sutton also gained a fourth in the 100 yards and a third in the triple jump. Coltart also doubled on several events to give a third in the 120 yards hurdles and a fourth in the 220 yards.

Malcolm Freeth gained a second and a third in the 100 yards and 220 yards whilst Robert Thompson did the same in the two miles and one mile events.

In the field events we were less successful, Rawlinson's second in the javelin being the only noticeable achievement.

Result: 1st—Guy's, 2nd—Bart's, 3rd—London Hospital.

On the 7th May another triangular match was held between **Lloyds Bank, Metropolitan Police and Bart's.** In this match the track performers were not so good whilst the field events were more valuable to Bart's than in the previous match. **Rawlinson** won the javelin and **Jefferson** won the long jump with distances that would have won the previous day, this augers well for the coming season.

With some second and thirds gained on the track, the outcome of the day rested on the relay. The police dropped the baton on the first takeover leaving Bart's and the Bank to fight it out. Lloyd's just made it giving a final result of:

1st: Bank—62 points.
2nd: Bart's A.C.—58 points.
3rd: Police—57 points.

The **United Hospitals Relay Meeting** was held on Wednesday, May 12th on a very sunny day on a perfect track at Paddington.

Relays 220 x 110 x 110 x 440—Freeth, Goodall, Sutton, Coltart—3rd.
880 x 220 x 220 x 440—Sutton, Freeth, Goodall, Coltart—3rd.
4 x 110 yards (for weightmen only)—Pope, Rawlinson, Jolly, Jefferson—4th.
4 x 440 yards—Coltart, McIntyre, Foxton, Sutton 3rd.
4 x 110 yards—Goodall, Coltart, Sutton, Freeth —5th

Field Events. Each hospital entered two competitors, places being awarded on the summation of the best distances of each performer.
Shot Putt and Discus—Jolly and Cooper—3rd in both.
Javelin—Rawlinson and Pope—**1st.**
High Jump—Rawlinson and Sutton—**1st.**
Long Jump and Triple Jump—Jefferson and Goodall—2nd.

The invitation races saw Bart's distance runners to the fore. Foxton won the ¾ mile race which was his last for the club after a long and distinguished career in Athletics and Cross Country, Thompson was second in the 1½ mile race, ably supported by Sanders, Martcham and South.

Result: 1. Guy's, 2. Thomas', 3. Bart's, 4. St. Mary's, 5. London.

CROSS COUNTRY CLUB

Final Report and end of season summary

On March 27th at Barnet we had the privilege of entertaining and defeating the Dartmouth Royal Naval College team, thus reversing the decision forced upon us during our West Country tour.

On Sunday, 25th April, some members undertook stern work in Yorkshire when they tackled the annual Three Peaks Race. This event involves climbing the following Peaks:

Ingleborough—2,373 feet.
Pen-y-Ghent—2,273 feet.
Wherniside—2,404 feet.

and running between these Peaks a total distance of some 23 miles. For the sake of description, this arduous task may be compared to the Brighton walk. Robert Thompson finished 48th, Roger Sanders 84th, out of 115 starters and both received time Certificates. The team finished 9th out of 14. This is very pleasing as it was the first time we have in fact managed to enter and finish as a team.

Summary

The Club has continued to flourish this year. This is due to the faithfulness of our older members and the enthusiasm of our new ones.

Foxton, Thompson, Sanders and Markham have all represented the University and Bart's has remained the mainstay of the United Hospitals team, all our runners having turned out for U.H. during the season.

The Season's Record (Last year's performances in parenthesis).

Selwyn College Relay, 1st team 9th, 2nd team 39th, (10th); Borough Road College Relay, 1st team 7th, 2nd team 19th, (15th); University of London Championships, 5th—1st in minor College Cup (—); St. Mary's Hospital Hyde Park race, 1st (1st); Inter Hospital Cup, 1st (1st); Imperial College Hyde Park race, 30th, (32nd); University League, 8th, (5th).

For the first time we have been able to turn out two teams for relay races. We had seventeen members running in the Inter Hospitals' Championship and regained the cup awarded to the first smaller College in the University Championship.

This year we are unfortunate to lose Terry Foxton who has given us such sterling service during his five years at Bart's. Next season, therefore, we shall have to work very hard to retain our position but if the efforts shown by our new members this season are continued, we should not find it too difficult to make good Terry's loss.

R.J.T.

BOAT CLUB

May 15th. University of London Regatta.

This annual event was held at Chiswick for all Colleges of the University. The second eight were entered for the Clinker eights and rather disappointingly lost to Imperial College. A certain lack of fitness was evident after the second minute and the coverage began to progressively decrease. There was a great deal of rush and bad blade work in the bows.

Silverton was beaten easily in the final of the Senior sculls.

The first eight entered the Roderick Hill Trophy for Shell eights and drew King's College first. Due to the bend in the course King's started ½ length up. By the end of the second minute we had drawn level after an uninspiring start. We drew slowly past striking 31 while King's were 3-4 pips higher. **We won by ⅔ of a length.** This took us into the final to meet St. Thomas's who had beaten Imperial College by a canvas and St. Mary's who had beaten the Royal Veterinary College. There was a deal of hatred and needle before the race, particularly as the organisation was poor which had left us very angry. We got a good start but were led by both crews and after two minutes we were trailing 1 length to Thomas's and ½ length to Mary's. The second half of the course was rough and we coped with it better than the other two and soon left Mary's behind. Coming up to the last minute we came level with St. Thomas's who panicked and we managed to draw away to a **⅔ length lead** at the finish. A sound victory and a good Trophy.

The University pairs were won by Nicholson (Bart's) and Hodgson (U.C.).

May 24th-26th. United Hospitals Bumping Races.

1st Eight. After the previous week's victory we had high hopes of bumping St. Mary's and St. Thomas's. However the nearest we got was ½ length on the first night. Mary's came within 3 ft. of St. Thomas's but didn't make it. This shows again that we are still faster than the other two but not fast enough. This stalemate of the Bumps must be finished.

2nd Eight. On the first night again their fitness let them down and they were bumped by St. Thomas's II although well up on Mary's II. On the third night they scored a technical bump over Royal Veto.

3rd Eight. This gentlemans' eight proved very fast and soon dispersed with St. Georges I and Guy's II. Stallard stroked well with good support from Parr and Anderson. They only missed a third bump on technical grounds, but did just manage to pass them for good measure!

4th Eight. This novice eight was extremely successful and gained a bump each night in order Westminster II, St. Thomas's III and St. George's I. If they had been a little fitter they may well have got Guy's II as sandwich boat on the last night. A tremendous effort by the whole crew.

5th Eight. The Rugger Eight did well to be bumped by St. Thomas's IV and U.C.H. But why didn't they let St. Thomas's V bump them and then they would be bottom. I'm sure their refusal to allow us to coach them and something to do with it. The technique of eight different beginnings has been tried before—without success.

A.B.A.

TENNIS CLUB

During the month of May, the first team have won four matches out of six, and the second team are undefeated with four wins. This is an excellent beginning to what is likely to be the fullest season the club has seen. The keen spirit of the club is best illustrated by the close competition for places in the second team.

The selection of the first team offered no problems, and the pairing which was settled by the second match will most likely remain for the season. Stability of pairing is a firm base on which to build a team. The experience obtained from an understanding partnership is an invaluable weapon in doubles match-play.

In the London University inter-collegiate Cup, after beating **West Ham College 6-1** we went on to narrowly lose **4-5 to College of Estate Management** (runners-up 1964) who had knocked us out last year. All our pairs beat their second pair, and thus it was disappointing to see their third pair bringing down our lower two pairs.

In the Hopsitals Cup, after beating **Westminster Hospital 6-1** in the second round, we are now due to meet **Guy's Hospital** in the semi-finals. This is the third consecutive year the team have reached the semi-final round of this competition. We know that **Guy's** are very strong this year, as they **beat us 7-2** on May 22nd at Honor Oak Park. They have three very strong pairs, and ironically enough it was their first pair who suffered defeats. A. Edelsten and M. Setchell, our first pair beat them 6-4, 6-2, and then our 3rd pair played very well to beat them 8-6 in the final set. N. Ireland and C. Garrard are to be congratulated on such a good win.

The first team also had wins over **Northampton College 9-0** and **Charing Cross Hospital 6-3.**

Team: A. D. Edelsten and M. Setchell, M. E. Fryer and S. M. Johnson; C. Garrard and N. Ireland.

The second team had the following victories:
v. West Ham College, WON 6-3.
v. Westminster Hospital, WON 6-3.
v. London Hospital, WON 9-0.
v. London Hospital, WON 6-3.

Team: M. Nightingale, R. Farrow, M. Spence, S. Heyworth, C. Roche-Berry, R. J. Wenger, H. Oxley, J. Trowel, M. Nicol, M. Brueton.

A.D.E.

SWIMMING CLUB

Annual Tour

This year's tour had an ominous start when the captain and goalkeeper's chauffeur-driven Volkswagen broke down in High Holborn. The aforementioned passed a peaceful hour scratching their heads and awaiting the R.A.C. before it was pointed out that it was the state of the petrol tank that was at fault.

Without further ado they sped down to Portsmouth in good time to assist the team in being soundly thrashed by the Navy. The high standard of swimming set by **Portsmouth Command,** the Inter-Service's champions, enabled our swimmers to themselves record some good times. Notable amongst these were Hanley in the back-stroke who achieved his best ever time, and Quinn in the Individual Medley. Smallhorn maintained the tradition originally started by Hanley of taking leave of his tea immediately after his first race.

In the second match against **North Sea Swimming Club,** Patterson, inspired by achieving his life-ambition of visiting H.M.S. Victory, and capping it by doing this in its 200th Anniversary, swam magnificiently to win the Butterfly, having come 2nd on the previous night. Hanley won the back-stroke, and the match was decided on the last relay, with our hosts gaining a 4-point victory.

The third and last match was a triangular against Portsmouth T.C. and University of Sussex. We beat both teams convincingly, aided by more very good swims by Hanley, Quinn and Patterson.

Lask in the breast-stroke completed a hat-trick of second places, though only just beating Blackbourne, who has improved beyond recognition in the last few weeks.

Surprisingly the Polo team was disappointing despite a very good season in the U.L.U. League. Whilst we never hoped to beat Portsmouth Command, the remaining matches should both have been won. Much more thought and effort was required throughout the team, especially Jolly who tends to wait for the ball to come to him. Coburn played his usual good game, Patterson and Britton worked extremely well together, whilst Hankey and Anderson made a solid defence. Blackbourne kept goal in the usual fine style. However the length of the pool somehow disrupted the usual smooth teamwork and led to poor results.

Socially the Tour was once again a great success, Hayling Island still proved to be a very happy hunting-ground, and we even made some friends including, astoundingly, a couple of landladies.

Colours have been awarded to Anderson, Blackburne and Quinn. B.D.L.

CRICKET CLUB

2nd May. Putney Eccentrics.

For most this was the first match of the season and consequently many were lacking in confidence. However Bart's batted first and thanks to a slow but patient innings of 42 from Hopkins Bart's totalled 151; the trouble was that many people took so long in laying the foundation of their innings and then somehow got themselves out.

When Putney Eccentrics batted the pitch had dried out and became easier, and with some loose fielding and poor bowling they soon had an opening partnership of 128 before being separated. However they eventually won by seven wickets with half an hour to spare; this was not a very good start to the season but we felt sure that with practice here lay the foundation of a good team.

Bart's 151, (G. Hopkins 42). Putney Eccen. 152.3.

Team:—C. Vartan (capt.), J. Gately, R. Thomas, J. Harrison, G. Hopkins, C. Grafton, R. Wood, R. Hand, K. McIntyre, J. Pemberton, N. Griffiths.

May 8th v. Morphy-Richards.

Bart's 150-5 (dec.), (R. Higgs 51., N. Griffiths 42). Morphy-Richards 37, C. Vartan 6-12.

Team:—C. Vartan (capt.), J. Gately, R. Higgs, G. Major, P. Savage, D. Delaney, D. Husband, J. Harrison, R. Wood, C. Richards, N. Griffiths.

Oxford Tour:—

May 13 v. University College, Oxford.

On a fine sunny day University College batted first on a perfect batting wicket and an opening partnership of 117 was reached before the openers were separated; this however was not due to poor bowling, both C. Vartan and P. Savage beating the bat, the latter frequently, and more luck was deserved. When Griffiths separated the openers the scoring rate fell sharply, and with the fall in runs further wickets fell due to good bowling by Harrison and Vartan, however they eventually declared at 199-7.

When Bart's batted they failed to make use of a perfect batting wicket and apart from R. Higgs who hit a powerful, although lucky at times, 45, was foiled to gain the upper hand and some good leg-spin bowling saw them all out for 112.

University College 199-7 dec, (Vartan 2-57, Harrison 2-21, Griffith 2-96); Bart's 112. (R. Higgs 45, N. Griffiths 23, P. Savage 14).

Team:—C. Vartan (capt.), J. Gately, R. Higgs, N. Offen, J. Harrison, G. Hopkins, P. Savage, R. Hand, C. Grafton, D. Pope, N. Griffiths.

May 14 v. Braesmore College.

On the following day a weakened team, due to the unfortunate return to London of last year's captain, batted first on another beautiful batting wicket but the same story is told of the batsmen failing to get the upper hand over the bowlers and somehow getting themselves out. This applies to all except Higgs and Hopkins the former hitting his way to another 54, one wishes he would go on. Eventually however Bart's were all out for 134 leaving the opposition 2½ hours to get the runs. This they did with 7 wickets and 10 minutes to spare but not until they had been restrained for a long period at the start of the innings by Savage and Vartan who again bowled well.

Bart's 139, (R. Higgs 54, G. Hopkins 20).

Braemore College 136-3.

Team:—C. Vartan (capt.), J. Sately, R. Higgs, P. Savage, G. Hopkins, R. Wood, D. Pope, R. Bates, R. Hand, D. MacPherson, N. Griffiths.

Saturday, May 15th v. Chrishall.

With a mixture of so-called sportsmen Bart's batted first on the village pitch at Chrishall. However, our star of the Oxford tour, R. Higgs, had had a restless night after the View Day Ball and did not see the ball too well; this applied to some others so we found ourselves 18 for 3 and eventually due to some lusty hitting by Vartan and Phillips, Bart's totalled 134.

When Chrishall batted they started well being 104 for 4 then good bowling by C. Vartan aided by the benevolence of the umpire, brought about a collapse. The last six wickets adding a further 13 runs, with J. Harrison bowling the last man in the last over. Consequently Bart's won by 7 runs.

Bart's 134, (C. Vartan 33, H. Phillips 33, N. Griffiths 27).

Chishall 127, C. Vartan 6-21, I. Harrison 2-32.

Team:—C. Vartan (capt.), R. Higgs, I. Harrison, H. Phillips, R. Hand, D. Bostock, D. Pope, P. Bradley-Watson, R. Atkinson, Jeffries, N. Griffiths.

Sunday, May 16 v. Romany

Our fourth consecutive day of cricket saw us field first against a strong Romany side. There had been a shower of rain the previous evening and this had made the wicket very lively and P. Savage and C. Vartan made full use of this sending back the first three batsmen for 32, at lunch Romany were 50-3 but a further shower before lunch dampened the pitch more and made the ball difficult to hold and Romany made full use of this, eventually declaring at 203-7.

When Bart's batted the opening batsman found B. Stordley in good form and he sent back the first five batsman for a personal cost of 30; however, our morale was rekindled by aggressive batting of D. Husband but there was no one who could stay with him and Bart's were eventually all out for 142, D. Husband being not out for 64.

B. Romany 203-7 dec., (C. Vartan 5-49).

Bart's 142, (D. Husband 64, R. Higgs 20).

Team:—C. Vartan (capt.), J. Gately, G. Major, I. Harrison, P. Savage, H. Phillips, G. Hopkins, R. Wood, D. Husband, R. Higgs, N. Griffiths.

Saturday, May 22nd v. Streatham Wanderers.

Bart's batted first on a perfect batting wicket at Chislehurst and soon the runs were coming. Thomas and Major had an opening partnership of 40 which laid the foundation of the innings which was eventually declared at 219 for 4, Thomas making a fine aggressive 93 well supported by Gately and Delaney who both made good use of the wicket timing the ball well.

When Streatham Wanderers batted, hostile bowling by Savage and Vartan restricted the runs to 35 in the first hour, the former being again unlucky in having several catches dropped. Griffiths then came on and the next three wickets fell for 14 runs; however, there was then a 100 partnership which ruined any chance of there being a decision and Streatham Wanderers batted out time to 182-5. This result emphasises the usefulness of a leg spin bowler on such a wicket.

Bart's 219-4 dec., (Thomas 93, Gately 35, Delaney 39, Major 22).

Streatham Wanderers 182-5, (Griffiths 3-38, Savage 2-44).

Team:—C. Vartan, J. Gately, R. Higgs, G. Major, S. Thomas, D. Delaney, R. Wood, P. Savage, G. Hopkins, D. Husband, N. Griffiths.

N.V.G.

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CONTENTS

THE REWARD OF PROGRESS

It has long been accepted that care of the sick is one of the most valuable functions to be discharged in a civilised society. In return for this care which is entrusted to them, those who practise medicine have always demanded society's respect and an adequate financial reward; and men, who are terrified of disease, have usually been glad to grant both of these demands. The Egyptian court physician Imhotep, who practised five thousand years ago, was actually deified.

In recent years the spectacular increase in medical knowledge has transformed the quality of the care which doctors can offer their patients. The possibility of factual diagnosis instead of idle speculation has ruined the Hippocratic game of 'Prognostics', the academic exercise of guessing how long the patient will survive (developement of the Hippocratic facies was an important sign that the end was close at hand). It is therefore a matter of some irony that at this stage the modern doctor should have lost his position in society as well as his proper financial remuneration. George Orwell writes as follows in *The Road to Wigan Pier:* "Small boys used to count the plum stones on their plates and foretell their destiny by chanting, 'Army, Navy, Church, Medicine, Law'; and even of these 'Medicine' was faintly inferior to the others and only put in for the sake of symmetry." Since Orwell wrote these words the introduction of a National Health Service—a necessary and humane reform—has virtually destroyed the ability of the individual general practitioner to bargain with his patients. Today there are about a hundred family doctors left in Britain with an entirely private practice.

In the past it may well have been that medical men exacted extortionate fees from ignorant and frequently desperate customers. We read of Chaucer's Doktour of Phisik, omniscient in "the cause of everich maladye," that he was notably close-fisted:

> And yet he was but esy of dispence;
> He kepte that he wan in pestilence;
> For gold in phisik is a cordial;
> Therefore he lovede gold in special.

Several centuries later the medical men in Hilaire Belloc's *Henry King* were no less mercenary:

> Physicians of the Utmost Fame
> Were called at once; but when they came
> They answered, as they took their fees,
> 'There is no cure for this disease'.

It may be that the doctor's decline in pay and prestige is due in part to the divorce of medicine from mystique, as truth replaces supposition. Before the domination of science began, medicine was governed by superstition, quackery and a minimum of useful knowledge. Hippocrates' four humours of the body derived from the four fundamental qualities or elements of Aristotle. Medical theory became frozen after Galen's time, and Chaucer's Doktour remained a staunch advocate of the humours. Following the grand thaw of the Renaissance progress remained appallingly slow, despite the anatomies and the ingenious metaphysics. Science and philosophy dallied with medicine; Stahl and Descartes contested the hegemony. These were great days indeed for unscrupulous practitioners, with a theory to justify almost any therapeutic measure.

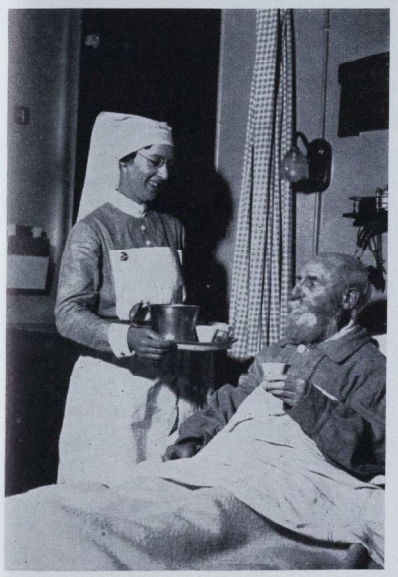
Nowadays the leeches are confined to an annual airing on View Day; mystery and superstition have lost their sway, and Naessens is imprisoned for quackery. Current concepts of aetiology are often plausible and sometimes proven; likewise modern treatment need rarely be empirical. Furthermore disease has become the burden of older people, as diphtheria, typhoid and tuberculosis are brought to heel. Society, as a result, has become casual in its attitude to medicine, and success is frequently taken for granted. The glamour and the private patients have passed to the hospital specialist and the osteopath. And the family doctor, whose knowledge and responsibility is greater than at any time before, is merely in danger of being despised by the society he is at last equipped to serve.

LETTERS TO THE EDITOR

MISS FLORA WAY

Sir,—Many of your readers will be sad to learn of the death of Miss F. M. Way in Switzerland on 16th March. By a strange coincidence she died on the same day as did Dr. Edward Cullinan whose ward sister she had been for so long.

Nobody who worked with Flora Way will ever forget her kindness, her humour and her devotion to her patients. I venture to send you a photograph of her, taken almost thirty years ago in Rahere Ward of the old West Wing. She had then just been appointed Sister on Dr. Geoffrey Evans' firm and, as I had recently become his house physician, I know what a remarkable effect she immediately had on the morale of the ward. She had a wonderful way with patients of all ages and they would do anything for her. The bearded old gentleman in the photograph was a Charterhouse Brother.



Subsequently she took charge of the women's ward on the firm, being well known as Sister Colston until her retirement two years ago. She had a long and brave struggle against chest trouble but I have never met a Sister to compare with her.

Yours sincerely,
E. C. O. JEWESBURY,
136, Harley Street,
5th June. W.1.

THE DAVID WEITZMAN MEMORIAL FUND

Sir,—Last Autumn you were kind enough to publish a letter announcing the launching of the David Weitzman Memorial Fund. (See *October, 1964 Journal*).

I am happy to be able to say that this Fund has now been established, the sum of over £1,300 having been collected. This will permit an annual prize of between £60 and £70.

With the co-operation of the Dean and Drs. Hayward and Hamer, it has been decided that the David Weitzman Prize will be awarded on the basis of an examination in the cardiological field and will be confined to Bart's students within three years after the date of their first clinical appointment.

The first award will be made in the Spring of next year.

Sincerely Yours,
H. A. ISENBERG,
583 High Road,
26th June. Tottenham, N.17.

HIGHER EDUCATION

Sir,—Perhaps if Mr. Bailey had taken a degree in Animal Physiology or Natural Sciences, he would not hold such a typically one-sided Bart's view of the clinical course as his letter reveals. (*See July Correspondence*). I am sure that not even the June Editorial writer would want the Hospital "to alter its examination and jobs schedule" to suit Oxford and Cambridge graduates, but it could show some respect for the teaching of General Pathology and Bacteriology in these universities. Why does

the Medical College compel us to waste our time on the Introductory Course listening to repetitious lectures, when other London teaching hospitals have found simple solutions? For example, at U.C.H. the Oxford intake (6 ex 55 last year) were excused the pathology part of the Introductory Course and went to Out-Patient sessions instead; no-one had extra work to take on, they were merely interested observers, and the gesture was much appreciated.

One of the privileges of going to the "provincial universities" is that one has the opportunity not only to broaden one's background knowledge by taking a higher degree, but also of benefiting from the combined teaching of two great centres of medicine. Surely this is to be encouraged. Graduates of Oxford and Cambridge at this Hospital are not trying to turn the Bart's Course to their advantage, for we remain a minority and are particularly proud of "the terrible stigma of having different letters after (our) name"! "A quarter or a third of the intake" is *not* an insignificant proportion, and a minimum of respect for our former teaching would remove the wasteful, useless repetition, dominated by compulsory attendance, in the Bart's Course.

Yours sincerely,

ANDREW CROWTHER,
Abernethian Room.

7th July.

MILITARY DENIAL

Sir,—In the article "On Students and Stipends" in the May issue of the Journal, it was stated that "Of those in the armed forces all either owned a car, or were married, or indulged in both these luxuries." I beg to point out that I completed and returned my form, and that despite the alarming number of letters that arrive addressed to '2/Lt. and Mrs. Richardson', I am as yet unmarried. Neither do I own a car.

Secondly, I believe that a wife and a car should be classified as necessities. However, like Osbert Sitwell before the war I am willing to deny myself the necessities of life, so that I can indulge in its luxuries.

Yours etc.,

2/Lt. JOHN RICHARDSON, RAMC,
Abernethian Room.

26th June.

Engagements

AUSTIN—BAIRD.—The engagement is announced between Dr. Anthony John Austin and Miss Christina Marjorie Baird.

DUFF—HART.—The engagement is announced between Dr. Thomas Brian Duff and Dr. Deirdre Alison Hart.

KINGSLEY—DAVIS.—The engagement is announced between Patrick John Kingsley and Miss Lucy Ann Davis.

Births

CAMERON.—On May 30, to Veronica and Dr. Donald Cameron a third son, (Alistair Charles John).

ROBSON.—On May 27, to Judith (née Wilkey) and Dr. John Ryder Robson a daughter, (Sophie Louise).

Deaths

HADFIELD.—On June 15, Charles Frederick Hadfield, M.B.E., M.R.C.S., L.R.C.P., F.F.A., R.C.S., aged 89. Qualified 1904.

PINNOCK.—On May 31, Dudley Denham Pinnock, F.R.C.S., aged 80. Qualified 1908.

Appointments

Royal College of Surgeons

The Diploma of Fellowship has been granted to Dr. G. F. Abercrombie.

University of London

The title of Professor of Zoology has been conferred on Dr. Dennis Lacey, F.R.C.S.

The title of Reader in Radiobiology has been conferred on Dr. Patricia Lindop, M.R.C.P.

August Duty Calendar

Sat. & Sun., 7th & 8th.	Sir R. Bodley Scott
	Mr. Hunt
	Mr. Aston
	Dr. Boulton
	Mr. Cope
Sat. & Sun., 14th & 15th.	Dr. Black
	Mr. Naunton Morgan
	Mr. Manning
	Dr. Cole
	Mr. McNab Jones
Sat. & Sun. 21st & 22nd.	Dr. Hayward
	Mr. Badenoch
	Mr. Manning
	Dr. Gillett
	Mr. Hogg
Sat. Sun., 28th & 29th.	Dr. Spence
	Mr. Tuckwell
	Mr. Aston
	Dr. Bowen
	Mr. Fuller

Physician Accoucheur for August is Mr. Bourne.

Obituary

DR. V. GODSALVE WARD

M.D. Lond.

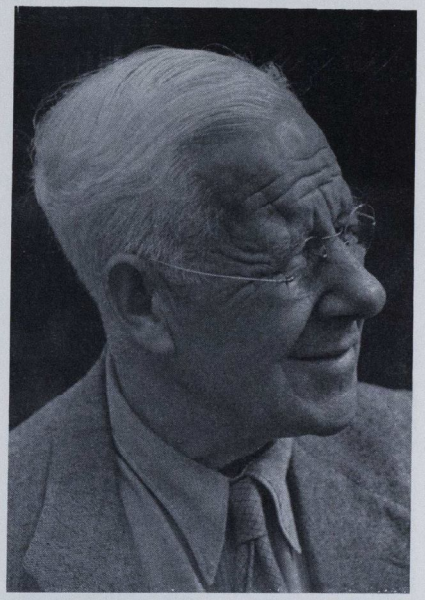
Dr. V. G. Ward died on 17th May at his home in West Byfleet at the age of 87. He had served the medical profession for over 50 years, first in practice and later as a hospital administrator.

Vere Godsalve Ward was one of ten children of the vicar of Rainham, Essex, and was educated at St. John's, Leatherhead. He studied medicine at Bart's, where he captained the soccer XI, and qualified in 1902 to become Sir Anthony Bowlby's first houseman. On leaving Bart's he took a post as anaesthetist at Gloucester Royal Infirmary, subsequently serving for 3½ years as R.M.O. at the London Temperance Hospital, before establishing a practice at West Byfleet, in 1906. The same year he took the degree M.D. During the First World War he served as 2nd M.O. at Sandhurst. As a practitioner, Dr. Ward worked in close association with the local hospitals, and after his retirement in 1938, he devoted his considerable energy and talents to hospital administration. Until 1954 he was medical superintendent of Woking Victoria Hospital, later becoming its chairman and finally president. He was Chairman of the Management Committee of the Rowley Bristow Orthopaedic Hospital. It was he, in fact, who suggested that the old Waifs and Strays Homes of St. Nicholas and St. Martin, Pyrford, should be renamed in honour of his old friend Rowley Bristow, who had done so much to develop it as an orthopaedic unit. On his retirement from the Committee in 1957, one of the wards was named the "V.G." Ward in recognition of his long and distinguished services to the hospital.

A keen sportsman, he played centre-forward for the old Casuals and hockey for Gloucestershire. He was captain and later president of the Byfleet Cricket Club, and also keen on golf, shooting, and squash.

Dr. Ward never lost his interest in Bart's, and only a few weeks before he died, he contributed an entertaining article to the Journal (*see June edition*), enclosing a generous donation. He kept his mental vigour and enthusiasm for life until the end. Everyone connected with the hospitals at Woking and Pyrford, and all his many friends will be sad to see him go.

In 1908 Dr. Ward married Janey Stoop. She survives him with their son, Mr. F. Godsalve Ward, who trained at Bart's and is now an orthopaedic surgeon.



BALLOONING

by ROGER CLAYTON

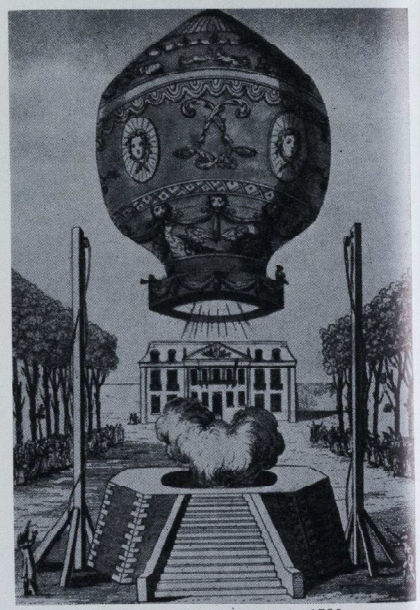
While strolling through a murky churchyard near Avignon one breezy March day of 1782, Joseph Montgolfier gazed up and marvelled at the clouds. In a fit of scientific endeavour he rushed to the nearest library and started methodically reading Priestley's investigations on gases and from this was led to experiment over the kitchen fire with cloth and paper bags. Joseph's brother Etienne became caught up in the intrigue and finally in November at his house in Avignon Joseph saw a bag of silken fabric filled with heated air rise to the ceiling of the room. In his excitement he began playing with bigger and better bags.

Eventually on 5th June, 1783, Joseph with Etienne repeated his experiment publically on a large scale in the market place at Annonay in Vivarais. A fire of wool and straw heated the air in a highly picturesque balloon, made of linen and paper, thirty five feet in diameter. It rose to about three thousand feet then descended.

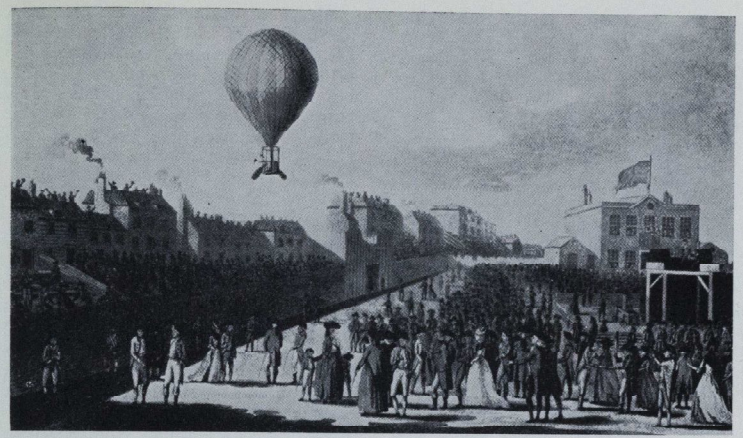
The news spread rapidly and the Paris Academy persuaded Professor Charles to investigate the authenticity of the stories. He started off by assuming that they had used hydrogen gas and on 27th August, 1783, he sent up a small hydrogen balloon, thirteen feet in diameter, at Champ de Mars which landed at Gonesse. As it fell low over the trees near Gonesse a gang of peasants, not knowing whether it was a gift from God or a hideous monster which threw doubt on their future existence, pursued it and when it landed in a nearby field the noise of the issuing gas and the flapping of the balloon led them to conclude that it was indeed a monster and accordingly they picked at it with their pitchforks and killed it in terror.

Etienne Montgolfier repeated his demonstration before the Academy of Science, Paris and at Versailles before the court. At Versailles in a basket suspended beneath the balloon were placed a duck, cock and sheep—they landed safely and were subsequently put into the Royal Menagerie at Versailles.

The King was wildly excited, a contrast to his usual listlessness, and happily announced that he wanted criminals to be put into the basket next time but Pilâtre de Rozier, an onlooker, said he wanted to have a go. The King reluctantly agreed and on 15th October, 1783 Pilâtre went up eighty feet in a tethered,



The first aerial voyage. Paris, 1783.
Pilâtre de Rozier's "Montgolfière" Balloon.



The first aerial voyage in England. 1784.
Lunardi ascending from the Artillery Ground at Moorfields.

captive, 'Montgolfière', hot air balloon. On a second and third occasion he went up still higher. Finally on 21st November he took part with the Marquis d'Arlandes, an infantry officer, in the first aerial voyage. Before a jostling crowd they ascended from the Château de la Muette in the Bois de Boulogne. They travelled five and a half miles in twenty-five minutes and after crossing the Seine landed in Paris at Butte de Cailles, now Place d'Italie. The balloon, previous to its ascent, was supported by two poles and rigging mounted on a take-off platform and in flight hot air was generated by a brazier slung in the neck of the balloon. Wool and straw were used as fuel which was thrown through specially constructed firing holes around the gallery at the base of the neck.

Meanwhile Professor Charles had been caught up in the craze and ten days later, on 1st December, Charles and one of the Robert brothers went up from the Tuileries in a hydrogen balloon or 'Charlière', the gas being generated by running dilute sulphuric acid over iron filings. The balloon itself was made of varnished silk impregnated with rubber and covered with a net from which the basket or car carrying the aeronauts was suspended. They took with them ballast and a barometer. After ascending before four hundred thousand people, about half the population of the city, they travelled twenty seven miles to Nesle where they landed two hours later. Charles went up alone later by an ambiguous moon light to make scientific observations.

During Christmas and the New Year of 1783/4 everyone in France went mad on balloons, these fantastic aerial voyages stirring up their imagination. Snuffboxes, ivories, porcelains, fans, watches and even furniture took on the 'balloon style' in that they were either balloon shaped or decorated with them. Special stamps and copper engravings were issued many of which are now to be seen in collections all over the world. Many people started building their own hot air balloons—so eager and fearless were they that in April, 1784, an Ordinance was passed 'Prohibiting the launching of Balloons and other Aerostatic Machines' unless certain precautions were taken. In early 1784 balloons were to be seen over Lyon, Rouen, Provence, Marsailles, Nantes and Bordeaux. In spite of the crude methods involved in getting a balloon up, whether manned or not, there were no serious accidents, although several 'Montgolfiers' caught fire after which their popularity died down.

The first aerial voyage in England was by Vincent Lunardi of the English Neapolitan Embassy. Originally the English as usual had been dubious and sceptical and little effort had been made to follow the French in their love of ballooning; so it was a foreigner who made

a start in that direction. Lunardi made his ascent one bright day in September, 1784, from the Honourable Artillery Ground at Moorfields, taking with him a rather disreputable looking cat, a pigeon and various victuals, including a tasty leg of chicken. After two and a quarter hours of oblivious ballooning in ideal conditions he set down briefly at North Mimms, where the cat decided that he had had enough and rushed away to ravish an innocent country cat before resigning himself to the long journey home. Lunardi again threw ballast and landed near Ware, Hertfordshire, a journey of twenty-four miles.

Lunardi was an extrovert and his oiled silk balloon was fittingly coloured red, white and blue and to the basket were fixed two racquet-shaped wings or oars with which he believed he could navigate. Obviously they were useless but in his vanity he proclaimed his miraculous oars a godsend. His ascent was observed by the Prince of Wales and some hundred and fifty thousand onlookers.

In all things man becomes more and more ambitious often at his own expense. On 7th January, 1785, Jean-Pierre Blanchard crossed the channel with Dr. John Jeffries, an American physician, who financed the trip. They set off with little trepidation and a bottle of brandy. The balloon however leaked and the knotty meteorological problems which followed made the crossing tricky—in fact the bottle of brandy and Blanchard's trousers were thrown into the sea in a desparate attempt to keep the balloon up. They finally landed at Grûnes, twelve miles inland from Calais and the car used is today to be found in the Calais museum.

The idea of financial gain to be derived from ballooning had not escaped Blanchard who was a prolific ballooning showman and he started the habit, which was eventually acquired by many, of financing his adventures by charging the gathered crowds at his point of departure. Blanchard, in spite of the fact that the public thought of him as a nasty precocious little man — he was only five feet tall — was an extremely capable and skilful aeronaut introducing ascents to the Netherlands, Belgium, Germany, Poland, Czechoslovakia, Switzerland and the United States of America. He made a total of sixty successful ascents and earned a great deal of money. It was Blanchard who first thought of the rudder and on June 3rd, 1785, he made the first human parachute descent from a balloon. This was repeated many times as part of his 'act'.

Blanchard made his first ascent in America on 9th January, 1793, from the old Washington Prison, Philadelphia, the American capital, before President Washington. The crowds were wary and preferred standing outside his barriers and not paying for the spectacle. After forty-six minutes he landed in Gloucester County, New Jersey. For some reason Blanchard aroused latent feelings of hatred in most people he encountered and his balloon when later exhibited throughout the country was stoned on numerous occasions.

In 1785 ballooning was losing some of its popularity and this was precipitated to a certain extent on 15th June, 1785, by Rozier's dramatic death. His mind boggled at the prospect of ballooning and to cross the channel he constructed a hot air balloon, with brazier, beneath a hydrogen balloon in order, as he thought, to permit safe changes in altitude without sand ballast and by a rather complicated series of manoeuvres. After thirty-five minutes the hydrogen balloon caught fire and Rozier and his friend Romain were consumed in the vast conflagration which followed. Observers at Wimereux near Boulogne fancied that the cause of the fire was a mischievous flash of lightning.

As with most new inventions man racks his brain minded to use them for the purposes of war and in the 1790's captive balloons were used to observe enemy movements, an idea developed by Coutelle, a prominent physicist. On 2nd June, 1794, the French balloon *Entreprenant* was sent to besiege Mauberge to appreciate the situation. It was a spherical hydrogen balloon, the gas having been generated in the usual manner in the field. Later, on June 26th, Coutelle and General Morlot spent a pleasant day above the Battle of Fleurus. Nevertheless the inevitable did not occur until 1849 when Venice was formidably bombed by the Austrians with pilotless 'Montgolfières' set with time fuses. This was the first bombing raid in history and a picturesque one at that. Balloons were used during the American Civil War 1861-63 and sixty-six participated in the balloon service out of besieged Paris in 1870-71. On this latter occasion the balloons carried mail and all but five carried pilots who had never flown before. They took off in the night to fly over the German lines hoping eventually to land on friendly soil. Two men found themselves at daybreak over the North Sea and, determined against a lingering death in the icy cold water, tried to ignite their hyrogen. They failed and subsequently landed in the Norwegian mountains.

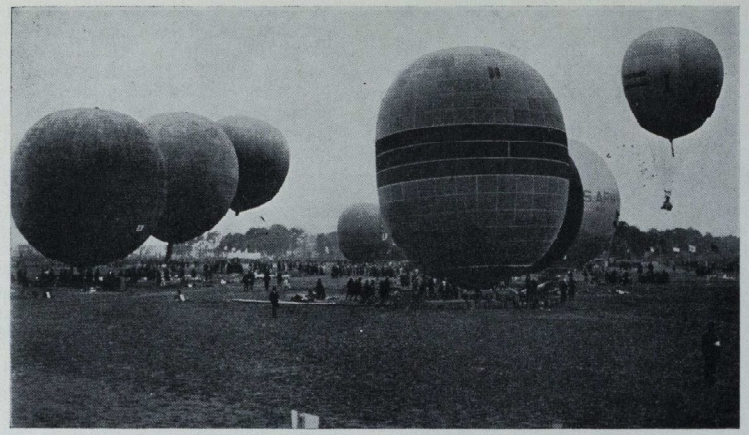
On December 3rd, 1804, Napoleon was crowned by the Pope in Paris's Place de la Concorde and a memorable feature of the occasion was a huge captive balloon with eagle decoration which dominated the sky. One of the four, surrounding, small, coloured balloons got free and drifted to Italy unwittingly crashing on Nero's tomb.

Madame Blanchard, wife of the famous Jean Pierre, died in a singular but fashionable way in 1819. Before happy Parisians she ascended to music and merriment from the Tivoli Gardens to give a firework display from her balloon. After a few minutes though the balloon burst into flames and began to fall. Madame Blanchard coolly threw ballast to prevent a fast descent but it was too late, the car hit the nearby rooftops and she was thrown to the street with a broken neck. Madame Blanchard was the first professional woman aeronaut and oddly petrified of travelling in carriages; she made an ascent at Napoleon's marriage festivities in 1810.

A famous English aeronaut of the early eighteenth century was Charles Green, who first took to ballooning in 1821. He made a grand total of five hundred and four ascents, the last in 1852, and was the first to introduce coal gas and the trail rope. He died in 1870, aged eighty-five, from heart failure. In 1836 he built a very fine silk balloon, coloured crimson and white and of twenty-seven thousand cubic feet capacity. On November 7th and 8th he sailed from London to Nassau, a record trip of four hundred and eighty miles, in eighteen hours. The project was paid for by Robert Holland, M.P., who was a passenger. They went up from Vauxhall Gardens and at nightfall were over Belgium. After crossing the Rhine they landed in a field eight miles from Weilberg in the Duchy of Nassau. The balloon was originally christened Royal Vauxhall Balloon but was afterwards re-named the Great Balloon of Nassau.

Green made pots of money from ballooning, and travelled all around England through the years. All aeronauts had their idiosyncrasies and Green spent huge sums of money on the

Rural sports: *Balloon Hunting*. 1811. (*Cartoon by Thomas Rowlandson*)



The line-up for the first Gordon Bennett race. Antwerp, 1926.

production of the most elaborate and colourful posters advertising his ascents: 'By permission of the magistrates Mr. Chas. Green, the celebrated aeronaut, respectfully announces his intention of making Another Ascent'.

The idea of constructing a navigable balloon or dirigible had not escaped these early aeronauts and there were many ambitious and fantastic designs for these which took on peculiarly imaginative shapes and sizes, varying from duck to sausage-shaped concoctions. Massive oars, propellers, sails and even bird traction were exploited. The first serious attempt to build one was in 1816-17 when Samuel John Pauly and Durs Egg, gunmaker to George III, worked furiously in their Knightsbridge workshop. It was never completed and after the hefty publicity it became known as 'Egg's Folly'. The balloon was to have been propelled by oars and a huge propellor about ten feet long and to be painted with mouth, eyes and scales, to simulate a fish.

Also in 1816, Sir George Cayley, the father of British aeronautics and wealthy Yorkshire baronet, who invented caterpillar tractor wheels, artificial limbs and founded the Regent Street Polytechnic, proposed a Navigable Balloon to be propelled by propellers driven by a steam engine. The idea of an engine for propulsion had never been thought of before, but it was a highly complicated design, four hundred and thirty-two feet long and with bits of wire and sails and things everywhere. It never left the drawing board.

In the middle of the eighteenth century when, after 1850, Arnaud, owner of the famous Hippodrome near the Place de l'Etoile, finally added ballooning to his presentations, aeronautics became infiltrated by crude gimmicks and flagrantly non-scientific pursuits. There were ballerinas dangling from balloon-supported platforms, ascents on horseback and parachutings of prettily clothed cats and dogs, all of which seemed to appeal to the proleteriat.

Balloon hunting was a fine and favourite pastime in the 'middle' ballooning period—chasing a balloon by road or on horseback, over country and greeting the aeronaut on his landing. Dr. John Sheldon started this by following Lunardi on his first flight. There are many amusing accounts of the fate and misfortunes of these rustic hunters. In the contemporary caricature illustrated by Thomas Rowlandson, evidently there has been an argument between the passengers or a panic on the part of the generously proportioned lady, who makes a desperate umbrella descent while a flock of passing birds is target for the sportsman in the tower. The horse in the foreground seems a little upset by the goings on.

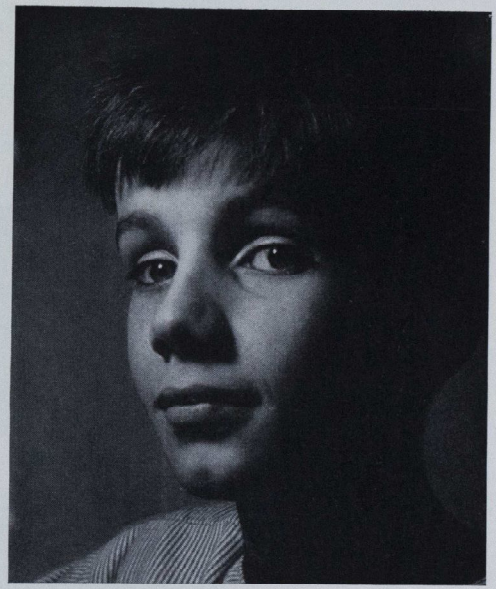
Thus ballooning continued until the early twentieth century. In the last part of the nineteenth many balloons were used for atmospheric tests, meteorological observations,

photography and exploration—even polar. The courage and overt enthusiasm shown by these early aeronauts in their journeys into the unknown can be appreciated and their genius, which often resulted in techniques which were used even after the invention of the aeroplane, cannot be denied. In 1901 the Aero Club, later The Royal Aero Club, was founded and ballooning then became a sport for many ordinary men and women. There were regular meets at Ranelagh and Hurlingham and 1908 saw the peak of the balloon renaissance, but in 1909 when Europe was very aeroplane conscious, there was a decline in the sport which disappeared by the first gloomy years of the war. The Gordon Bennett race, founded in 1906 by James Gordon Bennett, son of the founder of the *New York Herald*, tended to keep ballooning alive. The first started from the Tuileries, Paris, and was won by a four hundred and two mile flight by the American Lt. F. P. Lahm who landed at Whitby, Yorkshire. It was a distance race and other popular events were point-to-points where the winner was the one to descend nearest to a prearranged spot.

Pictures by kind permission of Charles H. Gibbs-Smith.

View Day Photographic Exhibition

First Prize in the Portraiture Section awarded to C. Fagg.



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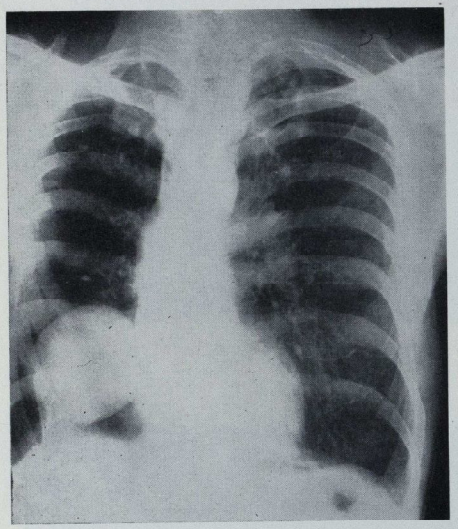
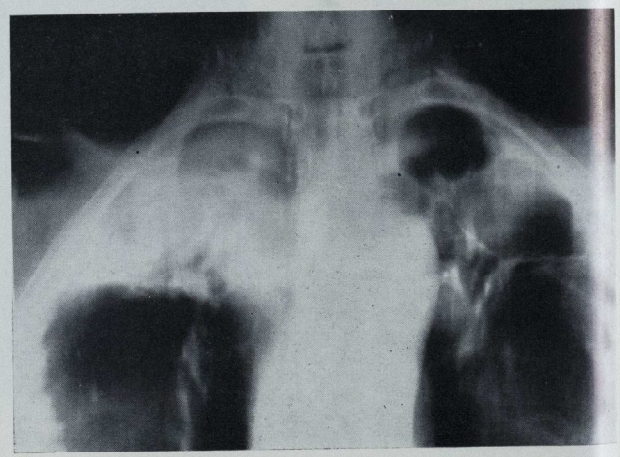


CASE
No. 1

Answer P. 328.

CASE
No. 2

(A-P tomogram)



CAT SCRATCH DISEASE

by C. C. H. DALE

Registrar, E.N.T. Department

The cat has been recognised as a source of disease for several centuries. Defoe records in his Journal of the Plague Years published in 1722 that the magistrates ordered the destruction of all cats and dogs so as to diminish the spread of the evil influences, and in fact the cat has been shown capable of transmitting the plague. She has also been incriminated in the transmission of tuberculosis, diphtheria, ringworm, brucellosis, leptospirosis and tularæmia, and it was in the investigation of the last named disease that a number of cases was found that did not fit the clinical pattern. In 1930 Dr. Lee Foshay who had made a study of this disease noted that these patients did not react to the specific antigen for tularæmia and in nearly all these cases there was a history of contact with cats. He called these cases atypical tularæmia. Dr. Robert Debre made the same observation in Paris in 1932. In 1945 Dr. Franklin Hanger and Dr. Harry Rose prepared an antigen from aspirated pus and with this obtained an intense reaction in Hanger who had had the disease. Foshay's patients reacted to this antigen and in 1947 Debre in Paris obtained a positive reaction in his patients with the American antigen. Atypical tularæmia was thus recognized as a separate disease and called Cat Scratch Fever. (Fever however is not a constant feature and Cat Scratch Disease is now preferred.)

Since 1947 the disease has been observed throughout Western Europe, North America and Australia. There is a definite seasonal fluctuation in the incidence of the disease. The maximum prevalence is in the winter months and this may be explained in the Northern Hemisphere by the close contact man has with his domestic animals during these months.

Clinical picture

Classically the disease shows a primary inoculation like an insect bite usually on a limb. The patient may recollect a scratch from a cat. 3-5 days later the regional lymphatic glands become swollen and tender but there is no lymphangitis; there is an erythema over the swollen glands occasionally. Fever, headache and malaise are experienced though fever is only noted in about 50% of cases. These symptoms last 3-6 weeks and the lymphadenitis subsides spontaneously or the glands may suppurate and require aspiration in about 35% of cases.

Pathology

Cat scratch disease is probably caused by a virus but no specific bacterium or virus has yet been isolated. The evidence suggests that the disease is due to a virus related to the psittacosis-lymphogranuloma venereum group. Between 60-80% of adults with cat scratch disease show a positive complement fixation test with lygranum (an antigen prepared from the L.G.V. virus but which is not specific). The Frei intradermal test for L.G.V. is invariably negative in cat scratch disease as are agglutinin tests for Br. tularensis, Br. abortus, Streptobacillus moniliformis and Syphilis.

Attempts to culture the virus on Hela cells, human embryonic liver, blood cells and conjunctiva, monkey kidney and lymph node and cat kidney have all failed to show any change in the cells of the culture medium.

Winship has described the histological changes in the cutaneous lesion and the lymph nodes. The cutaneous lesion shows an area of superficial ulceration with underlying inflammatory changes extending to the dermis. There is a perivascular concentration of lymphocytes and polymorphonuclear cells and in the early stages plasma cells and eosinophils are prominent. Histiocytes appear in increasing numbers as the disease progresses and giant cells of the foreign body and Langhans types are seen.

The initial change in the lymph nodes appear at the site of entrance of the afferent lymphatics in the periphery of the node; here are seen one or more ill defined areas of reticulum cell hyperplasia with infiltration by plasma and polymorphonuclear cells. In these areas develop round or irregular abscesses (Fig. 1). Epithelioid cells become apparent when the abscesses are well formed and giant cells are present in the majority of cases: (25 ex 29 of Winship's cases). Fibroblasts appear at the 4th-8th week and form a solid ring of fibrous tissue around

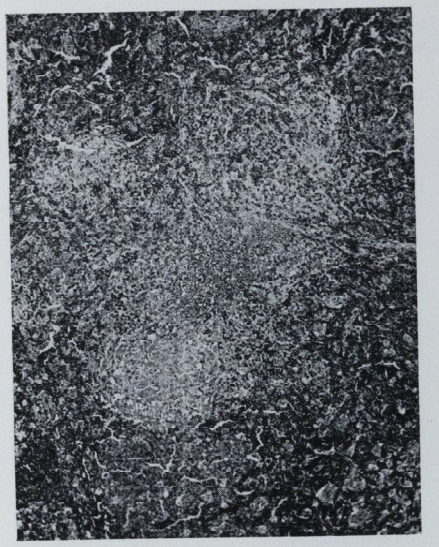


FIG. 1.—Multiple abscesses beginning to coalesce.

the abscesses which become replaced by a solid core of fibrous tissue.

Case report

The patient, Mrs. A., a lady of 51 years, attended the Ear, Nose and Throat Department with a history of six weeks' swelling in the neck and a lump in the throat. At first the swelling had been painful and her own practitioner had diagnosed cervical adenitis and treated her with penicillin. The pain had eased but the swellings persisted and fearing the possibility of malignancy her practitioner referred her to hospital.

Here she was found to have two firm mobile glands on the left side of the neck. Her nose, pharynx and larynx were normal but the postnasal space could not be seen as she did not tolerate the mirror.

A tentative diagnosis of malignant adenopathy was made and the patient was admitted for examination of the postnasal space and gland biopsy.

Investigations: Hb. 94%. W.B.C. 5,000, N 57%, L 30%, E 2%, M 11%.

X-rays: Sinuses, postnasal space and chest—all normal, but on admission Urine showed 2% sugar. Blood sugar 450 mgs. %.

She was a known diabetic who had been well stabilized on insulin and there was no obvious reason why she should become uncontrolled.

She was not considered suitable for a general anæsthetic in this state so the gland biopsy was performed under local anæsthesia.

This was reported on as showing no evidence of malignancy but the appearances were characteristic of cat scratch fever.

The patient readily confirmed that she had a cat which was in the habit of climbing on to her shoulder and she had suffered numerous scratches on the back and neck from the cat's claws. In retrospect the history was very typical and that her disease was due to an infection rather than a malignancy was suggested by the increase of her insulin requirements, and her sensation of a lump in the throat could be postulated as due to para-pharyngeal lymph node enlargement.

Review of other cases

In the 15 years 1947-1963 9 cases including the one described have been diagnosed at St. Bartholomew's Hospital. The main points are summarized in Table 1. All age groups were involved and the majority (6 out of 9) were seen in the winter months October-March. In only 2 cases was the diagnosis made clinically and in one of these the child's elder sister had been treated here 6 weeks before for cat scratch disease. The disease is one of low infectivity and the occurrence of 2 cases in one family is uncommon: and in this case resulted in the demise of the cat.

A positive skin test is not always obtained and in the case described it was not until 3 months after the onset of symptoms that the test became positive, and this delay may account for the 2 cases with negative skin tests as they were only performed on one occasion. Spaulding and Hennessy however also noted that some patients with a typical illness did not have a positive skin test and they also found that the CFT in children for L.V. was usually negative but was positive in 50% of adults.

The histology is fairly typical and in the 7 cases in which gland biopsies were examined, all were positive (See pathology and Figs. 1 and 2.)

Summary of Bart's cases

		No. of cases
Total number of cases		9
Contact with cats	7	
Scratch with thorn	1	
Contact with mice	1	

Clinical diagnosis of cat scratch disease		2
Positive intradermal test with cat scratch antigen		8
Typical histology		7
Regional nodes involved		9
upper limb	2	
lower limb	4	
neck and face	4	
Suppuration		3

TABLE 1.

Of the sites of lymph node involvement Spaulding and Hennessy in a series of 83 cases found that the axillary were the most commonly involved (44), the cervical in 20 and the inguinal in 17. The epitrochlear nodes were occasionally involved either alone or with one of the other groups.

The disease is a self limiting one and the prognosis is excellent. Various antibiotics have been given, frequently before a diagnosis had been made, but none had altered the natural course of the disease. Willcox reported on 2 cases in which he had tried demethylchlortetracycline (ledermycin) and oxytetracycline neither of which reduced suppuration. When there is suppuration Spaulding and Hennessy advise closed aspiration every day or on alternate days, and found that only 6 of 26 cases required aspiration more than once. They regarded incision as inadvisable owing to the risk of producing persistent sinuses. Of the cases seen at St. Bartholomew's Hospital 3 suppurated; 2 were drained by aspiration and 1 was incised and continued to discharge for a fortnight.

In considering the differential diagnosis all causes of lymphadenopathy have to be excluded, particularly glandular fever, Hodgkin's disease and in the case of cervical adenopathy, a carcinoma of the buccal cavity or upper air passages. Tularæmia closely mimics cat scratch disease but can be distinguished from it by agglutination tests. In the present small series the following clinical diagnosis were made: suppurating tuberculous lymph nodes, Hodgkin's disease, incarcerated inguinal hernia and metastatic lymph nodes. In view of the diversity of the confusion that this disease has caused it would be as well to keep it in mind whenever examining a case of painful lymphadenitis.

Summary

A case of Cat Scratch Fever is described. Eight other cases seen at St. Bartholomew's Hospital in the last 15 years are briefly reviewed. The disease is self limiting and no form of treatment appears to affect it.

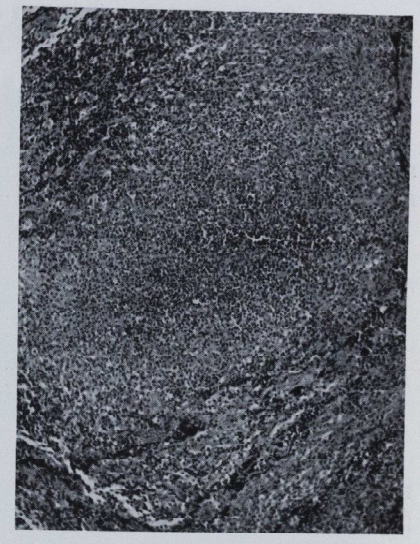


FIG. 2.—Later stage, showing large abscess breaking down. Endothelioid and giant cells present.

Acknowledgements

My thanks to Mr. Fuller for his encouragement and for allowing me to publish his case and also to Dr. Black who also looked after her. To Dr. Henry and Mr. P. Crocker for the photographs and to Miss Jones for patiently typing the paper.

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BART'S MUSIC SOCIETY CONCERT

Sympony No. 1 in B flat major ... ... Boyce

Brandenburg Concerto No. 2 in F major ... ... *J. S. Bach*
Susan Hudson (clarinet) Paul Swain (flute)
Robert Hadfield (oboe) Roger Boston (violin)
Bart's Music Society Orchestra Director: Robert Anderson.

Trial by Jury ... ... *Sullivan*
The Learned Judge ... ... Christopher Hood
The Plaintiff (Angelina) ... ... Mary von Berg
The Defendant (Edwin) ... ... Cavan Roberts
Counsel for the Plaintiff ... ... Philip Savage
Usher ... ... Patrick Kingsley
Foreman of the Jury ... ... Sam Thompson
Pianist ... ... Elizabeth-Ann Smith
Bart's Music Society Choir Director: Robert Anderson

The orchestra began the concert with William Boyce's *Symphony No. 1 in B flat major*. Although better known for his choral works, this 18th century composer in fact wrote eight symphonies. One does not often have the opportunity of hearing them, perhaps because they are not great works, but they contain some very attractive melodies (especially remarkable since the composer became deaf in 1750). The orchestra started straight in with confidence, and played the three movements very competently, with a nice degree of 'togetherness' throughout. Much of the credit for this latter quality must go to the conductor, Mr. Robert Anderson. The orchestra are very wise to employ the services of such an experienced professional, and one hopes that this will only be the beginning of a long and happy relationship.

For their second piece, the orchestra chose a much more ambitious work, Bach's *Brandenburg Concerto No. 2 in F Major*. This is a most intricately constructed work, and requires stringent attention to detail. This finesse was not always there, but some of the richness of musical experience still came through. In the first movement, the wind section were a little ragged, though the strings again played together beautifully. It was in the Andante that Robert Hadfield, the oboist (imported for the occasion) showed himself to be the outstanding soloist. He played the delicate part with great sensitivity and confidence. Paul Swain (flute) and Roger Boston (violin) both played richly at times, though their technique was not always perfect. It was unfortunate that (due presumably to changing temperatures) the soloists had difficulty in keeping in tune with the spinet, played consistently well by Elizabeth-Ann Smith.

But let us not disparage over detail, for the large audience (and the orchestra we hope) spent an enjoyable and worthwhile evening. We trust that the orchestra, now placed firmly on its feet by Roger Boston, will continue to flourish under its new Secretary, William Goss.

After a brief interval—too brief alas for refreshment—choir and soloists tackled *Trial by Jury*, one of the earliest and shortest Gilbert operettas. Sullivan, the Victorian idol, was a little short of inspiration here, but the choir sang with enthusiasm and the soloists, gaining gradually in confidence, began by the end to enjoy the performance almost as much as the audience. Christopher Hood (bass) was outstanding as the Learned Judge, and a good judge too. Mary von Berg (Angelina) sang sweetly enough but a little sotto voce, and praise is due to Elizabeth-Ann Smith, the pianist, for providing admirable continuity. Your correspondent is led to understand that The Messiah is next on the agenda for the Music Society, and it will be interesting to see how the choir, and especially the soloists, respond to the somewhat fiercer challenge of George Frederic Handel.

From our Music Correspondent

We are not amused

The above photograph was kindly contributed by **Mr. John Betjeman,** a distinguished neighbour of the Hospital. In his accompanying letter he explains how it came to be taken.

"I was collaborating with my friend Stewart Farrer, who writes some of the Dr. Finlay scripts for tele, in the writing of a television play, and to stretch our minds I took him to see the Hogarth staircase and the glorious Great Hall at Bart's. Some sort of repair work was going on in the Hall and those busts were standing on the floor. He is a very good photographer and had a camera with him. There was something so odd about Queen Victoria queuing up with a lot of eminent doctors that we photographed them. The busts were taken just as we saw them. They were not specially arranged."

Counting from left to right, the illustrious heads are as follows: —

1. Sir William Lawrence, Bt., F.R.S., surgeon 1824-1865, P.R.C.S. 1846 and 1855.
2. Sir William Scovell Savory, Bt., F.R.S., surgeon 1867-1891, P.R.C.S. 1885-6-7-8.
3. Alfred Willett, surgeon 1879-1901 (he married Abernethy's grand-daughter).
4. Victoria R. I. (both Lawrence and Savory were surgeons to the Queen).
5. Unknown.
6. William Harvey, appointed "Phisycon of this Hospital" in 1609, author of *Exercitatio Anatomica de motu cordis et sanguinis in animalibus,* published 1628.
7. Unknown.
8. Sir Sydney Hedley Waterlow, Bt., Lord Mayor of London 1873, Treasurer of the Hospital 1874-1892.

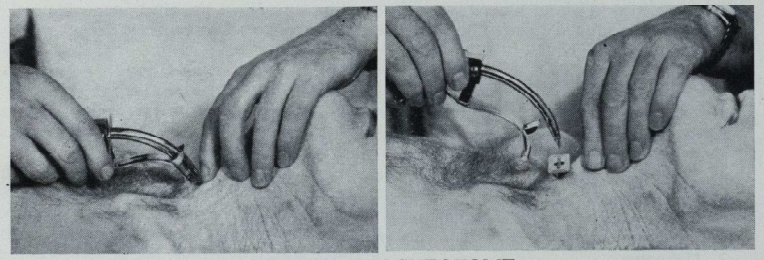
aurelius

OLYMPIA '65

Just as farmers conglomerate in London for the Smithfield Show, motorists for the Motor Show and gardeners for the Chelsea Flower Show, so doctors and hospital administrators had their busman's holiday in London from May 31st to June 4th, for the combined *International Hospital Equipment and Medical Services Exhibition* and the *Medical Exhibition* at Olympia. Holding the two concurrently for the first time served the purpose of bringing together administrators and doctors. The Hospital Equipment Exhibition probably had more to interest the administrators whilst the Medical Exhibition drew the doctors, though there was much overlap of interest. The enormity of this sort of exhibition is at first overwhelming; one does not know where to start or what is really going to be interesting, and anyway everyone is so nice that one ends up listening to a detailed description of a laundry machine, a vacuum cleaner, nurse's uniforms or a new catering system—all very important to the administrators but to be avoided by the average medical man. Laundry equipment seemed to be exhibited in every corner, and when one could get away from that it was invariably to find a display of hospital beds. These came in all shapes, sizes and prices. The Rolls Royce of them, at about £170, had walnut headboards and could be put through a wide range of movements by nurse or patient by the lightest touch of an electrical button. An extra was the bed-table which had a nice variation on the rose-tinted spectacle idea, a mirror tinted pink to deceive the patient into thinking he looked healthy.

Of more interest was the operating theatre equipment and instruments. A particularly eye-catching novel device was the vicious-looking Penlon Tracheotome, illustrated below. This recently refined instrument for performing emergency tracheostomies is claimed to be so safe and simple to use that it can be used by anyone sufficiently qualified to recognize the need for operation. Then there was the Vitalograph, an easy-to-use instrument for testing lung function which visitors were invited to use (if they dared). Certainly the sample vitalograms seemed to be very clear diagnostic aids.

High pressure sales techniques were much more in evidence at the Medical Exhibition. The stands were more attractively designed and the salesmen and



PENLON TRACHEOTOME

Introduction *In situ*

women smoother and more persuasive. One was invited to drink sherry suitable for diabetics and sample dried milk. Low grade calory foods, a variety of contraceptive agents, vitamin pills and drugs were given away. Manufacturers of contraceptives formed quite a large number of the pharmaceutical exhibitors, doubtless because of the great commercial value of these products. Ortho Pharmaceuticals probably had the widest range of chemical gynaecological preparations (including their recently perfected 3-minute antibody pregnancy test), whilst the London Rubber Company had the most comprehensive display of mechanical contraceptive devices. The salesmen were very distressed that medical students receive so little education on the subject, and these exhibits provided a useful way to learn a little about this important matter. Allen and Hanbury's had some interesting historical pieces in their exhibit, depicting the 250 year growth of the company. Ames Laboratories were demonstrating their familiar urine testing reagents, and the new 'Dextristix' for rough estimation of blood glucose.

We left the Exhibition with arms full of useless pamphlets and pills, a headful of information, very little of which is useful, but knowing that we shall probably be drawn back next year by the crowds, the noise, and the fascination of a medical commercial carnival.

DRINKING DRIVERS

Although it is an offence for an intoxicated person to be in charge of even a stationary car, the vast majority of drunken drivers only appear in court because they have been involved in an accident. Even then, a large proportion of them are acquitted because the criteria of drunkenness are so equivocal. The dangers are not so grave as to forbid a man to drive after the consumption of any alcohol at all, and it would be an infringement of public liberty, as well as an undesirable curb on the very English social customs of pubs and cocktail parties to do so. For many years discussion has centred around the quantity of drink which a driver should be allowed to consume, and the best method to estimate its effect. The B.M.A. report on The Drinking Driver (May 1965) firmly comes down with the recommendation that blood alcohol level is the only really reliable estimation. The report suggests that a level of 80-100 mgs. per 100 ml. should be the upper limit acceptable, although this is not to say that lower levels do not have some deleterious effects. Whilst this is said to be roughly equivalent to 5-9 measures of whisky or half-pints of beer, they emphasise that the quantity consumed is not a reliable or relevant indication because of individual variations in tolerance.

On June 18th, the Minister of Transport asked Mr. Graham Page (Crosby C.) to withdraw his private Bill making it an offence to drive with a certain blood level of alcohol, because the Government proposed introducing a similar Bill before the end of the year. There are of course problems in such legislation. As Mr. Ronald Brown (Shoreditch and Finsbury Lab.) said, drivers coming out of public houses would be more obvious suspects than home drinkers. The prospect of being subjected to a venepuncture every time one emerges from a pub is certainly not a happy one. What is important is that implementation of the law should be made clearer, so that doctors will be able to give evidence on a scientific basis instead of vague clinical assessments. Then too will the task of educating the public against the folly of driving after a night out be made easier.

SOCIAL CHAPTER looks at FIRM PARTIES

The various changes in the nature of firm parties reflect interestingly on certain other changes of a social nature in hospital life.

Before the last war firm parties were essentially the prerogative of the consultant. A number in Bart's would regularly invite the students to their homes, usually in Harley Street, where they not only consulted but lived as well. Such evenings were strictly male affairs, (female students were only admitted in 1947 anyway).

Life in the hospitals during the war inevitably did much to break down the official barriers between the male and female sides of the staff. Many senior members recall those days at Hill End as particularly carefree in this respect. At the end of the war the old traditions never stood a chance and a new type of party started with the students inviting out the nurses from their firm. These would appear to have caught on well for one registrar remembers how a firm of five gallantly escorted some sixty nurses in relays on the Metropolitan Line to the Prospect of Whitby.

In due course with the benefits of grants and more respectable flats, it was a natural step for the senior staff to be asked to these parties as well. Thus one reaches the situation of today.

Before considering it more fully one must not of course forget that several consultants still give parties for the students—slightly modified perhaps in that we all enjoy female company with them!

There is, thank goodness, no understood form with the student firm parties but as many people have mixed feelings about them it seems sensible to consider firstly whether they are necessary at all, and if they are then what goes to make the most successful ones.

Most firms will at least discuss the possibility of laying on a firm party and sometimes there is even a vague sense of obligation. But to whom? The senior staff are never insistent about them and so the balance is held by the enthusiasm of the students and the nurses. The latter are not so easy to please for as a recent firm pointed out most of them through no fault of their own are unable to reach the party until after nine, and even then some may not turn up at all, or alternatively they may arrive in quite unmanageable numbers. Despite all this, for the none too common chance of relaxing with the staff, firm parties are surely emphatically worthwhile.

If the recent batch of firm parties are representative then it is apparent that they can cost anything between £10 and £25, a bill which the students must at least intend to cover themselves although a varying amount of financial and alcoholic support may arrive with the party itself. A number of the parties start immediately after supper (cunningly avoiding the food problem) but the most successful invite the staff early and lay on a meal for them. You can usually count on two to three hours of crasher-free time in which to do your entertaining. At about ten thirty most of the staff will have gone and you can leave the door on the latch; fill your glass for the last time and smile pleasantly at the intruders. For better or worse crashing has become an accepted risk of any firm party and the smallest criticism is surely that they might provide a bottle.

How many people have considered that perhaps today a more suitable form of firm party may be one which the unqualified nurses and students combine to give? The costs are shared, the nurses invite the sisters and belts while the students the medical staff. Both hosts and hostesses could thus arrange the expected turnout and course of the evening to their greater satisfaction.

wines from eastern europe

by tim wheeler

YUGOSLAVIA

Wines have been imported from Yugoslavia for the last sixteen years and the Rieslings from Lutomer are well established. They come from the north where many of the wines closely resemble those from the Rhine. The pick incidentally is reckoned to be Lutomer Traminer at 13s. 6d. A rather different wine from the same area is Ranina Radgona or "Tiger Milk"; this is made from grapes which are deliberately picked late in the summer when they have become shrivelled and have a high sugar content. It is a strong and rather sweet wine best drunk well cooled. Zilavka which comes from Herzegovinia in central Yugoslavia is also strong but far drier.

Turning to the red wines several are now available. The Cabernet is a bit rough but one worth trying is "Castle d'Almain" which comes from the peninsular of Peljesac. This is a particularly strong wine which is allowed to ferment fully and thereby reaches 14% alcohol by volume, the maximum for an unfortified wine. It is also described as having "a faint suspicion of sweetness combined with a clean dry after taste", an elusive detail.

HUNGARY

The wines imported from Hungary are without exception of good quality and can all be recommended. Two white wines grown around Lake Balaton are Balatoni Furmint a medium dry, really great news; rather sweeter and particularly smooth is the Balatoni Riesling. Anyone interested in a very dry white wine should try Mori Eserjo a delicate wine which must be well iced before it is drunk.

It is worth remembering that historically the making of wine spread from the east and many of the wines are duly celebrated in legend. An example is Egri Bikaver or "Bull's Blood". It is said that in 1552 the town of Eger was successfully defended against the Turkish army by a handful of men, inspired needless to say by the local wine. It is strong, robust and best kept well out of modern warfare.

In conclusion a mention of the famous Hungarian wine, Tokay Aszu. This is made from a mixture of three different grapes and is a rich golden colour. Well worth getting hold of somehow although the budget has just increased the cheapest variety to 20s. 3d.

GREECE

There is nothing like doing Greece on a shoestring for coming to terms with Retsina. Before the era of the bottle and cork, the resin, which gives this wine its peculiar taste, was essential as it prevented the wine from going vinegary. However it still is included to satisfy what has become a national preference. To be fair, take down the first glass or two fairly rapidly before making a decision about it.

The original and most famous of all Muscatel wines comes from the island of Samos, Vin Muscat de Samos. Apparently this is the wine which Byron went for in a big way. Contemporary verdict: the poet knew his stuff. Samos Sec comes from the same place and is a light and particularly pleasant white wine. Don't expect miracles from Bacchus, a dry red wine which comes from the mainland. But it is strong.

Price Note: unless stated otherwise all the wines mentioned in this review cost between 10s. and 12s. per bottle. They are selected from those shipped by the largest importers. In the case of Yugoslavia — Teltscher Brothers; Hungary — F. & E. May; Greece — Greek Wine Importers Corporation. I am extremely grateful to these companies for the help they have given.

To be concluded

Eating Indian

Our reporter—**John Turner**—confines himself to a few of the more expensive and interesting restaurants. A footnote is contributed by **Mark Whittaker.**

A decent curry should make a meal in itself and anyway by its nature is incompatible with most other foods. The prices mentioned are simply the average cost of a curry including a glass of lager, that admirable flame quencher. I have avoided recommending specific dishes as I have always found that it is easier to be guided by the waiter who will interpret the desired level of heat into proprietary terms, which vary from restaurant to restaurant.

The Star of India (154 Old Brompton Road, S.W.5) Haunt of young accountants, it is usualy fairly full from 8.30—10 p.m., so that booking (FRE 2901) is advisable if you want to eat between those times. The food is good but not exceptional; however the service is rapid and chili peppers are provided on the house. Prices come out around 12s. 6d.

Jamshid's India (Glendower Place, S.W.7). Though rather unprepossessing from the outside, inside it is small and has a very pleasant nocturnal atmosphere. This restaurant has an international reputation and booking (KNI 2309) is essential unless eating early in the evening. Prices are a bit steep (17/6d.) but the food is excellent when it arrives. Service is rather slow but the menu assures that this is due to the loving care being lavished on each dish. Samosas—small deep fried meat pasties—are a very pleasant appetiser while waiting for the main course.

The Naraine (Kenway Road S.W.5). This is a quiet restaurant with decor reminiscent of traditional English rather than Indian. The food again is excellent, beautifully presented and in large helpings. The manager/owner and his wife are very helpful in suggesting suitable delicacies and generally keeping their clients contented. The Naraine is as yet undiscovered by the majority of curryphages so booking is not necessary; it is also one of the few Indian restaurants where the coffee is worth drinking. Price around 15s 0d. and very good value.

Veeraswamy's (Swallow Street, W.1). Within sniffing distance of Piccadilly Circus. It provides undoubtedly the best Indian food in London served in an almost authentic raj atmosphere. All accessories including four different types of chutney, poppadoms, Bombay duck and more are provided with the main course and are a meal in themselves. Though not essential to book it is advisable to do so (REG 1401) otherwise one is obliged to wait in the bar to the further detriment of one's pocket. Expensive (25/-) as Veeraswamy's is, the decor, costumes of the waiters, and of course the food are more than adequate compensation for the financial loss.

With Indian food it is as much the bits and pieces which make up a memorable meal as the curry itself and all the restaurants mentioned provide more than the usual in this respect. Finally if you have eaten too well and none too wisely yoghourt is recommended as a specific antidote to subsequent abdominal distress.

Footnote:

The Indian Grill (106 Mile End Road, E.1. near Whitechapel). All regular curry-eaters should make a point of going to "Rocky's" (Proprietor Raquib). The menu covers all the popular Indian and Persian dishes, with all the sundries. By ringing STE 4877 from College Hall you can have a meal ready for when you get there. Rocky himself cooks special dishes of his own contrivance for his friends. The food is good, the requisite heat will be provided (in the end), and the prices are within a pauper's means.

medicine in literature

A Scene from

WOYZECK

by GEORGE BÜCHNER
(1813-1837)

Translated by John Holmstrom

The story of the play is that Woyzeck, a poor soldier, earns some extra money as the subject in an investigation by the Doctor into the effects of eating only peas. It does, in fact, cause him increasing mental instability, and when he discovers his wife has been seduced by the Drum-major, he murders her.

Scene 9: The Street

(*The Captain comes wheezing after the Doctor: he stops, pants, and looks around.*)
Captain: Hey, Doctor, don't be in such a confounded hurry! And stop waving your stick in the air like that! You're chasing yourself into your grave, I tell you. A good chap with a good conscience doesn't hurry like that. Not a good, decent chap; no. Allow me, Doctor, allow me to save a human life. (*He seizes hold of the doctor's coat*) Doctor, if you knew how damned melancholy I am these days; I mean, it's crazy, I only have to see my coat hanging on the wall and I start crying.
Doctor: Hm! Let me see, now. Fat, puffy, thick neck, apoplectic constitution. Yes, my dear Captain, apoplexy looks a strong possibility. But don't worry, you may only get it on one side, thus only being half paralysed; or on the other hand, with a bit of luck, it may only affect the brain, so that you will survive as a sort of vegetable. Those, roughly speaking, are your prospects for the next four weeks! However, let me assure you that yours is a most interesting case, and should it be God's will that half your tongue should be paralysed, we will make the most immortal experiments.
Captain: Doctor, stop frightening me! Don't you realize that people have frequently died of fright, sheer bloody fright?—Good Lord, I can see 'em already, fellows holding lemons in their hands. But at least they'll say: He was a good chap.—Ah, my devil Coffin-nail!
Doctor: What's that, Captain? . . . Numbskull!
Captain (*folding his coat over*): What's this then, Doctor? One fold! Now look: twofold! (*He cackles shrilly.*) No offence meant, you know. I'm a good chap, really, but I can do it, Doctor, I can do it when I want. (*He cackles again. Woyzeck comes hurrying past.*) Hey, Woyzeck, where are you dashing off to now? Come here and be civil, will you! You run through the world like an open razor, people cut themselves on you. Anyone would think you'd got to shave a regiment of eunuchs and be hanged before the last hair went. But now, what was I saying, something about long beards, wasn't it? Long beards, Woyzeck, you know . . .
Doctor: Long beards under the chin, wearing of by soldiers, to be discouraged. Pliny said so.
Captain (*continuing*): Oh dear, yes, those long beards! You haven't been finding hairs in your soup, eh, Woyzeck? Know what I'm driving at, eh? Human hairs? From the beard of a sapper, or a corporal, or—a drum-major, eh, Woyzeck? But of course you have a splendid little wife; not like other chaps.
Woyzeck: That's right, sir, but—what are you trying to say, sir?
Captain: Look at the fellow's face! —Well, maybe not in the soup, Woyzeck, but suppose you hurried around a certain corner, you might find one on a certain pair of lips. Lips, Woyzeck—ah, I've known what love is . . . Good God, man, you're as white as a sheet!

Woyzeck: Look, Captain, I'm only a poor devil, and she's all I've got in the world. If you're just having a joke, sir—
Captain: Joke? I joke, man?
Doctor: Your pulse, Woyzeck, oh dear, your pulse! Short, violent, jumping, irregular.
Woyzeck: The earth's as hot as hell, Captain—and I'm cold, sir, cold as ice—hell must be cold, I'd bet on it . . . No, it isn't true, though! God, God! It can't be!
Captain: For God's sake, man—your eyeballs are out on stalks! They're going right through me, stop it! I'm only thinking of your good, Woyzeck, because you're a good chap, you know, a thoroughly good chap.
Doctor: Optic muscles tense, rigid, with occasional twitching. Deportment tense, excited.
Woyzeck: I'm going. Anything's possible. That swine! Anything's possible . . . Nice weather we're having, Captain, sir. Nice solid grey sky, sir. Makes you want to bang a pulley into it and string yourself up there, just because of the gap between Yes, and Yes again . . . and No. Yes or No, Captain? Is No responsible to Yes, sir, or Yes to No? I must think about that, musn't I? (*He moves away with long slow strides, gradually accelerating.*)
Doctor (*rushing after him*): Great stuff, Woyzeck! You're earning your rise!
Captain: He makes me quite dizzy, that chap. Look at the speed of them! The big one striding out like a spider's shadow, and the little one trotting behind him; the little one's the thunder, the big one's the lightening! Ha! ha! Grotesque, grotesque!

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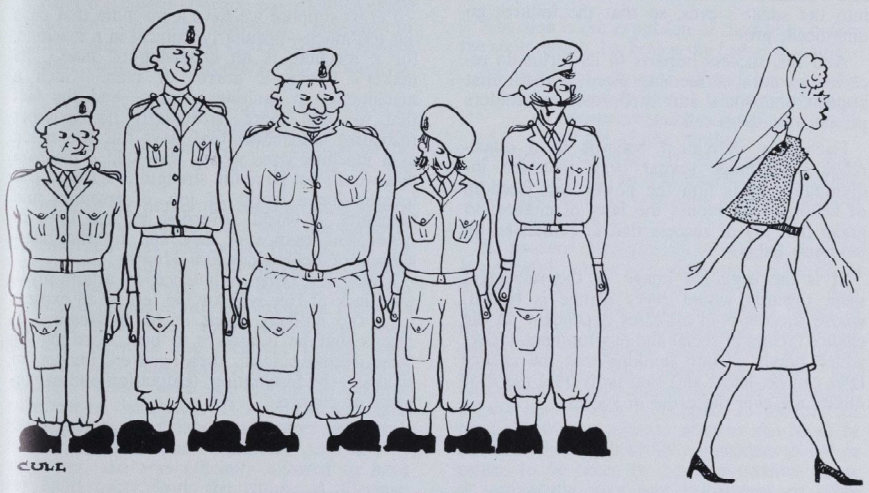

'THE REASONS WHY MEN CONTINUE TO JOIN THE R.A.M.C. (T.A.) ARE DIFFICULT TO SUMMARISE.'

. . . . . from R.A.M.C. (T.A.) by Neville C. Oswald, St. Bartholomew's Hospital Journal, July 1965.

at Charterhouse

Fruit Machines

A fruit machine appeared in the College Hall Bar; after a short trial period it disappeared. Rumour had it that it had been impounded for paying out too much—but then are rumours ever to be trusted? Anyway a machine of sterner stuff appeared in its place and still offers its delights to the weak-minded like me. The incident has provoked the following saddened night thoughts.

THE machine of chance makes its appeal to a very profound dichotomy in modern man, to that deeply felt duality in which his desperate longing to defy the laws of chance sleeps uneasily with a submissive acceptance that these laws are absolute. This is the fascination, the mesmerism, of chance.

But this fascination holds our gaze to success like a small animal blinkered to stare helplessly into the snake's eyes, so that the failures go unnoticed; grey.

And this success imparts to its fortunate receiver an aura of seeming merit, a merit that appears both social and intellectual and confers privilege over his fellows.

Each new individual believes in a quasi-religious—perhaps sexual—way that his individuality lends him the power and freedom of action to overcome the laws of chance; to grasp that joy of success that is demanded by his inner being.

It is the beguiling image of the successful man, towards whom every glance is turned, whose success is in all cases dependent on the chance factors of social and environmental luck; which blinds us into thinking that the chance laws can be defied and that individual merit or ability are ever the cause of success.

The compulsive adulation by each one of us of the man made successful by pure fortune confers on him this apparent superiority and this mutual acceptance, an unreal superiority in relation to his fellows; the basis of the autocratic structure of society, the basis of the desire in each individual to judge every other individual against himself in terms of wordly success, the basis of a class of privilege, of all social misery.

Let us suppose we have a machine that pays out too much—peculiarly ironical in a machine, for a machine is an extension of man's, its maker's desire—a mirror of man. Such a machine is an exciting outrage—and the fact that we, and more particularly its Sponsors recognize a machine that pays out too much as a machine *gone wrong* shows in a measure that we do not have the strength to support our longing for a world of joy, of freedom and benignity, a world governed by the laws of benevolent chance or fate and by the interactions of benevolent individuals.

Man's terrifying impotence to attain joy—total lack of free will (or the refusal to express it in the unlikely event of his possessing it) means that he is always to be fobbed off by these seeming joys, these graven images of success—the fascination, temptation and excitement of chance.

Paul Swain

(*Errata:* we must apologise for an error in the June Journal. The women's Cloakroom Attendant is in fact Mrs. Butterworth, not Mrs. Butter as stated).

ABORTION

by T. J. Clogger

The danger drug, thalidomide, a sedative blamed for the birth of hundreds of deformed babies has brought the problem of legal abortion very much to the fore. The drug was withdrawn in Britain in November 1961 and in July 1962, in the House of Lords it was said that the possibility of a child being born deformed because of the drug, was not in itself a lawful ground for ending a pregnancy.

Abortion in the Republic of South Africa is an offence only at common law, the legislature not having enacted any statute defining or in any way altering the common law crime, as has been done in England by the Offences against the Person Act, 1861. The common law basis for lawful abortion has been correctly summarized in the following passage in *Gardiner and Lansdown* (1929) *South African Criminal Law and Procedure,* 4th edition, p. 296: -

"No crime is committed in those instances in which an obstetrician, under the clear dictates of his science, decides that the removal of the foetus is necessary to save the life of the mother."

Amongst the numerous concentration camps in Germany during the last war, the camp at Ravensbruck was unique in that it was for women only. In the early days no children were officially allowed to be born in the Camp itself. All pregnant women, except a few who managed to conceal their pregnancies, were aborted. Most of the pregnant women were Germans who had become pregnant by Polish workers. These were not eligible to become members of the Reich. If a woman managed to conceal her pregnancy until after the eighth month, when it was considered too late to abort her, she was officially allowed to have her child away from the camp. A German inmate was sent home; while a non-German (usually a Russian, as these women were apparently adept at concealing their pregnancies), to a charitable institution and the mother returned to the Camp. Terminations took place up to the eighth month of pregnancy. The methods used were:

(1) Abortifacients, such as quinine, by mouth, or posterior pituitary extract, in conjunction with the introduction of laminaria tents.
(2) Routine dilatation and curettage.
(3) Abdominal operation. This method was not often employed.

Some cases of late termination by the vaginal route were attended with disastrous results to the patient. (*The Medical Services in the Concentration Camp of Ravensbruck,* H.M.S.O.).

Abortion is the expulsion of the foetus before the sixth month, i.e. before the foetus is viable—

(1) Artificial, abortion caused intentionally.
  (a) Criminal, illegal abortion, because unnecessary for saving the health or life of the mother.
  (b) Justifiable, artificial abortion done for saving the health of the mother.
(2) Spontaneous, occurring naturally without intervention.

To procure or to attempt to procure abortion is unlawful, unless it is done in good faith in order to save the life of the woman. Any woman, being with child, who with intent to procure her own miscarriage, unlawfully administers to herself any poison or other noxious thing, or unlawfully uses any instrument or other means with the like intent, or any person who, with intent to procure the miscarriage of a woman, whether she be or be not with child, unlawfully administers to her or causes to be taken by her any noxious thing, or unlawfully uses any instrument or other means with the like intent, will be guilty of felony (Offences against the Person Act, 1861, s. 58). In *R. v. Brown* (1899) 63 J.P. 790, it was held to be an offence for a woman to take a quite harmless drug because she believed she

was taking a noxious one in furtherance of her intention to cause her own abortion (*Dictionary of Medico-Legal Terms* by Crew and Gibson).

The Report of the Inter-departmental Committee on Abortion, 1939, records the general impression that the annual number of abortions is between 110,000 and 150,000, of which perhaps 40% are criminal. The number is probably now much greater. Dr. Keith Simpson in his book *Forensic Medicine* states that no accurate figures on the incidence of criminal abortion are likely ever to be obtained owing to the natural desire of women to preserve their "successes" as secrets. It is the unfortunate complications that provide the figures. He also reveals at p. 164 that nearly all criminal abortions take place at about the second or third month, when the woman has became certain of the cessation of her periods and morning sickness has confirmed pregnancy. Where means less certain to effect the desired abortion than instrumentation — drugs or repeated vaginal douching—have failed, she may have reached the third or fourth month. Rarely indeed does any deliberate interference other than proper therapeutic procedure take place later than the fifth month.

On a charge of abortion the Crown must satisfy the jury that the accused did not perform the operation in good faith for the purpose of preserving the life of the mother, and the word life must be liberally construed. This was held in the case of *R. v. Bourne* (1939) 1 K.B. 687. The accused, an eminent obstetrical surgeon was charged with the abortion of a girl of fourteen who had been raped. He performed the operation without fee and with the consent of the girl's parents after consulting another doctor. He stated that, after examining the girl, he formed the opinion that the continuance of her pregnancy would cause her serious injury and lead to her being a physical wreck for the rest of her life. The jury acquitted him after a full direction of the law. Macnaghten, J. said:

". . . The killing of an unborn child was by the common law of England a grave crime: see *Bracton*, Book 991. (De Corona), fol. 121. The protection which the common law afforded to human life extended to the unborn child in the womb of its mother. But, as in the case of homicide, so also in the case where an unborn child is killed, there may be justification for the act. Nine years ago Parliament passed an Act called the Infant Life (Preservation) Act, 1929 (19 & 20 Geo. 5, c. 34). Sect. 1, sub-s. 1, of that Act provides that 'any person who, with intent to destroy the life of a child capable of being born alive, by any wilful act causes a child to die before it has an existence independent of its mother, shall be guilty of felony, to wit, of child destruction, and shall be liable on conviction thereof on indictment to penal servitude for life. Provided that no person shall be found guilty of an offence under this section unless it is proved that the act which caused the death of the child was not done in good faith for the purpose only of preserving the life of the mother.' It is true, as Mr. Oliver has said, that this enactment provides for the case where a child is killed by a wilful act at the time when it is being delivered in the ordinary course of nature; but in my view the proviso that it is necessary for the Crown to prove that the act was done in good faith for the purpose only of preserving the life of the mother is in accordance with what has always been the common law of England with regard to the killing of an unborn child. No such proviso is in fact set out in s. 58 of the Offences Against the Person Act, 1861; but the words of that section are that any person who 'unlawfully' uses an instrument with intent to procure miscarriage shall be guilty of felony. In my opinion the word 'unlawfully' is not, in that section, a meaningless word. I think it imports the meaning expressed by the proviso in s. 1, sub-s. 1, of the Infant Life (Preservation) Act, 1929, and that s. 58 of the Offences Against the Person Act, 1861, must be read as if the words making it an offence to use an instrument with intent to procure a miscarriage were qualified by a similar proviso.

"In this case, therefore, my direction to you in law, is this—that the burden rests on the Crown to satisfy you beyond reasonable doubt that the defendant did not procure the miscarriage of the girl in good faith for the purpose only of preserving her life. If the Crown fails to satisfy you of that, the defendant is entitled by law to a verdict of acquittal. If, on the other hand, you are satisfied that what the defendant did was not done by him in good faith for the purpose only of preserving the life of the girl, it is your duty to find him guilty . . . Mr. Oliver wanted you to give what he called a wide and liberal meaning to the words 'for the purpose of preserving the life of the mother.' I should prefer the word 'reasonable' to the words 'wide and liberal.' I think you should take a reasonable view of those words.

"It is not contended that those words mean merely for the purpose of saving the mother from instant death. There are cases, we are told, where it is reasonably certain that a pregnant woman will not be able to deliver the child which is in her womb and survive. In such a case where the doctor anticipates, basing his opinion upon the experience of the profession, that the child cannot be delivered without the death of the mother, it is obvious that the sooner the operation is performed the better. The law does not require the doctor to wait until the unfortunate woman is in peril of immediate death. In such a case he is not only entitled, but it is his duty to perform the operation with a view to saving her life.

". . . Apparently there is a great difference of opinion even in the medical profession itself. Some there may be, for all I know, who hold the view that the fact that a woman desires the operation to be performed is a sufficient justification for it. Well, that is not the law: the desire of a woman to be relieved of her pregnancy is no justification at all for performing the operation. On the other hand there are people, who, from what are said to be religious reasons, object to the operation being performed under any circumstances. That is not the law either. On the contrary, a person who holds such an opinion ought not to be an obstetrical surgeon, for if a case arose where the life of the woman could be saved by performing the operation and the doctor refused to perform it because of his religious opinions and the woman died, he would be in grave peril of being brought before this Court on a charge of manslaughter by negligence. He would have no better defence than a person who, again for some religious reason, refused to call in a doctor to attend his sick child, where a doctor could have been called in and the life of the child could have been saved. If the father, for a so-called religious reason, refused to call a doctor, he also is answerable to the criminal law for the death of his child. I mention these two extreme views merely to show that the law lies between them. It permits the termination of pregnancy for the purpose of preserving the life of the mother.

"As I have said, I think those words ought to be construed in a reasonable sense, and, if the doctor is of opinion, on reasonable grounds and with adequate knowledge, that the probable consequence of the continuation of the pregnancy will be to make the woman a physical or mental wreck, the jury are quite entitled to take the view that the doctor who, under those circumstances and in that honest belief, operates, is operating for the purpose of preserving the life of the mother . . ."

If pre-natal injuries cause the death of a live-born child the crime may amount to murder. This was held by Maule, J. who, in *R. v. West* (1848) 2 Cox C. C. 500, directed the jury:

". . . in point of law that if a person intending to procure abortion does an act which causes a child to be born so much earlier than the natural time that it is born in a state much less capable of living, and afterwards dies as a consequence of its exposure to the external air and puts it merely in a situation in which it cannot live, is guilty of murder."

Coke referred to the killing of an unborn child as "a great misprision and no murder." Willes, J. when he gave evidence on the question of child-killing before the Capital Punishment Commission of 1866 said:

> "I take it that the law is that an injury inflicted upon a child which has not actually been born into the world, causing death before it has been born into the world, even though it has breathed, does not constitute murder . . .; it is right to say that there is authority to the effect that in such cases the mother is guilty of what is called a misprision, but the law of misprision is antiquated, and in truth you will never find an indictment in practice except for concealment or for murder. If that law of misprision could be revived, and if an injury inflicted upon a child unborn could constitute an offence of that description, which would give rise to doubt, the Judge would not be able to inflict an adequate sentence, because the Acts which affect hard labour do not apply, and you could only impose a sentence of simple imprisonment. But practically I think it must be taken that there is no law applicable to that case by reason of the obsolete character of the law of misprision" (B. P. P., 1866, 21, p. 274).

A child is born alive when it exists as a live child, breathing and living by reason of its breathing through its own lungs alone, without deriving any of its living or power of living by or through any connection with the mother (*R. v. Handley*, 13 Cox 79). A woman cannot be convicted of manslaughter merely on the evidence that, knowing she was near the time of delivery, she wilfully abstained from taking the necessary precautions to preserve the life of her child after its birth, in consequence of which it died (*R. v. Knights*, 2 F & F. 46).

Nurses' Column

Never in the field . . . . .

The social scene at present is dominated by The Few*, who are greatly improved, and who have increased their repertoire to include several superb numbers. The group incorporate an electric mandolin with which they are hoping to make their first record this summer. Their enthusiastic efforts certainly provided good value for money for one set (who had invited guests to their block party in hats).

But the House have monopolised most of this month's gossip; the new jobs were awaited with anxiety and interest, but there were few surprises this time. Then there was the House Dinner . . . about which too much has already been said. Despite great efforts to the contrary everyone survived, and it seems unlikely that the bill for damages will exceed four figures.

Although the good weather continues, tennis is disappointingly lacking in support—and how about some new faces at the painting classes?
(*Anyone interested in hiring The Few should contact Bill Castleden, Abernethian Room).

The Good Old Days

An old Bart's man recently told me the story of the occasion of the first inter-firm seven-a-sides when the ball was kicked off by a sister—no less. No prizes are offered for anyone who can suggest which of our present ladies in blue might be best equipped for this arduous task, should the laudable and ancient custom be revived.

Food for thought (from a poem by Ruth Bentley).

Vitamin A's concerned with growth,
(A really vital issue)
With visual purple for the eye
And epithelial tissue.
Both growth and sight are poor without
And horny grows the skin;
Milk, cheese, fish-oils, tomatoes, cress—
All have this vitamin.

(There follows some detailed information in exemplary rhyme, on how to avoid pelagra, scurvy, rickets and worse, with a fine Betjeman-esque conclusion a propos of Vit. K:)

There's anti-haemorrhagic power
In liver and in greens;
There's also some in cauliflower
And some in runner beans.

Answer to Diagnostic Problem (Page 310)

Case 1

Summary: This patient, aged 54 years, a Buddhist working in a Salvation Army printing works, received treatment for pulmonary tuberculosis in 1954.

A bulla was noted at the right base at that time and this has persisted. In 1960 he had a myocardial infarction and a severe recurrence in April 1963 for which he was treated with anti-coagulants. A fortnight after his discharge he was readmitted with severe haemoptysis apparently caused by failure to maintain satisfactory control of his prothrombin percentage after his discharge from hospital.

The film taken three days after his haemoptysis showed a dense opacity at the right base which, in the lateral view has two fluid levels. Most of this shadowing cleared and there remained this egg-shaped opacity which was considered to be due to blood in the emphysematous bulla. It has got progressively smaller since it first appeared, presumably due to the shrinkage of the clot.

He remains reasonably well and is in full-time work.

Case 2

Summary: This patient, aged 70, was diagnosed in 1954 in Brussels as having pulmonary T.B. and received triple chemotherapy with streptomycin, isoniazid and P.A.S. The details of this are not available. An X-ray taken in 1955 showed bilateral apical cavitation. An opacity first appeared in the lower right cavity in 1960 and it was then one inch in diameter. There has been a gradual increase in size and it is now about two inches in diameter. His sputum has been persistently negative for tubercle bacilli. He has had several haemoptyses, one of which required transfusion.

His serum precipitin tests for aspergillus precipitins were positive. His skin test was negative to aspergillus antigen and aspergillus has not been found in his sputum.

On the basis of the typical X-ray appearances and the precipitin tests a diagnosis was made of a mycetoma.

(We would like to thank Dr. T. A. W. Edwards for providing the cases).

NEW PENGUINS

A FILE ON THE SAINTS

The Penguin Dictionary of Saints by Donald Attwater. 6/0d.

The only literary work that can be ascribed with any confidence to God is the Bible. Thereafter He left the field to hagiographers and, by and large, they have not made a good job of it. They have told lies as white as albinos, they have been mercilessly didactic, they have driven the thoughtful to atheism and the rest to torpor—all because they have aimed to edify with wonders rather than relate the truth. With a few exceptions, the only way a saint has been able to ensure that only the truth be known about him has been by writing it himself and it is no coincidence that most of the famous saints have been writers: Augustine, Aquinas, Francis of Assisi, Teresa of Avila, John of the Cross, Ignatius Loyola, Francis de Sales, etc.

For the rest, it has been a poor look-out—humanly speaking, half the value of a saint is lost without a good hagiography. Take Dionysus of Paris, for example—to become a saint with a name like that was not enough—because he wasn't a writer, all we know about him is that he was a missionary to France who eventually had his head cut off, after which he carried it to his place of burial, thus earning the title 'cephalore' (head-carrier). Now if he had had a biographer worth the name (Boswell, say), he might still be an inspiration to us today.

It is a great pity that hagiography has been in such straits, for sanctity is the aim of every Christian and therefore it should be of supreme interest to read the lives of those who achieved it. Donald Attwater has done a marvellous job in this volume in clarifying the vast amount of material and sifting it for what is true and important and interesting. His style is lucid and his historical judgement excellent.

Valuable uses for the book come easily to mind: as data towards a distinction between sanctity and religious mania (cf. Simeon the Stylite, surely a test case); to check up on the latest historical film (e.g. Becket was apparently of Norman parentage, which vitiates one of Anouilh's themes); to get a fair ruling on an ecumenical issue (e.g. re Peter's burial below the Vatican, 'the results of recent excavations there are impressive and of profound interest, but not wholly conclusive on this point'); to look up a patron saint (e.g. that St. Bartholomew's emblem in art is a butcher's knife suggests a new sequence of events as the history of this hospital: Rahere hungry in France, dreams of steaks, resolves to open meat market on return to England, dedicates it to the patron saint of butchers, hospital with same name grows up nearby to deal with butchers' cuts, pious errors by historians); and lastly, of course, the traditional reason, to get inspiration (— and if anyone is in danger of underestimating saints, he should turn to the entries about, for example, Perpetua, Francis Xavier, Peter Claver, or Benedict Labre; or, indeed, passim).

It is easier to look something up in a dictionary than in any other kind of book and the Penguin Dictionaries of Psychology, Music, Science, etc. have proved so good that one has begun to feel their lack on any subject not yet covered. This was especially true of religion and Donald Attwater's volume goes some way to filling it—but at least two more are needed: one of theology and one of denominations.

Jeremy Davies.

PROGRESS TO THE POWER OF HARMONY

Introducing Music by Otto Karolyi. Pelican Original. 6/0d.

Of all the books currently on the market intended for the amateur musician, Mr. Otto Karolyi's recent addition is one of the clearest and best written. It is intended to be read through as a book, but its subject headings enable it to be valuable as a reference book.

Mr. Karolyi cleverly steers a course through the world of musical tabulation and mechanics, explaining as he goes along, with the help of pertinent historical references and charming old pictures and diagrams. He is very careful not to feed the reader too much at a time, preferring to give a good choice of 'Further Reading' for those who wish to pursue the subject.

Many amateurs are apt to pooh-pooh books written for them by professionals—sometimes with justification—because they think they are

being talked down to, but it would be a mistake to think like this about 'Introducing Music', many of the later chapters being quite advanced.

For those who are at any stage of musical development, this book will prove useful, and for those who are prepared to do some concentrated reading it will certainly repay the effort in enlightenment about the mechanics of the art and the sound of the science.

Francis Shaw.

QUAI DES ORFEVRES

Maigret in Court by Georges Simenon. Penguin. 2/6d.

Maigret's Failure by Georges Simenon. Penguin. 3/6d.

Here are two more Penguin editions of books from the master-hand of Georges Simenon, "Maigret in Court", and "Maigret's Failure". Both are excellent, but preferable is "Maigret in Court", a particularly fine example of Simenon's build-up of trivial incidents to provide the incentive and impetus for violent crime. The book starts with an apparently closed case; the accused is on trial. But the inconsistency of a man who loves children needlessly murdering a child, leads Maigret to further minute observation of the man's life and past until violence once more overwhelms him. In "Maigret's Failure" Maigret himself is more closely observed as he seeks the murderer of an arrogant, unscrupulous and sadistic man whom he himself had many reasons to dislike. His failure to protect Fumal adequately while alive, is followed by his failure to produce a murderer to stand trial, but not until his investigations have revealed the hatred and bitterness that surrounded Fumal in his life and the method and author of his death.

Antonia Lloyd Williamson

FORSTER IN INDIA

The Hill of Devi by E. M. Forster, Penguin Books, Price 3s. 6d.

Devi is a sacred mountain which stands above the Indian State of Dewas. Mr. Forster paid two visits to this part of India and here in letter form, as he himself puts it, "attempts" to describe "this amazing little state which can have no parallel except in Gilbert and Sullivan opera"

The state is ruled by twin dynastics whose possessions lie peppered in and out of each other and prove impregnable to the tidy minds of the British administration of the time. This sequence of intriguing anecdotes confirms the traditional picture of an aristocratic Indian community delighting in confusion, corruption and expensive generosity. Forster's host, the young 'Rajah of Dewas, Senior Branch,' appears to have been a fascinating and charming if inscrutable character. The complexity of the Indian hierarchy may be too great for European comprehension but the feuds and intrigues of his court are as comical and passionate as those of Shakespeare's England.

Mr. Forster gives a glimpse of a vanished world which was later more fully revealed in his more familiar book, "A Passage to India."

Elisabeth Macdonald.

MEDICAL BOOKS

Radiology

Principles of X-ray Diagnosis of the Skull, by G. H. du Boulay. London: Butterworths, 1965. Price 150s.

This execellent book is written for the radiologist in training and for those specially interested in neuroradiology, and for them the book is really obligatory. For the undergraduate it is as a whole too detailed and too expensive, but it should be in every hospital library since there is so much in it which the clinician in training should know about, and so many things which it would be convenient for him to look up as occasion arises.

One might mention the changes which can be found when an increase in intracranial pressure is suspected, the differential diagnosis of isolated or multiple translucent areas in the vault and the place of radiology following trauma to the skull; this section should be read by all undergraduates.

The book is clearly written and well illustrated, and for the most part the reproductions do show the features which they are trying to demonstrate, and it fills a much needed gap in the radiological teaching.

G.S.

Principles of Bone X-Ray Diagnosis. Second Edition. George Simon. Butterworth. London. 1965. Price 67s. 6d.

Dr. Simon's book about bone disease has already proved its usefulness, and is valued by many student radiologists and younger clinicians. This is the second edition, and there are improvements and additional illustrations. Its great merit lies in the method whereby the mind is trained to use radiological evidence. The chapters concern themselves with manifestations of disease arranged in broad groups, e.g. "Increases in bone density" and "Alterations in bone shape", whose sub-divisions indicate which disease may present such an appearance and discuss the differential diagnosis. This is the usual way in which radiology is practised on patients before a diagnosis is reached, and it is extremely good training to be made to think in this fashion. The book is therefore a kind of study-exercise forcing the reader to re-classify his existing knowledge (one of the most effective methods of learning) and also, of course, filling in many gaps.

Basically it is an elementary book and because it reveals so much about the discipline it is an excellent primer in radiology for medical students and those who have recently qualified. Radiology, being a method of looking at morbid anatomy below the skin, is half-way between the bedside and the laboratory and is used or mis-used on almost every patient who reaches hospital. A simple radiological textbook, just as a simple pathological text-book, ought to be essential reading at an early stage in clinical training. The one danger is that Dr. Simon is so lucid that the untrained may over-simplify the subject and not realise the elaborations of technique and the complicated decisions about its application, in clinical management and in research, which modern radiology needs.

Dr. Simon himself, as many will know, exemplifies in his work the fact that the complexities of modern radiology make a radiologist a member of the clinical team. His book provides the simple background.

G.H. du B.

Radiology for General Practitioners and Medical Students, by Dr. David Sutton. Published by E. & S. Livingstone. Price 12s. 6d.

This is a small, concise and informative book covering in a brief and simple manner the scope, application and uses of Diagnostic Radiology. There is little to be criticized in this publication other than a few minor suggestions which might be incorporated in the next edition.

1. In examining the duodenum the appearance known as Frostberg's sign is mentioned without description. This is given much later in the book when it might with advantage have been inserted when the term is first used.
2. Comment is also made that small diverticula are often detected in the duodenum although in fact many of the diverticula seen are of considerable size, some indeed being very large.
3. In relation to lack of filling of the gallbladder by opaque medium given orally the occasional occurrence of pyloric stenosis, with retention of the opaque medium in the stomach, has not been included.

There has to date been lacking a small concise hand-book which Medical Students in particular could read with advantage about the field which Diagnostic Radiology now covers and to have made clear to them in concise terms how the more involved radiological examinations are undertaken. This book at last fills the gap which has been conspicuous for many years in Radiological literature. It can be commended to their perusal in the knowledge that the reading of 83 pages including 74 illustrations would add greatly to their knowledge within a short time.

R.A.K.H.

Surgery

Bailey & Love's Short Practice of Surgery—13th Ed. Revised by A. J. Harding Rains & W. Melville Capper; Published by H. K. Lewis & Co. Ltd. Pp. 1286; Price: £4 4s. 0d.

"The time has now come for others to carry on our work" writes McNeill Love in the Foreward.

This universally popular textbook has been a best-seller for over 30 years and with the death of Hamilton Bailey, his co-author, he has handed the responsibility for the 13th Edition (189th thousand!) to the next generation of surgeons. Professor Rains and Mr. Capper (a Barts' man incidentally) have had the task, together with many leading experts, of completely revising and modernising the text and illustrations. This they have done successfully without adding to the length of the book. In fact the new edition is 10 pages shorter!

The biggest change is a reorganization of the initial chapters dealing with the fundamentals of surgery and they have brought the subjects of infection, haemorrhage, shock, electrolyte balance, burns etc., up-to-date. These chapters were in need of revision and this has been successfully done.

There is a new chapter on the diseases of arteries and veins with the modern approach to their treatment. In these days of increased immigration, tropical lesions which may be encountered by the surgeon are given more scope.

Each chapter (now headed with Arabic rather than awkward Roman numerals) has been scrutinized. Recent advances in management have been incorporated and "dead wood" discarded.

However, the revisors, to their credit, have retained the popular characteristics of the book and superficially, with its easy-to-read type and well-headed subject matter, it looks much the same as its predecessors.

The illustrations are still profuse and have been rearranged and added to, yet space has been saved. I think the reproduction is better than before. Some of the classic Bailey & Love "cartoon" illustrations which have helped to impress a fact on many a student are retained but could probably be dropped without undue loss. For example, the widow Dimanche's sebaceous horn, the country squire impaled on his shooting-stick and the city gent slipping astride the man-hole cover.

The helpful biographical and etymological footnotes remain, though I note that the christian name of our Professor of Surgery is misquoted!

Conclusion—this modernised version of the most popular pre- and post-graduate surgical textbook maintains the high standard of its originators and despite its new editorship it will continue to be known as Bailey & Love (—and the price is unchanged).

N.G.R.

The Principles and Practice of Surgical Nursing by D. F. Ellison Nash. Published by Arnold. 3rd edition. Price 50s.

When Mr. Nash first published his surgical textbook for nurses in 1955, the number of books written specially for student nurses was not as great as it is today, and many of these were not very distinguished. He wrote it for an intelligent audience who would want to understand something of the scientific bases of their art, and not merely as an aid to passing examinations. The justification for his belief that this intelligent audience existed is shown by the issue of the third edition ten years after the date of publication.

The size has increased by 50 pages from the last edition, and the price by 14s. It is now near the limit of convenience in handling, and as new material is required, less-used equipment (such as Potain's Aspirator, Fig. 34, 9) could be deleted.

Turning to the new material, one finds a good account of the cytotoxic drugs and their action. The thoughtful discussion on the management and needs of cancer patients is of great importance to student nurses, who feel much anxiety and uncertainty about this situation. The section on arterial disease and the measures that can be taken by the surgeon to alleviate it is informative, interesting and well illustrated. The chapter on the adrenal glands is new, and the importance of these glands in surgical nursing is fully described.

The type, paper, illustrations and layout make this an attractive book to handle. We in this school are proud to have Mr. Nash as one of our teachers, and wish him every success with his new edition.

W.E.H.

Dermatology

Skin Diseases in General Practice, by F. Ray Bettley, T.D., M.D., F.R.C.P. **With chapter by Denis Hill,** M.B., F.R.C.P., D.P.M. Published by Eyre and Spottiswoode. Price 45s.

As a G.P. with a special interest in dermatology, I have read this book with pleasure and profit. The author's selection of the commoner skin diseases is to be strongly commended, with the exception of two minor quibbles, (a) that pityriasis rosea might have been given more prominence with a photograph of the typical distribution of the rash and herald patch, and (b) Guttate psoriasis, which is probably the commonest initial presentation of psoriasis in general practice, also deserves a paragraph.

The chapters dealing with eczema in its varied manifestations are excellent. This is the commonest dermatological problem for the G.P. and the author gives generously of his wisdom and wide experience. His sound advice on certification of occupational dermatitis is a valuable summary of this perennial problem with its pitfalls for the unwary. He clarifies the issue of multiple hypersensitivity. In the treatment of eczema he recommends the value of a limited number of remedies, well tried and skilfully used.

Some aspects of treatment that appear in this second edition, might well have been dropped, e.g. the description of Unne's paste bandaging, which I imagine, has never been seen by the younger generation of general practitioners. Also, words like "opotherapy" and "skeptophylaxis" are out of place in a book of this type. I would put in a special plea for greater use of carbon dioxide snow therapy in general practice—a cheap and useful form of treatment for warts, acne congoblata and the nodular lesions of rosacea.

Dr. Denis Hill's contribution on the psychological aspects of skin diseases is presented in a very interesting manner with excellent case histories. Would that the results of psychotherapy in the treatment were always as successful as in these cases.

The photographs in black and white are excellent illustrations of the conditions described. Finally, this is a book I can strongly recommend to the G.P. or the final year student.

A.P.

Manual of Dermatologic Syndromes, by Dr. Butterworth; McGraw-Hill Publishing Co. Ltd., 28s.

This manual, although well intentioned, is more likely to encourage dermatological brinkmanship than an understanding of the subject. While it offers some ease of reference to symptom-complexes, eponymously or otherwise labelled, by its brevity it is inaccurate and often lacks any sense of priorities.

In the introduction the authors take the trouble to point out that "when seemingly unrelated pathologic conditions occur as a result of a known biochemical abnormality, the complex is recognised as a 'disease'. The term 'syndrome' is a very convenient substitute for a description of a symptom-complex which would require a plethora of words to insure accuracy and clarity." Yet on page 1 they list adrenal cortical insufficiency as the Addisonian Syndrome, when by definition it should be referred to as a disease.

This publication does not fulfil its need adequately and it is hard to recommend its purchase at a price of 28s.

T.W.E.R.

Immunology

Immunology for Students of Medicine, by J. H. Humphrey and R. G. White. Second Edition. Oxford: Blackwell Scientific Publications. Pp. 498. Price 47s. 6d. net.

Few subjects can have rivalled immunology in evolving in a few years from a tedious, super-science bringing tears and groans from students and teachers alike, into a vital bedside subject, bursting with clinical applications and explanations. Only a tiny fraction of the large number of people currently thinking immunological thoughts and using immunological techniques have had any formal training in the subject. With the possible exception of biochemistry, no complex science has been so widely (including widely of the mark) applied on a do-it-yourself basis. The new disciples have brought to the fusty subject great energy and enthusiasm, little discipline, and—since they spent so much time groaning in the lectures— very sketchy backgrounds. The result has been enormous output, endless repetition and some real advances. We are over the first stage and the time has come for a quiet remustering of immunological forces. Just at the right moment, Humphrey and White produced their excellent, full and lucid account of the whole subject. The first edition having been gobbled up by hungry would-be immunologists, the second revised edition has already appeared. If you can't get any lines on your Ouchterlony plate, read it. You may find you don't need to do the experiment after all.

F.O.G.

SPORTS NEWS

Editorial

POLITICS AND SPORT

In this present era when politics are playing an increasing part in so many spheres of life the question frequently crops up—should politics and sports be mixed?

With the arrival of the South African cricket team in this country for their summer tour the topic has again received much wide-spread publication, and our attention has been drawn to this in our daily newspapers by such well known sports critics as J. L. Manning. Last year in the Olympic Games at Tokyo the Olympic Committee took the unprecedented step of banning South Africans from taking part in the games. Then only recently at Wimbledon, with the presence of the Russians and their political outlook, the question arose again. At Wimbledon in 1964 and in many of the major lawn tennis tournaments this year the Russian players made their own political stand against apartheid in S. Africa by withdrawing from the tournaments when faced by a S. African opponent. Obviously this attitude could not be tolerated at Wimbledon (the greatest tennis tournament in the world) by those who are responsible for ensuring the smooth-running, and maintaining the standard, of the tournament. They quite rightly felt that the championship should not be marred because of political differences between two countries. Thence the Russian players had to undertake not to withdraw from the competition when faced by a S. African opponent if they were to be allowed to play. The players did this, not on their own undertaking but only after advice had been received from higher authorities within the Soviet Union. Clearly in this instance it was not the players who wished to make their feelings known in this way, but the affair arose as the result of political interference from administrators who probably were not even interested in the game. This was a splendid example of a very capable authority squashing mis-directed political interference.

Returning to the S. African cricket team, we saw ample evidence of the considerable anti-apartheid following in this country even before the tourists had arrived. Through one medium or another this following is endeavouring to persuade cricket supporters to make their stand against apartheid by boycotting all the South African matches played in this country. On their last tour here three years ago, despite the slogans of the anti-apartheid followers, the efforts to disrupt the S. African matches failed miserably for there was no noticeable drop in attendance or change in the attitude of cricket lovers. These people obviously felt that here was a cricket team they wanted to watch and, irrespective of political influences brought to bear in the selection of the team, they were going to follow their progress. To them cricket was a game and whatever the conditions or rumours enveloping the game, the game itself would not change and would still provide entertainment.

However, in the past year with so many incidents to remind us of this tremendous problem the position may well have changed. Already one man of very high authority has spoken out against apartheid and many will probably follow his example. We refer of course to that great cavalier of West Indian cricket, Sir Learie Constantine. He has said that he feels his conscience is such that he must give vent to his feelings by refusing to report on all the S. African matches in the Daily Sketch (for whom he is sports correspondent). Here is a man who is an elder statesman, having been High Commissioner for Trinidad and Tobago and who at the same time is one of the world's leading authorities on cricket. A man surely, who must have given the problem much thought before deciding to make his own stand against apartheid in this way. He believes that by doing thus he will help to break down the barriers of apartheid in sport—but will he?

Few in this country can tolerate political apartheid, even where it is applied to sport, but what are people like Sir Learie Constantine and the anti-apartheid followers acheiving by their own petty demonstrations? All that these demonstrations are likely to achieve is to widen the existing rift. Because people show a certain distaste for the S. African cricket side, the latter will hardly return home and insist that the administrators select coloured Africans to represent them. Apart from anything else they are indoctrinated to believe that there is no coloured African worthy of selection to play in a Test side. No, political policies of a nation are not going to be radically changed because of a few feeble demonstrations at a cricket match. For sport to survive in this present generation, where too many people are content to put their feet up and watch television, what is needed is wholehearted support from the genuine enthusiasts. In most cases the people who try and bring politics into sport are not such but comprise the sort of person who enjoys stirring up trouble. In this respect Sir Learie Constantine is an obvious exception but even he must realize that his move is a step backwards rather than forwards. As long as people try to influence sport with political propaganda they will assist merely at the death of something, which is at the moment at a very low ebb, and will merely embitter themselves in the eyes of true sports enthusiasts. After all any sport is only a game and is played purely for the enjoyment of player and spectator so why mar it with politics?

GOLF CLUB

Wednesday, June 3rd. University Championships at Denham.

Bart's entered a team of five players for the Championships. On a beautiful day when scoring conditions were ideal there was no excuse for the high returns from the large entry. After the morning round Atkinson was favourably placed with a 72 nett but fell away in the afternoon, while Sadler and Bowen played steadily all day and finished 4th—on nett score. Bart's managed to finish 3rd out of the 10 teams entered, Guy's winning easily from the College of Estate Management.
Team:—Atkinson, Bowen, Sadler. Also played Vartan and Grieve.

Tuesday, June 15th, v. Chislehurst Golf Club at Chislehurst.

This now annual fixture was for the second year running played in very wet conditions and correspondingly the standard of the golf deteriorated. The match ended with a very satisfactory result of 5 games all. When the holes were added up even these were equal and so it was a very honourable half. The game was followed by a most enjoyable evening with the members of Chislehurst Golf Club and we extend our grateful thanks for all they have done for Bart's.
Team: M. Bowen, R. E. Atkinson, D. Grieve, C. Vartan, J. Sadler, R. Begent, M. Hares, C. Richards, G. Kerrigan, J. Pemberton.

Wednesday, June 16th, v. St. Mary's at Moor Park **(Cup Match).**

After the dilemma of who to leave out of the team the problem was settled when M. Bowen was unfortunately involved in a car accident on Tuesday night. Despite his absence the team rose to the occasion, and R. Atkinson in cavalier style showed the way to victory with a convincing win. A victory by 3 games to 2 means that we now face Middlesex in the semi-finals with a very good chance of reaching the finals. Team: D. Grieve, C. Booth, R. Atkinson, J. Sadler, R. Begent.

The Summer Meeting of the Golfing Society was held at the Thorndon Park Golf Club on Wednesday, 16th June, when 19 members attended.

The competitions were held under the Stapleford method of scoring, and were won by the following members:

Gordon-Watson Cup:	J. O. Robinson	37 pts.
Runner-up	P. Sleight	34 pts.
Gillies Trophy:	T. Coltart	30 pts.
Corbett Cup:	M. Pare tied with L. Garrod. Won by Pare on the last 9 holes with 14 pts.	

The Autumn meeting of the Golfing Society will be held at The Royal Wimbledon Golf Club on Thursday, 14th October.

M.M.B.

THE SWIMMING CLUB

On June 16th the A.G.M. was held and the following officer's elected:— to Captain, D. Hanley: to Secretary, J. S. Blackburne. The retiring Captain exercised his right to talk at length and among the swimming topics mentioned were:— That the year had been quite successful and the tour, even though it may not have been a great swimming success had certainly been a social one; that P. Quinn had represented the University in the individual medley event and finally that Doug Patterson who had been the non-medical dolphin expert for the hospital had now decided to return to Canada to start his medical course. In the evening a triangular match was held with St. Mary's Hospital and the City of London Old Boys when Barts, apart from providing a large attractive female audience, only really distinguished themselves by winning the free style relay, and the backstroke (D. Hanley). P. Quinn did very well to finish second in the 100 metres freestyle as he was against some very strong opposition.

On Friday June 18th the U.H. swimming heats were held and P. Quinn and D. Hanley qualified for the finals as also did the relay teams. The finals were held on the 24th. D. Hanley came third in the backstroke and the relay teams comprising Anderson, Britton, Coburn, Hanley, Lask, Jolly and Quinn quite surpassed themselves in coming second equal in the Medley event and second in the freestyle event, which overall meant that Bart's has now moved up from lying sixth in the U.H. table to third equal.

J.S.B.

BADMINTON CLUB

Last winter is the first season that competitive badminton has been played at Bart's. The results obtained by our two teams in the University League have not been remarkable but do show that there is sufficient interest and ability in the Hospital to justify the existence of a club.

The **Men's team** has had an unfortunate series of injuries and two matches have been conceded because of our inability to produce a team. These difficulties meant that it was impossible to keep regular pairs but Mathur, Anderson and Freeth played well with their varying partners. The one pair who played regularly together, Allen and J. Pilling, were consistent at a fair standard. Curry, Clark and Hudson also played.

Results: *P* 10 *W* 3 *L* 7

The **Mixed team** has played well, often against much stronger and more experienced opposition. We have good ladies and we have been particularly fortunate on occasion in being able to call upon Miss Foley, the secretary of the University Club. The regular first couple V. K. Mathur and Miss Taverner were beaten very few times throughout the season but again lack of frequent play together by any other couple produced the inevitable result. The other ladies who played were Miss S. Byrne, Miss V. Dent, Miss J. Williams, and Miss J. York.

Results: *P* 9 *W* 3 *L* 6

Every Friday evening during the season is a Club Night to which all badminton players in the Hospital are invited. This is the opportunity for team couples to practise together as well as for novices to improve their play. Those who have played at Club Night this season have enjoyed their badminton but would welcome many more.

Club Night reopens on Friday 17th September.

All home matches and Club Nights are held in the gymnasium of the Medical College, Charterhouse Square. The court is free to play whenever the gym is not in use by other clubs.

J.B.P.

CRICKET CLUB

Inter Hospitals Cup—1st Round v. St. George's at Chislehurst on 8th June.

It was a bright and cheery day that witnessed a sad start by Bart's. George's won the toss and saw fit to put the home team into bat on yet another beautiful Foxbray track. The first ball of the day sent our No. 1 back to the pavilion bowled for a golden. R. Hand and G. Hopkins, facing an embarassing scorecard reading 1 wicket for 0 runs, then settled down and steadily pushed the score up to 29 before Hand was beautifully picked-up in the slips. N. Griffiths joined Hopkins and proceeded to lay the foundations of a great knock. These two eased the bowling away for those most welcome ones and twos before Hopkins in aggresive mood was caught when the score was 51. He had made a useful 24.

J. Gately and Griffiths, now went on to build a formidable total and 135 for 3 at lunch augured well for Bart's. After lunch both continued to bat in savage form producing a fourth wicket partnership of 158. Griffiths scored 95 before being lbw whilst Gately carried his bat through the innings for an invigorating 110 (not out). This was his maiden ton and a truly fine example of foot work and concentration.

Bart's declared at 296 for 8 wickets.

Bart's innings:—

R. Higgs, b Williams	0
R. Hand, ct. Spence, b Ward	14
G. Hopkins, ct. and b Collins	24
N. Griffith, lbw Marriott	95
J. Gately, not out	110
R. Wood, ct. Olsen, b Marriott	13
G. Major, ct. Sayer, b Walmsley	7
D. Berstock, st. Olsen, b Walmsley	0
C. Vartan, run out	11
J. Harrison, not out	12
Total (for 8 wickets) ...	296

P. Savage did not bat.

Fall of Wickets: 1 for 0; 2 for 29; 3 for 51, 4 for 209; 5 for 229; 6 for 245; 7 for 246; 8 for 296.

A tired and disappointed St. George's now faced a large total and a potentially good bowling attack in the form of Vartan, Savage and Harrison. A bitter uncertainty remained though as to how efficiently Bart's could bowl on a wicket that had proved most pleasant to bat on.

All uncertainty was soon removed when Savage dismissed George's No. 1 in his first over. Vartan soon left his mark and within 15 minutes George's were reduced to 3 runs for 2 wickets. By tea their skipper, Collins (57) had rallied them to 30 for 2.

However, after tea wickets fell cheaply. Harrison bowled well making short work of the tail-enders. St. George's were all out for 132 runs.

Bart's Bowling:—

	Overs	Maidens	Runs	Wkts.	Average
Savage ...	15	6	26	3	8.66
Vartan ...	13	2	26	2	13.0
Harrison ...	6.5	1	13	4	3.29
Griffiths ...	11	2	38	0	—
Berstock ...	5	2	10	1	10.0

Inter Hospitals Cup—2nd Round v. Guy's at Honor Oak Park on 17th June.

This was a game of mixed fortune for both sides. Vartan was lucky enough to win the toss, and he asked Guy's to bat first on what appeared to be a dampish wicket.

This soon appeared to be a very good decision, and Guy's opening batsmen were soon in trouble against the opening attack of Savage and Vartan. Within the first half hour of play, Guy's had scored twelve runs for the loss of their first four batsmen. Savage bowling with the wind behind, and from the more lively end was very hostile and difficult to get away.

However, with this fine start Bart's then went through a bad period. Guy's number 6 batsmen in the space of the next hour and a half was dropped four times, and went on to make 50, Guy's going into lunch at 89 for 4.

After lunch Savage again struck quickly bowling the No. 6 batsman in his first over, and from then on Guy's wickets fell at regular intervals until they were all out for 165 at 4 p.m.

P. Savage and C. Vartan returning the excellent bowling figures of 5-65 and 3-40 respectively.

In the forty minutes before tea Thomas and Higgs together put on 35 runs without being separated. But it was ominous how frequently they were playing and missing at Knoot, a fast and hostile bowler.

After tea this proved to be so when Knoot yorked Thomas for 20. Higgs soon followed, and with Griffiths and Gately getting themselves out to stupid shots the score had altered from 35 for 0 to 56 for 4. The tide had now turned in favour of Guy's, and with Knoot bowling well from one end, and an accurate slow bowler tempting us from the other end there followed an anxious period. However, with Hopkins now playing the fast bowler well and Delaney occasionally hitting a four the score progressed to 96.

Hopkins after an excellent innings fell prey to the accurate slow bowling, soon to be followed by Wood. Thus at 96 for 6 the tide had turned once more and the game was wide open.

Delaney and Berstock, although both being dropped early in their innings, batted very sensibly, and the score progressed onwards. It was not checked by bringing back Knoot who only bowled at half pace. It was perhaps that he had bowled 20 overs previously without being given a rest that cost Guy's the game.

Finally Delaney and Berstock passed the Guy's total with fifteen minutes to spare. Delaney scoring a match saving 50, and Berstock adding 30 very promising runs in this his first important Cup Match.

Team: C. Vartan (capt.), J. Gately, P. Savage, J. Harrison, S. Thomas, D. Delaney, R. Wood, G. Hopkins, R. Higgs, D. Berstock, N. Griffiths.

Bart's innings:—

S. Thomas, b Knoot	20
R. Higgs, ct. Jones b Davoodbloy	9
G. Hopkins, ct. Crots, b Davoodbloy	28
N. Griffiths, ct. McGregor b Knoot	8
J. Gately, ct. Jones, b Davoodbloy	0
D. Delaney, not out	53
R. Wood, ct. Jones, b Davoodbloy	4
D. Berstock, not out	30
Extras ...	13
Total (for 6 wickets) ...	167

P. Savage, C. Vartan, J. Harrison did not bat.
Fall of Wickets:—1 for 35; 2 for 37; 3 for 53; 4 for 56; 5 for 93; 6 for 97.

Guy's innings 165 all out.

Bart's bowling figures:—

	Overs	Maidens	Runs	Wickets
P. Savage	25	4	67	3
C. Vartan	18	3	40	5
J. Harrison ...	9	5	18	0
N. Griffiths ...	14	5	18	0
D. Berstock ...	2	0	5	0

Saturday, May 29. v. R.N.V.R.

R.N.V.R. batted first and Savage and Vartan soon had the batsmen in trouble, the former taking a wicket in his first over. The batsmen found runs hard to come by off accurate bowling, and after 2 hours the R.N.V.R. were 76 for 6 wickets; the wicket now became easier and with the latter batsmen chancing their luck they were able to declare at tea 140-8.

On resumption Hand and Higgs soon were amongst the runs and they were not separated until 60 runs were on the board. On completing his 50 Higgs hit 21 off the next two overs before he was out and Bart's went on to make the necessary total with half an hour to spare. Result: R.N.V.R. 140-8 dec. (Harrison 3-28, Savage 2-25). Bart's 141-3 (Higgs 71, Hopkins 20).

Team: C. Vartan (capt.), J. Gately, R. Higgs, P. Savage, J. Harrison, G. Hopkins, D. Husband, D. Berstock, R. Hand, C. Grafton, N. Griffiths.

Saturday, June 5th. v. Queen's College Cambridge.

Bart's batted first and thanks to some patient innings by Harrison, Wood, Gately and Vartan amounted a total of 162 for 9 before declaring at tea.

Queen's also found runs hard to come by off the opening attack of Vartan and Harrison, and it was not until some of the lesser known bowlers were given a chance did Queen's score increase more rapidly, then with the batsmen throwing their bats at everything Queen's very nearly reached our total, being 3 short at the close of play.

Result: Bart's 162-9 dec. (Wood 32, Vartan 29, Gately 28 not out, Harrison 26). Queen's 159-4 (Vartan 2-41).

Team: C. Vartan (capt.), J. Gately, R. Higgs, R. Wood, J. Harrison, D. Husband, P. Raine, W. Goss, S. Thompson, R. Kendrick, N. Griffiths.

Sunday, June 6th. v. Parkfield.

Bart's 174 for 3 dec. (Higgs 81, Griffiths 43, Major 26 not out). Parkfield 104 for 6 (Vartan 2-39, Harrison 2-39, Husband 2-16).

Team: C. Vartan (capt.), R. Higgs, G. Major, D. Husband, J. Carmor, R. Browne, S. Thompson, J. Pemberton, P. Bradley-Watson,

Saturday, June 12th. v. Old Tauntonians.

Old Tauntonians 126 (P. Savage 6-25) C. Vartan 2-30). Bart's. 127-5 (J. Gately 34 not out, D. Berstock 21, J. Harrison 29).

Team: C. Vartan (capt.), J. Gately, R. Higgs, P. Savage, G. Hopkins, D. Berstock, P. Raine, D. Pope, J. Pemberton, R. Browne, N. Griffiths.

Sunday, June 13th. v. Horlicks.

Horlicks 77 (P. Savage 3-19, J. Harrison 1-26, N. Griffiths 3-5, C. Vartan 2-20). Bart's 78-1 (R. Higgs 50 not out).

Team: C. Vartan (capt.), J. Gately, R. Higgs, D. Delaney, J. Harrison, H. Padfield, R. Hand, P. Savage, P. Raine, P. Bradley-Watson, N. Griffiths N.J.G.

LAWN TENNIS CLUB

Report on matches 1st June-25th June.

Due to the lack of both suitable weather, and ability of many of our opponents to raise a team, there has been a remarkable lack of match tennis this month. In fact only 4 matches have been played 2, by the 1st VI and 2 by the 2nd VI. Consequently, we have had more than the usual number of useful if not always so enjoyable practices at Chislehurst.

1st VI. Cambridge Tour 1965.

The tour of 4 matches against College teams was arranged for June 9th-12th. Although rain reduced the number of matches played to 2, the social life at that particular time in Cambridge more than made up for the lack of tennis. In fact, we found the Colleges more eager to entertain us at cocktail parties than play us at tennis.

Thursday, 10th June v. Pembroke College. W 5-3.

Our 1st pair of Edelsten and Setchell played well to win all their 3 rubbers.

Garrard and Ireland, the 2nd pair, won 1 and lost 1 with Ireland also beating his opposite number in a singles game.

Unfortunately, C. Roche-Berry sprained a shoulder muscle early in the match, and continued playing only with a good deal of pain. To a large extent, this contributed to the 3rd pair loosing 2 rubbers, the 3rd one not being played.

Friday, 11th June v. Clare College. W 5½-3½.

As we started this match rather late it was decided that each rubber should be only 2 sets, with both sides taking a ½ if this resulted in 1 set all.

Edelsten and Fryer, the 1st pair, played steadily if not spectacularly to win their 3 rubbers without losing a set.

The 2nd pair of Garrard and Ireland drew all their 3 rubbers 1 set all.

The 3rd pair of Setchell and Roche-Berry played well to draw 2 and lose 1 rubber.

Thus the match ended in a 5½-3½ victory.

2nd VI.

Thanks to the able captaincy of M. Nightingale, the 2nd VI has shown consistency in both play and results. So far they are unbeaten in 5 matches.

Results:

Saturday, 22nd May v. London Hospital 2nd VI. W 6-3.

Both the 1st couple of Wenger and Roche-Berry and 2nd couple of Nightingale and Farrow, won all their rubbers. The 3rd couple of Trowell and Brueton were unused to match play and lost their 3 rubbers.

Saturday, 19th June v. Guy's Hospital 2nd VI. W 9-0.

Although this was a rather hurriedly arranged match resulting in the opposition not putting out their strongest 2nd VI, this was a remarkably fine victory, and helped compensate for the 7-2 beating of our 1st VI by Guy's earlier.

All 3 pairs of Wenger and Roche-Berry, Nightingale and Farrow, and Spencer and Heyworth won all their 3 rubbers without dropping a set.

M.E.F.

ATHLETICS CLUB

Saturday, May 29th.—County Championship.

Every County holds its athletic championships on the week-end before Whitsun. In the Nottinghamshire championships Brian Scott gained second place in the 440 yards hurdles and third in the 120 yards hurdles.

In the Dorset championships John Coltart came third in the 440 yards and Malcolm Freeth fourth in the 100 yards.

Thursday, June 4th.—v. Goldsmith's College at North Cray.

The club continued its successful run with a convincing victory aided by Mark Orr who captained the club four years ago. Particular mention must be given to the 4 x 440 quartet Coltart, Thompson, Sutton and Scott who averaged 54 secs. per man in beating the Goldsmiths team by some hundred yards.

100 yards: 1. Freeth, 3. Coltart, time 10.7 secs.; 440 yards: 1. Sutton, 2. Scott, time 53.4 secs. 1 mile: 3. Thompson, 4. Sanders, winners time 4 min. 26.8 secs.; 2 miles: 3. Thompson, 4. Sanders, winners time 9 min. 56 secs.; Long Jump: 1. Jefferson, 2. Rawlinson, distance 18 ft. 8½ ins.; Triple Jump: 3. Jefferson, 4. Sutton, winners distance 40 ft. 6½ ins. High Jump: 2. Rawlinson, 3. Scott, winners distance 5 ft. 7 ins.; Shot: 3. Orr, 4. Rawlinson; Discus: 2. Cooper, 3 Orr; Javelin: 1. Rawlinson, 2. Orr; 4 x 110 relay: 1. Bart's, 2. Goldsmith's. 4 x 440 relay: 1. Bart's, 2. Goldsmith's.

Match result: 1. Bart's 85 pts., 2. Goldsmith's 71 pts.

Wednesday, 16th June, v. Westminster Bank at Norbury.

In continuous rain the athletic club entered its winning run with a convincing victory over the Bank. Although the rain minimised the performances the Bart's strength in the middle distant events was particularly obvious and Chris Sutton's quarter in 53.7 secs. deserves special merit.

100 yards: 3. J. Coltart, 4. D. Goodall; 220 yards: 1. B. Scott, 3. D. Goodall; 440 yards: 1. C. Sutton, 2. B. Scott; 880 yards: 1. C. Sutton, 2. J. Coltart. 1 mile: 2. R. Thompson, 3. D. Tunstall-Pedoe; 5. R. Sanders; Javelin: 1. K. Rawlinson, 3. M. Orr; Long Jump: 1. D. Jefferson, 2. Westminster Bank.

Match result: 1. Bart's, 2. Westminster Bank.

Thursday, 17th June, v. King's College Hospital at Dog Kennel Hill.

In fair weather Bart's suffered a very disappointing defeat at the hands of King's. We were abysmally weak in the field events except for the fine javelin throwing of Keith Rawlinson with a winning throw of 174 feet. However, it must be added that King's produced much stronger opposition in the field than we expected and emphasized the danger of under estimating one's opponents. Robert Thompson, Dan Tunstall-Pedoe and Roger Sanders ran their opponents into the track in the mile and three miles lapping the King's competitors in the latter event.

John Coltart easily won the 880 yards and with the match lost restored some of our spirit by breaking the track record in the 440 yards winning in 53 secs. It must be added that the track at Dog Kennel Hill as its name suggests has an uphill stretch.

Results:—100 yards: 3. M. Freeth, 4. B. Scott; 220 yards: 2. M. Freeth, 3. B. Scott; 440 yards: 1. J. Coltart (track record), 4. R. Thompson; 880 yards: 1. J. Coltart, 2. R. Thompson; 1 mile: 1. D. Tunstall-Pedoe, 2. R. Sanders; 3 miles: 1. R. Thompson, 2. R. Sanders; High Jump: 3. K. Rawlinson, 4. M. Redfern; Long Jump: 2. D. Jefferson, 4. K. Rawlinson; Discus: 3. D. Cooper, 4. D. Jefferson; Shot: 3. K. Rawlinson, 4. D. Cooper; Javelin, 1. K. Rawlinson, 4. D. Jefferson; Relay: 1. King's, 2. Bart's.

Match result: 1. King's 71 pts., 2. Bart's 62 pts.

At a meeting of the Club's Union on the 17th June the athletic colours were ratified to D. Jefferson, R. Thompson and R. Sanders.

Wednesday, 23rd June, v. London School of Economics v. Royal Veterinary College.

A small but talented team revived the unbeaten record of the "Vets". Great strength was added by Peter Fairclough in the field events including a fine win in the discus.

Results. 100 yards: 2. Scott, 6. Jefferson, winners time 10.9 secs.; 220 yards: 2. Scott, 5. Coltart, winner's time 23.4 secs.; 440 yards: 1. Coltart, 2. Scott, time 52.8 secs.; 880 yards: 1. Coltart, 4. Scott, time 2 min. 4 secs.; 1 mile: 3. Thompson, 6. Markum, winner's time 4 min. 41 secs.; 2 miles: 1. Tunstall-Pedoe, 2. Thompson, time 10 min. 6.5 secs.; Javelin: 1. Rawlinson, 3. Fairclough, distance 174 ft. 2 in.; Shot: 3. Fairclough, 4. Cooper, winners distance 37 ft. Discus: 1. Fairclough, 4. Cooper, distance 106 ft. 2 in.; Long Jump: 3. Rawlinson, 4. Jeffferson, winner's distance 19 ft. 11 in.; High Jump: 3. Rawlinson, 5. Scott, winner's distance 5 ft. 3 in.; Triple Jump: 3. Rawlinson, 5. Jefferson, winner's distance 40 ft.; Relay: 1. Bart's, 2. L.S.E., 3. Vet's.

Match result: 1. Bart's 112 pts., 2. Vet's 111 pts., 3. L.S.E. 71 pts.

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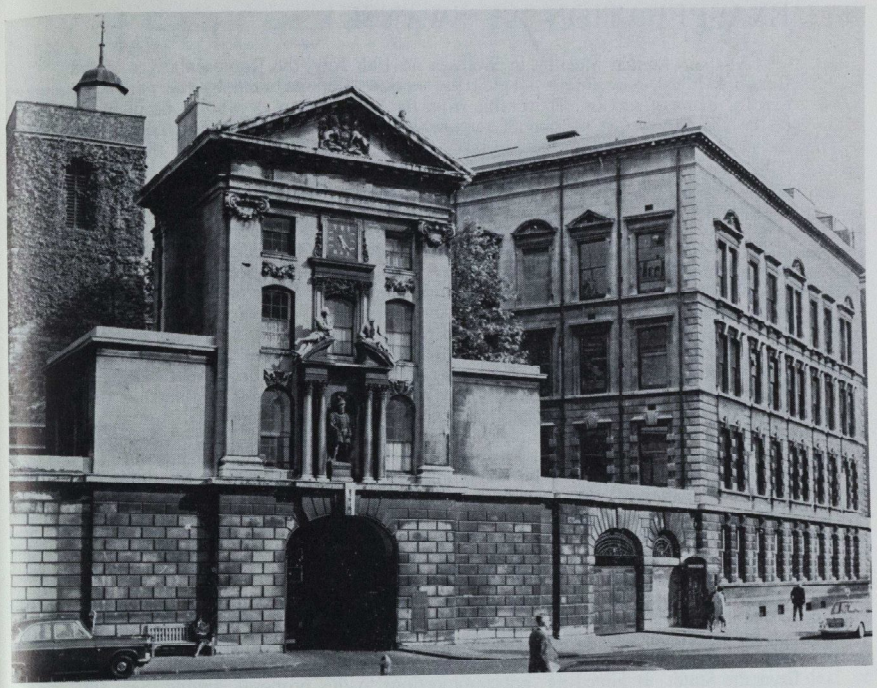

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