50
60
70
80

If the trouble is pollen-
count on 'Actifed' to relieve it

The potentiated combination of antihistamine (triprolidine) and decongestant (pseudoephedrine) in 'Actifed' relieves the respiratory congestion of hay fever more effectively than either constituent used alone. Relief is obtained within 10-30 minutes.

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Saint Bartholomew's Hospital
JOURNAL

Vol. LXXI No. 5 — 10th May, 1967

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A PROBLEM OF SOCIETY

That we have used the words "Drug Addiction" on the cover of this issue yet question the use of the term "addiction" within the text of the *Journal* is perhaps indicative of the confusion that surrounds the whole problem of drug addiction, dependence, habituation and abuse. The difficulty lies in interpretation, different writers mean different things by the word "addiction" as is discussed by Dr. Connell and Dr. Glatt. To the public the words "drugs" and "addiction" have now become so emotionally charged that misinterpretation is inevitable and rational assessment, with tobacco and alcohol being conveniently ignored, has become difficult.

In this issue we hope to be able to clarify ideas about the problems of drug abuse, indicate where the dangers lie and suggest lines along which progress could be made to deal with the problem. The present problem is rather exaggerated out of proportion to that due to alcohol by press publicity, yet it is most important that it be tackled now in an effective manner, otherwise at the present rate of increase in, for example, heroin/cocaine addiction, there could well be a problem as great as that in New York, with criminal elements dominating the situation.

There have been announcements about the setting up of GOVERNMENT TREATMENT CENTRES, but one must receive this with some scepticism, for the N.H.S. is not conspicuous in allocating funds for new projects and it is a sober fact that these Treatment Centres will have to be well equipped and have highly qualified medical and lay staff if they are to be at all effective. Money will have to be spent and staff recruited, for the Centres will not appear by waving a magic wand over a pile of *E.C.* 10 forms.

A new Bill (DANGEROUS DRUGS BILL, 1967) has just been published by Parliament to deal with anomalies and abuses in the prescription of drugs classified under the Dangerous Drugs Act. Briefly it requires (at last), the formal registration of addicts, and prevents medical practitioners prescribing specified drugs to addicts except under licence. One presumes that this will complement the Treatment Centres. This is very laudable, but there is a possible danger still that there might be a vacuum created, if practitioners would not supply even licensed prescriptions, and there were not enough places available in treatment centres, which would let in the criminal elements. The Government must therefore take care not to precipitate the very situation they seek to avoid.

VIEW DAY SUPPLEMENT

The *Journal* is very pleased to include with this issue a supplement presented by the Board of Governors outlining the projected development plan for the Hospital precinct site. The changes are sweeping and could change the whole character of the Hospital. We hope that the supplement will provoke discussion among visitors, students, and lay nursing and medical staff, for some of the proposals such as the destruction of the West Wing might seem unpalatable to some, while to others the return of grass to the square might be some small compensation. We would like to take this opportunity of reminding readers that this *Journal* does have a correspondence column and we hope that comment on the supplement will be forthcoming.

LETTERS TO THE EDITOR

WARD SHOWS

Sir,—May I correct Mr. Roger Clayton, who happily erred in thinking (in your February column) Bart's to be the only London hospital still presenting shows on the wards at Christmas. From this address our group—the Manic Depressives—take a selection of the year's brand of madness around the wards, giving eight shows in a week and a further two to patients at our Hampstead convalescent home and at the Soho Hospital for Women. Plus of course the real thing in the evenings.

Strangely we do not have this trouble of yours with pre-show Christmas pud and turkey, or rather the lack of them,—eschewing such heavy fare for lighter premedication. Perhaps it has something to do with our respective scripts? Ours are always rather upsetting on a really full stomach but float excellently in the right medium. No doubt your product is altogether more effervescent and requires a solid lining. We wish you victory and good eating.

Yours faithfully,
ANDREW ADAM,
The Middlesex Hospital Medical School,
London, W.1.

20th March

THE MATRON'S BALL

Sir,—It has come to our notice that "The Matron's Ball" was first held in 1927. Miss Dey—Matron from 1927-1949 asked the Clerk of the Goldsmiths Company if they would consider lending their Hall for a Nurses' Dance. They agreed.

The Treasurer and Almoners Committee, Lord Stanmore and six other gentlemen were asked if they would pay for a Nurses' Dance each year. They were delighted with the idea and it was held at the Goldsmiths' Hall, Christmas 1927. Sir John Mullins the Chief Warden that year insisted on paying for the whole evening.

In 1928 it was held at the Merchant Taylors Hall and so in alternate years up to the outbreak of the Second World War.

At Christmas 1945, it was held in the Mansion House, and in 1946 it was held at the Grosvenor for the first time. The title "The Matron's Ball" dates from the first negotiations with Lord Stanmore and his Committee for they insisted that it should have that title.

Yours faithfully,
ELIZABETH FERREIRA,
Charterhouse Chambers,
Charterhouse Square,
London, E.C.1.

28th March

Engagements

CUTLER—STEVENS.—The engagement is announced between Brian D. Cutler and Miss Susan M. Stevens.

FREETH—FITZMAURICE-PETTY. — The engagement is announced between Malcolm Owen Freeth and Miss Geraldine Leta Fitzmaurice-Petty.

GOODCHILD—WELLS.—The engagement is announced between Nigel Thomas Goodchild and Miss Patricia Ann Wells.

Marriages

GORDON—DAVIES.—On March 11, Dr. John A. Gordon to Miss Patricia M. E. Davies.

SMALES—MILLER.—On April 1, Oliver R. C. Smales to Miss Elizabeth A. Miller.

Births

BAERSELMAN.—On January 26, to Dr. Gillie (née Percival) and Flt. Lt. Jim Baerselman, a daughter (Jan.).

HILLIER.—On March 21, to Anne (née Houldersham) and Dr. Richard Hillier, a son (Charles Edward Montague).

JACKSON.—On February 19, to Gitta (née Garrelts) and Dr. John Jackson, a son (Sven).

NORBURY.—On February 27, to Jennifer (née Wheatley) and Dr. Keith Norbury, a daughter (Lucy Frances).

PULESTON.—On February 23, to Brenda (née Billington) and Lyn Puleston, a daughter (Joanna Ruth).

PRIZES AND SCHOLARSHIPS

Prize		Winner
Brackenbury Scholarship in Medicine		D. J. Coltart } aeq M. E. Roberts }
Burrows Prize		R. C. N. Williamson
Brackenbury Scholarship in Surgery		P. B. Wood
	Prox. Access:	R. C. N. Williamson
Walsham Prize		P. B. Wood
	Prox. Access:	R. C. N. Williamson
Willett Medal		Not awarded
Matthews Duncan Prize		J. A. W. Webb
		Medal not awarded
Weitzman Prize		D. J. Coltart
Roxburgh Prize		D. S. Browne
Skynner Prize		P. B. Wood
	Prox. Access:	N. J. Ireland
Prize in Ophthalmology		A. A. Brown
Sydney Scott Prize		D. J. Coltart
Hitchens Prize		J. A. Russell
Kirkes Scholarship and Gold Medal		Not awarded
Senior Scholarship in Anatomy, Physiology and Biochemistry		M. M. M. A. Stewart
Foster Prize		A. J. Huskisson
	Certificate:	N. McI. Johnson
Prize in Histology		M. S. Baylis

Deaths

COLLYNS.—On March 7, John Moore Collyns, M.B., D.P.H., aged 91. Qualified 1900.

Honours

Sir Herbert Seddon has been appointed an officer of the Order of the Cedar of Lebanon.

Royal Photographic Society of Great Britain.

The Medical Group merit award has been awarded to the Department of Medical Illustration.

May Duty Calendar

Sat. & Sun., 6th & 7th.
Mr. Ellison Nash
Dr. Black
Mr. Manning
Dr. Boulton
Mr. Fuller

Sat. & Sun., 13th & 14th.
Mr. Badenoch
Dr. Hayward
Mr. Manning
Dr. Cole
Mr. Cope

Sat. & Sun., 20th & 21st.
Mr. Tuckwell
Dr. Oswald
Mr. Aston
Dr. Gillett
Mr. McNab Jones

Sat. & Sun., 27th & 28th.
Prof. Taylor
Prof. Scowen
Mr. Lettin
Dr. Bowen
Mr. Dowie

Physician Accoucheur for May is Mr. J. Howkins.

University of Hong Kong

Dr. B. Lofts has been appointed to the chair of Zoology.

Erratum

We regret that in "Two Cases of Cavernous Sinus Thrombosis" by Derek Browne in the April *Journal*, it was stated that Methicillin is given orally; it should of course have been given intra-muscularly.

Department of Psychological Medicine

Departmental Meeting, February 9th, 1967

Miss Maisie Holt presented a talk on Word Blindness and gave a comprehensive account of the condition, discussing the various aetiological factors concerned. Miss Holt herself has had extremely wide clinical experience of word blindness and on the basis of this has developed her treatment which involves the simultaneous use of the auditory, visual and proprioceptive senses.

We were also fortunate in having among our guests other workers eminent in this field and a lively and informative discussion followed.

Departmental Meeting, March 9th, 1967

At the March meeting of the Psychiatric Department, Mr. John Wilder, Director of the **Psychiatric Rehabilitation Association** talked about the work of the association in the East End of London and showed us a film illustrating this called "Stop the world—I want to get back".

This association was founded to help patients discharged from mental hospitals to return to a full and active life in the community. It was, to a large extent, based on the idea of getting patients to help each other as well as themselves.

The work of the association is of particular relevance to the Department of Psychiatry at this Hospital as we have undertaken responsibility for the Psychiatric Unit of Hackney Hospital, and thus come into close contact with patients who have already received help from the P.R.A. In addition, we shall presumably be having many patients for whom we shall seek its assistance.

Abernethian Society

Thursday, 16th March:

Mr. Norman Tanner, M.D., F.R.C.S., *"The Wind" or Flatulence.*

The Society was very fortunate to have this opportunity of hearing Mr. Tanner, the Senior Surgeon at Charing Cross Hospital and one of the leading general surgeons in the world, speak on the ill-documented subject of "Wind".

Mr. Tanner began by saying that one of the commonest symptoms of which patients complained was wind, and he stressed the importance of establishing what they mean by this self-diagnosis. It might mean excessive belching, epigastric pain, a feeling of distension or fullness, dyspepsia, or the passage of flatus—(average=1½ ml. per minute). Abdominal radiography showed that most of these patients in fact do not have an increased volume of abdominal gas.

Speaking of the physiology of gastro-intestinal gas, he explained that 70 per cent of the gas was swallowed air, whilst 30 per cent resulted from fermentation and capillary gaseous exchange. One of his housemen had injected air into his own stomach and showed that it was passed per rectum in about 30 minutes. That eructation is physiologically important had been demonstrated in a patient who had acquired a cardio-oesophageal valve as a result of gastric surgery; his acute distension had to be relieved by further surgery. It had also been demonstrated that "winding" of babies is important, as if they are laid down after feeding, the gas is not eructated, and their discomfort is soon made evident.

Basically there were three factors involved in the accumulation of gas in the gastro-intestinal tract: aerophagy, stasis and fermentation in the gut, or the introduction of extraneous gas. Belching most commonly was the result of aerophagy which the patient mistakenly believed would relieve his discomfort. Mr. Tanner illustrated the part played by these factors with some fascinating case histories and their X-rays. In certain anatomical defects such as eventration of the stomach there was accumulation of gas. A man with this condition had found that 30 minutes after lying down in bed, he passed large quantities of flatus. Although quite odourless this considerably disturbed his relationship with his newly acquired wife. Stasis with resultant fermentation caused the accumulation of foul smelling gases. In the early days of vagotomy when pyloroplasty was not done as well, eructation and halitosis had been a major problem. A company director who managed to eructate noiselessly was so embarrassed by his colleagues' search for foul drains that he felt he should retire, but a simple drainage procedure of his pylorus obviated this need. That the gases could be inflammable was demonstrated by the lady patient who presented with burns around the nose; her cigarette had been lit while she was discreetly eructating.

The introduction of extraneous gases also provided some unusual case histories. A patient with achalasia of the cardia had found that if she drank a certain brand of carbonated water and closed her nasal passages, she could generate sufficient pressure to force food into the stomach. She was greatly relieved by operation, not least because she reckoned to have spent one hundred pounds on the beverage. A thirsty young man who had climbed high into the Alps quenched his thirst by hastily drinking a fizzy drink; the gas ruptured his oesophagus and only emergency surgery prevented his demise.

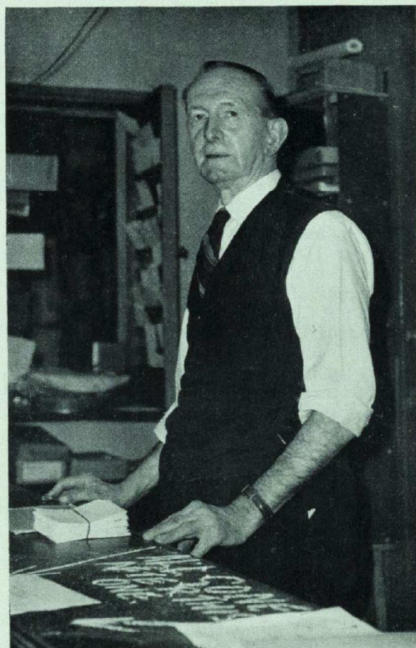
Dr. H. Wykeham Balme thanked Mr. Tanner for his authoritative and entertaining lecture.

Paul Belchetz was elected a Committee member to replace Peter Quinn, who has retired. His enthusiastic and valuable work for the Society has been greatly appreciated.

M.E.S.

OBITUARY

Frederick George Bailey



The death of Frederick George Bailey on 27th March at the age of 72 means little at first glance to readers, but the fact that Fred of the Students' Cloakroom will never be seen behind the counter again immediately strikes one as a calamity. Since 1953 he had presided over his domain, sorting the mail, dealing with white coats, taking telephone messages, answering innumerable questions on all subjects, and in general trying to be helpful to students. Fred appeared to be so much part of the place that he might have spent his entire life in that hive of activity. In fact he came to Bart's when most men would be thinking of retirement, a subject that Fred Bailey steadfastly refused to discuss.

Fred had worked in a brewery at Greenwich, but in 1915 he joined the Inniskillin Dragoons, and was soon promoted to the rank of sergeant, serving in France and Belgium. He then learned the art of saddlery, but left the army in 1923, married, and became a caterer in Shoreditch. His property was compulsorily purchased in 1953, and he then came to Bart's.

Every institution housing students has a few outstanding characters that are always remembered. Former students returning after many years absence, visit favourite haunts in search of familiar faces, and the Cloakroom is an obvious choice. No longer will the familiar upright figure be there to provide the smile of recognition. Fred was a fount of information, and could render unexpected services. He repaired white coats, restrung rackets, and fancied himself as a carpenter and handyman. He could sell anything, and find required items at short notice. Fred was keenly interested in student activities, particularly sport, and his notices of impending matches of importance always contained words of encouragement, and later, appropriate comments on the results. Fred's notices will be sadly missed. They were always striking, and served their purpose. "Modern medicine is in. See Fred" struck one reader at the time as being rather comical, but was doubtless appreciated by those awaiting the current issue of *Modern Medicine*.

With the passing years notable figures disappear from familiar haunts, and another has now passed from our midst. One of Fred's "standing orders" regarding appointments with Dr. Coulson, ended with the words "Thank you Fred". We re-echo those words, to one of the best-known servants of the College, a friend to those in trouble, and a figure who will be sadly missed. Thanks Fred!

An appreciation of Fred appeared in our *September* 1965, issue (pp. 366-7), and provides further information on his activities. We also desire to express our sincere condolences to his widow and sons.

B.C.

ON PSYCHOPHARMACOLOGY...

by Hannah Steinberg

and Michael Besser

Psychopharmacology, the study of drugs with psychological effects, has a long past but a short history. Concoctions containing potent substances, such as opium, alcohol and mescaline, have been used for centuries in folk medicine and in ritual practices. As a distinct experimental science, psychopharmacology was born when such phenomena began to be recorded and studied systematically.

History and recent development

One of the first to try to determine the effects of drugs like alcohol and caffeine on simple skills involving the speed of adding numbers or threading needles, was Ernst Kraepelin who wrote a classical monograph in 1892. His results led him to anticipate some of the ideas which are now being tested experimentally. For example, he thought that it might be possible to produce reversible models of abnormal mental states in human subjects by means of drugs and so to be able to study and modify them under controlled conditions. One of the reasons for the recent intense interest in drugs like LSD is that they appeared to produce a psychosis-like state in man (hence the term "psychotomimetic"); since this can occur with minute doses, such as 25 μg., it was thought possible that some psychoses might be due to naturally occurring LSD-like substances in the brain. Although this now seems unlikely, the idea led to a great deal of valuable basic research on possible transmitter substances in the central nervous system. Other experimental models which are being explored in both animals and man are reserpine-induced 'depressive' states, amphetamine- or adrenaline-induced 'anxiety', and barbiturate-induced 'fatigue'.

In the early part of this century, there were only sporadic attempts to study centrally acting drugs under experimental and controlled conditions. This did not prevent drugs like amphetamine, bromides and barbiturates from being used clinically alone or sometimes even in combination in a variety of mental disorders without any real understanding of the changes in performance, behaviour and emotions which they could induce, or indeed, of whether they really worked. However, it was clear that these drugs were not of substantial help in the treatment of major mental illness.

The first important new drug with therapeutic implications was chlorpromazine. It was discovered in 1952 during a systematic survey of antihistamines with sedative effects. (For accounts of the history of this and other new drugs, see Jarvik, 1965). It was found to have multifarious, unusual and powerful properties. French workers showed that, apart from having hypnotic actions, it could dramatically quieten agitated psychotic patients. The use of this and of other phenothiazine derivatives has played a major part in allowing patients who would otherwise have had to be kept in hospital to return to the community. Since the introduction of these drugs, the number of people in mental hospitals has dropped markedly throughout the world, and partly as a result of their effects society's attitude to the mentally ill has altogether changed, allowing these patients often to be treated in their own homes.

The first real 'antidepressants' were discovered more or less by chance. Intelligent observation of the occasional euphoria produced in patients with tuberculosis who were being treated with isoniazid, led to the trial of this compound in depressive illnesses. Soon other and more effective antidepressants, such as imipramine and monoamine oxidase inhibitors, were discovered, and today drugs are more often than not preferred to electro-convulsive therapy, which hitherto had been the only really effective treatment of depressions.

There is now a vast battery of compounds with potent and complex central actions, and the major problem is to decide which to use and when. Decisions of this kind can only be made rationally on evidence obtained from appropriately designed clinical trials based on relevant laboratory experiments on both animals and man. It is not enough to study

the effects of drugs on the primary condition to be treated. 'Behavioural' as well as other forms of toxicity must be considered. Side effects such as altered reaction times, confused thinking, aberrations of judgment or modification of perception may be so great that they outweigh the therapeutic benefits. For example, monoamine oxidase inhibitors are now rarely used in depressive illnesses because of their dangerous interaction with sympathomimetic amines which may be contained in other compounds and in some cheeses.

Recently 'social' psychopharmacology has aroused increasing interest, and the consequences of the potential abuse of centrally acting drugs are being examined by both scientific and non-scientific bodies. It is a moot point how far so much public attention and discussion act as advertisements and so intensify the very situation they are ostensibly trying to avert. Furthermore, emotional over-reaction to the problem of drug abuse may well obscure the potential therapeutic properties of such compounds and prevent their full investigation. This may obstruct new developments.

With the eruption of the subject of psychopharmacology, a vast number of tests developed in experimental psychology to study human and animal behaviour are now being applied to the assessment of the equally vast, and increasing, number of drugs available. With such potent compounds, it is relatively easy to obtain definite alterations in behaviour, especially with large doses. This is an attraction, a snare and a danger since such alterations may not be particularly relevant to the understanding of basic modes of action of drugs or to the human situation. It is usually more promising to use relatively small doses and meaningful experimental models; but decisions about what is 'meaningful' can be very difficult. At the time when attempts were first being made to study the effects of LSD in animals, it was observed that it often made mice walk backwards. The following interpretation was suggested. When a mouse is placed facing forwards on a downward tilted surface, its normal reaction is to press backwards with its feet to prevent itself from slipping. If it were to do this on a level surface, the effect could be to make the mouse walk backwards. Thus it was thought possible that LSD gave mice a hallucination of being on a tilted surface. This kind of interpretation seems naive, far-fetched and probably impossible to verify. Nevertheless, it did highlight the need to observe animals carefully rather than merely to put them through a series of standard tests, and in this sense drugs like LSD have probably had a salutary effect on animal experiments in psychopharmacology.

Research

Research in psychopharmacology can be broadly divided into two main approaches—'screening', and more basic research. The development of new drugs (screening) and the study of their toxicology is chiefly carried out by pharmaceutical companies, while the basic analysis of their effects and their clinical applications is more usually done in independent academic and clinical departments. Co-operation between these various groups is, of course, essential.

Screening usually involves a series of steps from the synthetic chemist through a number of animal test procedures which, it is hoped, act as increasingly fine sieves, filtering off unpromising substances so that finally only the most promising are left. Of necessity the criteria at each stage must be based on previous experience, and this is bound to be only an imperfect guide to the discovery of new drugs; compounds with hitherto unsuspected patterns of effects may be rejected if they lack established characteristics and if the test methods are insensitive to new ones. Yet to discover drugs with just these new properties is one of the principal aims of the process. In this way, the intrinsic mechanism of the screening procedure may militate against its prime object. Actually, relatively few therapeutically useful new psychoactive drugs have so far been discovered by conventional screening tests. It has been estimated that out of something like 3,000 compounds of all kinds submitted for testing, only one gets to the stage of being considered for clinical trial. (Vane, 1964; Laurence, 1966). In the present state of our knowledge, the screening of psychoactive drugs is particularly expensive and often inefficient, and this largely accounts for the high cost of the drugs eventually marketed. One hopes that a better understanding of fundamental principles will lead to new discoveries with less expenditure of animals, labour and money.

Fundamental psychopharmacological research concerns both animals and man and the relation between the two. Its aim is to approach problems analytically so that a given situation is followed through in such a way that one can learn something of the physiological and psychological sites of action of a drug and the

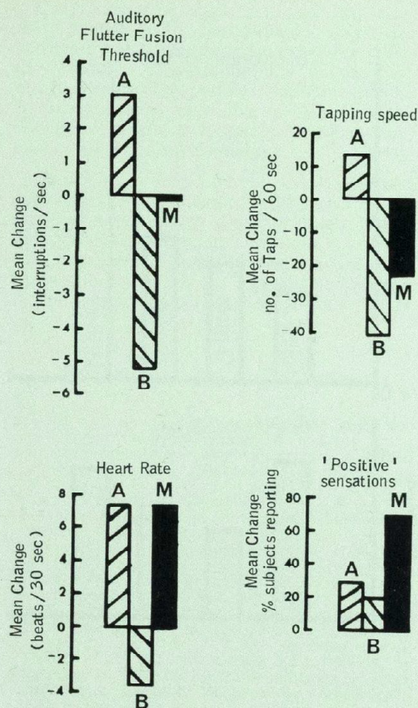


Fig. 1:

Pattern of effects of amphetamine and a barbiturate given alone and as a mixture on various reactions in human subjects. All results are expressed as mean differences between the active treatment and a placebo, which is represented by "O". For auditory flutter fusion the doses were amphetamine 15 mg. and amylobarbitone 100 mg., and for the other reactions amphetamine 15 mg. and cyclobarbitone 300 mg. A = amphetamine, B = barbiturate, M = mixture.

mechanisms whereby different drugs may interact. For example, drugs may produce apparently similar effects on behaviour, but for different reasons. Thus barbiturates may reduce anxiety and fear by acting directly on mechanisms concerned with fear, or by impairing the perception of or discrimination between fear-inducing stimuli, or by impairing memories of previous unpleasant experiences, or in some other way; these various possibilities can be analysed experimentally (Miller, 1964). If a particular factor can be identified as being primarily involved in the action of the drug and hence, probably, in its therapeutic effect, tests for this particular factor can then be used to try and select other compounds with similar actions, and in this way fundamental research can contribute to screening.

Sometimes two drugs may each modify emotional, motor and perceptual functions in apparently opposite directions, and yet when these drugs are administered simultaneously, the manifest effects of the combination in the same subjects may be mutual cancellation on some reactions, predominance of one effect over another on other reactions, and indeed, most interestingly, sometimes there may be true potentiation—that is, the total effect of the drug combination may be greater than the sum of maximal effects obtainable with the constituents given separately.

This sort of phenomenon has been demonstrated in animals (Rushton & Steinberg, 1963, 1966) and in man (Legge & Steinberg, 1962; Besser, 1966; Besser & Steinberg, 1967), when amphetamine is combined with either barbiturates or chlordiazepoxide. Fig. 1 shows a pattern of effects when amphetamine and a barbiturate were given alone and in combina-

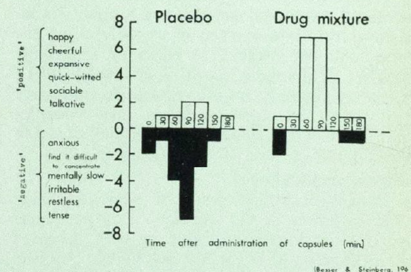


Fig. 2:

Effects of a mixture of dexamphetamine 5 mg. and chlordiazepoxide 20 mg. on sensations. The subjects described their sensations every 30 minutes on "checklists" listing 42 possible sensations, and the figure shows the incidence for a selection of these sensations. The "positive" changes in sensations with the mixture seemed to follow a definite time course.

tion to normal subjects. An apparent cancellation of their individual effects occurred on a perceptual process, auditory flutter fusion, and on a motor performance, tapping speed. The heart rate merely showed the effect of amphetamine, i.e. an increase, whether given alone or in combination. With subjective effects, however, the drug mixture increased the total number of some kinds of sensation reported and, in particular, the number of "positive" sensations (e.g. "happy," exuberant," "confident") as compared with the effects of the separate constituents.

Fig. 2 illustrates effects of a mixture of 5 mg. dexamphetamine and of 20 mg. chlordiazepoxide on sensations. The separate drugs appeared to have no effect as compared with a placebo, but with the mixture there was a marked increase in "positive" sensations and a corresponding decrease in "negative" ones, and these changes seemed to follow a definite time course of action. (Besser & Steinberg, 1967).

It is not only the absolute doses of the drugs which matter in this context, but perhaps even more so the ratio of the doses of the two constituents. It is of great interest that those ratios of amphetamine and barbiturates which have been shown to produce the greatest potentiation of activity in rats have coincided with those that tend to produce most marked effects in man. (Rushton & Steinberg, 1967).

Yet another and vitally important factor is the environment in which the drugs are taken. This is borne out experimentally by the greatly increased activity of rats given an amphetamine-barbiturate mixture when in an unfamiliar environment, but its lack of effect in a familiar one (Fig. 3, Steinberg, Rushton & Tinson, 1961). This may possibly be related to the frequency with which teenagers seem to take "purple-hearts" when in a relatively unfamiliar situation like a party, rather than when alone.

Clinical applications

From the clinical point of view, the only valid criterion is the efficacy of a particular drug as demonstrated both in well designed clinical trials and in general psychiatric practice. Trials should take into account not only such factors as placebo effects and the order in which treatments are given, but also the need to be able to change the dose according to the patient's response, and the interrelation of drug treatment with other supportive therapy. For example, in one careful study with chronic schizophrenic patients (Hamilton *et al.* 1963), it was found that female patients improved

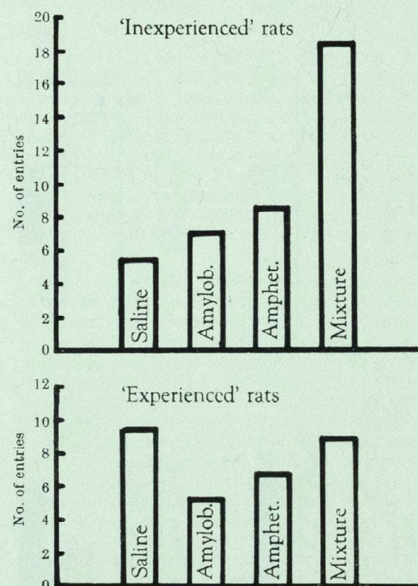


Fig. 3:

Effects of drugs on activity of rats in a Y-shaped runway. The "experienced" rats had had 32 previous three-minute trials in the runway, while the "inexperienced" rats had not left their home cage since weaning. Activity is expressed as the mean number of entries into the arms of the Y in a three-minute trial made by the eight treatment groups (n=6). The doses were amylobarbitone 15 mg./kg. amphetamine 0.75 mg./kg., and these two doses combined in a mixture. The mixture markedly increased activity in the rats to whom the environment in which they were being tested was unfamiliar.

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most if treatment with a particular phenothiazine was combined with intensive social and psychological support. Male patients did about equally well with similar social and psychological support, but for them it did not matter whether this was combined with the drug or with a placebo.

Drugs cannot be expected to act alone, since they interact with the patient's underlying personality and the circumstances under which they are taken. It is possible that the main way in which some of these drugs help some patients is to make them more able to utilise positive stimuli from the environment including especially supportive psychotherapy.

Clinical trials are becoming increasingly more sophisticated and attempt to take such factors into account, though this inevitably makes them more complex, and is time consuming and expensive. Clinical evaluation seems at present to be one of the biggest "bottlenecks" in the development of new psychoactive drugs, though, as has already been implied, this could be reduced if better pre-clinical evidence were available to help one decide which compounds are most worth trying out clinically.

Psychopharmacology is now a subject in its own right; one of its special charms is undoubtedly that it brings together workers from a great variety of disciplines (see e.g. Marks & Pare, 1965). The behavioural, pharmacological and therapeutic aspects have been most stressed in this article, and others, like the neurophysiological and biochemical, have had to be mentioned only in passing. The brain and behaviour and relations between them are to-day among the most important problems which scientists are trying to solve, and in this psychopharmacology is likely to have a crucial role.

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ADDICTION TO NARCOTICS

The Addict's Life — a conversation

Reported by John Sills

Well Chris, how did it all start?

I was introduced to heroin when I was 16 by another addict who was short of money. He used to sell me the stuff to pay for his "fixes" (injections). At first I only used to take it at weekends but gradually the frequency crept up from twice a week to every other day until finally I was needing shots daily. By this time it was too expensive getting the stuff privately so I went on the N.H.S., since I found I could not do without fixes; I was really hooked. At first I was on 5 grains a day of both heroin and cocaine: I am unusual in so far as I was introduced straight away onto *mainline* intravenous shots. Since then I have varied between 3 and 12 grains (1 gr.—60 mg.) of each and now I'm on 4 but am managing to take it intramuscularly.

What happens if you don't get a fix?

At first one feels tired and lethargic, and one feels rather like one does with a heavy cold; runny nose, shivers, and feeling hot one minute and cold the next, and one keeps on yawning until one has a fix. If one goes into total withdrawal, that is, has no more drugs, then after this period one falls asleep for about 24 hours and on waking up the vomiting, stomach cramps and cold sweats start. You're supposed to get goose pimples, the so-called "cold turkey", but I've never had this. These symptoms last for three days, if you can stand it. In the long run there are aches in the backs of the legs, insomnia and a complete lack of concentration; such that one cannot even read a newspaper. These effects can last up to two months and because of their nagging effect demoralise the addict considerably more than the three to four days of initial symptoms.

So really you take the drugs to ward off these withdrawal symptoms

Eventually; this is the physical addiction, but first of all there is the mental addiction phase.

How did the drugs affect you at the start?

The first shot is indescribable—it's out of this world, but then progressively you get more tolerant, so you need more for the same effect and so you get in a circle of ever increasing doses until suddenly you realise you are hooked; you can't do without a fix for more than 6 hours. This is far too expensive, so one goes and gets the drug on the N.H.S.

In the stage of *physical* addiction it's the cocaine that gives the "flash" the stimulant effect; sometimes you can overdo this. I've had on occasions up to 12 grains; this may send you paranoid and at times I've imagined the whole of the West London Police after me.

Has it ever helped you artistically?

Never; in fact I work better when I'm off drugs since my concentration is much better—it may loosen one's inhibitions a little but I've never found this very marked. Generally in large doses the responses are psychotic, especially paranoid, and in normal doses; irresponsibility.

How has it affected your work?

Since I've been on the drugs I've worked on three occasions in the theatre and filled in at a large catering firm, at car washing and labouring. It wasn't easy, one has to be hard on oneself and limit one's doses, but I lost them all because of the drugs—once I went paranoid and walked out; once I just couldn't be bothered to get up; and once I didn't bother to sign for the next season.

How do drugs affect personality?

Really one becomes totally introverted—life may well revolve around the doctor, the chemist and the prescriptions. One can have no real friends, and one becomes a rather obsessive character. Life is run to order, revolving around the next fix and the proximity of lavatories and phone boxes. Each fix is taken as a ritual and once the initial potency of the fixes has worn off, this ritual becomes an integral part of the addiction. As I said, one can have no relationships only intermittent companionships. There can be no relations with women, one's sexual drive is blunted, if not totally inhibited.

Drugs destroy you morally, you upset and even resent friendships and one may even steal things from friends to pawn for money to buy more drugs; conversely if one is living with other addicts one may become paranoid about them and suspect them of stealing one's own supplies. Thus the drug is the master, and if one is in need of a fix one may do anything to

get the money and one may easily turn to petty crime. Initially one is aware that one is doing wrong but there comes a time in the degradation when one just cannot care and there is no conscience.

An addict's state can obviously fluctuate, but he always has his escape from any problem—the fix is the end of all worry and pain.

As addicts go downhill, drugs become more and more the master. One doesn't eat much, due to the cocaine—and one craves for sweet things: one may exist on a diet of cornflakes and sugar. Proper meals are never taken, this is partly due to lack of money. There is chronic constipation, which with effort and foresight one can control; emptying the bowels just before a fix rather than after. Lack of protein produces malnutrition and one becomes debilitated and prone to infection. One may become flea infested (I haven't, incidentally), jaundiced, and get pneumonia, multiple abscesses or a septicaemia. Since the fix is the escape, one may take no notice of the early symptoms, and the illness may then be allowed to progress inevitably to its termination.

You are obviously aware of the hazards—how do you combat them?

Sometimes I am sensible and other times I just don't care or think. But now by eating regular meals, opening my bowels regularly and taking vitamins I think I am as healthy as the state of addiction will allow.

Most addicts, however, aren't in this state, they are unkempt, dirty and have lost all self respect. The average life span from addiction to death is about 15 years—you never see old junkies at the doctor's, and there was a time recently when I couldn't see myself surviving much beyond 35.

Have you never attempted to free yourself from the yoke of addiction?

In the last three years I reckon I've spent some five months in one hospital or another. I've had four attempts to come off drugs, all on the N.H.S. in mental hospitals. The first was withdrawal under tranquillisers and barbiturates, the second, crude apomorphine treatment, the third one was total deep sleep narcosis, and the last was modified apomorphine (they rotated other narcotic drugs, morphine, pethidine and methadone).

How successful were they?

The first time I was off for six weeks, the second for two months, the third one day and the last time I was taking drugs while still under treatment. I used to sneak out of the hospital and go up to London.

Wasn't this rather defeating the object of the treatment?

It was really the fault of the environment; I was with another addict, which was unsettling, and also being in a mental hospital—I was living with patients. There wasn't enough contact with medical or nursing staff, they just haven't the time available, although most are interested. There was nothing to do except occupational therapy. You can imagine how I was able to feel that it was all futile at that time.

Do you see any way to come off the drugs?

Yes, I've learned through experience. You see after coming off the drugs there is an initial period of near elation, this lasts for two months or so and then one enters the dangerous period when depression comes on easily. For although one has "kicked the habit" and is off drugs one is an addict still—the effects and the memory are still there and one can't afford to take a casual shot, as an alcoholic can't afford to take a social drink.

At the time of addiction no person can truly say they want to finish with drugs, for if this were so there would be no addicts; it is only when one is off drugs that things fall into perspective. The only way is to find a supporting attitude of mind, to realise that this slavery is not the ideal way to lead a useful and healthy life. This has to be the prop, the pillar to lean on. Personal support after coming off is also important, for one must not become introspective, that is the great danger, one must learn anew to live with people; and not only to be accepted but also to accept people without any of the old resentment. One must drop all insularity and realise that one is not a special person after all (most addicts are very egotistical). As a further guard against introspection one must keep oneself occupied during the day; this means getting a job and tiring oneself during the day so that one can get to sleep easily. But in spite of these intentions one may still fall, for you must remember that will-power is broken down, you can't help yourself; you fall. For example, after my second "cure" I went into a provincial repertory theatre and for two months I was fine. Then one day in London I ran into another ex-addict; over a beer we got talking about the past, he suggested a fix and before I knew where I was we were in a taxi and off to find a fix, which we did. Thus will-power has to be built up from the bottom.

There you have two more hazards; other addicts or ex-addicts and the knowledge of

where to get a fix. This is easy in London and hence that is why I went away to work.

What about the immediate future?

Well, although two of my hospitalisations were partially successful, the other two were hopeless for I was not mentally prepared to come off, and after the last episode I had more or less given up all hope of ever getting off. I felt I was so far gone that I couldn't revert to a normal way of life.

However, following a period of general hospitalisation, which took me away from my environment and gave me time to think, and which brought me into contact with sympathetic and understanding support from medical and nursing staff (surprisingly from both those of my own age group and the older staff, even the ward sister), I think I have reached a frame of mind compatible with abandoning drugs.

You will avoid all the pitfalls you spoke of?

Yes, more or less. The first point is that I stand no chance if I go into a mental hospital. You must have personal contact and you can't have contact with manics and schizos. So I hope to go into a private hospital for some six weeks, there I should have my own room, some privacy and much more contact with the staff. Then after that I reckon to have one week on holiday and then to go into a nine to five job.

Will this be difficult to find?

Some jobs are impossible if you have been an addict; generally any that require a medical are hopeless, but I hope to get a job in the theatre or more specifically in commercial films. I must work in something of this nature since this is what I have been trained in.

Will you be able to do this sort of work out of London?

No, unfortunately, and so I am aware that I am exposing myself to the availability, but really if you get to the stage of wanting drugs again you will do anything to get them. But I must have support from people. As an insurance against this I plan to have twice weekly psychotherapy sessions; two hours per session. This will also act as a deterrent since I will have a urine test at each session which will soon indicate if I have been on drugs. If I do betray this trust I will lose the support; he will have nothing more to do with me. I thus regard this psychotherapy as being of major importance since it will enable me to resolve any inner tensions and maybe it will reveal why I do take drugs, for I am sure there must be something in my past that could be responsible. I am prepared to continue the therapy for as long as a year, longer if necessary.

It seems as if you have thought carefully this time, but how are you with the drugs at the moment?

I'm on both heroin and cocaine, 4 gr. of each, but I'm taking it intra-muscularly. This means that I don't get the usual kick you get with I/V cocaine. I really take them to maintain a normal level for I can feel the effect if I don't take a dose, and of course to prevent withdrawal symptoms.

So you are in effect on top of the addiction?

Well more on top than before but to give a categoric "yes" would, I feel, be dangerously positive.

Have you anything else you would like to comment on?

Well I'd like to record a few thoughts on some of the other drugs. Progression is dangerous and for this reason as well as for its intrinsic dangers Amphetamine is not to be trifled with.

On the other hand one can combine a useful life with marijuana, as they do in the east. In my opinion there is nothing wrong with it itself, but the danger in this country, is that the people who push marijuana, push narcotics, so that sooner or later anyone exposed to marijuana will be exposed to the great temptation to try one of the narcotics, or cocaine.

How easy is it in fact to get hooked?

I'd say that up to six months one could be cured fairly easily, and at the other end of the scale, if one survives, addiction is reported to burn itself out in about 15 years: I only started with weekly shots but one pushes up the dose with the tolerance so that one can soon be on a fairly heavy dose.

Returning to the dangers; have you any views on the present situation concerning the availability of drugs?

It is quite easy to get prescriptions for more than one needs, and the common thing is to sell off the surplus, but that's one thing I've never done. I've also never introduced anyone else to the habit and I don't think I could. I feel that cocaine need perhaps not be prescribed for it is not an addictive drug in so far as withdrawal will not produce a typical physical syndrome, indeed when one goes for a cure the first thing they do is stop cocaine—all one gets from cocaine is the flash. Daily prescriptions might be helpful if doctors could be persuaded to do this.

It might be an idea if the power to dispense prescriptions to addicts could be restricted to a few doctors, specially licensed by the Home Office. I also feel that the initial application to have drugs on the N.H.S. should be subject to more scrutiny, and the patient should have to prove himself a genuine case and the dose required should be more carefully monitored. It is ridiculous that a new addict should be given 5 gr. per day as maintenance—that would cost £35 outside the N.H.S.

Finally I think that all people under a certain age, should if they apply to have drugs prescribed, be compulsorily detained in some special rehabilitation centre, where the latest treatments would be available; in California they have a place like this, called *Synanon.*

May I ask you a question to conclude?

Certainly.

As a medical student you must come into contact with narcotics, or if not now, certainly later in your career. In the light of what we have discussed could you ever consider taking drugs yourself?

Not as a calculated act, but I note the access that we have to narcotics, and bearing in mind that up to some ten years ago the majority of addicts were from the medical and ancillary professions, I am aware that in a moment of tiredness and weakness one might be tempted by curiosity, and so one will have to be very careful to control this curiosity.

Yes, it's a curiosity you can't afford!

COMMENT

by M. M. Glatt

Over the past five years or so a new type of addict has emerged on the British drug scene—the young Heroin-Cocaine addict. Although warning voices have been pointing to the steady increase of drug abuse and drug dependence among London youngsters for some time, the professional and the lay public have become really aware of the danger only during the past few months. Many aspects of this problem are still obscure and have to be tackled; such as an urgent need for research and a more intensive training in this field among medical students and doctors. The publication in a teaching hospital journal of answers given "straight from the horse's mouth"—a young heroin addict himself—is thus timely and valuable in helping to make students more aware of, more interested, and more knowledgeable in this important socio-medical problem—quite apart from the points stressed in the last paragraph of the article, namely the risk of medical students and doctors themselves becoming dependent on drugs because of their ease of availability. Incidentally, it is one of the features of the development of the British drug problem in recent years that the formerly more prevalent, professional, middle-aged "therapeutic" opiate addict has been replaced more and more by the non-professional "non-therapeutic" youngster.

Most of the following comments are based on discussions of the article with two groups of young addicts, namely a number of youths in prison, and a hospital group of twelve male and female youngsters—all in the age-group 17-25. In general these people felt that the article depicted conditions well and truthfully, but that certain points were considered worth commenting on:—

1. If Chris started his drug abuse by immediately going on to the "hard" drugs, this is unusual among the new wave of young H-C addicts, as is—to a somewhat lesser extent—his starting right away with "mainlining." (The widespread use of a special addicts' slang is only one aspect of the drug addict subculture.) Thus, of the twelve hospital H-C addicts only one had started right away with heroin; 11 had previously "smoked" cannabis; 9 had taken "purple hearts"; when going on to heroin only 4 out of the 12 had started on "mainlining" right away.

As in Chris' case, addicts generally start by buying drugs from addicts—usually (wrongly so-called) "registered" addicts, i.e., those getting it legitimately from a medical practitioner. Thus of the 12 hospital addicts, 10 had got their first supplies from a "registered" addict before they themselves, after a period of several months, "registered" with a doctor, 8 of them at first with a private practitioner. Incidentally, all "registered" addicts stated that at some time or other they had sold their surplus to others, although they are usually eager to make a clear difference between selling to addicts (in which

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case they feel no compunction) and young newcomers (in which case they claim to have more scruples).

2. The withdrawal symptoms are described well; the immediate abstinence manifestations being followed by other symptoms—such as lack of concentration, insomnia, depression, etc., which in many addicts may last 2 to 3 months and longer.

3. Some youngsters agreed that at first they became "mentally hung-up" before reaching the stage of "physical addiction" as "to start with taking the drug makes one feel great." Incidentally, the term "addiction" is usually taken to denote *physical* (pharmacological) dependence in contrast to *psychological* dependence ("habituation"). Recently the World Health Organisation has recommended the adoption of the term "dependence". Stimulant drugs, such as amphetamines and cocaine, do not produce physical dependence and can therefore be withdrawn suddenly.

4. Many heroin users (for example, 8 out of the 12 hospital patients) report vomiting after the first "shot", but they nevertheless felt "good" afterwards., "happy and relaxed". As far as cocaine is concerned the (very fleeting) "flash" and the paranoid feelings are quite characteristic.

5. As regards help "artistically" the prevalent feeling among the addicts questions was that the drug "may give you ideas, but you do not put them into practice". As regards work, there was general agreement that it was hardly ever possible to work when you were using cocaine regularly. Almost all addicts also tend to give up work after being "hooked" on heroin, their whole life becoming concentrated on "fixing" and what goes with it: living on National Assistance or, later on, by selling drugs to others, and in some cases stealing and prostitution. How far one's life and behaviour are centred on drugs is illustrated by one addict's statement that "one is afraid to leave one's gear even for a moment for fear it would be stolen". However, it may, at least in theory, be possible for the older, professional or therapeutic addict to go on working despite drug taking.

6. The downward progress of the heroin-cocaine addict is well described with the risks of malnutrition, intercurrent infections, septicaemia from asterile injections, accidental overdoses. (One hospital patient died a few days after leaving hospital, when he was given by a general practitioner a dose of 7 gr. heroin and 7 gr. cocaine—his previously increased tolerance having decreased during his hospital stay without drugs. The average addict's span of life is greatly shortened by his drug taking, though according to one American expert, those who reach middle-age may mature out of their addiction.

7. The results of hospital treatment are in general not too good, as illustrated by Chris' report about his unsuccessful mental hospital stay. On the other hand, society has not really provided sufficient specialised facilities with experienced, sympathetic, understanding staff; and, in this country, hardly any research has been carried out. Prolonged after-care is all-important; to allow the hospital-treated addict to return to his old friends (who usually "smoke" and "fix") is courting relapse.

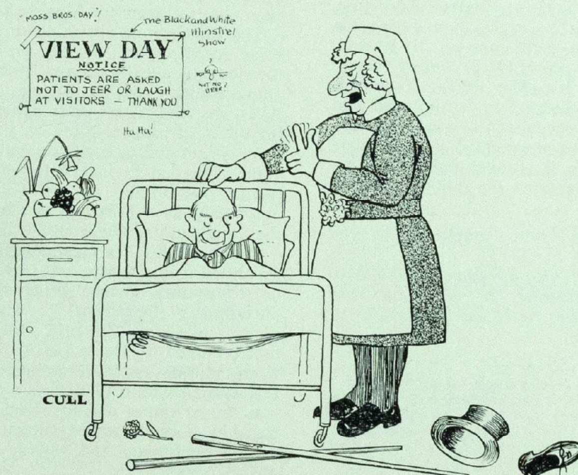
Attempts are just now under way to establish more treatment centres for addicts. Clearly, there is a need for various treatment techniques to be tried with a built-in research programme. Group-therapy is one of the techniques which are at present carried out in a number of places. Chris stated that being with another addict was unsettling; on the other hand, although having a number of addicts together may obviously create certain problems and risks, in general the great majority of addicts at St. Bernard's Hospital felt that they derived benefit from being treated alongside other addicts, rather than being on their own; and at their own request, after-care group meetings outside the Hospital, for ex-patients and patients, have been started. Many questions in regard to the respective merits of individual and group-therapy and as to the relative value of homogeneous (groups consisting of addicts only) and heterogeneous (e.g. groups consisting of addicts and alcoholics) groups remain unanswered. At present the prevalent view seems to be that if one is to treat addicts in groups this should be done in homogeneous groups. However, for what it is worth, the groups at St. Bernard's—where alcoholics and addicts live together in wards aiming at being "therapeutic communities"—many of the younger heroin-cocaine addicts feel that despite many disagreements between them and the middle-aged alcoholics, living with non-addicts "brings you down to earth, teaches you tolerance, helps you to learn to cope with problems". Our present view, therefore, is that one should keep an open mind about this question.

The addicts with whom this article was discussed felt that Chris was over optimistic as regards his chances to keep off drugs. Many would doubt his view that a private hospital would provide the addict with better chances than the modern psychiatric hospital run on the

therapeutic community concept. The view expressed that the average addict after as short a period as 6 weeks treatment and 1 week's holiday would be able almost immediately to enjoy a "9 to 5 job" would seem rather naive, despite the proposed weekly psychotherapy sessions.

Availability is an important factor, and as mentioned by Chris, until now it has been all too easy for anybody—even youngsters who had never taken drugs—to get both heroin and cocaine, and in much higher doses than required, quite legitimately on prescription. Selling the surplus of such easily obtained supplies was a major factor in leading to the present-day "addiction epidemic". Under the new regulations this will become probably less of a problem as one may hope that the doctors working at the proposed maintenance centres will have more time available and more facilities to check on applicants' stories than were available to practitioners in the past.

8. As to Chris' remarks on other drugs, his view on cannabis (marijhuana, hashish), etc., echo those of most other addicts. However, whilst a great deal of research is necessary in this field, certainly cannabis smoking is accompanied by risks other than those always stressed by "smokers", i.e. that cannabis being illegal it has always to be obtained from "pushers" and therefore drives the "smoker" into an asocial or antisocial environment. Though many cannabis smokers do not go on to "hard" drugs, it is equally true that, practically all heroin-cocaine addicts seen by us had previously "smoked" reefers. It is true, as every "smoker" stresses, that cannabis is not "addictive," but this is only in the sense that it does not produce physical abstinence symptoms on sudden withdrawal. On the other hand, it can lead in a certain proportion of "smokers" to psychological dependence; in many it interferes with work, and its effects depend on a number of factors, such as the underlying personality, the "smoker's" motivation for taking cannabis, the environment, etc. In fact, cannabis users are comparable, not—as they always claim—to social drinkers; but to those who take alcohol for "relief", as the average cannabis user smokes deliberately in order to change his feelings, and whilst in Western culture man has learned to live with alcohol, the same thing, of course, has not taken place with cannabis.



" . . . . Telling those two lay Governors that you were suffering from the Black Plague was not a very nice thing to do . . . . . "

Addiction to Amphetamines

by P. H. Connell

Introduction

The problem of drug addiction has recently come to the fore because of the onset of drug taking by adolescents who developed a socio-cultural pattern of behaviour which included taking amphetamines, usually in the form of the amphetamine-barbiturate mixture *Drinamyl*. The question of dependence on amphetamines has however been the subject of sporadic papers for a number of years some of which will be mentioned in this contribution.

The problem of semantics relating to addiction concepts and concepts of dependence, in which there was a confusion between those who regarded as addiction only those conditions in which the addict became physically dependent on the drug and had a typical "withdrawal syndrome" on abstinence from the drug, and others who included serious dependence on drugs such as the amphetamines which did not show a typical "physical" withdrawal syndrome under the concept of addiction, has been the subject of consideration by the Expert Committee on Drugs Liable to Produce Addiction, of the World Health Organisation during the years. The most recent opinion of this W.H.O. Expert Committee (W.H.O. *Technical Report Series* no. 273, pp. 9-13, *May* 1964) recommends that the term "addiction" is discontinued and that the term "dependence" is used, but that types of dependence are defined as they relate to particular drugs or groups of drugs. In the case of the amphetamines the following definition is suggested.

Drug dependence of the amphetamine type is:—

"A state arising from repeated administration of amphetamine, or an agent with amphetamine-like effects on a periodic or continuous basis."

Its characteristics include:—

1. A desire or need to continue taking the drug
2. Consumption of increasing amounts to obtain greater excitatory and euphoric effects or to combat more effectively depression and fatigue, accompanied in some measure by the development of tolerance
3. A psychic dependence on the effects of the drug related to a subjective and individual appreciation of the drug's effects and,
4. General absence of physical dependence so that there is no characteristic abstinency syndrome when the drug is discontinued.

It is hoped that the adoption of the term "dependency" will help in the understanding of the widespread effects of drug abuse and will mitigate against the previous tendency to regard drugs of dependency which do not cause physical dependence as being of no serious consequence, and thus to use them freely and unwisely without due precautions.

Pharmacology

The study of the amphetamines began in 1887 when the volatile amine phenylisopropylamine (amphetamine) was first prepared by Edeleano. Barger and Dale (1910) found it to be related to adrenaline in its pharmacological actions and therefore sympathomimetic, in common with a number of similar substances. Little attention was paid to this compound for some seventeen years since research workers were concentrating on ephedrine which had been obtained from the Chinese herb ma-huang.

The difficulty in obtaining supplies of ephedrine from natural sources led to the search for synthetic substitutes and to the synthesis of amphetamine in Los Angeles (Alles 1927). Alles was the first person to define the stimulating effect of amphetamine on the central nervous system and to suggest possible therapeutic value. This led to the evolution of the therapeutic possibilities of the volatile base of amphetamine in 1939 and to the production of the amphetamine (Benzedrine) inhaler in 1932.

Amphetamine is a racemate but later studies separated it into dextro and laevo isomers. The dextro-rotatory isomer being named dexamphetamine (Dexedrine). Methamphetamine (desoxyephedrine, Pervitin, Methedrine) was first prepared by Ogata (1919) in Japan as the hydrochloride, but little attention was given to this substance until 1938 when a number of German investigators demonstrated its close relationship to amphetamine sulphate and noted its central euphoriant and waking effects and its pressor action.

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Amphetamine, dexamphetamine (Dexedrine), methamphetamine (Methedrine), ephedrine, adrenalin, mescaline, phenmetrazine (Preludin) and adrenochrome are all closely related chemically.

More detailed reviews of the amphetamines and their uses are available (such as Leake 1958 and Connell 1962).

Psychological and Other Effects

The effects of amphetamines which are sought after by regular users of amphetamines and by those who become dependent on the drug are:—

1. Euphoria (an exaggerated sense of well-being). This is the basis of the use of amphetamines in depressive states. Though there is a large body of opinion which considers that the use of amphetamines in depression is worthless and it is true that very few psychiatrists these days use amphetamines for the treatment of depressive illness.
2. Lessening of feeling of fatigue. These drugs were used a great deal by forces in the Second World War to combat fatigue.
3. Production of wakefulness.
4. A tendency to loquaciousness.

Other effects include:—

5. Inability to relax in some cases.
6. Diminution of sexual activity.
7. Diminution of appetite.
8. Tendency to raise the blood pressure.
9. Tendency to produce dryness of the mouth.
10. Palpitations in some cases.
11. Headache in some cases.

Taken in "therapeutic" doses these drugs are remarkably free from side effects, but their efficacy in the conditions for which they are prescribed is open to doubt, and the danger of tolerance and dependence is very real.

Taken in large dosage, much higher than the normal therapeutic dose, the toxic effects will be shown by an exaggeration of the effects on lower dosage. Thus there may be:—

1. Marked euphoria and over-cheerfulness.
2. Restlessness.
3. Rapid speech.
4. Slurred speech at times.
5. Irritability.
6. Tension and anxiety.
7. Ataxia.
8. Teeth-grinding movements with rubbing of tongue along the inside of the lower lip, causing ulcers on lip and tongue (Ashcroft *et al* 1965)—this being unusual in the present writer's experience.
9. Tachycardia and cardiac arrhythmias (Meyler 1966).
10. Excessively dry mouth.
11. Brisk reflexes.
12. Dilatation of pupils with occasionally sluggish response to light.
13. Fine tremor of limbs.
14. Nystagmus (rare).
15. Signs of weight loss (occasionally).
16. A paranoid psychosis (amphetamine psychosis).
17. Hyperpyrexia and profound collapse (Meyler 1966).
18. The question of brain damage has been raised (Oswald and Thacore 1963, Connell 1966) and verbal reports from Japan suggest that patients in mental hospitals who were involved in the Methedrine taking epidemic after the war are showing organic types of mental disturbance.

It must be recognised, however, that those individuals who are taking large doses of drugs and who are dependent on the drug may well deny their drug taking, and thus a history of the drug abuse is frequently lacking. Recognising this, and also the fact that only in rare cases are positive physical signs in the central nervous system present, it will be clear that the diagnosis of amphetamine intoxication can be very difficult. Most of the psychological symptoms and the presence of dilated pupils, tachycardia and tremor could be explained in terms of an acute anxiety state. For this reason in cases of suspected amphetamine poisoning, it is always important to have biochemical tests available to demonstrate the presence of amphetamine in the urine. Thus the methyl orange test (a general test for amines) and chromatography have been employed (Connell 1958, Scott and Wilcox 1965) and more recently gas chromatography has been employed (Rowland and Beckett 1965).

Amphetamine Psychosis

This condition has been described in detail (Connell 1958). Essentially, the psychosis is in a setting of clear consciousness and the patient is fully orientated. Rarely, there may be a toxic confusional state lasting for a short time but this is usually, where it occurs, short lived and diagnosed by the patient's description or that of another informant. The details of the psychosis are well remembered by the patient, who will tell the examining doctor about his ideas of persecution, and about his hallucinations which may be visual and auditory. The following short case history gives an idea of the picture and is identical with that produced by phenmetrazine abuse, which is described by Swedish workers as *Police Paranoia*.

A man aged 32 years was put on dexamphetamine by his local doctor because he complained of tiredness, nervousness, and fear of broadcasting (he was an actor). He increased the dose of tablets and finally began taking the contents of amphetamine inhalers (now withdrawn from sale). He began to hear people come to the door at night and walk about the flats. He thought he heard a car and a motorcycle which were connected with taking him away. He would not leave his room. He noticed his aunt take an envelope and followed her and saw someone out of the corner of his eye going quickly upstairs. He heard scuffling and a key turning in the door. He saw a policeman outside on the drainpipe and smelt gas and broke

windows to let it escape. He dashed out, but wherever he went there was gas, and outside there was a car that he was sure was a police car. He took refuge in his room again but then decided to give himself up to get away from the gas. He ran out and was chased by cars with gas appliances. After further wanderings, during which people were throwing things at him and beckoning and making signs to each other, he was apprehended and taken to a police station and thence to a psychiatric ward.

He was orientated in time and space, but deluded and actively experiencing auditory hallucinations when admitted. He had vague, unsystematised paranoid ideas and thought disorder was very marked. He was at first diagnosed as schizophrenic but was later found to have amphetamine inhalers in his possession. He had no insight into his condition at that time but was discharged, recovered, after eight days when assessment of his urinary amines had shown that he no longer had amphetamine in the body, at which time his abnormal mental symptoms had disappeared.

It must be remembered that the condition "amphetamine psychosis" was described in relation to patients taking amphetamine or dexamphetamine or methamphetamine. In the 1950s individuals were ingesting the contents of amphetamine inhalers which contained 350 mgm. amphetamine base and this is equivalent to about 500 mgm. (100 tablets) of amphetamine. When, however, a barbiturate is added to amphetamine in such preparations as Drinamyl, Desbutal, Anxine, etc., the picture is modified and experience with adolescents taking large doses of Drinamyl at weekends suggests that the psychosis ("the horrors") is much shorter lived (Connell 1965 *a* and *b*). It is possible that disorientation and confusion may be commoner in the presence of the barbiturate.

Amphetamine Dependence

In the early days of amphetamine use there were the usual reports claiming its efficacy as a therapeutic weapon and drawing attention to the fact that patients who had been on the drug for long periods of time showed no tendency to become dependent. The few warning papers concerning dependence, addiction, and tolerance were not followed up by case histories of patients showing these phenomena. When one considers that the patient who is dependent rarely tells his doctor, particularly if it is a hospital doctor, one can understand that it took many years before the dangers of the amphetamines in this respect came to notice. The Japanese experience after the war (WHO Technical Report Series No. 102, 1956) and the reports of cases of amphetamine psychosis in this country (Connell, 1958) drew attention to the problem. Since 1958, however, there have been a number of papers drawing attention to this danger.

Beamish and Kiloh (1960) reported seven cases of psychosis associated with amphetamine consumption in Newcastle-upon-Tyne. Bell and Trethowan (1961) reported 14 cases admitted to a Sydney Hospital who were psychotic and were addicts, and stressed the poor prognosis and high relapse rate in which further recourse to amphetamines took place.

Connell (1962) stressing the dangers of amphetamine misuse drew attention to the overactivity which might lead to social consequences (for example car accidents) and aggressive behaviour, and also to the risk of suicide in the withdrawal phase when a severe depression can occur. Psychotic patients, too, could be dangerous.

Kiloh and Brandon (1962) noted that amphetamines in general are prescribed readily and light-heartedly. They scrutinised the *E.C.*10 forms dispensed by all pharmacists in the City and County of Newcastle-upon-Tyne during the months of May and November, 1960. Of a total of 119,208 scripts for May, 4,052 were for amphetamine preparations (3.4%). The amounts of amphetamines prescribed in the two large Newcastle hospitals — calculated as amphetamine sulphate tablet equivalents—was 223,500 tablets in May and 176,000 in November. In other words, "the average monthly quantity of amphetamines prescribed is approximately 200,000 5 mg. tablets, 53% of which are dispensed as "Drinamyl". These writers then go on to mention methods employed to obtain extra quantities, such as obtaining them from friends or from hairdressers; going to their doctors with a tablet obtained from a friend and asking for the same; going from doctor to doctor, or to another doctor in the same practice; claiming loss of prescriptions; forging prescriptions by altering them or by filling in blank prescriptions and so on.

Brandon and Smith (1962) reported an investigation into the amounts of amphetamine prescribed in general practice. Rather less than 1% of all registered patients in the practices in the Newcastle area investigated were receiving amphetamines. A tentative assessment of 2,600 individuals receiving amphetamine preparations at any one time was made. The monthly consumption of 200,000 tablets by this number of patients indicated a rate of 77 tablets a month per patient. Of those for whom amphetamines were prescribed 15.3% were males and 84.7% females. The general practitioners taking part in the investigation estimated that of those patients rather more than 20% could be regarded as habituated or addicted. It was suggested that approximately 520 patients were habituated to amphetamine in Newcastle-upon-Tyne.

McConnell (1963) reported cases of amphetamine addiction in Northern Ireland and suggested that there was excessive prescribing for "drugs which have such indefinite indications".

Oswald and Thacore (1963) refer to the commonness of amphetamine addiction and to Drinamyl prices of £1 per 24 tablets in London, and £1 for 25 tablets among Edinburgh factory workers. They demonstrated by the use of electroencephalographic methods that the normal sleep pattern was altered on withdrawal of these drugs and that the disturbance of sleep E.E.G. records continued some days or weeks after the drugs could have been assumed to have been all excreted.

Wilson and Beacon (1964) investigated the habituating properties of an amphetamine-barbiturate mixture in Liverpool and discussed ill-advised medication with drugs leading to habituation and addiction. Wilson defines ill-advised medication as "the treatment of patients by drugs without sufficient justifiable indication for their use."

These reports draw attention to the increasing interest in the amphetamine group of drugs, their dangers and the question as to whether they have a place in the therapeutic armamentarium. Even as long ago as the 1950's Connell (1958) noted that in his series of 42 cases eleven patients had been given the drugs in the first instance by doctors and the dose range taken by the addicts was 30-975 mgm. a day.

The Teenage Problem

The Brain Committee's (Interdepartmental Committee on Drug Addiction) first report (1961) noted that in 1959, 5,600,000 prescriptions (2.5% of the total prescriptions) were for preparations of amphetamine and phenmetrazine (Preludin).

The development of the adolescent pattern of drug taking commenced about 1961 and by 1963 concern was being shown about this. Reports appeared in the press in 1964 and the first reports in the medical press appeared in the same year (Connell 1964). Later reports followed (Connell 1965a, 1965b, 1966, and 1967).

Space does not allow of a long description of this problem but a brief account of the development of the problem may be of interest.

It seems likely that in the late 1950s there was a small group of "Chelsea" types who took amphetamines regularly and had them available at parties. In 1954 the writer remembers hearing from one such individual of bowls filled with Dexedrine tablets, which individuals helped themselves to as required, being available at parties.

For reasons which are not clear, in about 1960-61 a pattern of teenage life began, which involved going to the West End of London for the weekend, either on Friday evening or Saturday and staying out all night moving from one all-night club or coffee bar to another, taking Drinamyl (in those days a triangular tablet, pale blue and called by the teenagers a *purple heart*) to keep themselves awake. As time went on, greater and greater numbers of adolescents did this and they came from many parts of the country as well as from the suburbs of London. An unknown number of these individuals became dependent upon Drinamyl and some took as many as 120 tablets at a weekend. The clinical picture, for those who became dependent, was to start with small numbers at weekends, increase the dose and eventually, find that it was necessary to take them during the week as well.

Connell (1964) and in subsequent papers drew attention to the fact that as a small fringe group in these West End clubs there were narcotic addicts, prostitutes, transvestites, homosexuals, etc., and that although the teenage culture pattern regarded the "hard drugs" as dangerous and thought it was mad or "nutty" to take them, they all seemed to know where to get them if they wanted to, and therefore all the factors for a spread or a change from amphetamine taking to heroin and cocaine taking, were there should the culture pattern change and accept such a practice as "big" or "fun" or a "giggle". In the last year or so there has been evidence that adolescents and young adults who have taken amphetamine-barbiturate mixtures for as long as two years are now going over to intravenous heroin taking so that the feared development is now reality.

A further development (Connell 1967), mentioned at The London Hospital Conference on drug addiction in September 1966 has been the spread of availability of amphetamines to the periphery so that adolescents no longer have to go up to the West End to obtain drugs. Anywhere where adolescents meet together is likely to be a centre where these drugs are available or where there is "a person" who can tell the adolescent where to get the drugs. The recent report in the Press of the police stopping a car on the way to Southend confirms the impression that, although there does not appear yet

to be a Mafia-type widespread organisation for the distribution of drugs there are smaller, more amateur organisations which are supplying these drugs to the adolescent population.

The development of this pattern of adolescent behaviour, the presence of drug taking in schools and universities and in the "pop group" culture, the availability of the drugs, the difficulty in diagnosing drug taking and the apparent indifference of some parents to the behaviour of their adolescent sons and daughters raise major social problems which will need remedy and not least of which will be the control of L.S.D. taking.

The Adolescent Drug Taker

Recognising that the patients seen in the hospital service are a highly selected group of the total adolescent drug taking population certain features have been described (Connell 1965a, b, 1966, 1967) relating to patients seen in his evening clinic at the Maudsley Hospital. The patients began their drug taking through a friend for "giggles" or "kicks" and had tried numbers of drugs such as marihuana, Dexedrine, Benzedrine, amyl nitrite sniffing, etc., but found that Drinamyl was the best. They had all taken the drug for many months before their parents had any idea of what they were doing; they knew where to get heroin and cocaine and had problems of adolescent adjustment with such behaviour problems as truancy, verbal aggression and sometimes police prosecutions unrelated to the drug taking and starting before they actually started their drug taking.

There are no estimates as to the prevalence of drug taking in the adolescent population and, indeed, only a study of a random sample of adolescents together with biochemical estimations of the urine to demonstrate drug taking would give an accurate figure. Many adolescents when asked about drug taking would deny it, even though knowing that the investigator was carrying out epidemiological and sociological surveys and that the information would be confidential. The biochemical investigation, therefore, is essential.

Scott and Willcox (1965) however, with a highly selected and "captive" population in two London remand homes found that at least 18% of admissions—both girls and boys—had positive tests for amphetamines in the urine. This study was carried out in 1964. Of considerable interest and of great social importance was the finding that these individuals (some of whom would seem to have received amphetamines from parents and other relatives who visited the remand home) when compared with a group of amphetamine negative remand home admissions, showed no differences in respect of such parameters as, types of offence which lead to the remand home admission; average number of previous offences; seriousness of offence; ethnic grouping; average number of siblings and family backgrounds. The drug taking, therefore, appeared to be incidental to the delinquency though "probably having similar roots in opportunity and predisposition."

Assessment and Treatment

There would appear to be two distinct problems relating to amphetamine abuse requiring consideration.

1. *The adult (classically the tired housewife) who becomes dependent upon amphetamines (usually amphetamine barbiturate mixtures) some of whom take doses well above the therapeutic limits.*
2. *The adolescents or young adults who take amphetamines as part of a socio-cultural behaviour pattern, some of whom become dependent on the drug and a proportion of whom as a consequence cannot function at work or at centres of higher education.*

The assessment of both groups will involve a comprehensive scrutiny of the individual, his personality and life situation and the stresses he or she is having to face. In this respect, it is usually important and sometimes essential to have the comments and history from another informant who knows the patient well. Access to biochemical facilities is important.

Treatment for both groups will involve attempts at remedying the basic problems, whether these be psychiatric in terms of an anxiety state, depression, marital dysharmony, etc., and, of course, attempts at withdrawing the patient from the drug when there is sufficient motivation to make such attempts worthwhile. In-patient admission is usually required for the adult group in order to secure withdrawal.

Assessment and treatment of the adolescent group will require a careful evaluation of the adolescent problems of development and especially in relation to methods of child rearing used by the parents. Treatment may well involve helping the parents to understand their son or daughter and handle the situation more sensibly when they have greater understanding of the needs of their adolescent. For instance, the parents who still persist in "babying" their adolescent at the age of 15 or 16 will encourage hostile rebellious attitudes and encourage outward expression of these by overt rebellion to them and by anti-social activities. Similarly, the parents who abrogate reasonable responsibility

and firmness towards their adolescents will leave their progeny without the security and support that the adolescent needs in this formative period of development.

The tragedy of the adolescent drug culture is that the adolescent who, at that age, goes through a phase of sensitivity, shyness, emotional variations with mild depressions, and so on, may find that drugs give a temporary solution to these "growing pains". However, once embarked on this artificial solution the adolescent may find firstly that he does not grow up emotionally, and secondly that patterns of thinking and behaviour become established which make adjustment to the challenges of adulthood difficult and perhaps impossible.

It must be mentioned, however, that although both adult and adolescent drug addicts are likely to be unstable personalities before taking the drug it is by no means certain that individuals with normal previous personalities are free from the risk of becoming addicted to amphetamines or other drugs. This applies also to alcohol. It would seem that there may be a very small proportion of sound personalities for whom the drug may have such potent and specific effects that dependence may ensue. This may be particularly relevant if the individual has a personality which includes definite mood swings (a normal personality type) but finds that the depressive swing is overcome by the drug.

Action Required

There are no follow up studies of individuals dependent upon amphetamines though it is generally accepted that relapse to drug taking in those who have been withdrawn is common.

It is clear that if the drugs were not available—and this means not prescribed, as well as not available through illegal sources—that this problem would not exist in relation to amphetamines.

Certain action would seem to be obvious.

1. More careful supervision and control of the amphetamines. Schedule IV of the poisons rules is a very loose schedule and it has been suggested (Connell 1964) that a tighter control such as the D.D.A. regulation might be considered. Although the Drugs (Prevention of Misuse) Act gives the police certain powers there are not many teeth in this act and the close supervision of manufacture, and distribution required is not provided under the terms of this act.
2. Education of the medical profession concerning the dangers of these drugs. It is incredible that after so much time there is so little widespread knowledge in the medical profession as a whole concerning the dangers of these drugs.
3. Basic research into the therapeutic value of the drugs for the conditions they are prescribed. Psychiatric circles now rarely use these drugs and research into their use in general practice is urgently needed. Perhaps the *College of General Practitioners* should sponsor such research.
4. Provision of assessment centres so that patients, whether they come from general practitioners, school medical officers, Juvenile or Adult Courts, can be assessed and advice given.
5. Provision of treatment centres (both in-patient and out-patient) so that adequate help can be provided.
6. Provision of rehabilitation services so that drug dependent patients can be helped back to a place in the community without having recourse to drugs. In this respect, the withdrawal as an in-patient, of patients who are drug dependent may be the easiest part of the process but will fail unless out-patient supervision and rehabilitation is effective.

Inherent in the above is the concept that drug dependence is an illness which requires medical assessment and may require medical treatment.

The Second Report of the Brain Committee (1965) whilst dealing with narcotics did refer to the growing problem of amphetamine taking and recommended that a Standing Advisory Committee on Drug Addiction be set up which would consider all forms of drug dependency including amphetamines. This has now been constituted and is sitting regularly.

This report also emphasises the need for treatment facilities and for research and it is hoped that Research Units such as the one to be set up at the Institute of Psychiatry and the Maudsley Hospital will contribute to knowledge about this field, about which there is so much ignorance, and which looks as though it will cause one of the main sociological problems of our times in Great Britain.

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Prospect

The student revolt at the London School of Economics is over, at least for the present. It was given headline news coverage for several days, in which the most frequently repeated description was irresponsible. Were they so irresponsible? To be responsible is to be morally accountable for one's actions, capable of rational conduct. Views cannot be described as irresponsible but actions can. The students took direct action. The majority of them are, however, by no means militant, the students themselves stress. The new leader of the student union, for example, is politically Conservative, a member of the "Bow Group" of Young Tories. The student activities were much criticised but little publicity was given to the issues under dispute.

The dispute, wisely confined to term-time, ends with the implementation of a thoroughgoing series of reforms. These cover the government of the school, teacher-student relations, discipline and tutorial methods. Until now the founding charter of the college denied the students the sort of Students' Union which most universities and colleges acquired naturally and have, as we have, allowed to fall into apathetic disregard.

Within L.S.E. the hastening of disciplinary reforms is taken as evidence of a victory for the process of student protest. The whole schedule of reforms actually results from a detailed survey of the organisation of L.S.E., first started three years ago. But Dr. Walter Adams will probably take over as the new director on 1st October in a new atmosphere. For the process of reform should be largely completed. He should not be confronted by the need for immediate and critical decisions. It was protest at the appointment of Dr. Adams which sparked off the fuse which led to the explosion. It has been said that he was on remarkably good terms with his students in Rhodesia. It was rather the staff with whom he found himself in dispute. Perhaps he will find the London students more politically aware than their Rhodesian counterparts seem to have been.

However, there are basic issues, both here and elsewhere, which remain unsettled. As universities grow in size the staff tends to feel a pressure to reduce academic standards. Degrees, some feel, are almost too important. A new meritocracy is selected in the process of winning them. Increased staff-student communication is going to be widely needed to prevent such unrest from spreading.

E.A.M.

The British Library of Tape Recordings for Hospital Patients

The Library is a registered charity run for patients who are unable to read while in Hospital, whether as a result of eye troubles, operations, paralysis or any other cause. The Library caters for all these patients while in Hospital—whereas a similar organisation—"Nuffield Talking Books" can only cater for registered blind people at home.

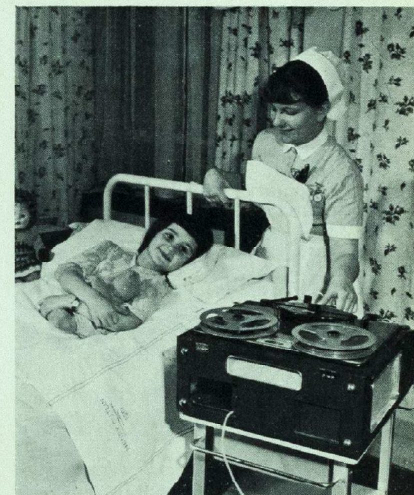
The British Library began in 1960 in a very small capacity, it was an immediate success and by 1964 enough money was raised from a number of charitable funds to begin a four year experiment.

The Library supplies to the Hospitals, a free service of books recorded on tapes for the use of individual patients—the tapes are run on a "playback machine" loaned by the Library. The machine is very similar to an ordinary tape-recorder, but because of copyright agreements must operate with a wider tape. The mechanics for working the machine have been simplified for use by patients.

Frequently the Hospital decides to buy one or more of the machines after a trial run with one belonging to the British Library. However, the tapes continue to be provided free of charge on a "lending library" basis, and it is usually the Hospital Librarian who acts as agent. The range of "books" is wide—a list of tapes is given to the patient who can then pick his choice. There is also a very good selection for children—including books like "Swallows and Amazons" and "A Bear called Paddington." The adult section includes plenty of popular novels and many books of crime which are always in demand. The books have been recorded by both amateur and professional readers, including a number of actors and actresses.

Patients are enthusiastic about the scheme and find it relaxing and enjoyable, and many people who do not normally read for pleasure enjoy the books. One is able to listen with very light comfortable ear-phones or lie with a small foam pillow containing the loudspeaker—but this tends to lull one to sleep! The tapes obviously fulfil a great need, and brighten what is often a tedious period of a person's life.

At Bart's, the Library of Tape Recordings has been a great success. Mr. Hugh M. O'Connor, O.B.E., T.D. is Chairman of the Executive Committee of the Library. We began using the machines in January 1966, when the Rahere Association bought the first play-back machine. It was always in demand from patients and its success was assured—so another machine was donated by the Women's Guild. Two further were bought with ward funds and the fifth obtained with money from a special bequest. They are all kept and run by the Patients' Library, and the machines are in use the whole time—however, the Librarians find that five are a sufficient number to run comfortably in the Hospital.



The pillow loudspeaker in use.

The pleasure that is derived from the tapes and machines is immense—one hopes that the Library will be established on a permanent basis if enough money is raised from the benefactors by 1968.

E.F.

The Library's address is 1, *Bloomsbury Square, Holborn, W.*1.

British Medical Students' Association

Bart's was represented by three delegates and one Executive Officer at the 1967 A.G.M. of the B.M.S.A. held recently at Queen's University, Belfast. The B.M.S.A. is the national association of medical students to which over 90 per cent. belong at approximately 1/- per student. This is a report of some of the things B.M.S.A. is doing at the present.

1. **B.M.S.A. Publications:** B.M.S.A. produces the following publications:—

(a) For every student
  (i) *Diary*
  (ii) *Medical Student News*
  (iii) *Introducing B.M.S.A.* (for each fresher)

(b) On application to B.M.S.A. Reps.
  (i) *Directory of Student Vacation Appointments*
  Giving information on clerkships obtainable in this country for both clinical and pre-clinical.
  (ii) *How to Go Abroad*
  Giving information on foreign clerkships—mainly clinical.
  (iii) *B.M.S.A. International Identity Card*

(c) **British Medical Students Journal.** This has in the past cost 1/- but from now on is to be smaller and distributed in limited numbers free of charge.

2. **Education:** At the moment the Royal Commission on Medical Education is collecting evidence, and the B.M.S.A. as the representative body of medical students, has submitted written and oral evidence. Over the past few years the Association has produced a number of reports on aspects of medical teaching and in 1965, after a National Symposium on Medical Education drew them together into one report and this formed the basis of the Association's evidence. While the Royal Commission is deliberating, the Association can do little more than encourage a greater co-operation between students and staff in seeking to improve the present system and to provide information as to how various problems may be overcome.

3. **Grants and Welfare:** In this field the Association seeks to put forward the special problems of the medical student, to supplement rather than to supplant the views of the National Unions who negotiate for students as a whole. At this period of economic restraint there can be little hope of any major increases in grants in the near future.

If individual students have any problems concerning grants, they should contact the B.M.S.A. who may be able to help them both with information and by representation.

4. **International:** In the past few years the number of students from this hospital going abroad for part of their clinical course has greatly increased, and many of these have taken advantage of the international department of the Association. The international work of the Association may be divided into two parts:—

(i) The Association finds suitable clerkships for clinical students in almost any country in the world, most of which provide free board and lodging. In addition, it also provides a number of paid clerkships in the United States and of the 50 arranged this year, five are from Bart's. A total of over 500 students per year are placed by the Association, 250 outgoing and 250 incoming.

(ii) British Medical Students Trust offers grants and scholarships to medical students travelling abroad in pursuance of their medical education. Since asking 6d. per diary to go to the Trust, this hospital has been in the forefront in applying for grants, and last year seven were awarded to Bart's students. If more money were available more could be awarded—hence our donation, and soon a national appeal is to be launched for a far greater amount.

5. **B.M.S.A. and You:** Apart from what has been mentioned above, B.M.S.A. arranges rugby competitions, a National Medical Conference, a National Tropical Medical Conference and at a local level, visits, lectures and dances. These services are all provided by students for students, so please take advantage of what is offered—it will benefit both you and the B.M.S.A.

Your representatives are—

Pre Clinical: Miss S. Rouse
D. Stringer

Clinical: I. Corral
R. Whitelocke

Use them and watch the Notice Boards so you may find out what B.M.S.A. is offering you.

J. Hobbs

Penguin Reviews

COLETTE

My Mother's House, by Colette. *Novel*, price 6s.

If you read good modern literature most of it is probably French—at least English literature has been asleep since Conrad. If you don't, and you want to start (remember some of us will be ordinary G.P.s) then there is no better introduction than the works of Colette. First of all her language and imagery are superb; she creates in a short paragraph the atmosphere of hot, lazy Victorian summers, with children playing in the sun-trap gardens or picking poppies in the tall meadows. The heat of the sun and the cool of the old stone house is reflected with the utmost accuracy in the moods and tempers of her characters. Her ability to create a symbiosis of nature and human mood is no better illustrated than in this book.

The book itself could be regarded as an introduction to her work. Her mother's house was the happiest place she ever knew in a very rough unstable life, and their association the fuel of her brilliant career. Her work has the same poetry and significance as that of Gide—surely there cannot be finer praise than that.

James Griffiths

My Apprenticeships and **Music-Hall Sidelights,** by Colette. Price 5s.

The book contains two works by Colette. The first, **My Apprenticeships,** refers to that period of her life when she was married to the notorious Willy (pen-name of Henri Gauthier-Villars). It begins with some short sketches of people who made an impression on Colette but inevitably leads to the person who dominated so much of her early life—Monsieur Willy.

Colette writes about Monsieur Willy with a detachment astonishing in a woman speaking of the man who was her husband for thirteen years. However, one feels that although she claims there is no bitterness on her part for the unhappiness he caused her, she is, by writing about him over thirty years after their marriage ended, purging her feelings about that period of her life.

Gradually, throughout several chapters, Colette builds up a vivid picture of the character of Monsieur Willy—a selfish, dominating, rather eccentric, bullying and dissolute person who dominated her, forcing her, against her inclination, to write salacious novels and accounts of her youth and school-days (forcing her, even to the extent of locking her in her room and making her produce so much copy for so many hours' work!), prevented her from making friends and treated her abominably over the matter of his many mistresses. Yet Colette herself admits that she accepted this treatment without murmur.

A certain tinge of sadness pervades the whole account. The few bright lights are her very few friendships, her affection for her mother and the happy memories she has of her childhood and her love of the countryside. Finally she explains how she submitted just as quietly to the suggestion that she should leave her husband. It is ironical that Colette who had been planning for so long to do just that, could never bring herself to do so until her husband told her to go. She writes, "I would have liked to be the one to say 'It is all over'. Since I had said nothing I could only hold my peace".

She held her peace for thirteen years. One cannot help feeling that had she not done so, she might have had a happier life with "Willy". In all, "My Apprenticeships" is a sad but immensely revealing and readable insight into her early married life.

Music-Hall Sidelights suffers, I feel, by comparison with "My Apprenticeships". It was written after six years spent on the music-hall stage. It consists of a series of disjointed scenes and character-sketches of people, animals and things she encountered during that time. She shows a remarkable faculty for describing both people and scenes in a few well chosen words, for example, the vivid picture of a company on tour, with their dirty crumpled clothes, tired faces, yet brave and determined air. But nevertheless I found it rather tedious reading, mainly because of the large number of sketches and also because of the style. In this work Colette is an observer rather than a partaker (she only speaks of herself once or twice) and thus my interest was not aroused as much as in the more personal "My Apprenticeships".

The overall impression is once again that of sadness, together with the sordidness, loneliness and in some cases poverty of the music-hall life. Surely there must have been a brighter side? Perhaps Colette was basically just a sad and slightly disillusioned woman.

Bernice Jordan

TRAVEL

Journey into Russia, by Laurens van der Post. Price 6s.

The purpose of the author's extensive journey through Russia in 1961 was an attempt to discover the real people behind the uniform official mask presented to the outside world, and to discover the impact of the Soviet system on them. The book forms a striking parallel to an account written a century earlier of Sir Richard Burton's visit to the newly founded Mormon community of Salt Lake City (The City of the Saints—Sir Richard Burton). Both are journeys undertaken by famous travellers to discover the truth about states which have aroused considerable horror in the popular imagination.

Van der Post's journeys took him from Moscow through Siberia to the Far East near the Pacific Coast; and from Tashkent and the Black Sea in the South to Leningrad in the North. His main concern was to meet as many people as possible and learn about their lives. He found the people very hard-working with a genuine desire for economic advancement and learning, their main aim being to surpass the United States. By British standards the people enjoy little freedom, and on leaving he was conscious of a great weight lifted from his spirit.

His account of his travels and the people he met seem both unbiased and well observed and form a most fascinating and readable book. Because of its self imposed isolation the Soviet Union arouses both fear and admiration in outsiders and this book should help them form a more rational view of this country.

C. J. Hubbard

RUSSIAN-GERMAN CONFLICT 1941-45

Barbarossa, by Alan Clark. Price 10s. 6d.

To most people the second world war, in as far as the conflict with Germany is concerned, consisted essentially of the Battle of Britain, Dunkirk, Alamein, the Italian campaign and D-Day and the ensuing final defeat of Germany. There was however in Eastern Europe another war, which was probably far more brutal and costly in terms of both men and materials than that in the west. *Operation Barbarossa* was the German plan for destroying Communist Russia to win *lebensraum* for the Aryan peoples.

Mr. Clark has produced a fascinating account of the struggle from the early crushing victories of the fresh German armies to their ultimate defeat around Berlin. He gives us not only strategic details but also the reasons, at times rather obscure, behind the various decisions and their consequence in other theatres of the war.

In particular Mr. Clark attempts to assess the significance of the conflict between Hitler and his Generals on the course of the war. Hitherto Hitler has shouldered much of the blame, but in this book the position is restored to a more even balance of responsibility, and one must reappraise Adolf Hitler as a war leader and tactician.

As variety in this long book, extracts from personal accounts of the fighting are included and the passages describing the struggle for Stalingrad are particularly vivid. Perhaps the passages of this book most relevant today, are those depicting the treatment of the civilian population during the German Occupation; the brutality and the account of the rivalry between the various factions of the occupying forces for booty and manpower, e.g. SS, GBA, *Ostministerium*, is sickening. If one gains anything from this book, it must be a greater understanding of the basis of the present Russian policy over divided Germany. Indeed perhaps we ourselves, should be cautious about advocating the re-unification of Germany.

J.A.S.

MEDICAL BOOKS

Medical Education

The Teaching Hospital. Evolution and Contemporary Issues. Edited by John H. Knowles, M.D. Published by Harvard University Press, Cambridge, Massachusetts, 1966. Price 32s.

This volume is a collection of four Lowell Lectures concerning the position of the teaching hospital in the United States of America. The reader looking for ideas that could be applied to the improvement and development of teaching in this country will be disappointed, for the uniting theme of the Lectures is finance. The problem in America, where a high proportion of the patients is in the private category and financed by voluntary insurance schemes is very different from this country, where private patients' fees do not contribute materially to the running of hospitals and their medical schools.

Common problems, however, are the "rational utilisation of medical manpower and the extension of the hospital interest to the community". In both countries, with the rapidly increasing complexity of medicine and almost geometrical rise in its cost since the war, it is difficult to make progress and provide the high standard of treatment the educated public has come to expect, if budgets remain stationary or rise at a rate slower than the increase of costs.

In America, as here, too small a proportion of the total hospital beds is used for teaching purposes, and this system leads to "islands of excellence in a sea of mediocrity". The teaching hospitals must take increasing district responsibility, and their very survival in this country as efficient teaching units depends on such extension.

Though the tendency in America is to increase the Federal contribution and control, there is clearly fear that if this progresses the hospitals might fare worse "under the heel of politically determined priorities on the tax dollar". This is certainly true under the Health Service in this country, and University and Endowment funds are increasingly less able to cope with the financial demands of the post war medical centres with large departmental research budgets.

There is no doubt that in both countries the medical profession has been backward in making it clear to the people and their elected representatives, the increase in the financial demands of modern medicine —at the Massachusetts General Hospital a tenfold increase from 1940-1964. Whilst some economies can clearly be made the public must be made to realise that the enormous benefits to be derived from the explosive increase in modern medical knowledge can only continue if a considerably larger proportion of the national income is devoted to the health services, whether this be made by direct payment or national taxation.

This little book is certainly to be read by anyone interested in the problems of the American teaching hospital; but it is relatively expensive to own and in this country must mostly be found in a medical school library.

I. M. Hill

The Evolution of Medical Education in Britain, edited by F. N. L. Poynter. Published by Pitman, London, 1966. 238 pp. Price 40s.

This volume contains the papers read at the Fifth British Congress on the History of Medicine organised by the Faculty of the History of Medicine and Pharmacy of the Worshipful Society of Apothecaries, held in London in September, 1964. Covering a wider field over an extensive period it is obvious that some of the subjects must be treated superficially, but several of the papers have extensive lists of references for further reading. Lord Cohen of Birkenhead provides an interesting Introduction, which is followed by papers by A. H. T. Robb-Smith on "Medical education at Oxford and Cambridge prior to 1850"; H. P. Tait on "Medical education at the Scottish universities to the close of the eighteenth century"; R. S. Roberts on "Medical education and the medical corporations"; Sir Zachary Cope on "Private medical schools of London (1746-1914)"; A. E. Clark-Kennedy on "London hospitals and the rise of the university"; S. T. Anning on "Provincial medical schools in the nineteenth century"; W. H. McMenemy on "Education and the medical reform movement"; J. R. Ellis on "Growth of Science and the reform of the curriculum"; Charles Newman on "Rise of specialism and postgraduate education"; F. N. L. Poynter on "Education and the General Medical Council"; John Anderson on "Medical education and social change"; and Sir Brian Windeyer on "University education in the twentieth century". These provide a brief survey of medical education over several centuries with close-ups of certain outstanding features. Much remains to be written, but the material is still buried in archives, newspapers, manuscripts and similar documents. For example, the history of teaching at this Hospital has been very inadequately recorded, and one obstacle to the completion of a history of the Medical College lies in the large gaps still to be filled, despite investigations conducted over a number of years.

Everybody interested in medical education should read this book, not only to appreciate the development of the subject through the ages, but to be reminded of the necessity for continual re-assessment. They will note gaps in the history, and by means of the references provided, might well initiate investigations that will fill those gaps. This book contains little that has not already appeared in print, much of it from the pens of the contributors, but it presents between two covers a conspectus of a subject of topical interest.

J. L. Thornton

Medicine

The Metabolic Basis of Inherited Disease, by J. B. Stanbury, J. B. Wyngaarden and D. S. Fredrickson. 2nd edition, published by McGraw Hill. Price £14.

The first edition of The Metabolic Basis of Inherited Disease by J. B. Stanbury, J. B. Wyngaarden and D. S. Fredrickson was soon established as a standard work on genetically determined diseases, and the welcome appearance of the second edition is a tribute to the indefatigability of the editors, whose preface hints already at plans for a third edition, and to the industry of the contributors.

The number of diseases which come within the scope of the book has increased greatly during the past six years, and great efforts have obviously been made to keep up to date on a wide front. These have been generally successful, although the current intensive activity in the field of human metabolism makes perfection unattainable, and some chapters show signs of having been completed in good time for the publication date.

The first three chapters deal with some aspects of molecular biology and genetics. The remainder of the book is divided into sections dealing with disorders of carbohydrate, amino acid, lipid, steroid, purine and pyrimidine, metal and porphyrin metabolism respectively. There are also sections on diseases of connective tissue muscle and bone, the blood forming organs, diseases manifested primarily in disordered epithelial transport, and deficiency of plasma proteins and circulating enzymes. The biochemistry, history, clinical aspects, nosology and treatment of each disease are covered in detail and the reader sometimes gains the impression that comprehensiveness was the goal towards which the contributors were urged to strive above all other. This leads to a degree of diffuseness in some places, but the summaries with numbered paragraphs at the end of each chapter largely compensate for this and help to leave the reader with his attention focussed on the salient points. There is also an extensive bibliography at the end of each chapter.

This book can justly be described as "good" from both the clinical and biochemical aspects, although the detailed treatment of the biochemical implications of the diseases remains its unique feature. It should have no difficulty in retaining its place as a standard work of reference on biochemical topics for clinicians and on clinical topics for biochemists.

R. W. E. Watts

Neurophysiology

Basic Ideas in Neurophysiology by Tristan D. M. Roberts, 1st Edition. Published by Butterworths. Price 25s.

Dr. Roberts states in the preface to his book that his intention is not to provide a comprehensive text on neurophysiology. He has chosen certain topics which he regards as fundamental to the understanding of the workings of the nervous system, with the aim of discussing them in greater depth than is possible in the standard physiology textbooks.

The topics selected are concerned with the postural control of the skeletal muscles in vertebrates. They include the mechanical properties of skeletal muscle, the action potential, transmission at synapses, the initiation of nerve impulses at receptors and the coding of sensory information, and the muscle spindle and its role in the stretch reflex.

As a group of basic ideas in neurophysiology this selection is fully justified. Moreover, they are aspects in which our knowledge has been greatly extended by the researches of recent years.

Having set out with such admirable intent it is a pity that the book proves to be somewhat disappointing. The principal fault is that, even within the restricted compass to which the author has limited himself, the extent to which the different problems are examined varies so greatly. For example, saltatory conduction in myelinated nerve is dismissed in half a page without any mention of the relevant experimental evidence, while no less than six pages are devoted to the principles of servo-mechanisms.

A further criticism is the scarcity of figures. Many of the classical experimental results which appear as figures in physiology textbooks are surprisingly absent here. In other instances the use of a figure could have considerably reduced the length of the text and increased its clarity.

For these reasons the undergraduate student would probably be unwise to rely on this account as the sole source of information about the aspects of neurophysiology enumerated above. On the other hand the treatment of some topics, such as the classification of nerve fibres or the histology of the muscle spindle and its relation to the function of the receptor, is excellent and the book could be read with profit for these sections alone.

The book is written in a readable style, which may commend it to those who dislike the highly condensed writing of the average textbook.

N. Joels

Psychiatry

A Summary of Psychiatry, by Alexander Elkes and J. G. Thorpe. Published by Faber & Faber. Price 13s. 6d.

This book purports to consist of brief notes on most topics pertaining to Psychiatry and Clinical Psychology. It is badly written and in parts is condensed to the point of incomprehensibility. It offers no logical classification of psychiatric disorders.

The authors show poor judgment in the way they allot space to different syndromes, e.g., psychotic states in Canadian Indians, Malays and Cantonese get as much space as anxiety states, while in the chapter on addiction, tobacco is dealt with at length while hashish and L.S.D. are not mentioned. Similarly in the chapter on sexual deviations, the commonest of all—exhibitionism—does not appear. The few references are selected capriciously, and no suggested reading list is given.

This book cannot be recommended either for the student or the doctor.

C. P. B. Brook

SPORTS NEWS

100 years of Bart's Rugby (1866-1966)

by P. A. Ashby

The St. Bartholomew's Hospital Rugby Union Football Club has just completed its Centenary Season. This has not been too successful as a whole, the 1st XV have won less than a third of their matches, but there have been some outstanding successes. In the Centenary game, they beat the United Hospitals' XV by 19 points to 8, and the victories against almost unbeaten Rugby (8 points to 3) and Streatham, who had beaten all the other Hospital sides, (22 point to 8), were no mean performances.

The highly successful Welsh Tour saw Glynneath and Treorchy well beaten, which made a tally of six wins in a row to finish the season in great style.

There has been some controversy as to the exact date of origin of the Club, for the records up to 1935 were destroyed in the war. Some authorities have claimed that "Rahere, Court Jester to Henry II" was the originator, for he "used to carry a bladder about with him", whereas the Bart's *Journal* dates the Club to 1873. However, the Assistant Secretary to the R.F.U. did some research and wrote to Mr. Cope with the following information from the oldest annual (1868) in the Union's possession:

"Founded in October, 1866, with 60 members. The subscription was 5/- and the Secretary: P. Butler Stoney.

The colours were dark blue jersey (with badge) and socks, with white shorts, and the Club played on the Middlesex County Cricket Ground, which was 10 minutes from the Caledonian Road Station on the North London Railway." A few years later, games were played at Battersea Park until 1894, when the Winchmore Hill ground was bought. Today's colours were adopted in 1905.

The Inter-Hospitals' Cup Competition was started in 1875, and Bart's first won it in 1881 under T. C. Gibson (against The London). Two years later we won it again, this time against St. George's, with C. O'Brien Harding as Captain.

In the Anatomy Theatre on July 17th, 1892, the Amalgamated Clubs' Union was formed and under its constitution the Rugby Club received a grant of £40 0s. 2d. for that year (it now receives £725 p.a.!)

In April, 1894, 10 acres of land were purchased at Winchmore Hill, which remained as the Bart's ground until Chislehurst was bought in 1936. There was one rugger pitch there.

1900 saw the institution of the Junior Cup Competition. Even in those days the problems of getting people to train regularly posed themselves frequently. The Secretary in 1904 said in his report on a poor season:—

"It is the Captain's job to get men down to Winchmore at least once a week and encourage them to box, swim, or anything, in fact, but loaf around the Square for two-thirds of the afternoon".

These words might have had some effect, for in the following season the "A" XV lost narrowly to Guy's in the Junior Cup Final. However, the 1st XV did not reach another final until 1914, when they lost to The London.

In 1920 we again reached the final, this time against Guy's, but were again beaten in pouring rain. His Majesty King George V came to watch this game and it is interesting (though perhaps not surprising) to note that no monarch has attended a final since then! Several members of that side are alive today and they may remember how, during the evening after the game, one of the team entertained the audience (and the performers) at the *Hippodrome* by falling out of a first floor box into the bass drum in the orchestra.

In the following three years we lost to Guy's in the final *twice* more, before finally beating King's 14-6 to win the Cup in 1924 under the devoted leadership of G. W. C. Parker. That year Parker and Gaisford had England trials and M. G. Thomas played for Wales. The "A" XV distinguished themselves by winning the Junior Cup, which they also won in 1926, '27, '29 and '31. The Senior Cup was won again in 1928 under R. N. Williams and two

years later, although we beat Coventry, Moseley, 'Quins and Rosslyn Park, we lost to Guy's in the final.

The following season, with J. Taylor as Captain, we won both cups, and J. W. Cope, now Dean of the Medical College and President of the Club, was a member of the victorious "A" XV side. The "A" XV lost the cup in the final the next season, and in 1933 Guy's again beat us in the Senior Cup final. A short poem appeared in the *Journal* about this time, which went as follows:—

"For everybody ought to know,
That all the Rugger XV go
To bed by ten, and up again
They get at six or seven."

Surely a smack in the eye for those who so readily accuse the Club of "waking up" College Hall late at night. But back to history . . . the "A" XV again reached the final in 1936 and Chislehurst was obtained later in the year, mainly through the offices of Sir Girling Ball, the then President of the Club.

At an Extraordinary meeting of the Club in May, P. L. Candler (the Captain and later England fly-half) was empowered to borrow £600 from the E.R.F.U. at 2½% for a Grandstand at Chislehurst, the President and Vice-presidents standing as guarantors.

An opening match was held on 10th November and the XV lost 19-11 to John Tallent's XV, which contained four internationals and three county players.

During the war years, some of the games were played at Hill End and Mrs. White ably took charge of Chislehurst whilst husband Laurie was away. The preclinicals were stationed at Cambridge and in 1945 won the Cuppers Competition there.

In 1951 Mr. J. W. Cope became fixture Secretary—this was a new post designed to achieve continuity of fixtures and to relieve the Club Secretary of a very difficult and trying job. Mr. Cope kept this position for 12 years until his election to President in 1963. He was succeeded by Mr. McNab Jones.

In 1953 we were beaten 6-5 in the final of the Middlesex 7's by Gala, and four years later reached the cup final again under Mackenzie, beating Guy's and St. Thomas's before losing 5-3 to The London in the replay of the final. Percy, the mascot featured prominently in this cup series. Guy's took his head on the evening of the game, but this was soon "re-won". The next day, however, Guy's captured the *whole* of Percy and this required two stages for recovery—*stage* 1, the re-capture from Guy's of the body, and *stage* 2, the inspirational scheme which led to the finding of Percy's head in a Guy's flat by the 1st and "A" XV en masse, and resulted in the safe return to Bart's of that same caput.

Then after the first final against The London, he was again captured and taken to The London. This time, however, spies located his whereabouts and having drugged the guards with the hop and the grape, they rescued Percy once more.

In the next season the Club's achievements were not on the field—they crewed the only boat to win for the Hospital in the U.H. Regatta and they drank Chislehurst dry before the coachload of nurses arrived after the Inter-Firm 7's.

In 1959, John Hamilton's XV reached the final but lost the replay to Mary's 0-6. The Club did not achieve much more success until '64 and '65, when it reached the finals of the U.H.7's, losing on the first occasion and winning on the second. 1966 saw the Junior Cup back at Bart's, but the high hopes of retaining the cup this season were dashed when the "A" XV were well beaten in the semi-final by The London Hospital "A".

In the last five years we have been three times in the final stages of the Middlesex 7's and the Club's playing strength is now sufficient to put out seven sides each Saturday.

We have played in the Senior Cup final 19 times and have won it five times; the Junior Cup has been won six times and we have often reached the final of that competition too.

Among our more notable players have been:—

M. Thomas (Wales)
W. Gaisford (England)
P. L. Candler (England)

and we hope that Brian Rees (Wales) will be able to play for us whilst he is at Bart's

Remarkable for his loyal association with the Club, both on and off the field for 50 years, is Mr. F. C. W. Capps, who together with Mr. Cope, has been very helpful in compiling material for this History.

PRESIDENTS OF THE CLUB

(This list is not complete, as the early records have been destroyed.)

A. Bowlby, Esq.	1893-
J. H. Drysdale, Esq.	1908-1924
Mr. W. Girling Ball	1924-1928
Dr. J. Barris	1928-1938
Sir W. Girling Ball	1939-1944
Professor Hadfield	1944-1948
Professor Scowen	1948-1960
F. C. W. Capps, Esq.	1960-1963
J. W. Cope, Esq	1963-

RUGBY CLUB

Welsh Tour

We arrived at **Glynneath** at kick-off time having travelled all day. Despite this, two penalties kicked by Griffiths gave us a 6-0 lead in the first ten minutes and as a result our confidence grew and the weary travellers were transformed into super-fit players. The game was fast and exciting with good sorties from the base of the scrum by McIntyre and some useful line-out work by Mason and Britton.

Glynneath replied with a try in the corner and a penalty to make the score 6-6. After the interval Mason scored half way out from a forwards' passing movement. The Glynneath centres then shook off some tackles for the first time and after a fast run, one of them made the score 9-9. At this time Bart's were playing an open game, obviously determined not to have a draw, but sometimes they looked as if they were going to throw the game away. Glynneath were less fit than Bart's and when Jefferson made a perfect scissors with Savage to dive over the line the result was not in doubt.

Result: **Bart's 12, Glynneath 9**

Next day at **Treorchy** there were five changes, and a confident team were ready to make this the first unbeaten Welsh Tour. The ground was like concrete, making tackling a hazardous business and Bart's were slow to settle down. We had a few anxious moments as tackles were missed near the line but Hopkins brought the game back to perspective as he picked up a loose ball, ran twenty yards, jinked outside his man and scored a neat try in the corner. There was little entertainment in the rest of the first half apart from the occasional run down the Bart's left wing.

In the second half we soon increased our lead as McIntyre wriggled over in the corner from a line-out. Fairclough produced a few mighty runs down the centre of the pitch dragging many men with him and from one of his runs the ball was switched left to Britton who did well to commit his man as he passed to Griffiths with an unmarked man outside. Instead of passing, Griffiths dummied inside and just made the line—he failed to convert. The score was now 9-0 to Bart's. Soon after this Jackson was up quickly on his opposite number, and plucking the ball from his hands ran over to touch down making the final score 12-0.

Result: **Bart's 12, Treorchy 0**

This stretches our run of consecutive successes to six, and makes eleven wins so far this season with one more match to play.

D. B. Jackson

HOCKEY CLUB

It is fitting that the last report of the 1966-67 season should contain two events of which the club can feel justifiably proud. In order of they are:—The Final of the U.L.U. Cup and the Easter Guernsey Festival.

Bart's v. Orpington, Won 4-0

This match produced the best crop of goals from our forwards since before Christmas. This sort of score reflects the capabilities of our very talented forward line, but is alas rarely produced. Orpington's forwards made very little impression on a solid defence; indeed most of the play took place in the Orpington half.

University of London Cup

Semi-Final

Bart's v. College of Estate Management, Won 2-1

Territorially Bart's dominated this match, but unfortunately did not manage to demonstrate their superiority by producing an impressive score. The goals, one in each half, were good efforts by Edmonson and Jefferson. C.E.M.'s consolation goal was scored in the last minute of the game.

Final

Bart's v. Imperial College, Won 1-0

We won this match as much on the sheer determination of our defence as on the goal scored by Steve Thomas. The goal came in the second half of extra time, as a result of a penalty stroke. This was awarded for a foul which obstructed Thomas, who was on the point of scoring following a fine move by the inside-forwards.

It is however to Imperial College's credit that they fought until the last, only to be repelled time and time again by our tireless backs and half backs who worked so well together (as they have throughout this season), to place the final

advantage with our own forwards—indeed, in the words of the "Telegraph" correspondent, a "Triumph for Bart's".

Team: P. R. Jordan; G. Benke, A. J. Barclay (capt.); C. Yates, J. B. Thompson, P. V. Curry; N. Houghton, R. P. Barclay, D. Edmonson, R. S. Thomas, W. Goss.

Guernsey Easter Festival

Results:

Bart's v.	Guernsey I	Lost	0–3
,, ,,	Guernsey III	Won	9–0
,, ,,	Dragons	Drew	0–0
,, ,,	Guernsey G.S.	Won	6–0
,, ,,	Wurzels	Won	1–0

The fourteen members of our tour party enjoyed the hospitality of Guernsey on this, our first visit to the Hockey Festival.

Heavy rain and flood tides on one day diminshed the number of games played, but this only served to increase the social side of the event.

Several individual performances both on and off the field would be worthy of note, but it would be unfair to single out anyone for praise or otherwise. This was a time for solidarity in the face of adversity, and I'm sure that this was the message that left its impact on the good people of Guernsey. Such was the favourable impression we left, that they have invited us back again next year—need I say more?

End of Season Results (Including Festival):

	P.	W.	D.	L.	Goals F.	Goals A.
Bart's I ...	31	14	7	10	60	41
Bart's II ...	17	7	0	10	27	46

P. R. Jordan

BOAT CLUB

Head of the River Races

These come as a form of reward for the uncomfortable months of winter outings. Fitness and strength had been gained by interval training in the boat—a system supposed to be physiologically more stimulating, and certainly less tedious than long pieces of rowing—and by weight training in the gym; again a tried and tested method for developing strength, but achievement is related directly to a clockwork attendance at sessions. In the boat itself progress was disappointing but, on reflection, one can see where mistakes were made. An VIII is most definitely a precision machine, and when oarsmen who have never rowed together before hope to combine into a good crew, those eight men must be settled with the least delay into an order. Spirit, a fixity of purpose, and good coaching will then be enough to sort out most problems.

This was, of course, our policy but it could not be adhered to for various reasons, some unavoidable, others not so. Thus it was an VIII which had been rather played about with—to the frustration of both crew and coaches—that rowed up to Kingston one Thursday evening in darkness and pouring rain in company with the 2nd VIII.

Kingston Head, 11th March. Having holed our brand new shell VIII, Chris, on a shoal opposite Duke's Meadow (it has since been buoyed, I notice) we were to row this race in a borrowed shell. But confused orders from the bank at the start caused our division to be turned prematurely, and in the turmoil our rudder was sliced off without hope of repair. Rather too readily the 2nd VIII gave up their boat. After six minutes of racing we were involved in a second collision and forced to retire, rudderless and sinking at the bows.

Reading Head, 18th March. *Started 55th, finished 52nd.* This was a satisfactory row in our repaired shell and paradoxically we were pleased to be only four seconds slower than Guy's who have this year a good VIII which had beaten us by a far greater margin only ten days previously. The 2nd VIII started 117th and finished 139th.

The Tideway Head, 25th March. *Started 44th, finished 98th.* A last-minute defection to East Africa caused four's seat to be taken by an Irish Policeman, and an operation to put two's eye straight meant two substitutes. There was fortunately a following wind, but the water was rough at the start and with our as yet bad watermanship it was only occasionally that the boat was running as it should. All the way we were pressed by Q.M.C. and it was only by sheer willpower that we managed to keep ahead. A most uncomfortable row, but it showed us

that we could keep work on in unfavourable circumstances. We look forward to calm summer evenings.

1st VIII.—P. C. Cobb, R. E. Franks, P. I. Featherstone, T. F. Coyle, B. D. Cutler, P. A. B. Cheetham, B. O. Moore, J. D. C. Martin, J. Brooker.

2nd VIII.—R. Packham, R. J. Horton, C. Forrester-Wood, R. Wilmshurst-Smith, M. Castleden, I. B. M. Stephen, M. J. Simmons, N. J. C. Snell, M. Martin-Smith.

J. N. G. Gilchrist resigned as Secretary, but the post has not yet been filled.

J. D. C. Martin

CROSS COUNTRY CLUB

Middlesex Hospital Relay

This race was held over a $3\frac{1}{2}$-mile course of road, path and wet grassland on a warm sunny Wednesday. Bart's, competing against five other Hospital teams, were given a good start by Phil Wood who finished in fourth place. However, at the end of the second lap, we were astonished to see John Brooks come home in the lead with the remainder of the field nowhere to be seen. In fact he had been unfortunate enough to be confused by the difficult markings of the course and consequently missed out a one-mile stretch. On the third leg Willie Field tried the same trick, only to realise his mistake. This meant he had to run back on course and he lost himself at least two minutes in time; nevertheless he brought us into second place. Bob Thompson lost two places on the last leg, but he had had to repeat part of the course to make up for John's misdemeanour.

Results:—

Fastest lap—Hesselden (R.D.H.) 18min. 17sec.
Bart's Wood 21min. 0sec.
Brooks 14min. 31sec.
Field 23min. 5sec.
Thompson 24min. 28sec.
Winners—St. George's/R.D.H.

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King's College Relay

We entered this important relay race from Reading to Mitcham in fear and trepidation of being last; in fact five of our eight runners were borrowed from the U.H. Club, and we performed very creditably.

We were taken to the start by coach—ours got bogged down on a football pitch so we wasted valuable energy pushing it out—and we observed that the westerly wind should push us back to London at a rapid rate: in fact it never works this way in running; the wind is always against you. It also snowed.

In the absence of our chosen first leg runner, John Brooks, unfortunately out with a stress fracture, Steve Williams started us off, and very well did he run against good opposition. Although our next three runners ran as hard as they could we lost four positions and at the halfway stage were last but one. Bob Thompson caught up a little on the next and longest leg and a good run by Lew Steiglitz gave Graham Hesselden the chance to catch up three places on the long, straight stage on the A.3 to finish in 10th place. Dan Tunstall-Pedoe soon disposed of the King's runner and might have brought us in at 8th position had he not been misdirected. However, even the 12th place we gained was not bad against a field principally of University teams. Thanks must go to the non-Bart's men who made our afternoon's entertainment possible.

Results:—

Distance		Time min.	Time sec.	Fastest time on that leg min.	Fastest time on that leg sec.	Pos'n.
$4\frac{1}{2}$ miles	S. Williams (R.D.H.)	25	48	23	30	10
$4\frac{1}{2}$ miles	R. Scorer (London)	28	16	22	39	12
$5\frac{1}{4}$ miles	D. McGavin (London)	28	11	22	55	13
$5\frac{1}{2}$ miles	P. Wood	28	35	25	20	14
$6\frac{1}{2}$ miles	R. Thompson	31	54	27	27	14
$4\frac{3}{4}$ miles	L. Steiglitz (St. Mary's)	25	56	24	17	14
$5\frac{1}{4}$ miles	G. Hesselden (R.D.H.)	26	29	25	28	10
$4\frac{1}{2}$ miles	D. Tunstall-Pedoe	31	30	22	42	12
Winners—	Nottingham University	3hrs. 19min. 44sec.				
	Bart's time	3hrs. 46min. 39sec.				

R. Thompson

ATHLETICS CLUB

University Winter Athletics League

This league has six meetings at Motspur Park, three before Christmas and three after. Bart's are in Division I after last year's success, and in the first three meetings we excelled ourselves by winning each competition (beating King's, Guy's and Goldsmiths College). These successes were particularly due to Davies, Breeson and Scott. Unfortunately we were unable to field a team after Christmas owing to the call of cross-country and midwifery. The lack of support from the rest of the Club meant that we finished near the bottom of the division.

University Winter Relays Meeting

We were able to field a full complement of relay runners for this meeting. Thompson, Davies and Brooks ran well to make 5th place in the 880 x 880 x 1 mile relay but were not quite up to last year's standard when we came 3rd in this race. In the 220 x 220 x 440 relay, Brooks, Breeson and Scott came 4th. This is a very promising performance when it is realized that there are 40 colleges in the University.

Prospects for the Season

The response of many talented athletes, who have perhaps not been able to produce their best in previous years owing to exams etc., augers well for the coming season. We have some new fixtures and a tour is planned for mid-May. The Centenary Championships of the United Hospitals Athletic Club are to be held on 3rd June. This club has the distinction of being one of the oldest athletic clubs in the world and we must turn out in force for these important championships. They are to be followed by a Centenary Dinner at the Café Royal in the evening.

Sports Day

Sports Day will this year be on Wednesday, 24th May. Let us hope that a very much larger crowd will gather at Chislehurst this year than did so last year at what can be a particularly enjoyable event in the sporting calendar (not to mention the free beer!).

B. Scott

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SOCCER CLUB

4th March; v. Bedford College (U.L.), Won 1-0

Bart's were fortunate to take two points from this match, never having really settled down to any pattern of play. The first half was fairly even and the opposition having missed a penalty the score was 0-0 at half-time. Throughout the second half Bart's attacked but were unable to capitalise on their possession of the ball until Mumford scored with only a few minutes to go.

8th March; v. King's College Hospital (U.H.L.), Won 5-1

A fine hat-trick by Weir, and good goals from Bowen-Roberts and Raine gave Bart's a convincing win against a disorganised King's side.

11th March; v. Chelsea College (U.L.), Drew 1-1

Bart's approached this match knowing that a win would secure promotion for them. A very strong wind made play extremely difficult in the first half but the Bart's defence held up well and we started the second half feeling confident of making up our one goal deficit. However, despite a good goal from Sutton, the score remained 1-1 at full-time.

End of Season Report

The 1966-67 season ended with the Club's record standing as follows:—

P	W	D	L	F	A
34	16	4	14	65	67

In the University of London League our final position was 3rd, missing promotion to the First Division only on goal average. The Club finished about half-way down the table in the United Hospitals League. In our friendly matches this season, successes were few, but there were several closely fought and enjoyable encounters.

The side as a whole has played well throughout the season, and this is at least partly due to the ability of the three new members, A. Weir, D. Leech and R. Woodrow. Despite the loss next season of some of our more experienced players, the side should remain sufficiently strong to make its presence felt even more noticeably in the League and Cup matches.

S. Dorrett

RIFLE CLUB

Small Bore

The second half of the season has been as successful as the first and we could well end the season by winning several of the inter-collegiate leagues. The Postal "A" team is at present third in a very closely contested league, and as there are still several results to come in, they may well be able to regain the top of the league. Postal "B" is lying second, having been first for most of the season, but good results in the last few matches could remedy that situation and Postal "C" have maintained a good fourth position in the same league.

Novices "B" shot excellently and finished second to Q.M.C. in spite of beating them on aggregate by 250 points. Roger Field is to be congratulated on keeping an average of 90 over the ten rounds of the league. Novices "A" results are still incomplete but the team is lying fifth in Division I.

In the United Hospitals Competitions we have again acquitted ourselves very well, with the "A" team reaching the Final of the Group K.O. Competition, the results of which are awaited. In the Lloyd Cup, the "A" team is second, despite averaging 98 per man in their first three matches—the results of the last two rounds are yet to be received.

Only two members of the Club could be persuaded to enter the University Small Bore Championships. However, the results were excellent, with S. G. Crocker winning the Class "A" 25 yards Championship and the Hospitals' Championship, and C. I. V. Franklin winning the Class "C" 25 yards Championship and 50 Yards Championship, shooting all day in the open at ranges up to 100 yards—completely new to both competitors.

Pistol

The "A" Team is still lying second to the ever-present University College "A". The "B" Team is second in Division II with an excellent chance of winning, with the "C" Team lying fourth. Bart's has all four members of the University "C" Team—Battye, Blake-James, Cheetham and Turner—and they have won their division of the Inter-Universities League most convincingly. We also have two members in the University "B" Team.

Full Bore

Both the Bart's trials were quite well attended in spite of some rather unpleasant weather, and it appears that we have some very promising Freshers taking up this branch of the sport. For yet another year Bart's seems to have a phobia about attending University trials, which is a pity, as several people are of sufficient standard to shoot for the University if they made their abilities known. Despite this, two members have been selected to shoot in the first three University matches. With such a promising start, I hope we can look forward to another successful season, and also to several members shooting regularly in the University and United Hospitals' teams.

C. I. V. Franklin

Stop Press S. G. CROCKER has been awarded a team purple for his performances in the University of London 'A' team.

GOLF CLUB

1st March; **v. London Hospital at Royal Blackheath G.C.**

Against a weak London side on a windy but pleasant afternoon we had an easy victory, winning all five matches. Playing top, Chris Booth was 3 down at the turn but came home in par to win 2/1. Howard Rutherford played well to win 6/5. John Sadler was dormie six but only scraped home by 2/1. Richard Begent and Angus Hoppe completed the rout by both winning 4/2.

After the game Begent and his opponent searched the course for his car keys while Sadler propped up the bar with the keys in his pocket.

23rd March; v. **Imperial College at Hendon; match drawn 3-3.**

This was a new fixture for the club, and one that we will be eager to keep. Unfortunately both sides were somewhat depleted of their stars, Bart's probably being worse affected, and had it not been for the fact that I.C. made a mistake and produced six players instead of five we would certainly have lost.

Our first three players all lost; Stewart Davidson by 3/1, Chris Booth by 3/1, Howard Rutherford by 3/2. All these were closely contested matches—probably the opposition's knowledge of the course playing a vital part. Of our other two players, Angus Hoppe managed to scrape home one up. David Grieve, playing at five in his first game since an operation on his shoulder, disposed of his opponents in very severe fashion by 6/5 and 4/2—a remarkable performance.

There can be no doubt that we were lucky in the result of this fixture. The return, which will be at Chislehurst, should be an interesting match—particularly if both clubs are able to put out their strongest sides.

A. Hoppe

Annual Dinner

This event was held at The Olde Cock Tavern in Fleet Street on March 14th. Eighteen students and seven consultants attended

The evening started in the Hospital A.R. where eleven bottles of sherry were hastily disposed of. We then moved off to The Cock where further alcohol was consumed before the meal. This prelude induced a mild euphoria which was increased by the very pleasant red wine accompanying the good meal of roast beef.

With seven consultants present the after dinner speeches could hardly fail to be of the highest quality, and a note of frivolity was continued in all the speeches. But, without a doubt the dinner was Dr. George Graham's. What a remarkable man. He has now played in all but two of the staff matches since they began in 1920. He told us in his speech about the history of the Club, in the formation of which he has played a very active part.

After the dinner we returned to Charterhouse, with the police, regrettably, closely on our tails.

J. C. Sadler

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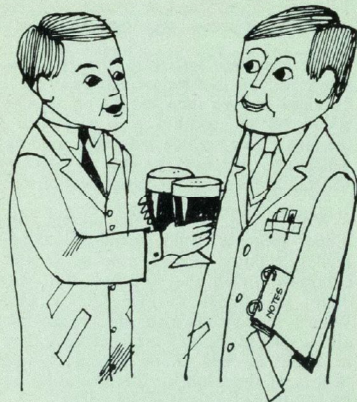

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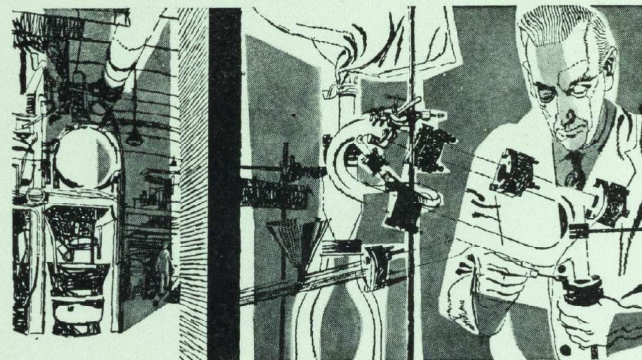

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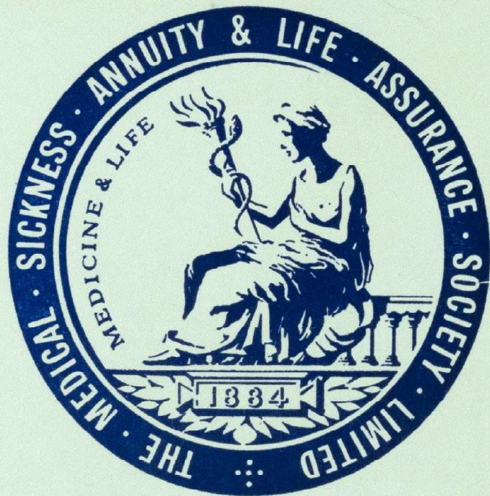

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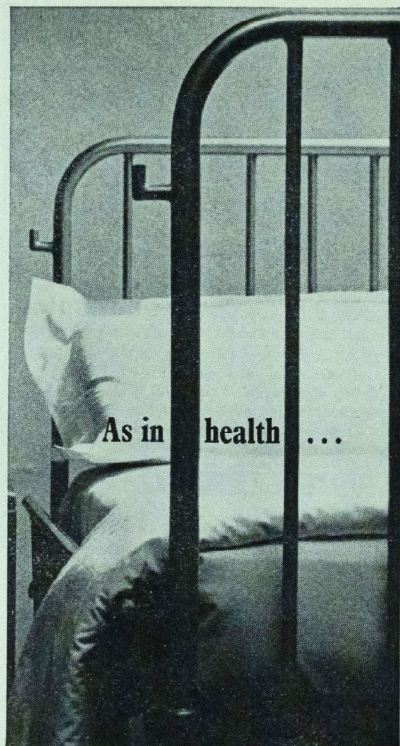

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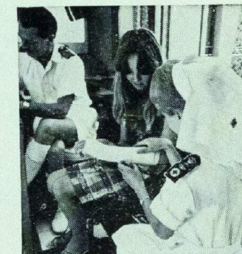

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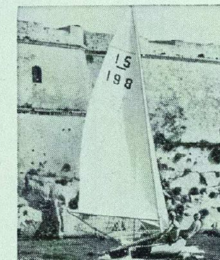

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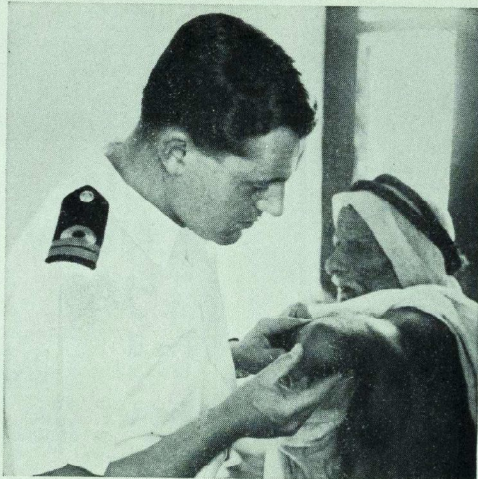

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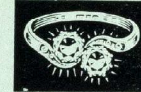

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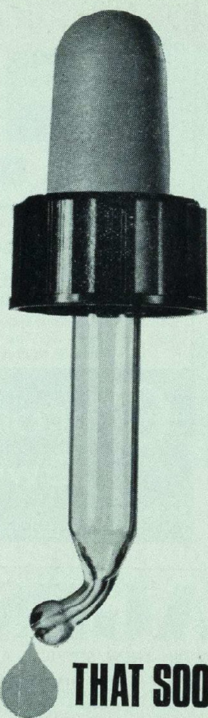

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JOURNAL

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How Common a Market

Once again the decision to apply for admission into the European Common Market has been approved on behalf of the electorate by a majority vote in the House of Commons, in spite of vehement opposition from certain elements of the national press. Back in 1962 when a Conservative approach was made, there was some concern expressed in the medical press about the effect successful application would have on medicine in this country. The debate centred on Article 57 of the Treaty of Rome which dealt with the reciprocal recognition of professional qualifications. Fears were expressed that continental qualifications might not be equivalent to our own and fall outside the requirements of the Medical Act (1956); this it was felt might prove unacceptable to the other member nations, since the Act was intended to protect patients, change in the Act could stir up serious opposition in this country. Similarly the existence of bodies such as the General Medical Council and the Privy Council as custodians of the ethical code in Britain, was a possible bone of contention among the continentals. One point that was not really discussed at this time was whether British qualifications would be acceptable to the common market countries—truly a sign of insularity!

The undergraduate training courses in medicine differ between the common market countries, but in particular post-graduate training and systems of qualification are very remote from our own. None of the common market countries suffer from our degree of "multiple diplomatosis" (perhaps this would provide a spur to rationalisation?). The national health systems on the continent are all on the insurance reimbursement scheme, how this would co-exist with the National Health Service, and how we would deal with any rush to "free British treatment" is a subject that warrants most careful study.

All these questions should ideally have been considered and discussed before ever application for entry was made, but since the rationale at present seems to be "get in first—and ask questions afterwards", it is imperative that when the time for asking questions does come round the Medical Profession in Britain should have thought long and hard about the implications. Whether the Profession is represented by the B.M.A., the J.H.D.A. or the M.P.U. is immaterial—what is important is that the Profession's rational voice is heard.

Nearer home however, the possible effects on the Medical Education and the actual practice of medicine must be considered. If application is successful there will surely be a great opportunity for broadening the course. Exchange studentships and elective periods in Paris, Rome or Bonn appear an exciting prospect, or will the British Medical Schools carry on with no concessions to the changed circumstances of Britain. We hope not.

There is of course a chance that the brain drain to the U.S.A. might be reversed by an influx of continentally-qualified men, but it is not impossible that this could be balanced by the frustrated registrars, instead of flocking to the New World or the Antipodes, settling for a quiet private, practice on the Mediterranean Coast, or by British general practitioners contemplating the mass annual exodus of their charges and deciding that their duty lay surely in following the health of their patients and setting up practice on the Riviera for the summer months to become a migrant species, as much a part of the resort as fish and chips, English ale, and "tea as Mum makes it".

As far as the *Journal* is concerned, we anticipate the day when we will have to abstract the *Journal* into the Common Market tongues and appoint a Translations Sub-Editor.

LETTERS TO THE EDITOR

NON-SMOKERS UNITE!

Sir,—Congratulations on your editorial "The Iniquitous Drag" in the April, 1967 issue of St. Bartholomew's Hospital Journal. As you say, the medical profession is in a particularly favourable position to exercise influence on both patients and the community as a whole in regard to the adverse effects of smoking, especially of cigarettes, on health.

Before the publication of the report on "Smoking and Health" by the Royal College of Physicians in 1962, followed two years later by a similar report of the Medical Advisory Committee of the Surgeon General, U.S.A., about two out of three doctors smoked. This proportion has now been halved. Example is undoubtedly better than precept, especially where the young are concerned.

Your readers may be interested to learn that there has been a reduction in the actual number of cigarette smokers in the United Kingdom of 1½ million in the past two years.

That the tobacco manufacturers have seen the writing on the wall is proved by their efforts at diversification into potato chips, perfumery and toiletries, and ceramics! They are also spending considerable sums on research into the possibility of producing synthetic "tobacco" free from carcinogens.

Although a smoker himself, the Minister of Health has been very active in doing all he can to persuade tobacco manufacturers to curtail poster advertising and to cease gift coupons and other incentives. Mr. Kenneth Robinson is the first Minister of Health who has succeeded in bringing about a ban on televising cigarette advertisements. He gave his full support to the motion put forward in the House of Commons by Dr. John Dunwoody on 9th December, 1966, and agreed to: "That this House, believing that the great majority of deaths from lung cancer are caused by cigarette smoking, urges Her Majesty's Government to take all possible steps to reduce cigarette consumption."

In the House of Commons on 27th January, 1967, the Minister made it clear that he expected widespread collaboration from owners of cinemas, theatres, restaurants and firms to curb smoking. In point of fact 34 out of 40 London theatres have already banned smoking in the auditorium and many departmental stores, chain stores and food shops have banned smoking.

The London Transport Executive has been most co-operative in increasing very considerably the accommodation for non-smokers in the Underground compartments.

It will be remembered that the Executive joined with the St. Bartholomew's M.R.C. Air Pollution Unit, directed by Dr. P. J. Lawther in carrying out a valuable survey on the incidence of lung cancer in garage and other workers which provides convincing evidence that cigarette smoking and not the fumes from internal combustion engines had a direct causal effect on the incidence of lung cancer.

According to an eminent M.R.C. authority on the subject, cigarette smoking was the cause of lung cancer in 24,000 out of the last 26,000 deaths from this disease in this country.

At the Ninth International Cancer Congress in Tokyo in October, 1966, Sir Alexander Haddow, director of the Chester Beatty Research Institute, stated that a third of cancer in the male in Britain is caused by smoking.

The National Society of Non-Smokers is concentrating its efforts on school children and teenagers, realising that it is far easier not to acquire the habit than to give it up once started.

Membership is open to everyone in sympathy with the Society's aims and you will notice that the Vice-Presidents include those from all walks of life.

I shall be happy to answer enquiries from any who care to help in our campaign and desire to become members.

Yours faithfully,
SELWYN SELWYN-CLARKE
13 Gainsborough Gardens,
Hampstead, N.W.3.

7th April.

FOOD FOR THOUGHT

Sir,—Fame and honour awaits the researcher who isolates the enzyme needed to detoxicate the gluten of the cereals. Drs. Brian Creamer, and J. D. Pink have recently found that the Paneth cells become degenerate and a patient whose cells atrophy and disappear fails to recover and slowly dies, even when put onto a gluten free diet. (*Lancet*).

Secondary pancreatic atrophy was found in several necropsies.

55 years of general practice and personal and family history have led me to the conclusion that the so-called "staff of life" is really the "cosh of death" to about 10% of our present population.

Dr. R. Shatin (*Lancet* March 2nd, 1963) explained how the discovery of cereals (5 or 6 thousand years ago) was so toxic when first utilised that the population explosion was checked in prehistoric and early civilisations, by the frequent lack of the appropriate enzyme. Now the mortality and morbidity is concealed by the multiplicity of the target-organs affected.

Dr. John Badenoch in *BMJ* September 24, 1960, page 879 listed about 20 effects in his series of 163 cases, with mortality 13%.

Coeliac disease is much the most frequent cause of the Malabsorption syndrome (G. C. Cook *BMJ* March 11th, 1967) Dr. Cook on page 615, noted that "Adult coeliac disease and coeliac disease are the commonest small intestinal causes of malabsorption in Great Britain "related", as both are precipitated by the same cause—gluten. Increasing evidence that two diseases are also by no means uncommon in both indigenous and expatriate populations in the tropics" (and on page 617) "have not been properly looked for."

African babies seem to have enough lactase and disaccaridase for 3 or 4 years, but in later life often fail to digest milk, even the Masai drink the blood of their cattle, not the milk.

I suggest that the lack of enzyme Glucose 6-Phosphate Dehydrogenase in so many Africans, which forbids them from taking salicylates, sulphonamides, primaquin and furadantin, without getting haemolysis, is the enzyme to search for. Dr. Jan Tomaskiewicz in the Lancet (1965) acting on this theory, cured or relieved about 40 cases of multiple sclerosis by injecting Menapthone, a Vitamin K analogue.

A useful hypothesis for explaining demyelinisation neuropathy and Kuru, (*Lancet*, March 25th, 1967, page 664) and the collagen and rheumatoid complaints in "adult coeliac disease", is that several factors (viruses, corynebacteria and sub-microscopic particles, carried as "badly-tolerated chronic viraemias") and the factor of an allergic heredity, unite to cause disease of gluten intoxication, when the trigger is pulled and the symptoms begin.

The symptoms may often be heralded by "irrational conduct", and the present crime wave and African and Far Eastern unrest and Chinese Turmoil, may be blamed on the rapid change from native diets to the habit-forming luxury wheat—called "sumpter" bread in the past, and confined to rulers and aristocrats and seen in history as dynasty after dynasty degenerated and exterminated themselves, and often their tribes or peoples, in idiotic fratricidal or aggressive wars.

See Metabolism and Madness (p. 253), and 'Mineral Metabolism Mania and Melancholia', (p. 262) by David M. Shaw—both in the *British Medical Journal* July 30, 1966.

Yours sincerely,
R. A. R. WALLACE,
40 Hadham Road,
Bishop's Stortford,
Herts.

3rd April.

DESECRATION OF COLLEGE HALL

Sir,—The seemingly needless butchery of two trees in front of College Hall strikes a sad comparison to the careful pruning of the trees in the Hospital Square.

Trees cut out light, and periodically need to be thinned. This is usually done sensibly, and detracts little from the beauty of the original trees. In this case the instructions seem to have demanded the removal of everything bearing a leaf, so that the trees now resemble well-worn "flue brushes". What experts, we ask, are *willing* to cut every branch at the same height above ground level, and do not protect the ends with tar?

The saddest aspect of this affair is that what is done cannot be undone, and it will be several years before the scars of a thoughtless decision no longer show. We hope that in the future more forethought will be used, and that the Students' Union will be consulted, as its members form the majority of the populace living in College Hall.

Yours faithfully,
HILARY BAGSHAW,
A.F.R. St. JOHN.
P. G. KITCHENER,
IAN M. CORRALL,
College Hall,
Charterhouse Square,
London, E.C.1.

19th April.

This letter was signed by 28 others, the original is available for scrutiny.—Ed.

UNFAIR TO THE FAIR SEX

Sir,—The list of "Recent Papers by Bart's Men" at the end of your Clinical and Research Supplement is very useful and informative, but it occurs to me that you are not being quite fair to one section of the Medical Profession.

As the April list contains the names of at least two Bart's *women* is it too much to hope that you will eventually amend your title and give them the recognition which is due to them.

Yours faithfully,
PAMELA C. ROGERS,
Clinic Clerk's Office,
St. Bartholomew's Hospital,
E.C.1.

1st May

Point taken; the fair sex have in the past had some difficulty in even entering the profession, but persistence has won the day eventually. What alternative title would suit all parties? 'Bart's Alumni' would be grammatically correct —latin plurals are always masculine if there be a mixture of genders—but this would only intimate, rather than specify the feminine contribution. Other suggestions welcome.—Ed.

June Duty Calendar

Sat. & Sun. 3rd & 4th.
Mr. Hunt
Sir Ronald Bodley Scott
Mr. Aston
Mr. Ellis
Mr. Fuller

Sat. & Sun. 10th & 11th.
Mr. Ellison Nash
Dr. Black
Mr. Manning
Dr. Ballantine
Mr. Cope

Sat. & Sun. 17th & 18th.
Mr. Badenoch
Dr. Hayward
Mr. Manning
Dr. Jackson
Mr. McNab Jones

Sat. & Sun. 24th & 25th.
Mr. Tuckwell
Dr. Oswald
Mr. Aston
Dr. Boulton
Mr. Dowie

Physician Accoucheur for June is Mr. D. Fraser.

Engagements

PHILLIPS—THOMPSON.—The engagement is announced between Dr. Simon Jeremy Phillips and Susan Jennifer Thompson.

REDMOND—CASTLEDEN.—The engagement is announced between Dr. Anthony P. Redmond and Miss Susanne Mary Castleden.

Births

HARPER.—On April 9, to Sylvia (née Mainprice) and Dr. Kenneth H. Harper a son (Nicholas Andrew), brother for Caroline.

JORY.—On April 22, to Carolyn (née Shepheard) and Dr. William Jory a son (Richard Norman) brother for David.

LEAVER.—On April 11, to Jane (née Clarke), and Dr. Peter Leaver, a daughter (Emma Jane).

PRISCOTT.—On April 17, to Leila (née Pharaon) and Dr. Robin Priscott, a son (Philip Justin) brother for Simon.

Deaths

BOLTON.—On April 12, Dr. Ralph Bolton, O.B.E., M.R.C.S., L.R.C.P., Qualified 1924.

GABB.—On April 14, Dr. John E. Gabb, O.B.E., M.R.C.S., L.R.C.P., aged 50. Qualified 1942.

HOGBEN.—On March 25, Dr. George Hamilton Hogben, M.R.C.S., L.R.C.P., D.P.H., aged 69. Qualified 1922.

TANNAHILL.—On April 12, Dr. Robert William Tannahill, M.D., M.Sc., M.R.C.P. Qualified 1913.

Appointment

Imperial Cancer Research Fund

Prof. E. F. Scowen has been elected Chairman of the Council of this fund.

Awards

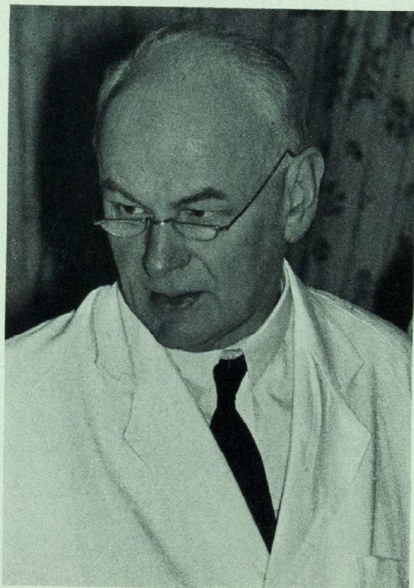
Sir Geoffrey Keynes has been awarded the James Tait Black Prize for the best biography of 1966 for "The Life of William Harvey".

Dr. C. Langton Hewer has been presented with the John Snow Medal by the Association of Anaesthetists.

Retirement

Harold Jackson Burrows

May 9th, 1967, will be remembered as one of the saddest days in the long history of The Royal and Ancient Hospital of Saint Bartholomew, because on that day HAROLD JACKSON BURROWS retired from the orthopaedic department at Bart's.



The name Burrows has been long held in respect at Bart's, because a centenary before, one of the physicians to the Hospital was Sir George Burrows.

Jackson Burrows himself comes from an eminent medical family. His father, Mr. Harold Burrows, himself a Bart's man, was a distinguished surgeon in Portsmouth, who, after the First World War, became interested in orthopaedics, and virtually founded this speciality in the Wessex area. The fact that Jackson Burrows was born, and spent his early days in the naval atmosphere of Portsmouth, may explain why, second to orthopaedics, the Royal Navy has been one of his greatest interests. Prior to beginning his medical career, he went to school at Cheltenham College, which surprisingly enough, has a very strong link with the Army, and it may be that its military influence explains why one of his main interests outside the medical field has been in rifle shooting.

On completing his school time, Jackson Burrows left the South West, and went to East Anglia, where he became a member of King's College, Cambridge. While there, he obtained 2nd Class Honours in the Natural Science Tripos, and also shot for Cambridge University acquiring a half-blue for his Rifle Shooting. In 1923, he started his Bart's career as a student, during which time he acquired the Bentley Essay Prize on Carcinoma of the Thyroid, and the B.M.A. Essay Prize in addition. He graduated with the Cambridge M.B. and the Conjoint Diploma in 1927. Throughout this period, there is no doubt but that he was most popular with his fellow students and worked extremely hard, so that he was a great asset to the Medical College.

After qualification, he began his distinguished surgical career by becoming house surgeon to Professor Gask and Sir Robert Dunhill. Two years later, in 1929, he became a Fellow of the Royal College of Surgeons. In that year also, he acquired a Beaverbrook Research Scholarship which lasted two years, when he returned to Cambridge and worked on Tissue Culture, and spent six months at the Rockefeller Institute in New York, working under Alexis Carrel. On his return to England, he continued research work in the physiology department of the Royal College of Surgeons, which led, in 1933, to his achieving the honour of being Proximo Accessit in the Jacksonian Prize awarded by The College. Also in 1933, he was elected Hunterian Professor at The College of Surgeons. Throughout this time, he continued to take a very close interest in clinical work, and became Chief Assistant to Bart's first orthopaedic surgeon, the great R. C. Elmslie. At the same time, he worked for Mr. S. L. Higgs, who when Jackson Burrows joined the consultant staff at Barts, was his immediate senior. In 1936, as a result of his brilliant work, he was given an M.D. In 1937, he became the sixth holder of the British Orthopaedic Association's Robert Jones Gold Medal, which was presented to him by Rowley Bristow—St. Thomas's Hospital's first orthopaedic surgeon—for a classic paper on Coxa Vara. 1937, also was a great year for Bart's, because it was then that Mr. Elmslie retired from the active staff, and Jackson Burrows became consultant orthopaedic surgeon to the Hospital. In addition, he had been closely linked with the Royal National Orthopaedic Hospital, where Mr. Elmslie was also attached, and so, at the same time he became surgeon to the R.N.O.H. When he started private practice, he originally shared his consulting rooms in Harley Street with Mr. (now Sir) Clifford Naunton Morgan, who also, sadly, has recently retired from the active staff of Barts. Later, he moved to Mr. Elmslie's house 23 Park Crescent—which was unfortunately bombed during the Second World War.

At the outbreak of war in 1939, Jackson Burrows became part of the Emergency Medical Service and, along with a large part of Bart's, was moved to Friern Barnet Hospital ("Colney Hatch"). He was, however, keen on joining the Services, and in 1943 he became a member of the Royal Navy. At first, he returned to his birth place, Portsmouth, where he was in the Royal Naval Barracks. From there he was posted to Aberdeen, but then he was sent to Sydney, Australia, and did not return to England until December 1946. During his spell in Australia he developed a close link with the orthopaedic speciality in the South Pacific, and as a result was, in 1945, elected honorary Fellow of the Royal Australasian College of Surgeons. When he was demobilised Jackson Burrows was appointed civilian orthopaedic consultant to the Royal Navy, a position which he has held ever since.

In 1946, The Institute of Orthopaedics, attached to the Royal National Orthopaedic Hospital was established as a post-graduate specialist training centre. Jackson Burrows was the first Dean, a post which he has held almost continuously, and there is no doubt that a very large part of the credit for the international reputation that The Institute has built up over the last twenty years is directly due to his personal efforts. In 1948, the present Journal of Bone and Joint Surgery, consisting of alternate American and British issues was started, and this has had a profound influence in increasing the Anglo-American link in medical matters generally. Jackson Burrows has been on the editorial board since its inception, and much of the credit of its outstanding success is due to his efforts and he is now Chairman of the British Editorial Board.

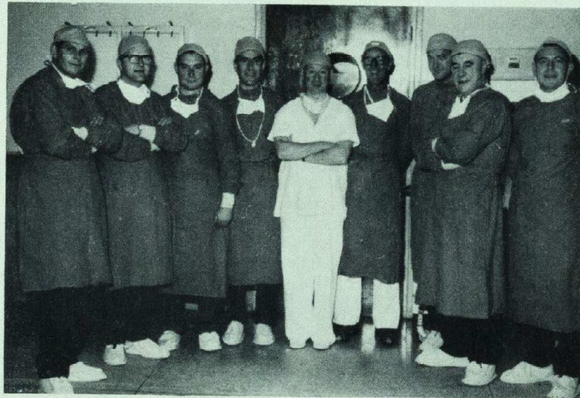
Apart from his conections with Barts and the R.N.O.H., Jackson Burrows' influence has been widespread throughout the world. In 1955 he was appointed Nuffield Visiting Fellow to The British West Indies on behalf of the Foreign Office, then in 1963 he was the Samuel Higby Camp visiting Professor at the University of California, San Francisco, and in 1964 he was also Visiting Professor at Los Angeles. In this country he is Consultant Advisor in orthopaedics to the Ministry of Health, and is Chairman of the Standing Committee on Artificial

Limbs. He has also been a member of the Council of the Royal College of Surgeons since 1963, and is now President of the British Orthopaedic Association, while in the recent past he was President of the Orthopaedic Section of the Royal Society of Medicine, and a few months ago was elected an Honorary Fellow of its Orthopaedic Section.

It is thus to be seen that the career of Jackson Burrows ("H.J.B." to his friends) has been a tremendous success and has brought very great credit to this great teaching Hospital, which therefore owes him a debt of gratitude which can never adequately be expressed. We wish him a long, healthy and happy retirement.

J.N.A.

The Young Travellers 1966-67



The Young Travellers 1966-67: *(left to right) T. B. Boulton; A. B. Lodge; M. Evans; T. M. Young; R. S. Atkinson; J. Alfred Lee; G. B. Gillett; W. R. Daniel; L. Langdon.*

The Young Travellers, a group of contemporaneous ex-Senior Registrars of the Department of Anaesthesia of St. Bartholomew's Hospital, held its second annual meeting at the Southend-on-Sea and Rochford Hospitals last October and proposes to hold its 1967 meeting at St. Bartholomew's on 2nd, 3rd and 4th November.

Dr. R. S. Atkinson was host at Southend-on-Sea. He and Mrs. Atkinson welcomed the party at their home on the evening of Thursday, 4th October for an excellent supper and an enjoyable reunion. On the Friday and Saturday he and his colleagues Drs. J. Alfred Lee and T. C. Thorne arranged an interesting and worthwhile programme. The morning of Friday, 5th October was spent in the operating theatre at Rochford; the techniques studied were halothane-oxygen with the 10 per cent Fluotec (Mr. A. G. Dingley—general surgery), extradural blocks (Miss J. Crow—gynaecology) and (by courtesy of the hospital cook who provided a lacerated hand) intravenous regional analgesia.

Lunch was taken at Rochford followed by a visit to the Air-Shields factory at Shoeburyness to study ventilators and humidifiers and the day concluded with a somewhat hilarious dinner at the Pied Piper.

On Saturday morning at Southend Dr. Lee entertained us with another gynaecological list and his well-known wit and wisdom. The meeting concluded with a much appreciated lunch by courtesy of the Hospital Management Committee.

Only two members were absent, one of these (M. Fielding) had at the last moment chosen the Saturday to enter the state of matrimony; his colleagues wished him every happiness in absentio.

T.B.B.

Microscopic Surgery of the Ear (Part 1)

by A. P. Fuller

Modern microscopic ear surgery can be said to have had its birth at this hospital by the arrival of a Zeiss operating microscope in December 1957 when the Department was at Hill End. There were several novel features about this microscope which improved ear surgery. These were:—

(a) Its excellent depth of focus;

(b) Its extreme mobility and ability to arrive at a new position quickly and without wobble by means of the counter balance concealed in the stem of the stand (Fig. 1);

(c) The ability to select, by the turn of a knob, magnifications of 6, 10, 16, 24 and 45 times.

Later the provision of a tutorial eye-piece (Fig. 2) enabled assistants and students to see what the surgeon saw and observe his every movement. This was a most exhilarating experience and it immediately removed otology from a do-it-yourself art to that of a demonstrable science. With the exceptional magnified vision thus obtained the anatomy of the middle ear became much easier to understand. It would not be going too far to say that no otologist is really happy about giving an opinion about a drumhead until he has inspected it via the operating microscope.

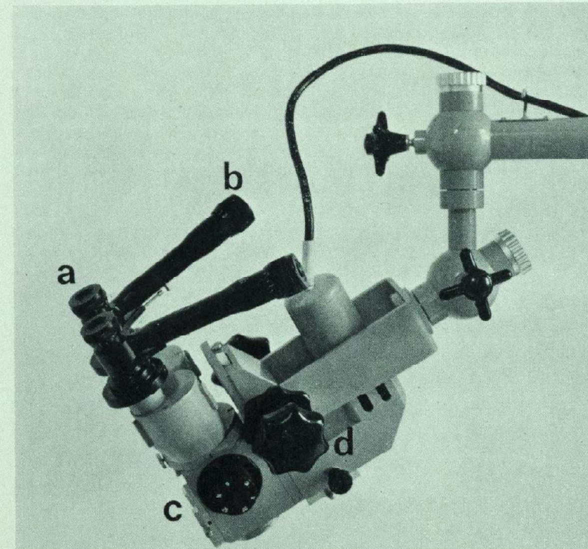


Fig. 2. *Microscopehead*
(a) *Binocular Eyepieces*
(b) *Tutorial Eyepiece*
(c) *Magnification Change Switch*
(d) *Fine Focus*

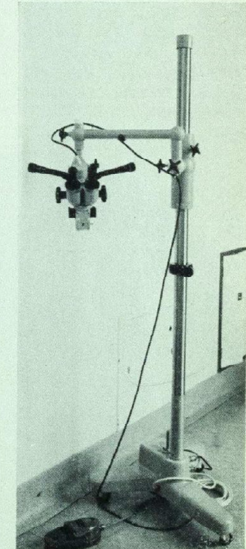


Fig. 1. *"Zeiss" Operating Microscope. (Note the counter-balance concealed in the column.)*

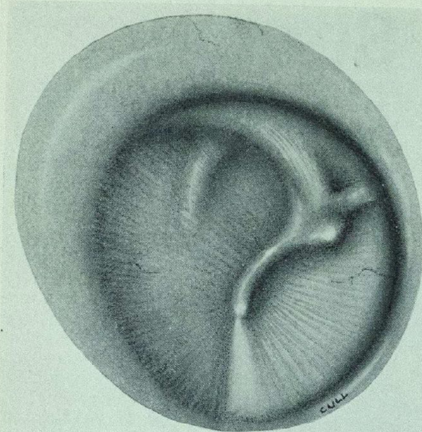


Fig. 3

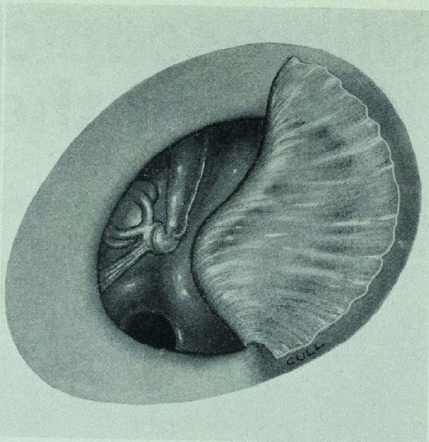


Fig. 4

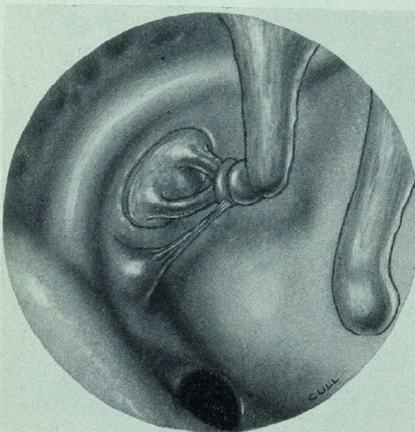


Fig. 5

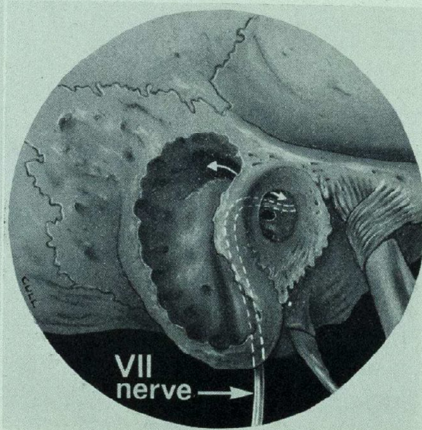


Fig. 6

In order to make my points a little clearer I shall now describe an outline of the anatomy of the middle ear with particular reference to the views obtained via the operating mircroscope. Non-otologists find it difficult to make a correlation between the traditional drawings of the tympanic membrane and the anatomy that presents itself through the otoscope. It must be remembered that the anterior meatal wall is grossly foreshortened and that the posterior meatal wall can be clearly seen. If attention is directed first down the anterior wall the "pole star" of the middle ear can be easily identified (Fig. 3). This is the lateral or short process of the malleus. It is remarkably resistant to disease and is found sitting up like a hillock just posterior to the anterior meatal wall about three-quarters of the way up. From this a fold runs forward delimiting the pars tensa below from Shrapnell's membrane above. This is the anterior malleolar fold. A similar fold runs posteriorly. Above these folds is the lax part of the tympanic membrane; the fibrous layer is absent. It is continuous with the deep meatal skin overlying the bony outer wall of the upper part of the tympanic cleft. This is the attic where perforations are dangerous and *cholesteatoma* is to be found. The handle of the malleus runs downwards and slightly backwards to end in the umbo. From this a cone of light is classically described running antero-inferiorly. This is not always so and has been the source of confusion to many students. Lying behind and parallel, but deep to the handle of the malleus is the long process of the incus. In some people with thin tympanic membrances this may be visible in a ghost-like manner. If the tympanic membrane is reflected forward by an incision in the posterior meatal wall from 12-6 o'clock the long process is clearly seen (Fig. 4). The chorda tympani can also be seen coursing forwards between the incus and malleus. A prominent landmark is the stapedius tendon as it runs forwards to be inserted into the head of the stapes and the incudo-stapedial joint. These findings are readily demonstrable in any operation on a normal tympanic membrane. The commonest is stapedectomy for otosclerosis as these patients normally have a normal tympanic membrane.

As we look deeper into the middle ear we can see the stapes filling the oval window with the facial nerve contained in the Fallopian canal above. (Fig. 5). Below we can glimpse the upper part of the niche for the round window. In particular, I must stress the otological importance of knowledge of the course within the temporal bone of the facial nerve. The genu of the facial nerve with its ganglionic swelling is easily visible above the promontory on the medial wall of the middle ear. It then passes backwards above the oval window. It is here that it can be most easily identified and traced backwards and forwards in middle ear operations. At the posterior limit of the oval window it swings outwards and downwards to form its descending part behind the bony pyramid out of which the stapedius emerges. Below and behind the nerve as it swings outwards is a small recess, the sinus tympani. This method of identifying the nerve above the oval window belongs essentially to the generation of microscope-trained surgeons.

The early identification of the facial nerve is of the utmost importance in radical mastoid surgery. In the conventional or older type of mastoid operation the outer cortex of the mastoid antrum was removed to allow access to the mastoid antrum, which is the large cell communicating with the middle ear by the aditus ad antrum. This is identified by the passage of a probe into the aditus, underneath which was the horizontal semi-circular canal and beneath which was the facial nerve. Then the anterior end of the digastric ridge is found, this corresponds to the well known digastric groove on the inferior surface of the skull. A line joining these two points gives the course of the vertical part of the facial nerve which can be respected.

When the antrum is opened in this manner a bony bridge is produced running supero-inferiorly with the aditus underneath and the mastoid antrum posteriorly and the middle ear and external auditory meatus anteriorly (Fig. 6). This concept of a bridge is essential in the traditional operation but it has no anatomical existence until the antrum has been opened. Most surgeons using the microscope open up the mastoid antrum by removal of the outer attic wall until the antrum is exposed. In this method the bridge does not exist. The ridge of bone overlying the facial nerve does remain. In operations without magnification it was prudent to leave a high facial ridge. With magnification the sinus tympani can be exposed with safety.

Following this descriptive anatomy I must give a brief outline of the surgical physiology of the middle ear. In order to understand the mechanism of transmission of sound across the middle ear it is easier to start at the organ of Corti than at the external auditory meatus. The first essential is that the hair cells of the organ of Corti should be stimulated. In order to do

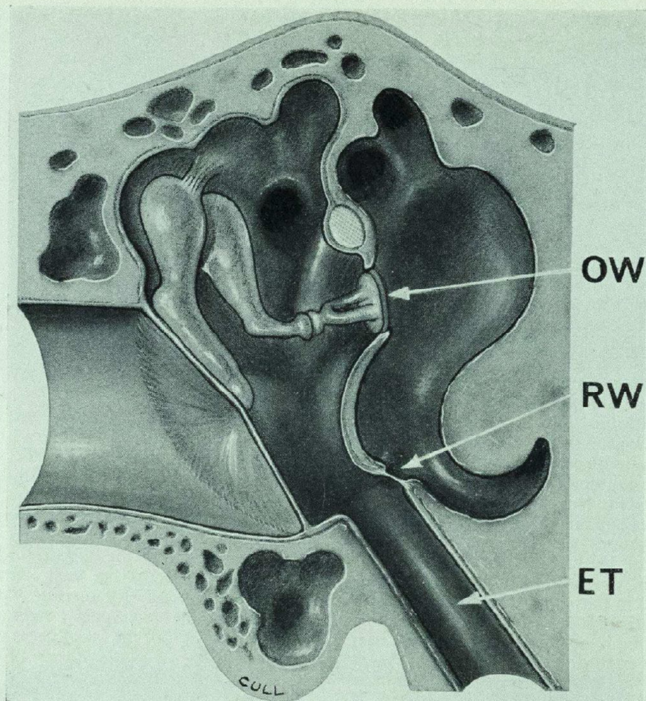


Fig. 8

OW=*Oval Window;* RW=*Round Window;* ET=*Eustachian Tube.*

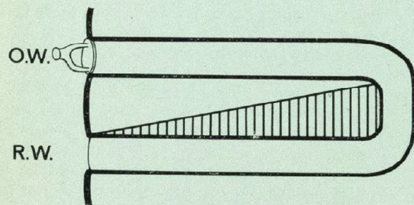


Fig. 7

this there must be a movement upwards and downwards of the basilar membrane (Fig. 7). The scala media which is bounded above by Reissner's membrane and below by the basilar membrane is a closed system communicating with the saccule by the ductus reuniens. Above Reissner's membrane is the scala vestibuli and below is the scala tympani. The former is separated from the middle ear by the stapes in the oval window and the latter by the round window membrane. Both scalae communicate at the apex of the cochlea via the helicotrema. If the basilar membrane is to respond to a sound at the oval window there must be a second window for compensatory movement of the scala tympani to occur. In French literature this is known as the "jeu de fenêtre". Obviously if sound were to arrive at both windows simultaneously and in the same phase then there would not be any movement of the windows.

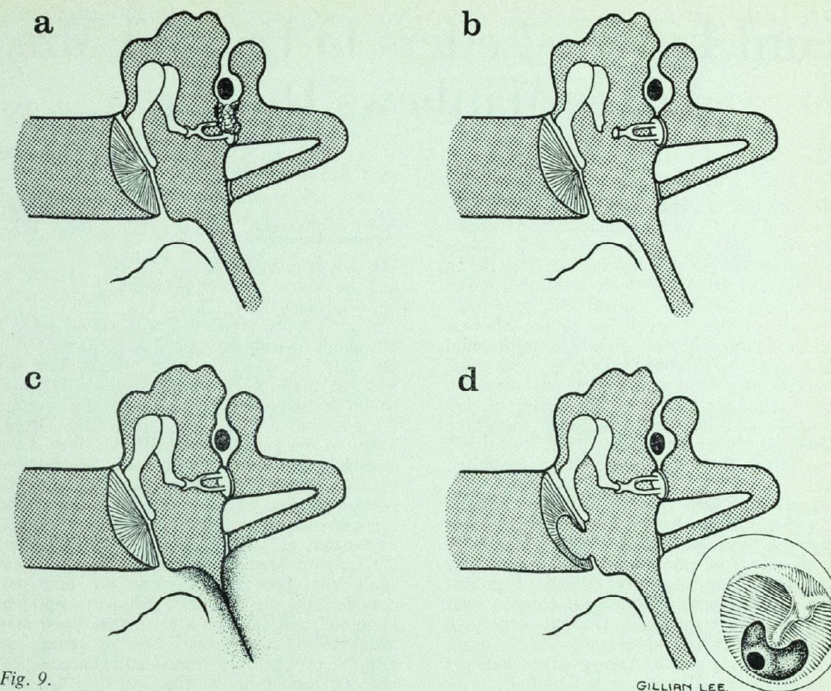


Fig. 9.

Therefore something must be done to screen or protect one window. If a screen is applied to one window then for it to be effective there should be an air space which will afford protection to the other window. The screen can be made more effective still if it can amplify sound by funnelling it from a large area to a smaller.

If we apply this reasoning to the normal middle ear we shall find that the two windows are the oval window and the round window (Fig. 8). The screen that is applied to the oval window is the tympanic membrane. It is applied via a chain of ossicles and there is effective amplification in the transmission from the large tympanic membrane to the small oval window. The round window is protected by the middle ear air space ventilated by the Eustachian tube.

The above drawings (Fig. 9) illustrate common causes of deafness where one of these requisites is missing.

(a) *Fixation of the stapes in the oval window as in otosclerosis.*
(b) *Disruption of the ossicular chain by destructive middle ear disease.*
(c) *Eustachian tube obstruction.*
(d) *Large perforation of the tympanic membrane producing failure of round window protection.*

In the surgery of deafness the object is to fulfil all the following requisites without which hearing cannot be restored.

(a) *Two windows.*
(b) *An air space between the two windows.*
(c) *A screen for one window.*
(d) *A union between the screen and a larger collecting area.*

In the second part I shall illustrate how we apply these principles to disease states. I am most grateful to Mr. Peter Cull and Miss Gillian Lee who drew the diagrams and to Mr. David Tredinnick for the photographs.

Lord Lister's Letters to Dr. and Mrs. James Matthews Duncan

by John L. Thornton

During this centenary year of the first publication of Lord Lister's principles of antisepsis many writings will appear dealing with various aspects of his life and work, and it is fitting that his long friendship with James Matthews Duncan (1826-1890) should be recorded. Evidence of this is available in the Medical College Library in the form of a testimonial and a letter to Matthews Duncan, and three letters to Mrs. Duncan. One of the latter is a letter of condolence on the death of her husband, and has been published elsewhere (Newlands, 1891; Thornton, 1959); it is dated from Riva, Lagi di Garda, 21st September, 1890.

James Matthews Duncan had been associated with Sir James Young Simpson (1811-1870) for some time, and collaborated with him in the discovery of chloroform as an anaesthetic agent (see Thornton, 1949). When Lister first went to Edinburgh Matthews Duncan was Simpson's assistant, and Duncan hoped to succeed to the Chair of Midwifery on the death of his chief in 1870. Among other eminent referees, Lister wrote him a testimonial:

Edinburgh,
23rd May, 1870.

Dr. Duncan is known throughout Europe by his writings as an authority in Obstetrics; while he has long taught and practised in that department with distinguished success.

I venture to express the earnest hope that one so highly qualified for the vacant chair of Midwifery in our University will be elected to fill it.

Joseph Lister.

Matthews Duncan was unfortunate in this instance, and the Chair went to Simpson's nephew, Alexander Russell Simpson (1835-1916), at which Duncan was very disappointed, and many people were horrified. He remained in Edinburgh for another 7 years, and the following letter reveals the nature of his invitation to Bart's as Physician-Accoucheur and Lecturer in Midwifery:

Edinburgh.
Most confidential 18th August, 1877.

Mrs. Lister is my scribe
and she is not a revealer of secrets.
My dear Duncan,

I don't know what you will say to what I am about to communicate. I have heard today on authority which is quite reliable that the Medical Staff of St. Bartholomew's Hospital would be unanimous in inviting you to occupy the position in that School which Dr. Greenhalgh is resigning, provided that they have reason to believe that you would be disposed to accept such an offer. I therefore write to you to ask you confidentially what you would think of such a proposal. Of course you are well aware that St. Bartholomew's is the largest of the London Medical Schools (a very different affair from poor King's). You will take into consideration the honour of such an exceptional invitation and the noble work that there may be done by an honest man in setting an example of what high-principled gynaecological practice should be, & you will also estimate at its proper value the great probability of a first-class and lucrative practice, together with the opportunity of devoting yourself exclusively to that department which you prefer.

Of course you will weigh the other side of the question, your position as the recognised head of your department in Scotland, your excellent practice carried on with little toil compared with that of a London life, & the associations of friendship and relationship in your native country, and also what you so lately put before me the question of expediency of making so great a change at your time of life.

All I can say is that, as a Londoner, I shall be truly glad to see you in the Metropolis, if your best judgment leads you thither.

I must beg of you to burn this letter when you have read it; because it is only on the condition that this would be done that I have been permitted to make this communication to you, so as to take the place of the oral informant who would have interviewed you had you been in Edinburgh. With the sincere wish that you may come to the right conclusion I remain,

ever most truly yours,
Joseph Lister.

Although this is marked "Most confidential", Matthews Duncan wrote on it: "retained by me because it was no secret to me when got.—J.M.D." Although Matthews Duncan may have been unfortunate in not gaining the post at Edinburgh, his initial misfortune was definitely to the advantage of Bart's and to London. He brought with him a reputation for skill in his profession, and this he enhanced in the Metropolis, bringing the subject to a level that was equal to, and even surpassed, that which it had reached in Edinburgh. It is interesting to note that Matthews Duncan was invited to Bart's, which proves that his reputation was appreciated in London, where obstetrics as a scientific subject was far below the level which it enjoyed in Edinburgh.

Lord Lister's next letter in the Matthews Duncan collection was addressed to Mrs. Matthews Duncan three years after the death of her husband, and acquaints her with the death of Lady Lister:

12 Park Crescent,
Portland Place.
High Cliff
Lyme Regis
Dorset
1st May 1893

My dear Mrs. Duncan,

I do not know whether you have heard of the terrible blow that has fallen upon me. My dear wife, after enjoying with me for a few days the lovely scenery about the little Italian town of Rapallo, was seized with an illness which soon developed into inflammation of the lungs and rapidly carried her away! on the 12th of April.

Her beautiful character shone with peculiar brightness during the day that passed after I had told her that she was not likely to recover, her intellect remaining unclouded to the last. Her patience was simply wonderful, her faith undoubting though very humble, and her love for others so strong that it seemed to make her think almost more of them than of herself, even in that solemn time. She desired me to send special messages of her affectionate remembrance to several of our friends, and among these to yourself.

I consider it a great privilege to have witnessed that beautiful closing scene.

I am intending to stay a fortnight longer at this sweet place, where I have the sympathetic company of my brother & his wife & some of their family & also of poor Lucy Syme, who is with us.

The sending of this message from my "departed saint" gives me the opportunity of doing what we had often spoken of, enquiring how you and yours are.

Believe me
My dear Mrs. Duncan
Yours very sincerely
Joseph Lister.

The final letter, also addressed to Mrs. Duncan, reads as follows:

12 Park Crescent,
Portland Place.
Foley Arms Hotel
Malvern
19th August 1896

Dear Mrs. Duncan,

Your letter has been forwarded to this place where I am staying at present in hopes of being able to prepare my address for the British Association at Liverpool.

I write at once to say that, after the statement you have made, I should be glad that my name should be on the canvassing card for Dr. Scott's daughter. It is indeed a very sad case.

I am very glad you find the New Forest such a pleasant place of residence.

You must excuse a hasty note.

Miss Syme unites in kind regards with yours very sincerely

Joseph Lister.

These letters reveal something of the kindly nature of one of the greatest benefactors of the human race, and although necessarily presented here isolated from the events they describe, they are significant items in the records of these happenings.

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SUMMER BRIEFING

Diversions (for lunch time, evening and weekend) Fashion, Epicurus, Clinical Notes

Fashion — Dick Soper Investigates the Latest Trends

How fashion conscious are the students of Bart's? On merely looking around one would say that we are just not quite with the Swinging (pronounced as in singe) London scene of which we form (though opinions differ) a part.

In view of this *The Journal* recently organised two Spring Fashion Shows at two of London's leading boutiques. The collections shown were designed to demonstrate how the latest, the very latest, men's fashions can be incorporated into the everyday life of the student.

Quite where **Lord John** fits into Debrett I don't know, but his name appeared over the salon in Carnaby Street where the first dazzling show of more formal attire took place. Fig. 1 shows leading model, John, demonstrating the Regency style "Round the Fountain" jacket. This attention-getter would be quite outstanding in the Square and its flattering formality would, no doubt, provoke much discussion and men who know a lot about clothes rate this as an exceptional coat.

The styles shown in Fig. 2, modelled so delightfully by John and Richard, are somewhat less formal. Richard is sporting the meticulously tailored "Charterhouse" coat which fits so well in the current Charterhouse scene. John's elegantly informal corduroy outfit is more for weekend leisure. The cap is worth noting and large export orders are expected.

In Fig. 3 we see Phillippe examining a Paisley lined smoking jacket that has taken his fancy. Phillippe himself is sporting one of the new satin lined capes—just the thing for keeping out those spring showers and piercing draughts, while still keeping up with the latest in "gear"—and one of the new kaleidescopically coloured, horizontally striped polo neck sweaters.

This collection from **Lord John,** one of Carnaby Street's leading stores, containing many more crisp, cool and contemporary clothes to suit your mood and the time of day, amounts to a lavish fashion extravaganza.

Our team of models, still dazed by **Lord John's** wonderful collection moved on next to Portobello Road where the second fashion parade was held at, or rather outside an establishment which proudly displayed the sign **"I Was Lord Kitchener's Valet".** It was therefore somewhat surprising to find that the proprietor was not at least in his eighties. The varied style of clothing and its very quantity suggest that Lord Kitchener had an extensive wardrobe and served in all ranks in every armed force. The show was designed to demonstrate the less formal fashions available today.

Fig. 4 shows model, Richard, expressing his delight at seeing such a beautiful selection of clothing and proving at the same time how comfortable, flexible and versatile are these military uniforms. How talented fashion designers can be! Phillippe can also be seen on the left in a Naval style dress coat and appropriately enough a W.R.N.S. hat. John is wearing a wonderfully with-it mixture. In Fig. 5 Elizabeth has come to join the tea set, sporting a close fitting military jacket cunningly designed to look as if it was made many years ago. Both Phillippe and John show beautiful scrolls of gold braid whirling round the wrists. All four models are seen in Fig. 6 about to leave Lord Kitchener's gay boutique in a limousine which has come off the production line even more recently than most of the clothes.

The styles illustrated are in fairly limited supply, indeed it is rumoured that the actual garments worn by our team had already been previously exported, mainly to France and Germany. Which all goes to show that London *still* swings.

SUMMER LUNCH HOUR

Liz Macdonald explores the City and beyond

If you have a spare hour at mid-day, whether it be at your own convenience or at the disposal of the girl next door or of an impressionable parent there are a great variety of untapped mines in close proximity.

If you want to impress, take a leisurely walk along Cheapside past the Bank and up Cornhill to the Leadenhall Market, where poultry and game change hands in a cloud of feathers. With whetted appetite, then proceed to lunch among the bowlers at the *George and Vulture* in St. Michael's Alley, and round it off with a glass of port at the *Jamaica Wine House*. If you are feeling more energetic learn your London from a three-dimensional map: climb St. Paul's dome or the Monument in Fish Hill Street. If you have even more energy to burn, go for a swim, indoors or out, at the Oasis at the top of Shaftesbury Avenue, or learn to play golf in Wigmore Street. An half-hour lesson costs 17s. 6d.

For the historically inclined a visit to some of the City Livery Companies and Guilds holds a store of fascination. To ensure personal attention admission is by ticket only on specific dates which, together with tickets, are available at the Information Centre in St. Paul's Churchyard. Similarly the Law Courts in the Strand are worth a visit in a private capacity!

For those suffering from lack of intellectual stimulus, St. Mary-le-Bow is the centre for what are rather dryly designated "Lunch-Hour Dialogues". Each Tuesday at 1.5 p.m. one or more of a great variety of personalities make their appearance; DAVID FROST on June 6th, ARCHBISHOP ROBERTS, one of the most outspoken Jesuit "progressives" on June 13th, WAYLAND YOUNG, Labour peer (July 4th), MARK BONHAM CARTER, the chairman of the Race-Relations Board (July 18th), THE BISHOP OF WOOLWICH (July 25th) and that indomitable broadcaster and journalist JAMES CAMERON (August 8th). On other days there are recitals of recorded music.

But if you prefer your music out of doors and the weather agrees, relax in the peace of Lincoln's Inn Fields with a lunch-time concert as background or foreground music (Tuesdays and Thursdays). On the way back, call in at Hodgson's book shop at 115, Chancery Lane. Here monthly book sales are open for public viewing on the Thursday and Friday preceding the Monday sale. Bookworms will find a wealth of digestible material.

Worth a visit, perhaps more by accident than design, are the band concerts given on alternate Thursdays on the steps of St. Paul's and in Paternoster Square which is the precinct behind the tube station lately featured as backdrop to the "Smoker" Film (*February* St. B.H.J.). The music-makers are mainly military, showing little imagination in the choice of names for their group with the exception perhaps of the "5th Royal Inniskilling Dragoon Guards". Every Wednesday there is also a band-concert in Finsbury Circus Gardens adjoining Moorgate Underground station. Location of the actual site should not prove too difficult if you are there on the appropriate day. Students of military garb and amateur dress-designers pursuing the latest fashions may find the sartorial example and inspiration an added attraction.

I suspect that most of us are more often to be found in post-prandial stupor at this time of day and in this season. With this mood in mind there are deck-chairs to be found within sight and sound of the River beneath the wall of the Tower of London. Less far afield there are a number of nooks inset into the west wall of Paternoster Square to trap the sun and the weary walker. Failing all this there is always the P.M.!

These footnote gems are extracts from letters received in West Africa in connection with a free milk scheme for babies. They were contributed by *W. Chalmers Dale.*

Please send me form for cheap milk as I am expecting mother.

Please send me form for supply of milk for having children at reduced prices.

TOWER HILL

— Ian Fraser reports

"Moses was a queer—I know because I was in the bushes with 'im", pronounces our long-haired friend to the crowd which gathers on Tower Hill at lunchtime. From 12 to 2 each weekday, especially when it is sunny, there is enough entertainment to make the walk from Bart's worthwhile.

The atmosphere is not dissimilar to that at Speakers' Corner, Hyde Park. The humour, the religion and the politics have the same degree of enthusiasm and absurdity about them. In addition there is the attraction of an escapologist who always seems able to draw an audience away from the political groups. So a small group of men entertain and often stimulate participation in a crowd which always will enjoy a free show. The crowd consists of waist-coated clerks, secretaries in mini-skirts, continentals with their jabbering tongues and our transatlantic visitors with ever-clicking cameras. From this assortment come the few who will, with the encouragement of the crowd or at the expense of their laughter, attempt to argue with the speaker.

Undoubtedly the best speaker there is the Rev. Lord Soper. His clear voice projects good English to the back of his large group, who at times seem spellbound by his fluency. His wide range of topics are controversial, yet because he is so well-informed he can be very persuasive. Statements which at first seem illogical, e.g. "At least I *know* I'm a socialist and a pacifist, and I'll take the consequences", are explained with fervour. He is one of the few speakers who will listen to a heckler then deftly destroy his argument at the same time reinforcing his own points. His popularity can be judged by the huge crowd which he draws.

Our long-haired friend who knew Moses is not such an orator, yet is the most amusing character there. He is well known at other places of free speech and has featured on the cover of the *Observer* colour supplement. With a newspaper in hand and several others scattered about the chair on which he stands, he pokes ridicule and hurls abuse at key figures in history and politics. This evokes almost guilty laughter from the amazed gathering. He peddles religion and politics for laughs. At 2 p.m. he gives tips for the afternoon's racing and thanks the crowd for their generosity. Only twopence lay under the chair at the end, when I watched him.

Le Roy "doing his part for the Aberfan disaster fund", is the escapologist. Cracking his whip, he distracts the periphery of other groups towards his pitch. He selects a member of the crowd to tie him up in chains or in a straightjacket, passes round the hat, counts the contents (8s. 10d. on one circuit) and wriggles effortlessly out of his bonds. "I'm an old age pensioner of 71": he looks an old and sad clown.

The religious crusaders have a hard task trying to hold the half dozen who bother to stop. One with a board 'Jesus Saves' terrifies those nearby by suddenly bursting out into loud tuneless song.

I have a baby 12 months old, thanking you for same.

I posted the form by mistake before my child was properly filled in.

Will you please send me form for cheap milk. I have a baby 2 months old. I did not know anything about it until a friend told me.

I have a baby 2 months old fed entirely on cows and another child.

At 2 p.m. the office workers go back to work and the visitors go on to the Tower. The entertainers pack up. All that remains is a small group of men deep in argument and the singing crusader standing on a wall bawling out 'The Word' to the tune of "She'll be coming round the mountain. . . .".

Go there on a sunny lunchtime. You'll find plenty to amuse you.

SUMMER DIVERSIONS — reviewed by Ian Fraser

London provides adequate distractions to fill an unplanned summer's evening or weekend. The open spaces are the most attractive and one can decide when there, whether or not to join the throng. The following is intended to be an indication of what can be achieved without the use of a car while remaining inexpensive.

The ROYAL PARKS (Hyde, Regent's, St. James's, Green, Primrose, and Greenwich) are well known, but the dozens of others scattered around London can be delightfully quiet and yet still provide ample entertainment. The Parks Department of the Greater London Council publish their *Open Air Entertainment guide* (price 1s.) which shows these parks and gives a diary of the events to be held during the summer. Events from puppet shows to symphony concerts are listed and is a useful guide to inexpensive, if staid, entertainment.

Music in the open air can be interesting or soporific depending on the time of day and the state of mind. On Saturdays during June and July there are at KENWOOD HOUSE the Lakeside Symphony Concerts which start at 8 p.m. These concerts, given by the best of our orchestras, reach the audience from the half bowl across the lake where the audience recline in deckchairs or on the grass. Ballet and Opera are performed at HOLLAND PARK starting on June 12th. This year The Royal Ballet School and The Imperial Opera Company are amongst those giving performances. On Sunday evenings concerts are given at the Crystal Palace Concert Bowl and again at Holland Park. All these attractions cost only 4s.

Tuesday night is Jazz night at BATTERSEA PARK CONCERT PAVILION. Good Traditional Jazz at 3s. is provided (during June and July) by such bands as Kenny Ball's. Military bands play at their regular spots. VICTORIA EMBANKMENT GARDENS gives a good choice throughout the summer.

Gregarious souls may wish to participate in the heckling at Speakers' Corner in HYDE PARK, TOWER HILL (at lunchtime), LINCOLN'S INN FIELDS and Whitestone Pond on HAMPSTEAD HEATH. Here he can really test the use of so-called free speech.

Browsing types will have an absorbing time inspecting the masterpieces and masters scattered on the pavements or against the railings in parts of London. Changing each month from the end of May till mid-August the exhibitions on HEATH STREET, Hampstead, are amongst the best. There are a few paintings in VICTORIA EMBANKMENT GARDENS and some in KENSINGTON GARDENS, BAYSWATER ROAD, though the latter can be rather dull.

Motor enthusiasts are catered for on the afternoons of 5th and 28th August and 9th September, with motor and motorcycle racing at CRYSTAL PALACE.

On hot and still days the River offers the best chance of a cool breeze. Relaxing trips to Kew and Hampton Court are highly recommended for day outings. Downstream Greenwich makes a worthwhile outing. Visits to the Cutty Sark, the National Maritime Museum, the Observatory, the Tudor Palace and Greenwich Park will absorb and exhaust most visitors. Jasons canal trip from Little Venice (tube Warwick Ave.) to the London Zoo is a novel mode of travel through central London.

Even fishing is available. In season the G.L.C. parks allow fishing without a licence. Hampstead Heath ponds are stocked with roach, pike, and bream whilst Tooting Common lake offers perch and carp. The Royal Parks require a licence for fishing for such fish as gudgeon, rudd and dace.

There is obviously a great deal more to do in the open air as any guide will show. Most people will have their own favourite places but it is hoped that this short review has provided a stimulus to try somewhere different.

Sorry, I have been so long filling in the form but I have been in bed with my baby two weeks and did not know it was running out until the milkman told me.

I have no children as my husband is a bus driver and works night and day.

Milk is wanted for my baby. Father unable to supply it.

Epicurus

Continuing our researches into Gastronomy as Philosophy, I was flattered by my attention being drawn to a comment on the last column by none other than Dr. Samuel Johnson (1709-1784);

'I could write a better book of cookery than has ever yet been written; it should be a book upon philosophical principles. Pharmacy is now made much more simple, cookery may be made so too. A prescription which is now composed of five ingredients, had formerly fifty in it. So in cookery, if the nature of the ingredients be well known, much fewer will do.

What the excellent doctor (of whom it may well be said 'Nullum quod tetigit non ornavit') prophesied as a scientific advance, unhappily we see coming to pass. Eggs are banded from depot to depot till branded with the Imperial Leontine Stamp, oysters are sold (in March!) in polythene receptacles. The parlous state of our eating houses I mentioned before, and our imbibing habits are as delicate as the hippopotamus-headed Egyptian goddess of parturition, Taurt: 'the noblest prospect which a Scotchman (a man who manufactures *Scotch*) ever sees is the high road to England.' Dr. J. was a little mistaken if he imagined that 'Claret is the liquor for boys; port for men; but he who aspires to be hero must drink brandy' or merely sarcastic?

Gone are the days of the symposium, reclining Epicureans mixing wines in a bowl with frequent recourse to conveniently provided 'cabinets', engaged in a critique of Wittgenstein's Theory of the Continuum of Real Numbers (Primum vivere deinde philosophare). This spectacle, excellently described by Plato, Xenophon and Boswell, has degenerated from the Roast Beef Club, through the porter house, the gin parlour, the speak-easy to the '*1d R*d C*w'. From Hogarth's brilliant cartoon against the medical profession 'The Company of Undertakers' (Et plurima mortis imago!) the sadly debauched face of Smollet gazes down on me from the library wall, waving a chamber-pot.

From that culture which brought indolence and vice to the height of elegance, Lucius Licinius Lucullus (110 B.C.). Sulla's quaestor and later consul who, making a fortune out of the war with Mithradetes VI, returned to Rome and dedicated his life to sloth and his taste buds, and from the little-known 'Apician Morsels', a few ideas for your next lunch. Among the luxuries of the table in greatest demand, Gellius quotes out of Varro, the peacocks of Samos, the Phrygian turkey, cranes from Melos, Ambracian kids, the Tartesian mullet, trouts from Persenutium, Tarentine oysters, crabs from Chios, Taian nuts, Egyptian dates, Iberian chestnuts; all of which institutions of bills of fare were invented for the wicked wantonness of luxury and gluttony.

Albinus, who ruled in Gaul, devoured at one supper 100 peaches, 10 melons, 50 large green figs, and 300 oysters. And Maximus, the emperor who succeeded Alexander Memmeas, consumed 40 pounds of flesh in one day, and an amphora of wine, containing 48 quarts. Geta, the emperor, was also a prodigious epicure, causing all his dishes to be brought in alphabetically, and would continue feeding for three days altogether. . .

Vitellius, according to Suetonius, had a supper, where 2,000 rare, and foreign fish were presented upon the table, with other strange birds brought from the Straits of Gibraltar by galleys sent on purpose to transport them to Rome.

The most exquisite animal was reserved for the last chapter and that was the dormouse, a harmless creature whose innocence might at least have preserved it from cooks and physicians. But Apicius discovered an odd sort of fate for these poor creatures—some to be boned, others to be put whole with odd ingredients, into hogs' guts and so boiled for sausages. In ancient times people made it their business to fatten them. Aristotle rightly observes that sleep fattens them; and Martial, too, poetically tells us that sleep was their only nourishment. But the annotator has cleared up that point; he, good man, has tenderly observed one of them for many years, and finds that it does not sleep all winter, as falsely recorded, but wakes at meals, and after its repast rolls itself up in a ball to sleep.

This dormouse, according to the author, did not drink in three years' time; but whether other dormice do is not known, because Bambouselbergius's treatise of the mode of fattening dormice is lost. Though very costly, they became a common diet of great entertainments. Petronius delivers us an odd recipe for dressing them, and serving them up with poppies and honey which must be a very soporiferous dainty, and as good as owl-pie to such as want a post-prandial nap.

R.M.L.

In accordance with instructions, I have given birth to twins in the enclosed envelope.

LONDON MARKETS 3.

"OH YES, WE HAVE NO ROCOCO"—

Richard Staughton explores Portobello Road

SIR FRANCIS DRAKE lost his life in 1739 when Admiral Vernon took the town of Porto Bello in the Panamanian Isthmus from the Spaniards, and a patriotic farmer in Kensington renamed his house *Porto Bello Farm*. Some of the stones of the farmhouse still stand as part of St. Joseph's Home for the Needy and the lane which once led through the fields to it has now become the Portobello Road. But the transition was surprisingly recent, only 170 years ago Faulkner wrote of it as "one of the most rural and pleasant walks in the summer in the vicinity of London", and Sir William Bull recorded at the turn of the century that snipe were shot there in living memory.

The best approach for a Saturday afternoon's stroll is from the top of the hill at Pembridge Road, whence the view is lined on the right by a row of small Georgian houses each with its own flowering cherry, growing in what serves as a dustbin hatch in any other street. The wicker-sided minis nestling outside the black-enamelled doors announce that here the *Coq* is definitely *au vin*. On the left the shops are discreetly spaced and run by dealers who dress in waistcoats of embroidered silk and prefer to call their clients collectors and themselves connoisseurs. They exhale their voices softly through their noses as they pad amongst the carved Renaissance angels and medieval wrought-iron torch stands—"Unfortunately, we shan't be getting any more Rococo Fireplaces until next month". But as the hill steepens, the crowds thicken and the shops edge closer together until the pavements spill over turning the road into one long cluttered drawing room. Doors on these shops are built to open outwards, and reveal displays which rely more on the principle of levers for their arrangement than on any aesthetic considerations. The steady flow of strollers becomes arranged into a pecking order—the timid watch the bolder who point and ask, who are pushed aside by those prepared to pick up and search for the date on the bottom, and some actually take on the look of the hunter satisfied, but no purchases ever seem to be made. The dealers blame the sun—they say it brings out the "tourists" and tempts the serious buyers to their antique-filled cottages in the country—and pray for rain next Friday evening.

In fact Portobello Road is largely an international market. A whole street load of removal vans, crammed with the contents of declining country houses, descends on the road each Wednesday morning to be driven away empty by lunchtime, carcasses picked clean by the foreign dealers. Over 80 per cent of the trade goes abroad, and most of that to Europe, apparently chubby walleted Americans who have "just gotta have that li'l ole chair made by Chippendale before nails were invented" are a myth. The contents of one highly specialised shop do however find their way across the Atlantic in quantity. The owner deals only in mechanical musical instruments and operates from a desk in front of a monstrous Welte Orchestrion built in 1800 (which he might be prepared to sacrifice for three or four thousand guineas).

The same year that the Orchestrion was born the first town house (now 223a) was started, it stood alone and unfinished for so many years that it became known as "the Folly". Folly Lane nearby perpetuates the name and it is here, where the road widens, that the real street market begins. This is the domain of the "Revived British Army" where the throng really begins to be felt, as elbows, clothed in the colours of Hussar, Lancer and Bombardeer, jostle round their quartermaster's store—"The Uniform Shop". The proprietress looks happier every week; dressed up in her remodelled Salvation Army coat she charitably dispenses for three or four pounds "stuff that after all cost the army twenty quid apiece before the Boer War". It was in fact a man from Folly Lane who whispered to her the news of the coming call to arms, and the stalls around seem to have become infected with her success, falling over one another to jump on the next promised bandwagon. Plaster Buddhas stand alongside purple road lamps, whilst an itinerant Grenadier sells plastic badges from a card around his neck.

Below Westbourne Grove the road changes markedly in character. Stray bombs cleared the way for the blocks of sand brick council flats, each balcony with its line of washing flapping signals to kingdom come, while cooler minds knocked down the walls between the houses opposite assiduously applying the science of mass turnover to the antique trade. In "Chip and Dale" and "Portobello Antique Arcade" screens heavy with mezzo-tints stand behind counters loaded with flintlocks, genuine Japanese Samurai swords and bayonets (1st War, 2nd War, German or English). The crowds however remain faithful to the stalls outside where the only pigs in pokes are left. Most of the goods' claim to antiquity lies chiefly in their being secondhand, but silver brooches and prewar riding boots are not the only pieces that can be taken away for small change. "Course it's an antique—straight up lady, it's over 100 years old."

Past the reeking pavement of the "Colville" stained by the beer of a 1,000 Friday nights is the land where costermongers once ruled supreme. "Here one can see", wrote Woolf in 1909 "mechanic and artisan life at its best—the happy and sturdy husband with pipe in his mouth looking after his children perhaps with

one on his shoulder, whilst his better half is bargaining for the Sunday joint". On Wednesday evenings the stalls were used for a fair—vendors of patent medicine, conjurors and itinerant jugglers would perform under flaring naphtha lamps. But with the mass move of the neighbouring populace to the new towns the market adapted itself to its changing customers, and the old stall keepers dropped out one by one. Memories of "strawberries ripe—cherries on the rise" fade against the air of carnival which now pervades. Barrows are stacked high with yams, sweet potatoes and passion fruit, and the soggy ankled housewives, who haggle for these from behind prams laden with shopping and babies, are black. No more are apples squeezed for their ripeness but bananas bought when greenest. Across the street the porch of the "Imperial Cinema" shades the turbaned heads of the menfolk watching with unbelieving eyes the white mothers, transfixed at the T.V. shop window by the soundless jerks of the Saturday afternoon wrestlers.

. . . and only a mile up the road there will be no more Rococo fireplaces until next month.

Clinical Notes

ANOTHER FABLE OF OUR TIME

THE GAMMA PEOPLE

by C. A. KING

As they lay in the womb of the maternal plasma cell, the immunoglobin molecules contemplated their fate. What function could they perform in this world, where the antigens of the past no longer came? Were they directed against the antigens of the past (surface coatings from bacteria and protozoa long since lost in the tidal wave of chemotherapy)? If only they could be directed against those groupings present in the exotic organic molecules now coursing the blood stream. The genealogy of their family tree was long ago clouded by the vigorous division of their primitive mesenchyme ancestors.

Life in the germinal centre was all right—plenty of amino-acids, vitamins, etc., but no sense of adventure or challenge existed. Once released from their maternal environment the γ globulin molecules were free to wander the highways and byways of the body. However, it was ordained by the great god D.I.M.C. (Dynamically Integrated Metabolic Controller) that in 13 days half the number of γs originally present would be no more. Tales of the fates of the γ globulins were legion; one lasted only 0.35 microseconds, another was reputed to be the first γ produced in the neonate many moons ago. Although they knew their limitations, the γs were more elite than the α & β globulins, carriers of lipids, carbohydrates, etc. —merely molecules of burden. Each γ was tailor-made with each receptor site modelled to react with a particular region of an antigen. Among the γs the class system did not stop for three social classes existed γG, γA, & γM.

The γMs were the highest in the scale and were utilised extensively in the primary response. They were graded as 19S where S=Svedberg — father of the ultracentrifuge (mother unknown).

The γ Gs were considered common since they were responsible for most of the general antibody activities and were present in large amounts.

The γ As remained aloof from the molecular chatter and were surrounded in mystery. Were they the dreaded "reagin" molecules responsible for asthma, etc. or simply molecules of no great use pretending to be important?

At present even the mighty immunochemists were unsure—so what chance did the other γs have of deciding this fundamental issue.

Within the γG sect all was not uniform, two sub-groups existed γ_1G & γ_2G and when these were screened by the Electrophoresis Unit, further sub-divisions were found. It was even suggested in some gamma circles that each γ was an individual in its own right in the same way as human people! This was a flattering thought for the γs but filled the immunologists in charge of nomenclature, with horror.

In their free phase of wandering through the body, recurring thoughts stayed with them; why do we only have a half life of 13 days? Can we avoid the dangers of destruction?

One widely held opinion was that the γs were degraded by the cathepsins lurking in the lysosomes and were finally ejected from the body as Carbon Dioxide, Water and Urea—What a fate for a noble γ molecule!

Stop Press — FRAUDULENT γAs EXPOSED—

Ishizaka, K., Ishizaka, T. & Hornbrook, M. (J. Immunol., *97* 840, Dec., 1966) have shown "reagin" activity to be a function of the γEs (! ? !)

I require extra milk as I am stagnant.

A Non-Congenital Variation of Hepato-Lenticular Degeneration

by John Reckless

A variation on Wilson's disease or Hepato-Lenticular Degeneration is Idiopathic Incipient/Toxic Hypercupronickelaemia. This was described in a number of fish (Roach and Newt, *in translation*), and the symptoms are of course a little different from those seen in the human. The aetiology of the condition was said to be unknown and its onset insidious. The symptoms seen are certain choreic movements, a fixed open-mouthed smile, and difficulty in mental concentration, all typical of Wilson's disease. The last, of course, is difficult to test in fish, but no fish suffering from the disease is able to subtract seven from a hundred.

A recent study has revealed other features of the complaint, and would suggest the necessity of replacing 'idiopathic' by 'environmentally induced'. The work on goldfish at a fountain in St. Bartholomew's Hospital has shown a large concentration of coins of the realm. The fish in this fountain show spotty and patchy skin changes and loss of the golden yellow colour, with complete darkening of some specimens. The disease is said to be incipient but this is rather dependent on coin concentration and fish species. It is thought that a variety of effects previously not associated, have been due to the disease; thus a certain reddening of the fountain, mis-diagnosed as student misdemeanours, was probably haematemesis secondary to portal hypertension, the pallor of some fish supporting this.

Toxic effects may only be seen late in goldfish, a certain avariciousness delaying these till the poundage is sufficient. The detection in oblique light of a Kayser-Fleischer smokish-brown ring in the eye may be difficult without disturbing the animals. This is partly due to refraction at the air-water interface.

The apparent increased resistance to winter freezing in these fish may be a result of a partial immunity conferred by this syndrome, similar to Wilson's disease; a resistance to a freeze (and wage restraint and threat of devaluation).

The Choreiform movements described below

In the future it may be possible to follow the course of this disease in fish, and to see the accumulative effects of increasing dose. It is planned to test a variety of organs qualitatively for copper with rubeanic acid, provided that thymol flocculation does not cause too much swim-bladder flatulence.

The present study and that planned would not be possible without the generous support of friends of the Hospital. It is at present useful that a large number of the friends would appear to be Scottish, and that argyrophyria and skin darkening on exposure to light are not greatly complicating this research.

Sir, I am forwarding my marriage certificate and two children, one of which has been a mistake as you will see.

I cannot meet sick pay. I have 6 children. Can you tell me why.

This is my 8th child. What are you going to do about it.

More than meets the eye

Some less frequently encountered aspects of medicine

3. MEDICINE IN THE PORT OF LONDON

by W. G. Swann
Medical Officer of Health
Port and City of London.

There are many varied opportunities open to the medical practitioner to practise his profession in unusual circumstances. An illustration which may not be generally well-known is the appointment as a Boarding Medical Officer of the Port of London Health Authority. The Corporation of the City of London was originally constituted the Sanitary Authority of the Port of London under the Public Health Act of 1872. By the Public Health (London) Act of 1936 the title was changed from the "Port Sanitary" to the "Port Health" Authority, and more recently under the London Government Act of 1963 the Common Council of the City of London is reaffirmed as the Port Health Authority for the Port of London. To complete this summary review of the Port Health Legislation the limits of jurisdiction of the Port Health Authority formerly extended from Teddington to The Nore, some 70 miles of the River Thames, including the creeks and five major Dock groups as well as part of the River Medway. The jurisdiction was extended in 1965 some 22 miles eastwards into the Thames Estuary to be co-terminous with the new limits of that of the Port of London Authority.

One of the many duties of the Health Authority is the control of the importation of infectious diseases. This duty is carried out by a staff of Boarding Medical Officers appointed in the department of the Medical Officer of Health. The Port Health Authority maintains a hulk, the "HYGEIA", at Gravesend as a quarantine station where accommodation is provided for the Boarding Medical Officer. There is a Boarding Medical Officer on duty around the clock, 24 hours every day. Any ship with an infectious disease or suspected infectious disease on board is subject to inspection. "Infectious disease" in this context has a wide connotation. In addition to the six "quarantinable" diseases (plague, cholera, yellow fever, smallpox, louse-borne typhus and relapsing fevers) it includes any other infectious or contagious disease other than venereal disease or tuberculosis.

The Boarding Medical Officer has at his disposal a modern quarantine launch—the "HUMPHREY MORRIS" with a gross tonnage of 125 and a speed of almost 12 knots—one of the largest and best equipped medical launches. It has a consultation room, a small hospital with accommodation for two stretcher cases and three sitting patients. It is centrally heated and has very spacious and comfortable quarters for its crew of five. Radio-telephone equipment enables the Medical Officer to talk directly to vessels or the quarantine station on the "HYGEIA" as well as to the Thames Navigation Service at Gravesend. The "VICTOR ALLCARD" is also used as a second-in-line launch. This vessel has a gross tonnage of 38 and a speed of 10 knots. There is an ambulance room equipped to take two stretcher cases and six sitting patients.

The Master of a ship due to arrive in the Port Health district having on board a case of infectious disease or a suspected case or having had a case within the previous four weeks or circumstances requiring the attention of a Medical Officer, flies the international three flag signal LIM indicating "I require a Medical Officer". Between sunset and sunrise the same signal LIM is flashed in Morse code

The "Victor Allcard"

by lamp or indicated by a red light over a white light shown at the peak.

The Masters of any ships on arrival from a foreign port, other than most European ports which are excepted, are required to complete a Maritime Declaration of Health and have it countersigned by the Ship's Surgeon if there is one. The ship, if the paragraph above does not apply, will fly the international flag signal 'Q' and between sunset and sunrise flash the same signal 'Q' in Morse code by lamp or show a red light over a white light at the peak.

The Declaration is a statutory form and contains six "Health Questions" which briefly are framed to elucidate whether there has been a case or suspected case of infectious, and in particular, quarantinable disease on board or if there are other circumstances giving rise to alike suspicion. If the six questions are answered in the negative and the ship has not called at an infected port or any port in Asia, Africa or Central or South America, then "free pratique" can be given by the Customs Officer if he boards first and the ship is allowed to proceed to berth. The passengers and crews on ships arriving within 14 days from an infected port of the Continents listed above are required to have a valid vaccination certificate against smallpox. The Port Health Authority usually has notice in advance, if the ship is equipped with a radio transmitter, of any circumstances requiring the attention of a Medical Officer, for the Master is required to send a message to "Portelth London" not more than 12 hours nor less than 4 hours before arrival, containing the relevant information of the Maritime Declaration of Health. This message is received by the North Foreland Radio Station and telephoned direct to the Boarding Medical Officer on the "HYGEIA".

On arrival of a ship from a foreign port or an area infected with a quarantinable disease, no person other than a Pilot, a Customs Officer or an Immigration Officer is allowed to board or leave the ship until it is free from control of the regulations without the permission of the Medical Officer. The Master is required to take all steps necessary to comply with this provision.

On boarding, the Medical Officer interviews the Master or Ship's Surgeon and examines any patient with infectious disease or suspected infectious disease. When the diagnosis is confirmed or if there is doubt, if need be, the

patient is transferred by the "HUMPHREY MORRIS" or "VICTOR ALLCARD" to Denton Isolation Hospital near Gravesend. Cases of infectious disease can be isolated and treated here, even minor infections such as measles or whooping cough in children whose parents have no private home to go to and are proceeding to an hotel. But more important, doubtful cases can be fully examined in congenial surroundings rather than in the disadvantageous circumstances often found aboard, especially in crews' quarters.

The Boarding Medical Officer is in clinical charge of any cases of infectious disease retained in Denton Hospital. The more serious major infectious are transferred to appropriate Infectious Disease Hospitals.

Chickenpox is a notifiable infectious disease in the Port Health District. This and any other skin rash which simulates smallpox is a major concern of the Boarding Medical Officer. If there is any doubt regarding the diagnosis clinically he errs on the side of safety and treats the case as one of suspected smallpox. He accordingly decides whether or not the ship should be required to go to a mooring station. Complete kits of protective clothing comprising cap, gown or combination overalls, mask, gloves, overshoes are available on the hulk "HYGEIA" and the launches "HUMPHREY MORRIS" and "VICTOR ALLCARD". This is worn when attending a case or suspected case of smallpox. The Medical Officer of Health, if time permits, visits the patient and in any case notifies the Ministry of Health. If necessary, a Consultant from a panel is called in to give an opinion and specimens for laboratory investigation are taken in all cases, including clinical smallpox, and sent to the Central Public Health Laboratory. Standard kits for this purpose are held on the "HYGEIA", the launches and at the Hospital. A decision as to the disposal of the patient is taken immediately as one normally cannot wait for results of laboratory tests though reliable reports within a few hours have been given by electron microscope examination in a recent outbreak of smallpox.

When one is in the happy position of being able to decide with certainty on clinical grounds that smallpox can be excluded "free pratique" is given to the ship and the patient admitted to hospital or allowed to proceed and be treated by his own doctor as indicated by his clinical state.

When smallpox cannot be excluded on clinical grounds, the Boarding Medical Officer decides whether the patient should be admitted to the smallpox hospital at Long Reach Hospital, Dartford, Kent. It is for the Boarding Medical Officer to decide whether to keep a suspect case on board pending a Consultant opinion. A lot depends on the degree of doubt in a suspected case. This is also the crux in regard to admission to Denton Hospital in exceptional circumstances. If this is done any other patients there are removed beforehand and all occupants of the hospital protected by recent successful vaccination or revaccination. The strictest hospital quarantine comparable to that of a smallox hospital is maintained. The Boarding Medical Officer keeps in close touch with the Medical Officer of Health until a firm diagnosis has been established. A case of clinical smallpox is removed at once to Long Reach Hospital by ambulance. In these circumstances facilities are used at Denton Hospital for terminal disinfection of the patient's clothing and that of all who have been in contact with him since the onset of his illness and prior to his removal to Long Reach Hospital. Special care is taken to trace, collect and disinfect any of the patient's clothing or bed linen which has been sent to be laundered. Accommodation in the ship, quarters, launch, Denton Hospital, etc., occupied by the patient are also disinfected.

Routine action is taken to check an outbreak of smallpox by the tracing, vaccination and surveillance of known and probable contacts. If the ship with the case is a passenger liner bound for Tilbury, this may involve up to 1,500 passengers and 650 members of crew.

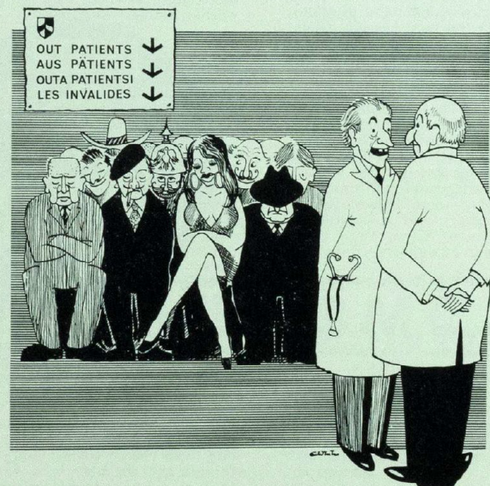
Careful enquiries elucidate a full and accurate list of all persons, who from the time the patient was taken ill are known or are likely to have been in contact with the case, such as other passengers, members of the crew, persons who worked in close contact with him, anyone who entered his cabin or quarters before they were disinfected and persons who handled his personal belongings, clothing or bedding, and anyone who disembarks from the ship or who goes on board. This will clearly include Health Department staffs such as public health inspectors engaged in terminal disinfection as well as launch crew who were in contact with the patient. Any person who has been in contact with the body of a patient should he die of smallpox should not be forgotten. The names and addresses of all travellers who are proceeding beyond the Port Health District are transmitted .on appropriate forms to the Health Department Guildhall. Each form when com-

pleted gives addresses at which the person will stay the first night ashore and for during the next fourteen days. Each traveller is also given a reply paid postcard on which he is required to notify the Medical Officer of Health at Guildhall of any change of address within 14 days of disembarkation, in case he is unable to give all this information when he fills in the form. All these persons are checked by the Medical Officer and must be offered vaccination or revaccination immediately whether or not they hold valid International Vaccination Certificates, and if probable contacts, irrespective of age or contra-indications. They are placed under surveillance for 14 days from the date of last possible contact. This is usually the date of isolation of the patient. The Medical Officers of Health of districts to which each traveller is proceeding are notified accordingly.

The intimate contacts of known or probable contacts of any person placed under surveillance should be vaccinated immediately in order to protect them before the onset of illness in the person under surveillance.

Possible contacts such as persons who visited the ship or other place occupied by the patient without actual contact with the patient, i.e. his sick berth or personal effects, are offered vaccination irrespective of age if there is no specific contra-indication. These are not put under surveillance but advised to call in their own doctor if they feel unwell within a specified period.

This is a short review of the main duties of a Boarding Medical Officer. In addition he undertakes medical emergencies and "first-aid" calls if his time allows. These include cases of cardio-vascular disease such as coronary thrombosis and indeed any cause of acute collapse amongst members of crews or passengers on ships in the River. Various accidents calling for immediate first-aid for haemorrhage, respiratory failure or fractures are attended to. This "Good Samaritan" service is given as an ex gratia service and helps to maintain the excellent good relations which obtain between Port Health Authority's Officers and the other Port Services, as well as Masters and crews of the Shipping Companies.



" . . . This is one aspect of the Common Market that Flash Harry didn't think of . . . "

MEDICAL BOOKS

Anatomy

A Manual of Human Anatomy—Central Nervous System, by J. T. Aitken, D. A. Sholl, K. E. Webster and J. Z. Young. Pp. viii 155, 47 figures. Published by E. & S. Lingstone Ltd., Edinburgh, 1967. Price 21s.

This book is the fifth volume of the second edition of the well-known series "Manual of Human Anatomy". Written and presented simply the authors have succeeded in portraying their subject with complete clarity. Since both gross and neuro-histological aspects of the brain and spinal cord are described, ideally the student should use this work while examining these areas in practical classes. Nevertheless, as a revision text the book has undoubted advantages, since numerous diagrams recall appropriate practical points. The compact nature of the presentation may not appeal to some students, who find this form of learning too concentrated. For the unwary it would be a mistake to think that the book can be read and assimilated in two or three nights.

Bound in semi-hard covers the book is light and of convenient size for easy transport. The text should prove to be valuable to many students who find neuro-anatomy a difficult and confusing subject.

John A. Clarke

Encyclopaedia

The Living Universe: An Encyclopaedia of the Biological Sciences. Published by Nelson. Price 22 gns. per set of 8 vols.

The Human Machine II and III.

These are well written books which are finely illustrated in colour with photographs and diagrams. The books frequently stress the fact that the patient is a member of society, has feelings and is an entity who should be studied and treated as such. A fact sadly forgotten many times in this age of over specialisation and fragmentation of medical departments. They appear to be written more for the layman than the medic, but a reasonable knowledge of medical vocabulary is essential to understand them. Subjects such as cardiac surgery are well covered, complete with coloured diagrams of the surgical procedures used to correct congenital malformations.

For those medics wishing some lighter reading which is medically instructive, or for a scientifically minded layman who wants to know more about medicine, I can thoroughly recommend these two volumes.

C. S. B. Roch-Berry

General Practice

The Doctor-Patient Relationship, by K. Brown and P. Freeling. Published by E. & S. Livingstone, 1967. Price 10s. 6d.

This 98-page paper-back is composed of a series of articles by the authors, partners in General Practice, which appeared in *The Practitioner* last year. The text is composed of thirteen chapters each devoted to a facet of the Doctor-Patient relationship. A short definition of the angle considered is followed by brief case hisories from the authors' practice and comments made thereon to illustrate the practical aspect.

The book will be of prime interest to those who have experience of general practice since without it the implications of the all too common situations cannot be fully comprehended.

Students reading this book might decide that an undergraduate appointment in general practice would broaden their medical outlook. To these and others intimately concerned with this field this interesting book can be recommended.

I. D. Fraser

Medical Novel

The Medical Misfortunes of the Slocombe Family, by A. E. Clark Kennedy and C. W. Bartley. Published by Faber & Faber. Price 25s.

Dr. Fetchquick guides us through the numerous ills of the Slocombe family, and he might as well be their private doctor for all the work they cause him. The Slocombe family live on a farm, but the idea of healthy farm life is utterly shattered by the train of misfortunes that befall the Slocombe's health. We are shown the workings of Dr. Fetchquick's agile mind as he diagnoses and cures ailment after ailment of the unfortunate family. It is great sport to guess what the next chapter will be about.

Farmer Slocombe's overworked Landrover ferries the Mrs. to and from the local hospital to see Sir Lancelot Ladywell, the Obstetrician, or his registrar, Miss Pinn; or to see the Paediatrician Dr. Child and his registrar Miss Kidd. The occasional intervention of Mr. Constant Cutter, the you know what, adds to the excitement. But farmer Slocombe gets his turn.

Experience always wins as Dr. Muggins knows, and as Miss Hustle's stand in, Miss Hurry, soon finds. A thoroughly readable, amusing and useful book, well worth reading.

S. R. Brennan

Nursing

Materia Medica for Nurses, by W. Gordon Sears. 6th edition published by Edward Arnold Ltd. Prices: Hardback 20s., paperback 12s.

The 6th edition of this standard textbook of therapeutics for nurses is sound and reliable. It succeeds best in summarising the preparations and average therapeutic doses of drugs in common clinical use, without detailing theories of their mechanisms of action which find a more appropriate place in standard reference books. Prominence is properly given to metric dosages and official names, although apothecaries' equivalents and proprietary names are given when appropriate. Inevitably some information is out of date, such as the classification of the hypnotic actions of some barbiturate drugs into those with short and intermediate time courses of action; this has not been substantiated in man. Indeed the section on centrally-acting drugs, particularly the anti-anxiety agents, needs major revision. Toxic and side effects of drugs are given due emphasis but perhaps too little detail.

It is a relief to find that the publishers of a text-book on therapeutics have produced two editions, one with hard covers and moderately expensive format, and the other in a cheaper paper back form. Such books have to be replaced within two or three years so that they should be disposable. Other publishers, please note! However, I am at a loss to explain why there is only 8s. difference in price.

Michael Besser

SPORTS NEWS

SPORTS EDITORIAL

Sport, according to the dictionary, is short for disport, (old French—*desporter*) and is defined as "a diversion, an amusement; fun, jest or pleasantry". A game, from the Anglo-Saxon—*gamen*, is defined as "merriment". Now, despite the fact that there are those among us who dislike organised sport and regard it as an unfortunate legacy from a previous era, there can be no doubt that to participate in a sport and become proficient to a greater or lesser degree is indeed great fun. Otherwise nobody would bother to play any sports.

Apart from this, the anticipation of representing one's hospital or even country and the pride on attaining this is very often in the back of a sportsman's mind, and although real glory seekers are few there is probably an element of glory-seeking in all our minds. What a wonderful feeling to dive over the line for the winning try, or to drive straight down the fairway onto the green or to perform some incredible contortion to take a catch in the slips. And how much more glorious is the feeling if there are people watching.

Moments of triumph like this occur in all sports and the feeling of elation is always shared (if not quite halved) by the supporters of the victor. So sport, in its definition as a diversion and amusement, can apply equally to players and watchers. It can be sport just to watch and the players need the watchers because in some miraculous way, the players perform better when watched. Maybe it's that they try just that little bit harder to achieve their moments of glory, especially, in the male-dominated sports if the watchers are female.

It is earnestly to be hoped, therefore, that the list of sporting events for this month which is printed below will be a sort of amusement guide for those nurses on their afternoons off or those avid Charterhouse croquet players or merely the Wednesday and Saturday afternoon loafers.

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"How do I get along to the ground?", you may say. Nothing simpler. Just go to College Hall on the appropriate day about an hour or so before the event and say, "I want to come and watch you lot play tennis/golf/cricket, etc". There are almost always spare places in cars going to events and for cup matches coaches are sometimes hired.

Events for June

Sat. 3rd Walton Regatta.
Tennis 1st VI v. Middlesex Hosp., Home.
4th Cricket Club v. Putney Eccentrics, Home 11.30 a.m.
7th-9th Tennis Club tour of Cambridge.
7th Tennis 2nd VI v. Royal Free, mixed. Away.
Sat. 10th Cricket Club v. The Crickets, Home 2.30 p.m.
" " Reading Regatta.
" " Rifle Club U.H. v. Colleges at Bisley.
11th Cricket Club v. Blackheath, Home 11.30 a.m.
" Golf Club v. Mr. Hankey's Team at Tandridge G.C.
14th Cricket Club v. London Hospital II, Away 2.30 p.m.
" Tennis 1st VI v. U.C.H., Away.
" Tennis 2nd VI v. Royal Free, Home.
" Golf Club v. Royal Dental & George's; Chislehurst.
Sat. 17th Cricket Club v. Old Tauntonians, Home 2.30 p.m.
" " Marlowe Regatta.
" " Tennis 1st VI v. University College, Home.
" " Tennis 2nd VI v. U.C.H., Away.
" " Rifle Club; Armitage Cup & U.H. Individual Championships at Bisley.
18th Cricket Club v. Horlicks, Away 11.30 a.m.
" Tennis 1st VI v. College of Estate Management, Home.
21st Tennis 1st VI v. Imperial College, Away.
" Tennis 2nd VI v. Imperial College, Home.
" Golf Club v. Charing Cross Hospital, Chislehurst.
Sat. 24th **Cricket 6-a-Side Tournament, Home** 2 p.m.
" " Tennis 1st VI v. St. Mary's Hospital, Away.
" " Tennis 2nd VI v. St. Mary's Hospital, Home.
28th Cricket Club v. City Police, Home 2.30 p.m.
" Golf Club v. St. Mary's Hospital. Moore Park G.C.
28th-July 1st Henley Royal Regatta.

BOAT CLUB

At an extraordinary meeting of the Boat Club held on 22nd April, Brian Cutler was elected to the post of secretary. Ken Webb is stroking the Tyrian VIII, and Barry Grimaldi is rowing in the London Rowing Club 1st VIII.

J. D. C. Martin.

STOP PRESS In the **United Hospital's Bumps Races** Bart's 1st VIII *retained* the Head of the River Trophy, rowing over on all three nights. A full report will appear in the *July* Journal.

CRICKET CLUB

The season started in its customary cold and damp fashion on Saturday, April 23rd with a "warm-up" game against **U.C.H.** when a Bart's side weakened somewhat by absence and greatly by lack of practice, was convincingly beaten by 9 wickets. The only thing worthy of note in this game was the very impressive debut of opening batsman Graham Purcell who scored a very creditable 64 out of a total of 120.

On the following day the game against **Queens' College, Cambridge,** at Cambridge, produced a slightly better result in the same adverse weather conditions. A fine innings by Nick Griffiths of 79 helped Bart's to a total of 147 for 9 declared. Queens' began their reply confidently, but thanks to a fine display of

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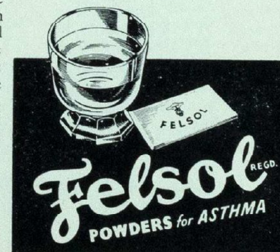

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bowling by Elwyn Lloyd, who took 6 wickets in his first game for Bart's, they were suddenly struggling and ended 37 runs behind with 2 wickets left.

Despite the unspectacular start to this season, the prospects for the remainder of it are bright, with a larger than usual number of people available and keen to play for the side. The factor which will probably most influence the results this season is the grooming of a successor to Charles P. Vartan as the other half of a formidable opening bowling partnership with Phil Savage. However, there is no shortage of applicants for this post which we hope soon to have filled.

The side this year is led by Graham Hopkins, and the club seems set for a happy and successful season under him.

One of the highlights of the season should be the Inter-firm 6-a-Side tournament to be held at Chiselhurst on Saturday 24th June at 2 p.m. This, coupled with the Tennis Club's fixture against St. Mary's, should provide a very good afternoon's entertainment.

P. J. Furness

BADMINTON CLUB

During the past season the club played 15 Men's and 7 Mixed matches of which we won 10 and 5 respectively. With these results we finished 4th in the Men's League Division II and 5th in the Mixed. Some of the results have been rather inconsistent due to the variation in availability of players, of whom we have too few, although what is lacking in quantity is compensated for in quality! Consequently, at times, it has been difficult to gather a full team due to such a small reservoir of talent. Next year, unless recruiting figures are higher, a complete team will be the exception rather than the rule and anyone interested in playing should contact C. H. Bowker in the Hospital.

This year's tournament was won by V. K. Mathur, who also won the mixed doubles together with Miss V. Pitt. The entry this year was smaller than in previous years, but this in no way detracted from the enjoyment.

The Captain this year was V. K. Mathur who is to be congratulated on being awarded his Purple. Others who played for the club were: M. O. Freeth, J. C. Allen, C. Wylie, C. H. Bowker, M. Buckingham, D. Ratsey and M. Kellett, and for the ladies the Misses R. Foley, W. Smith, M. Sumner, P. Taverner, S. Byrne, C. Sanderson.

C. H. Bowker.

RIFLE CLUB

The following are the results of the postal matches shot recently:—

University Leagues

Postal 'A'—to be received.
Postal 'B'—3rd in Div. II.
Postal 'C'—4th in Div. II.
Novices 'A'—5th in Div. I.
Novices 'B'—2nd in Div. II.

United Hospitals' Leagues

Lloyd Cup—3rd.

Tyro Cup—1st (an excellent win, with the five-man team, I. Franklin, J. Reckless, M. Knowland, G. Rowland and G. Tuckwell, averaging 95 per man).

Group K.O.—Bart's 'A' lost in the final to London Hospital.

Individual K.O.—

Div. I 3rd S. G. Crocker (393 ex 400).
4th M. J. Rymer (392 ex 400).
Div. II 1st C. J. Sedergreen (195 ex 200).
2nd P. Cheetham (194 ex 200).
3rd M. Hambly (193 ex 200).
4th I. Franklin (190 ex 200).
6th J. Griffiths (189 ex 200).

During the season we have had several members shooting for the University and United Hospitals' teams:—

U.L.R.C.—S. G. Crocker, J. Reckless, I. Franklin.

U.H.R.C.—S. G. Crocker, J. Davies, I. Franklin, M. J. Rymer, I. Battye.

John Davies, in his first year here, is to be congratulated on putting up the highest average in both Postal 'B' and Novices' 'A' teams.

S. G. Crocker.

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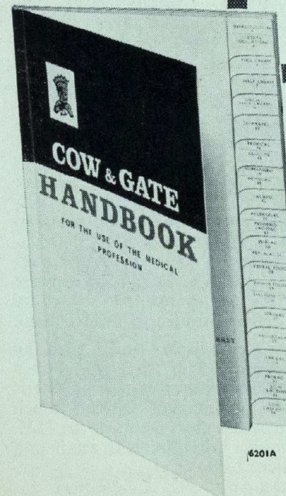

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RUGBY CLUB

United Hospitals' Seven-a-side Tournament

The suggestion to move the U.H. 7's forward in the calendar may be taken up next year; this Sunday, 16th April brought a poor turn-out for what could be the highlight of the season. Only six hospitals appeared on the day.

King's and Guy's II were knocked out in the first round. Bart's I, after easily beating London were drawn against Guy's I, tired by a hard fought victory over Bart's II.

After a disturbed start to the afternoon the supporters became more alert as the semi-finals approached. Thomas's v. Mary's was a close game. Mary's failed to use a faster back-line; Thomas's pack, faster than their opposite numbers, defended more efficiently and created more openings to win 9-3.

Bart's I v. Guy's I was the hardest and best game of the afternoon. Both teams were playing more recognisable sevens; a well spread defence not being tempted into bunching, and hard tackling from man-for-man marking. Both teams moved the ball rather than the man to create the openings. The Bart's pack, faster overall, denied Guy's the possession from loose and tight which they needed. Bart's scored first an unconverted try. In the second half Guy's equalised with a penalty but after a disabling manoeuvre in a mid-field scrum we scored under the posts, N. Griffiths converting.

The speed of the Guy's backs then began to show and after a fine run by their centre, scored under the posts—the conversion failed. In the remaining minutes Bart's covering and good tackling contained Guy's to win 8-6. The final between Bart's and St. Thomas's was fortunately more one sided. Most of the excitement was from Bart's attacking movements. K. McIntyre, as in all the games, played exceptionally well; his running and dispossessing were of special note. D. Pope and N. Griffiths made a fine partnership and were the instigation of many fine moves. R. Lambert scored two tries with fast and intelligent running.

After last year's unfortunate clash of fixtures we have recaptured the Seven-a-side Cup, one which I am sure will increase in esteem as sevens become even more popular and the date more propitious.

Teams: Bart's I: K. McIntyre, E. Lloyd, M. Britton, D. Pope, N. Griffiths, R. Lambert, G. Hopkins.

Bart's II: T. Fenton, A. N. Graham, A. Johnson, P. Buckley, C. Grafton, N. Packer, D. Jackson.

Middlesex Seven-a-Side Competition

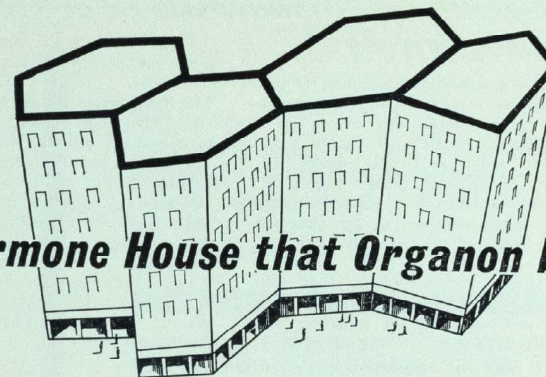
At Beckenham, one of many grounds used in the Preliminary Round of the Middlesex Sevens, Bart's II were the first to perform against a somewhat depleted Westminster Bank II. By the time we were 6-0 up, the Bank had a full complement, too late alas to stem the flood of scores. Our run was short, however, losing to Park House in the next round after D. Jackson left the field with a broken nose.

Bart's I started by playing Barclay's Bank whom they beat easily. The subsequent victory against Beckenham I, although in similar style did not lighten the prospect of meeting Sidcup in the Semi-Final, having lost heavily to them in a previous 15-a-side match. The outcome was a pleasant reversal of the previous meeting. Sidcup were unable to penetrate our defence. Bart's played hard and sensibly and the inevitable scores came, One try, scored direct from a kick-off, when our seven moved the ball back and forth until there were no Sidcup defenders remaining, brought deserved cheers from the crowd. Bart's won 19-3.

The Final was then between London Scottish I and Bart's. The first seven, undaunted, played better than ever. Within minutes a blind side break by K. McIntyre from a penalty, a break by P. Savage, and a fine movement ending with M. Britton heading fast for the line, were only just saved. A missed penalty could similarly have given us a half-time lead. Again in the second half it was Bart's attacking. However, Scottish were first to score, as with each of their scores, by a break from their own half. K. McIntyre then dispossessed a well-known (doubtfully Scottish) hooker and ran in to score, N. Griffiths converting. For a time 5-5 gave the Bart's supporters hope of a possible victory. Three more tries, however, the last a one-man effort by S. Wilson, put Scottish through to Twickenham.

Overall an excellent display and a pleasing climax to the season. The Club plays to a standard in full team fixtures as well as sevens which cannot be maintained without much application. For next season we have the U.H. Sevens Cup to retain, other things to attain and evidently the talent to do it.

C. Grafton.



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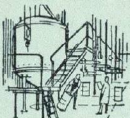
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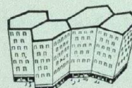
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ATHLETIC CLUB

University of London Championships, April 29th.

The turn out for this, the first match of the season, was very encouraging. The team was as follows:

J. Scarr (sprints), A. Breeson (sprints), P. Kitchener (880 yards), J. Brooks (mile), B. Scott (hurdles), J. Russell (pole vault), S. McCarthy (pole vault) and I. Sitwell (long jump). Several other members of the club although chosen were unable, or just did not turn up.

Injury and lack of fitness took its usual toll but the performance in general promises well for the season and we especially welcome two able pole vaulters, (Bart's first for very many years), and our new sprinter, Scarr, a Cambridge *Blue*.

As a result of the championships Scott was again chosen for the University team.

The Programme for the Season

On the 11th of May we left for the long promised tour, to the West Country.

The United Hospitals Centenary Year Championships will be held on 3rd June where we hope to improve on our 3rd position of 1965. The championships will be followed in the evening by the Centenary dinner at the Café Royal.

Other fixtures have been arranged against: St. George's Hospital, Royal Free Hospital, Westminster Bank, Lloyds Bank, and Pearl Assurance.

B. Scott.

SAILING CLUB

At the start of the season the club purchased another Firefly Dinghy and this extra boat means that we can participate in team races against other colleges without borrowing boats.

J. Shaw crewed by Miss P. Harris has sailed regularly for the United Hospitals team and have sailed against a number of University sides so far this year.

During the Winter a promising number of novices were taken sailing and anybody else interested in learning to sail and pass the Helmsmanship test or wishing to know anything about United Hospitals sailing at Burnham-on-Crouch, should contact M. Williams or J. Shaw at College Hall.

It is brought to everybody's notice that, under new regulations, *heavy fines* are now payable by clubs whose members borrow another boat's gear without permission.

The Rosenheim Points Series.

All three boats were sailed in the United Hospitals Winter Points Series at the Welsh Harp on alternate Wednesday afternoons. Our new boat, F.1606, won the series by a convincing margin and congratulations are due to J. Shaw who helmed in most of the races. We also gained an easy second place in the series with F.2989, sailed mainly by M. Williams.

Bart's v. Wembley Juniors

In light winds the 1st team scored an easy victory over Wembley Juniors in Fireflies. In the second race all three boats in the opposing team were either retired or disqualified at the finish.

Castaways Cup Weekend.

Two teams were entered this year for the University of London Team Trophy.

First Round—The 'A' team beat Q.M.C. after being down on points in the first race but the 'B' team lost their race rather badly.

Second Round—The 'A' team's opponents were City University and we scored an excellent victory by means of some very good team tactics.

Third Round—This race against Imperial College proved to be the easiest of the two days. We finished 1st, 2nd and 3rd in one race and 1st, 2nd and 4th in the next.

Semi-Final—In this we were drawn against a combined team from St. Mary's and the College of Estate Management (a cunning way of keeping the U.L. team together). In the first race M. Williams hit a mark on the starting line and we were unfortunately beaten overall by a very competent team, though the margin was small.

We can feel pleased, however, since our opponents won the final by a much larger margin over King's College.

Teams—'A' team: M. Williams, J. Shaw, R. Rowne.
'B' team: Miss J. Walsworth-Bell, Miss P. Harris, J. Winner.

Bart's v. City University

After beating this Club in the Castaways Cup we did not put out a very strong team for this event, but the result was still a convincing win for us.

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Bart's v. Hampton S.C., Away. Lost 28-36½

This event took place on the narrow and fast flowing waters of the Thames and for the first race there was little wind. M. Freeth had to retire soon after the start due to a collision with one of the opposition. Both J. Shaw and one of the opponents missed out a racing mark on the upwind legs and were disqualified. This left the placings for this first race as Hampton 1st and 3rd, M. Williams 2nd.

The second race proved more lively with a very changeable, squally wind and by the end of the race there were about as many Protest Flags as there were boats racing. However, the protests were all settled amicably after the race which resulted in a win for Hampton.

Team—J. Shaw, M. Williams, M. Freeth.

M. Williams.

JUDO CLUB

The Club has now completed an important "double" by winning both the U.H. Cup and the Wednesday Inter-College League. This League is a recent innovation and as yet there is no actual cup but when it arrives later in the year Bart's will certainly go down as the first winners.

The Club also took part in the British Universities Inter-College Championships but did not have such a large measure of success against very superior opposition. However, many lessons were learnt and we hope to do better in the event next year.

Gradings were held in March and the following three members of the Club were upgraded:

P. D. Clarke to Blue Belt.
J. Deerlove to Orange Belt.
J. Davies to Orange Belt.

The last two named men should give great encouragement to anyone thinking of taking up judo. They started only last October and have advanced through three belts.

The Inter-Hospitals' Cup Competition was held on Saturday, May 6th at U.L.U. gymnasium.

Bart's won the competition for the second year running.

P. D. Clarke.

GOLF CLUB

April 5th v. **Middlesex Hospital. Won 3-1.**

This game was played on a sunny afternoon at Chislehurst and the team showed no sign of rustiness after the winter. Mike Bowen swept confidently to a 5-4 victory and Chris Booth and Richard Begent also won by handsome margins. Tony O'Kane seemed all set to pull back to all square on the 17th, but his ball was knocked away from the hole by his opponent's approach shot, and he lost on the last hole.

Hospitals' Cup, 1st round

v. Charing Cross Hospital at Roehampton G.C. Won 4-1.

The decision to play this match as part of the Hospital Cup Draw was made at the eleventh hour. Enthusiasm was lacking because two of our men, being preclinicals, were unable to play. In addition, John Sadler, the Captain, was away doing a "Midder" course in Cambridge.

Thus it was a depleted team that drove off from the first tee—or so we thought. In actual fact, there was only one change in the team that so nearly took the 1966 Cup from Guy's last October, at the Royal Berkshire.

The Roehampton course is not too hazardous and our team made the ball travel long distances on the hard ground occasionally driving some of the longest holes in one.

Results:—

Dave Grieve won 7 & 6.
Mike Bowen won 7 & 5.
Richard Begent lost 1 down.
Angus Hoppe won 6 & 4.
Chris Booth won 8 & 6.

We now go on to meet The Royal Dental and George's in the Quarter Finals. The date of this match has yet to be arranged.

A. Hoppe.

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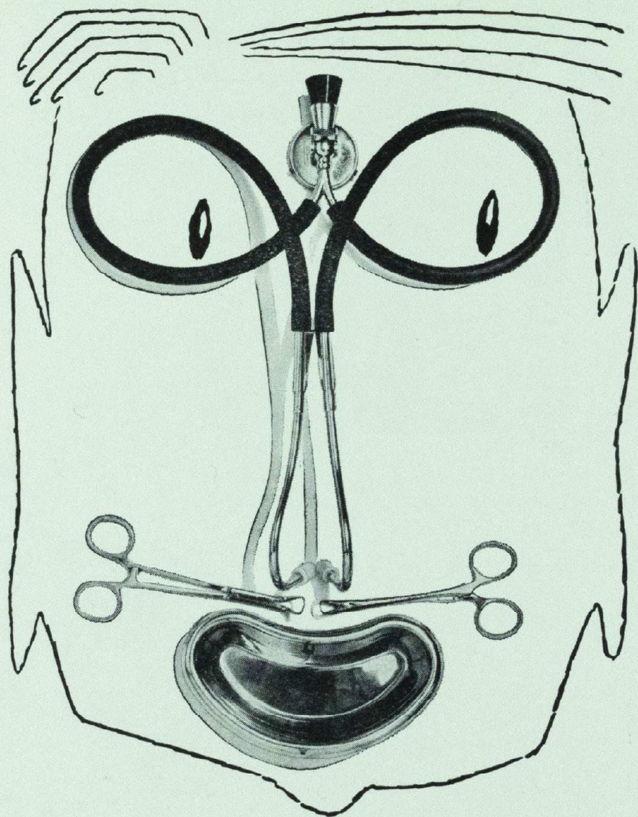

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1. Today's Drugs. Anticonvulsants. *Brit.med.J.*, **2:** 919, 1963.

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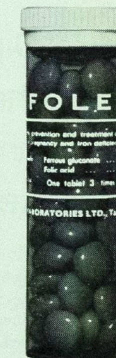
(1) *B.M.J. No. 5529. Page* 158.



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Saint Bartholomew's Hospital JOURNAL

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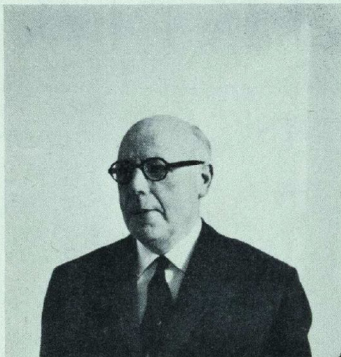
Editorial

It is our sad duty this month to announce the retirement of Dr. A. W. Franklin from the Chairmanship of the Publications Committee of this Journal.



Dr. Franklin has been our Chairman for nine years, succeeding Dr. Geoffrey Bourne on his retirement from the Hospital in 1958. Unlike the latter, however, it is not the termination of commitments but rather the assumption of new ones that has forced Dr. Franklin to leave us at this juncture. We congratulate him on his recent election to the Presidency of the British Paediatric Association and onto the Council of the Royal College of Physicians. We understand that his continued commitments to Queen Charlottes', the Invalid Children's Aid Association, whose thirteen years' Chairmanship ended in 1964, and his present research into problems of dyslexia in children have neccessitated his decision. All those who have been priviledged to serve under him extend their sincere thanks.

Dr. Franklin came to Bart's from Clare, Cambridge in 1926 to embark upon a distinguished student career during which he won the Wix Prize for an essay on Claude Bernard. He also found time to be an Editor of the Journal as well as be a co-founder of The Osler Club, of which he is still the Treasurer. He was the second House Physician to Dr. Harris's newly formed Department, for Diseases of Children. He won the Lawrence Scholarship and apart from a Fellowship year to Johns Hopkins, Baltimore, has remained with the department ever since. He has written papers on various children's diseases, especially on their social and family aspects, and has Edited several historical books, including the "Selected Writings of Sir William Osler".

Dr. J. W. Aldren Turner has kindly accepted the Chairmanship of the Publications Committee and we extend a warm welcome to him. Renowned throughout Bart's for brightening Monday mornings with his lively teaching sessions, Dr. Aldren Turner came to the Hospital in 1932 from Oxford, where he took 1st Class Honours in Physiology. As a student he won the Brackenbury Prize in Medicine in 1935 and was Prox. Access. to the Skynner Prize. A late Lt. Colonel in the R.A.M.C., he was elected a Fellow of the Royal College of Physicians in 1946 and has been Sub-Dean of the Medical College. His Publications include a textbook on "Clinical Neurology" and many contributions to "Brain".

LETTERS TO THE EDITOR

Sir,—The second appearance of full colour in the Journal—the Colour Supplement presented by the Board of Governors in May—was certainly interesting and stimulating. The section on hospital planning raises comments and questions, but there is a curious lack of some information which makes constructive comment rather difficult.

The Supplement features certain plans, present and proposed, but virtually no detail of elevations and space allocations. If the external shape and number of storeys of the buildings are known, then the contents of these buildings must have been planned in great detail. For the meeting in the Great Hall and the Journal Supplement to be considered a successful experiment in communications surely much of this information has to be available, and certainly more than was shown in the isometric view displayed in the Great Hall?

Virtually no idea is given of WHEN the various developments would be carried out, nor if the cost was to be met purely by the hospital or in part by the University and Ministry of Health. It would be interesting to know if the plans as presented to the Journal readers were accepted by these bodies, and by the appropriate planning authorities in the City. Are these parties completely enamoured of the plans?—for their approval will of course be needed even if the cost is totally hospital met.

As was said the extent and direction of further major and substantial redevelopment could not be determined until certain essential prerequisites were known—namely the number of beds on the Smithfield site; the relationship with other hospitals in the region; and the facilities to be provided for the University. I am not clear how plans can reach as advanced a stage as they appear to have unless these answers are known or surmised.

Having wished that more information was imparted in the Colour Supplement, which was in itself an admirable idea, I would like to make one or two comments on the things that were said, with particular reference to Student teaching and facilities at Bart's.

The Treasurer said: "I think we ought to face the fact that this sort of essential 'Make do and mend' activity has gone far in the last few years and we are really now up against the point where we are confronted with major policy issues for the future. And I'd like to take the line that it is our job in the Hospital to decide, and to stick to, a broad policy, thought out on the basis of what seem to us the most reasonable assumptions at the present time". After the three assumptions, to which few would take exception, the Treasurer continued: "The Board of Governors had recently pressed the Minister of Health for permission to take on an enlarged district responsibility and for the designation of a number of hospitals which were now the responsibility of the North East Metropolitan Regional Hospital Board . . . If a successful conclusion comes from this debate . . . to build up the total Smithfield site . . . not of very many more beds . . . much better clinical facilities for teaching, specialist services, and research activities . . ."

It would appear to be accepted that the list of projects given, past, present and future, are mainly 'make do and mend', and that the success of longterm development plans in the last 25 years is limited mostly to Q.E. block and to Gloucester House. In June 1953 in the Journal the Clerk to the Governors gave details of future plans. They were less ambitious perhaps than the present ones, but only those parts to which the Minister had appeared to give approval have now been accomplished. The Medical College was faced with extensive war damage, but the plans to rebuild Charterhouse were made and mostly carried through within a respectable length of time, to make the preclinical school the envy of most other teaching hospitals. With a not unsimilar problem the hospital has, with due respect, done far less for the student. It has, I know, responsibilities other than those to the University.

In the hospital the pre-war buildings that were part of the Medical College have not been renewed. The Almoners' and Medical Illustration Departments have replaced bombed lecture theatres and other facilities, leaving lectures to be conducted in the very ancient and inadequate ex anatomy dissecting rooms. The Museum, Library and cloakrooms remain very much as before the war, while improvements in the Pathology teaching area are not completely adequate. A temporary Abernethian room has been provided, but there is an almost total lack of tutorial

and seminar rooms and few audiovisual aids (which are not always used imaginatively).

The decision to face major policy issues now, must mean that the decisions of post-1941 and of 1953 have been forgotten about. The present increase in student intake need facilities when they arrive and not after they have qualified.

The wish to take on an enlarged district responsibility is important, but steps to this end were needed over 20 years ago when this was suggested. There *must* be a successful conclusion to this debate if the recommended number of beds per student is to be met, and similarly there must be an improvement in the clinical facilities. This is surely very urgent now, particularly to meet teaching needs in outpatients; in gynaecology where teaching is based on 50 gynaecological beds with ward rounds of maybe 30 students; and in particular in paediatrics, where up to 30 students might spend three months based on 40 beds if some did not make other personal clerkship arrangements. These poor facilities create problems for staff, students and patients.

It is planned to have 'not very many more beds on the Smithfield site'. It would be interesting to know how many, Minister willing. There would appear to be a multitude of reasons why the hospital might not be allowed any more at all. Many of these are noted in H.M. Stationery Office publication 'The Hospital Building Programme' (May '66; H.M. Cmnd.3000) when the Minister refers to policy for the North East Metropolitan Region. He notes a rising population, but also a large population migration to the suburbs leaving Inner London with a number of acute beds per unit population very much above the norm. The Minister plans no capital expenditure on Bart's in the near future (say 10 years) with the exception of the started pathology block. Even if costs were to be met out of Endowment Funds Capital the running cost would need to be met by the Minister. 200 beds in a teaching hospital can cost £200,000 more to run each year than if built in a non-teaching hospital.

Mention has been made of some of the facilities that the student at Bart's lacks, and this letter has been concerned with these. It has failed to give credit for the amount of work that goes into running such a large institution, and has also glossed over some of the difficulties in future planning, but the same problems are still to be surmounted despite the lapse of time.

Further details, though, are needed to discover what facilities are to be provided in the proposed 4 storey Pathology and Teaching Block, whether they are adequate, and when they will be provided. It is notable that while agreed plans for Bart's are minimal, the Minister has authorised large scale building and rebuilding in many of the other London teaching hospitals. I would not wish to see this hospital not among the leaders in clinical teaching in future years.

With this thought I was prompted to question the plans as presented, hoping that more details would be forthcoming, and that the improved facilities-to-be would help patients, research work, nursing staff and students with equal consideration. While the Education Committee of the Students' Union should be the channel for discussion on the teaching course, more information should reach the individual student. If more detail is to appear, then we may not assume that the plans are to be taken with a rather large pinch of salt, and then the 'experiment in communications' will have been more of a success.

Yours faithfully,
JOHN RECKLESS

96, Hodford Road,
Golders Green,
London N.W.11.

Bart's and the Future

Sir,—The Governors, the Medical Illustration Department and the Journal are to be congratulated on the View Day Colour Supplement (St. Barts Hosp. Journal, 10th May 1967. Vol. LXXI. No. 5).

In it you were kind enough to report some remarks of mine at the Symposium in the Great Hall on 14th December 1966 and, within the limits imposed by space, you did so accurately and fairly. I would, however, beg to be permitted to develop my theme a little.

What is needed is a new approach not just a new plan within the old framework. Medicine is inevitably moving into the technological age—ventilators, artificial kidneys, pump oxygenators, cardiac catheterisation and modern radiological techniques are but the heralds of a new era in treatment and diagnosis. These procedures require far more medical nursing and technical personnel per patient than previous techniques. If we are to continue to hold our own in this computer age we must embrace the concepts of "Intensive Care" in specialised Therapy areas and "Progressive" and "Self" Care as convalescence proceeds.

New techniques require new buildings not just adaptations of existing accommodation. The leading Scandinavian and North American Hospitals have accepted the challenge long ago and there is every reason why we should follow suit without delay if we are not to be left behind.

With the greatest respect I cannot accept the argument that "Bart's cannot have it because other hospitals have not got it". The mission of the Teaching Hospitals has always been and, one hopes, always will be, to lead. They can only lead if they are given the authority, equipment and money to experiment, develop and accept, and, if necessary, reject. When the Teaching Hospitals have discovered the answers, the solutions can then be applied to the rest of the Health Service at a comparatively low cost.

And where is the money to come from? I can suggest two sources. First, as the Chairman of the B.M.A. Council has already proposed, we must abandon the idea that the cost of the Health Service can be met entirely from taxation and make direct charges to those who can pay and we must avoid politically doctrinaire manoeuvres like the abolition of the prescription charge. Secondly we must cut back the dead-wood of the cost of administration which has soared out of all proportion since 1948; like Marks and Spencers, probably the most efficient firm in the country, we must year by year reduce overheads to produce greater cost benefit.

I qualified the year the Health Service came into being; it is a great concept in social welfare and I have been proud to serve in it during its formative years. Few of us would like to return to the old hand to mouth existence which was the lot of the majority of hospitals prior to 1948 but it is our duty to see that the Service meets the challenge of the future practically and realistically. Loyalty to the Service must not be allowed to stifle genuine constructive criticism.

Yours faithfully,
T. B. BOULTON,

Dept. of Anaesthesia,
St. Bartholomew's Hospital,
London, E.C.1.

7th June.

July Duty Calendar

Sat. & Sun., 1st & 2nd.	Prof. Taylor Prof. Scowen Dr. Cole Mr. Fuller
Sat. & Sun., 8th & 9th.	Mr. Hunt Sir Ronald Bodley Scott Dr. Gillett Mr. Cope
Sat. & Sun., 15th & 16th	Mr. Ellison Nash Dr. Black Dr. Bowen Mr. McNab Jones
Sat. & Sun., 22nd & 23rd.	Mr. Badenoch Dr. Hayward Mr. Ellis Mr. Dowie
Sat. & Sun. 29th & 30th	Mr. Tuckwell Dr. Oswald Dr. Ballantine Mr. Fuller

Physician Accoucheur for July is Mr. G. Bourne.

Engagements

BRETT—SPRING.—The engagement is announced between Dr. Charles John Scott Brett and Miss Jennifer Thea Spring.

MORRISON—METCALF.—The engagement is announced between John C. Morrison and Carolyn A. Metcalf.

CRAWFORD—DENT.—The engagement is announced between Mr. Robert Crawford and Dr. Veronica Ann Dent.

STEPHENSON—WHITEHOUSE.—The engagement is announced between Dr. Timothy Patrick Stephenson and Miss Sandra Whitehouse.

WHITTAKER—WINTER.—The engagement is announced between Mark Whittaker and Elizabeth Ann Winter.

Birth

GREEN.—On May 20, to Sheila (nee Minns) and John Green, a daughter (Emma Louise).

Deaths

BOLTON.—On 12th April, Dr. Ralph Bolton, O.B.E., D.F.C., M.R.C.S., L.R.C.P., D.O.M.S., aged 67. Qualified 1924.

CHAMBERLAIN.—On 1st May, Dr. Laurence Philip Blayney Chamberlain, M.R.C.S., L.R.C.P., aged 63. Qualified 1931.

HALE.—On 21st April, Dr. George Samuel Hale, M.R.C.S., L.R.C.P., M.B., B.S., D.T.M. Qualified 1925.

HARKER.—On 14th May, Dr. Maurice John Harker, M.B., B.Chir., M.R.C.S., L.R.C.P., F.F.A.R.C.S., aged 68. Qualified 1925.

QUICK.—On 23rd May, Mr. Hamilton Ernest Quick, M.B., F.R.C.S., aged 84. Qualified 1906.

WATKINS.—On 28th May, Dr. John Grandisson Watkins, M.R.C.S., L.R.C.P. Qualified 1905.

HARVEY-WILLIAMS.—On 9th May, 1967, Robert Harvey-Williams, F.R.C.S., aged 76. Qualified 1915.

Honours

Royal College of Physicians

The following were elected fellows: C.B.M. Warren, D. V. Bates, R. W. E. Watts.

Royal College of Surgeons

The following were elected fellows in the Faculty of Anaesthetists: Dr. B. J. Metcalfe, Dr. C. A. Fuge, Dr. J. C. Missen.

Newcastle-upon-Tyne

Dr. E. A. Cooper has been appointed to the chair of anaesthesia.

PRIZES

Harvey Prize	N. McI. Johnson
Herbert Paterson Medal in Biochemistry	N. McI. Johnson
Herbert Paterson Medal in Physiology	A. J. J. Huskisson
Treasurer's Prize	J. L. Heywood, M. Rowntree
Certificates	E. S. Elder, N. P. A. Fairhurst, R. N. Wilmshurst-Smith
Wix Prize (Life and Works of Lawson Tate)	P. R. Jordan

art exhibition

Anyone who paints, draws, sculpts or produces some such form of visual art may like to know that an exhibition of art by the students and staff, medical and lay, past and present is to take place in the Great Hall in October of this year.

It is much hoped that they will submit a number of their works in order that this may be a representative exhibition of all artistic elements of the hospital.

Anyone interested should contact Dr. Malpas, Mr. Cull, Mrs. Owen, Miss Gill or Mr. T. C. Spooner, any of whom will be glad to give them further information.

FINALS RESULTS

University of London Final M.B., B.S. Examinations, April 1967

Honours

Burgess, E. M. (Distinguished in Surgery)
Roberts, M. E. (Distinguished in Pathology and Obstetrics and Gynaecology)

Pass

Barber, E. R.
Brown, A. A.
Church, C. G.
Coles, R. W.
Cupitt, C.
Ferguson, A.
Griffiths, N. J.
Higgs, R. J. E. D.
Jeffries, J. D.
Macfarlane, D. E.
Newbold, M.
Porcherot, R. C.
Rousseau, S. A.
Sykes, C. A.
Watkins, C. J.
Barnett, R. J.
Browne, D. S.
Church, J. J.
Coltart, D. J.
Etheridge, R. J.
Foster, E. A.
Hares, M. M.
Hillen, H. A.
Jennings, J. A.
Mathur, V. K.
Pindred, J. R.
Rawlinson, K. F.
Royds, R. B.
Sykes, E. E.
Woodward, R. M.
Brett, C. J. S.
Challen, P. D.
Clayton, R. J.
Coulson, J.
Evans, G. A.
Foulkes, J. E. B.
Harfitt, R.
Holt, A. A.
Keighley, M. R. B.
Morris, R. H.
Pope, D. C.
Riddell, R. H.
Savage, P. E.
Thomas, W. O. H.

Supplementary Pass List

Part I

Barker, M. J. M.
Begent, R. H. J.
Bowen, M. M.
Brueton, M. J.
Darch, G. R.
Evans, C. W.
Fogarty, P. M.
Greig, A. M. W.
Gribble, R. J. N.
Harker, N. E. M.
Jack, B. A.
Jennings, M. R.
Johnson, R. W.
McCaldin, C. L.
McGechnie, D. B.
Miles, D. P. B.
Mitchell, J. N.
Pemberton, J.
Ratsey, D. H. K.
Silverton, J. S.
Spring, J. T.
Volkers, R. C.
Webb, J. A. W.

Part II

Miller, R.

Part III

Nil.

Part IV

Miller, R.
Wilson, P. B.

Conjoint Board Final Examinations, April 1967

Pathology

Freeth, M. O.
Hillen, H. A.
Davies, J. P. M.
Leach, F. C. J.
Libby, G. W.
Anderson, J. K.
Hambly, M. T.

Medicine

Coles, R. W.
Pope, D. C.
Holt, A. A.
Coulson, J.
Harfitt, R.
Etheridge, R. J.
Jeffries, J. D.
Brown, A. A.
Higgs, R. J. E. D.
Ireland, N. J.
Sykes, E. E.
Royds, R. B.
Barber, E. R.
Sykes, C. A.
Keighley, M. R. B.
Church, C. G.
Mathur, V. K.
Jennings, J. A.
Griffiths, N. J.
Challen, P. D.

Surgery

Evans, C. W.
Coulson, J.
Roberts, M. E.
Porcherot, R. C.
Morris, R. H.
Setchell, M. E.
Goss, W. H.
Clayton, R. J.
Kennedy-Scott, J. P.
Hillen, H. A.
Evans, G. A.
Rawlinson, K. F.
Macfarlane, D. E.
Rousseau, S. A.
Foster, E. A.
Burgess, E. M.
Anderson, J. K.
Watkins, C. J.
Church, J. J.
Jeffries, J. D.
Newbold, M.
Riddell, R. H.
Ferguson, A.

Midwifery

Ireland, N. J.
Raine, P. A. M.
Richardson, J. C.
Rees, D. L. P.
Brueton, M. J.
Ying, I. A.

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

Hillen, H. A.
Keighley, M. R. B.
Mathur, V. K.
Jennings, J. A.
Griffiths, N. J.
Challen, P. D.
Watkins, C. J.
Morris, R. H.
Rousseau, S. A.
Ferguson, A.
Brown, A. A.
Pope, D. C.
Coulson, J.
Harfitt, R.
Etheridge, R. J.
Jeffries, J. D.
Roberts, M. E.
Macfarlane, D. E.
Riddell, R. H.
Clayton, R. J.
Coles, R. W.
Church, C. G.
Sykes, E. E.
Royds, R. B.
Barber, E. R.
Sykes, C. A.
Evans, G. A.
Newbold, M.
Foster, E. A.
Burgess, E. M.

HOUSE APPOINTMENTS

July 1967

BART'S

Jun. H.P. to Sir Ronald Bodley Scott	Blackburne, J. S.
Jun. H.P. to Dr. Hayward	Ferguson, A.
Jun. H.P. to Dr. Black	Browne, D. S.
Jun. H.P. to Dr. Oswald	Graham-Pole, J. R.
Jun. H.P. to Professor Scowen	Coltart, D. J.
Casualty House Physician	Crowther, A. N.
Jun H.S. to Mr. Hunt	Griffiths, N. J.
Jun H.S. to Mr. Badenoch	Savage, P. E.
Jun. H.S. to Mr. Tuckwell	Pope, D. C.
Jun H.S. to Mr. Ellison Nash	Evans, G. A.
Jun H.S. to Professor Taylor	Brodribb, A. J. M.
Casualty House Surgeon	Jeffries, J. D.
Jun. H.P. to Dept. of Child Health	Sykes, E. E.
H.S. (3) to Orthopaedic Dept.	Gately, J. F.
,, ,,	Higgs, R. J. E. D.
,, ,,	Macfarlane, D.E.
H.S. (2) to E.N.T. Dept.	Pembrey, J. S.
,, ,,	Porcherot, R. C.
Rotating Locums (3) St. B.H.	To be allocated

REGIONAL BOARD HOSPITALS

H.P. (2) to Rochford General Hospital	Burgess, E. M.
,, ,,	Jennings, J. A.
H.O. Obstetrics to Rochford General Hospital	
H.P. to Southend General Hospital	Phillips, S. J.
H.S. (3) to Southend General Hospital	Sutcliff, J. R. H.
,, ,,	Watkins, C. J.
,, ,,	Gordon, J. F.
H.P. to Whipps Cross Hospital	Bates, T.
H.S. (2) to Whipps Cross Hospital	Browne, G. R. W.
,, ,,	Thompson, J. B.
H.S. (3) to Redhill General Hospital (To Mr. McGrigor) ..	Brown, A. A.
,, ,, (To Mr. Pitt)	Church, C. G.
,, ,, (To Mr. Stevens)	Keighley, M. R. B.
H.S. (4) to Royal Berks Hospital (Mr. Bohnand Mr. Lotto)	Dymond, J. P.
,, ,, ...	Riddell, R. H.
,, ,, ...	Trowell, J. E.
,, ,, ...	Wheeler, T.
H.P. (2) to Prince of Wales's Hospital	Day, C. J.
,, ,, ...	Graham, W. B.
H.S. (2) to Prince of Wales's Hospital	Roberts, M. E.
,, ,, ...	Hollingshead, J. F.
H.S. to North Middlesex Hospital	Coulson, J.
H.P. to Connaught Hospital	Barrington-Ward, E. J.
H.P. to Royal Cornwall Hospital	Wood, P. B.
H.P. (2) to St. Leonard's Hospital	Setchell, M. E.

NORTH VIETNAM 1967

by Martin Birnstingl

During the month of March, 1967, when I visited Vietnam, 77,000 tons of bombs were dropped on the North, which compares with the heaviest bombing of the continent of Europe during World War II.(1) But most of the bombing is by daylight and the first night I spent in Hanoi, kept awake by music-while-you-work from a foundry next door, was an introduction to the mole-like routine by which the Vietnamese survive. In countless small workshops, moved from abandoned factories, and in running the trains and convoys, a quarter of the country's adult population work all night.

Hanoi in March seemed a busy city of innumerable bicycles but few children. Most have been evacuated to safety, as have ministries, universities, schools and factories. But despite boarded-up shops and the bolt-holes at 12-foot intervals along every street, there were open theatres and cinemas, clattering trucks piled with sacks of rice, street markets with fresh vegetables and faintly protesting trussed hens. Destruction of buildings in Hanoi up to then had been slight, but whilst I was there I saw hospital wards being cleared in preparation for an intensification of raids on the town, which has since taken place.

A trip to Thanh Hoa province, a hundred miles south of Hanoi, took all night by jeep. We crossed about a dozen rivers in the plains. The pontoons which replace the bombed bridges at night are lashed bundles of bamboo, over which timbers are laid. The whole structure is completely dismantled and towed away at dawn. Thousands of trucks cross every night. Villagers on the route work one night in four repairing the railway and filling in the previous day's craters in roads and dykes. In one place a bombed train lay on its side. The track had been rebuilt round the wreck and maize was growing on the rim of the big, water-filled craters.

The present rice ration in North Vietnam, (35 lb. a person a month, 55 for miners and other hard workers) depends on the rice fields of these plains. In 1945, after disastrous floods, two million people died of starvation, and extensive water conservancy and irrigation schemes have now been developed. During the past two summers, American aircraft have attacked the dams and dykes, particularly those in Nam Ha, Quanh Ninh and Thanh Hoa provinces. In 1966, I was told, there were 24 raids on the Chu river system in Thanh Hoa and repair gangs on the face of the dams were bombed and strafed. I visited a dyke in this region after if had been bombed on March 25th, cutting off the water supply to hundreds of acres of growing rice, already sprouting six inches high. The sluices had been closed and the breaches were already being repaired by gangs of villagers.

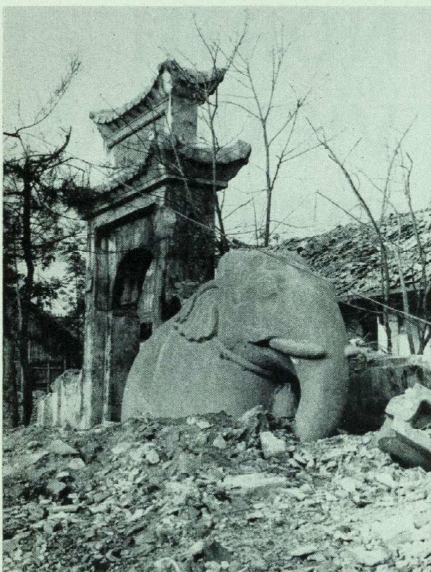


Fig. 1. A stone elephant outside a bombed Buddhist temple (photograph by author).

In this kind of emergency, much local organisation is in the hands of girls of about twenty, whose education qualifies them to take charge over the older villagers. I saw similar leadership whilst visiting Dan Loi hamlet, soon after an air raid with anti-personnel bombs. A young girl explained how she and her friends had organised evacuation of the casualties and burial of the nine dead. That the death rate in these densely populated villages has not been higher is a measure of the self-discipline of the inhabitants and the strict air raid precautions. In one country school, the children suddenly disappeared into slit trenches along each side of the open classroom and these led to a deeper shelter close by.

Visited by moonlight, the devastated town of Phu Ly looked like a lunar landscape. The larger city of Thanh Hoa still had a few buildings standing, though badly damaged. Two stone elephants stood knee deep in the rubble of an 18th century Buddhist temple (Fig. 1). I also visited the Jesuit convent of the Holy Cross, bombed a month previously. The city hospital and a big tuberculosis institute have also been destroyed (Fig. 2) Both were built less than ten years ago, the institute providing 600 beds and out-patient treatment for the entire two million people of the province. Its scattered two-storey buildings were mostly roofless, and there were huge craters throughout the grounds. The patients had long been evacuated, since most towns in North Vietnam have been repeatedly bombed by U.S. planes since the spring of 1965.

For an underdeveloped country, the loss of a number of large hospitals and schools is a tragic setback although patients and pupils are accommodated in temporary premises in the countryside and the mountains. The progress made by the North Vietnamese is now here more apparent than in the field of public health. Malaria has been eradicated in most regions. While there was a bad smallpox epidemic in Hanoi and Haiphong in 1952, there has been little or no smallpox, cholera or plague in the North for several years. Only trachoma and tuberculosis remain major scourges.

The main architect of North Vietnam's health service is Dr. Pham Ngoc Thac, whom I met several times. A youthful, erudite man in his sixties, from an Annamite mandarin family, Thac is an immunologist and tuberculosis specialist. In 1945 he joined Ho Chi Minh's administration and organised an inoculation programme against cholera and smallpox in the areas held by the Viet Minh. After the departure of the French he became minister of health and planned an ambitious scheme of expansion to parallel improvements in education and agriculture.

In 1945 Vietnam was a backward country, hygiene in the villages was extremely primitive and in the damp, subtropical climate parasitic and epidemic diseases were widespread. A vast problem had to be tackled with limited resources and it was obviously impracticable to wait until enough doctors had been trained to cover the whole field. Instead the problem was reduced to a pyramid of necessary skill, at its base involving the whole population in health education and basic hygiene. By 1964, 35,500 hygiene instructors were working in the countryside. The villagers built shallow, brick-lined wells, began to boil drinking water and in several villages I was shown closed double closets, which are used to convert human waste to harmless compost, by sealing alternate compartments for 3-month periods. The result is an ash-like grey powder, probably free from pathogens.

The basic structure of the health service is a network of small medical and maternity clinics in the villages, co-operatives and large factories. Each is staffed by several nurses, a midwife and

Fig. 2. Thanh Hoa tuberculosis hospital, opened in 1957 and first bombed 1st July 1965 (photograph by author).

usually an assistant doctor. There were 200 clinics in 1945; there are now 5,300. Almost all medical workers are recruited in the countryside and wherever possible go back to work in their own village. Rural nurses, midwives and specialist nurses are trained for about twelve months and after three years of duty in the clinics, some are chosen for further training to become assistant doctors. By 1964 23,500 nurses and midwives were working in the villages. The clinics deal with health education, ante-natal and maternity care, eye conditions and the inoculation programme; many have a specially trained nurse to do simple eye operations and treat trachoma, with which nearly 80% of the population are afflicted.

All preventative sera are now made in North Vietnam and mass inoculation is carried out against poliomyelitis, tetanus, typhoid, cholera, diphtheria, tuberculosis (with killed BCG) and smallpox. One result has been a rapid population increase to over 18 million and village and factory ante-natal clinics now provide birth control advice.

The village clinics are supported by a network of district hospitals, one to about 40 villages, able to deal with obstetric, medical and surgical emergencies; above this are the large provincial hospitals with training facilities and full specialist cover. Over 400 new hospitals have been built since 1954. After North Vietnam first became independent a number of doctors were trained abroad, but for the past five years teaching at both graduate and post-graduate levels has made this largely unnecessary. All doctors now practice an obligatory 3 years in the countryside after qualification and many have already worked as nurses and assistant doctors in the clinics. The doctor-patient ratio, excluding assistant doctors, was 1:180,000 in 1945 and 1:13,000 in 1964. There are now about 4 assistant doctors for every fully qualified doctor.

I visited several hospitals in Hanoi, where the standard of medical care was impressive, modern techniques being used in spite of difficult conditions and in an atmosphere of humane concern for the relief of individual suffering. I saw corneal grafting, mitral valvotomy and

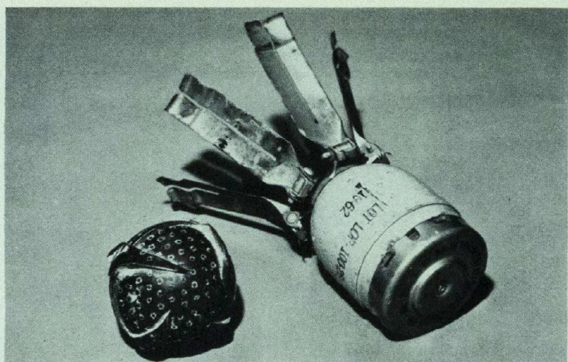


Fig. 3. Two unexploded anti-personnel bombs recovered in North Vietnam. Left the 'guava' type and right the 'pine-apple' type. The steel pellets can be seen embedded in the casing (Dept. of Medical Illustration S.B.H.).

partial hepatectomy. The last two operations were performed at the Viet-Duc Hospital by Professor Ton That Tung, an ebullient and versatile surgeon. A former pupil of Mallet-Guy in Lyons, Professor Tung joined the Resistance when the French returned to Vietnam and taught surgery at an improvised jungle medical school until the defeat of the French in 1954. He is now Vietnam's leading surgeon and has published a series of 331 partial hepatectomies, with a mortality of 14% (2, 3). The figure becomes credible when it is seen that 215 of these resections were performed for cholangitic liver abscesses due to Ascaris, a common disease in Vietnam. The partial hepatectomy which I watched was done for this disease, usually as in this patient confined to the left lobe (the Ascarids seem to have a preference for the left hepatic duct). The surgeon worked extremely rapidly, through a right thoraco-abdominal incision. The actual section of the liver substance was done mainly by compression between the fingers, by which most of the vessels were preserved and could then be secured before division. The raw surface of the liver was covered with omentum.

All the hospitals I visited in Hanoi and the provinces were caring for civilian air raid casualties, as bombing continues daily all over North Vietnam. Although most of the injuries were similar to those treated at Bart's during the War, about one third were due to anti-personnel missiles. The commonest type is a small bomb, the "guava", the size of a cricket ball. (Fig. 3) About 550 of these are carried in a tank-like container, or CBU (Cluster Bomb Unit). A single fighter-bomber usually carries 4 of these containers, each of which bursts open during descent, scattering the bombs over a wide area. Incorporated in the metal casing of the small bombs are about 420 steel pellets about 6 mm diameter, which are scattered at high velocity when the bomb explodes on impact. The injuries caused by these pellets are rather similar to a .22 bullet fired at short range, but diagnosis is difficult under field conditions due to lack of X-ray facilities and also because the small entry and exit wounds are indistinguishable from shallower wounds caused by fragments of casing. For this reason, Vietnamese surgeons advocate early laparotomy or thoracotomy for any patient with this type of injury. This weapon appears to have been used over North Vietnam for about a year, but the even more barbarous method, napalm bombing, has only been used widely in the South.

A two-week visit to North Vietnam leaves an overriding impression of a nation's pride in the achievements of the last twelve years. One of these is the health service, which has had not only to deal with the formidable tasks facing any undeveloped country, but also withstand an attempt at its destruction. The medical services are surviving the present onslaught due to extraordinary resources of courage and ingenuity and a sound basic organisation into which the whole population has been incorporated. The bombing serves only to strengthen their unity and determination.

REFERENCES:

1. LE MONDE, 29 April, 1967, p. 3.
2. TUNG, T. T. and QUANG, N. D. (1963) *Lancet*, **1**, 192.
3. TUNG, T. T. and QUANG, N. D. (1965) *Presse med.*, **73**, 3015.

Microscopic Surgery of the Ear (Part 2)

by A. P. Fuller

Since 1961 the number of ear operations performed annually at this hospital has shown a steady increase.

1961	151
1962	153
1963	202
1964	248
1965	267

The following classification will serve to group the various operations performed.

1. *Myringotomy and insertion of ventilating tubes*
2. *Suction toilet and atticotomy*
3. *Cortical mastoidectomy*
4. *Muscle grafting and obliteration of the mastoid bowl*
5. *Myringoplasty*
6. *Tympanoplasty*
7. *Radical mastoidectomy*
8. *Stapedectomy*

I shall describe briefly what we hope to acheive by such operations omitting for brevity the selection of their cases and their preoperative management.

1. Myringotomy and insertion of ventilating tubes

Paracentesis of the tympanic membrane is usually described for the relief of pus in acute otitis media. Since the advent of antibiotics such a reason has become less frequent. Nowadays myringotomy is performed much more commonly for the aspiration of non-suppurative exudates or transudates of the middle ear cleft. In the absence of suppuration the incision in the tympanic membrane tends to close very quickly, often before the middle ear has been able to return to normal. This leaves the patient in status quo. If however the perforation can be maintained so that the middle ear is ventilated, then the fluid contents, frequently very viscid, can drain easily down a narrowed or malfunctioning Eustachian tube. In order to do this a small polythene tube is inserted into the tympanic membrane **Fig. 1a a b.** It is left in place until tests have shown that Eustachian tube function is normal. Such patients have normal hearing as it is more important physiologically to have a ventilated middle ear cleft than a small perforation placed anteriorly.

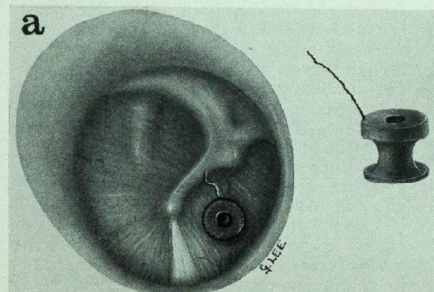


Fig. 1a.

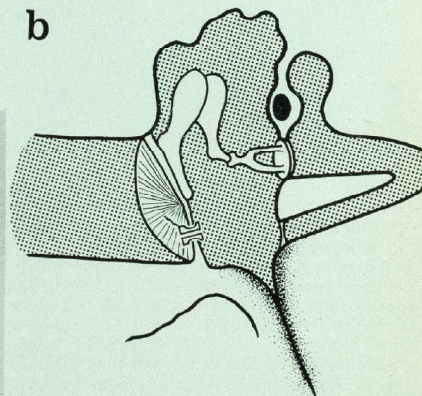


Fig. 1b.

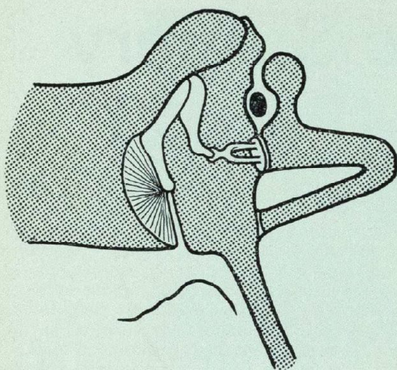


Fig. 2.

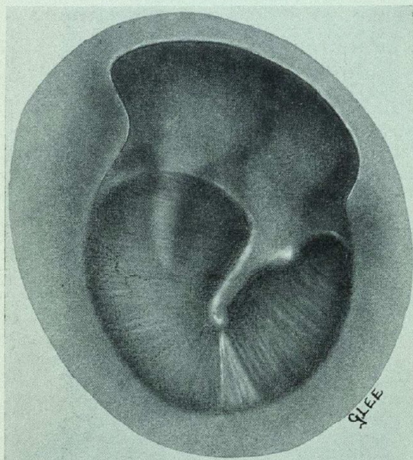


Fig. 3.

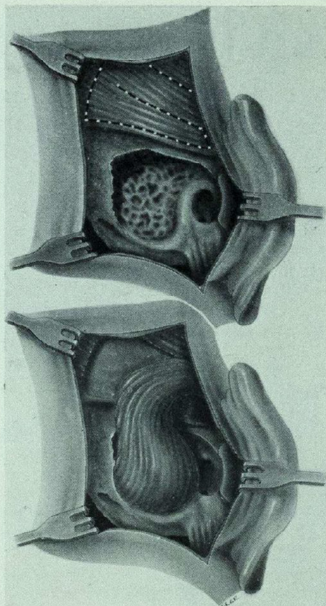


Fig. 4.

2. Suction toilet of the ear with or without atticotomy

If disease is localised to the attic of the middle ear then it can be extirpated through the external meatus. This is particularly applicable to a small cholesteatoma, commonly found when there is a small perforation through Shrapnell's membrane. As can be seen in the following diagram **Fig. 2,** removal of the outer attic wall creates a wide opening of the meatus into the epitympanum **Fig. 3.** This allows inspection and control of the disease through the meatus. If a secondary membrane can be persuaded to form over the aditus then a normally functioning middle ear can be obtained. Adhesions of the ossicles and interference with the suspension of the ossicles from the attic roof may vitiate a good result. Not infrequently the incus is partially destroyed; it can then be removed and the remains of the tympanic membrane laid over the stapes to fashion a single ossicle middle ear. I must stress that this procedure is only used when the disease is localised and when the surgeon is confident that all the disease and cholestaetoma has been removed.

3. Cortical mastoidectomy

In this operation all the mastoid cells are removed so that the mastoid segment contains one cavity which drains easily into the middle ear via the aditus. The external meatus is untouched as is the middle ear. It is not an operation for which microscopy is essential, but its use makes complete eradication of the cell system more certain.

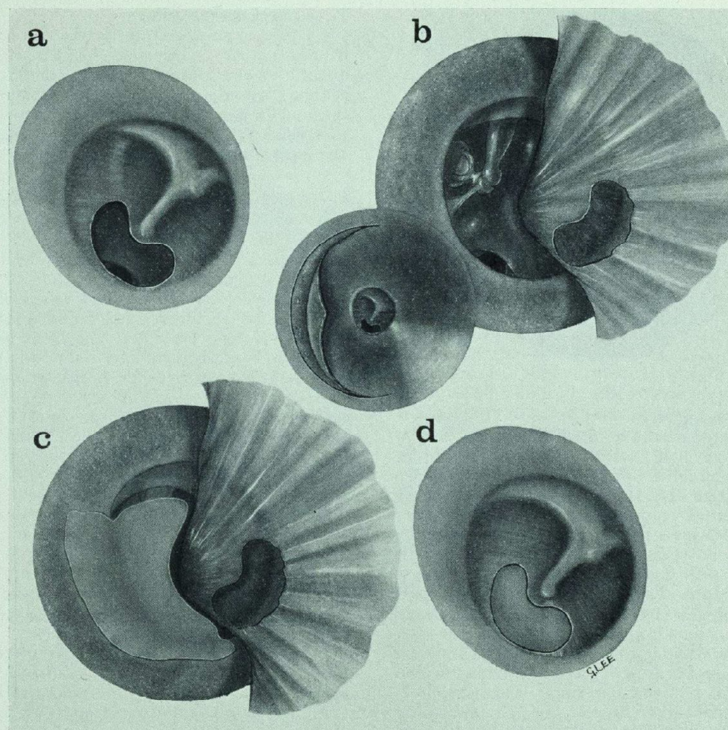


Fig. 5.

4. Muscle grafting and obliteration of the mastoid bowl

In patients where there has been a large cell system or extensive disease a very large radical cavity is obtained. Large radical cavities tend to be troublesome and to avoid this obliteration of the mastoid cavity is undertaken. This operation is also useful when there has been persistent post-operative infection in a radical cavity. The cavity is obliterated either by a muscle graft swung downwards from the temporalis muscle, **Fig. 4,** or by periosteum pedicled posteriorly from the sternomastoid insertion.

5. Myringoplasty

This operation is designed to close a defect in the tympanic membrane. **Fig. 5a.** If the defect impairs the protective function of the drum then a myringoplasty will restore normal hearing. The posterior meatal skin is reflected forwards, **Fig. 5b,** and also the remains of the tympanic membrane. The edges of the perforation are freshened so that at no point in its circumference is there continuity of tympanic epithelium and middle ear mucosa. The graft is then taken either from a suitable vein or (my personal choice) from the perichondrium of the tragus. The tragal cartilage is replaced so that the shape of the external ear is unaffected. The graft is placed underneath the reflected deep meatal skin and the tympanic membrane remnant **Fig. 5c.** These are repositioned and held in place, **Fig. 5d,** by packing, which is removed after seven to ten days. A successful result can be expected in over two-thirds of the patients.

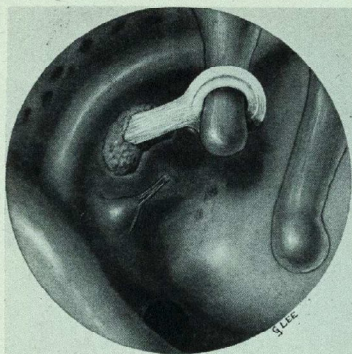


Fig. 6.

6. Tympanoplasty

This is the procedure used when a new middle ear is fashioned according to the principles enumerated earlier. The techniques involved vary from case to case. If possible a fully functioning middle ear is reconstructed. A compromise however is to place a tympano-meatal flap or a graft directly onto the stapedial footplate. This produces a small middle ear cleft with a protected round window. The hearing gain can rise to 30dB of normal. This level is very acceptable and means that the patient can manage most group conversations without an aid. Sometimes it is necessary to make a new second window in the horizontal semi-circular canal when the footplate immovable so that it can be covered with a protective graft. The results of tympanoplasty are not nearly so favourable as those of myringoplasty.

7. Radical mastoidectomy

This is not an operation for the conservation of hearing. It is designed for the complete eradication and control of infection in the middle ear and mastoid. In essence it is the conversion of the middle ear cleft, mastoid antrum with its associated air cells and the external meatus into one large continuous cavity.

8. Stapedectomy and prosthesis replacement

In otosclerosis the footplate of the stapes is fixed by an overgrowth of bone at first spongy and then sclerotic. This produces a marked conductive deafness. In the operation of stapedectomy a posterior meatal flap is raised allowing the tympanic membrane to be reflected forwards so that the long process of the incus and the stapes can be easily seen. Part of the bony meatal wall may be removed for better access. The stapes is then removed. Interest is now mostly centred in the variety of prostheses that can be inserted **Fig. 6.** A selection of these is illustrated **Fig. 7.** The results of this operation are most satisfactory, normal hearing being restored in 90%.

In these articles I have not mentioned the medical management nor the criteria for the selection of patients for operation as it has been my aim to give a general account of the otological surgical repertoire and to indicate how otologists search for new techniques in the conversation and restoration of hearing.

I am most grateful to the Department of Medical Illustration for their invaluable assistance with the illustrations. I would also like to thank my teachers and colleagues for opening up this new and exciting branch of surgery and my registrars and housemen for making me explain what we can both see.

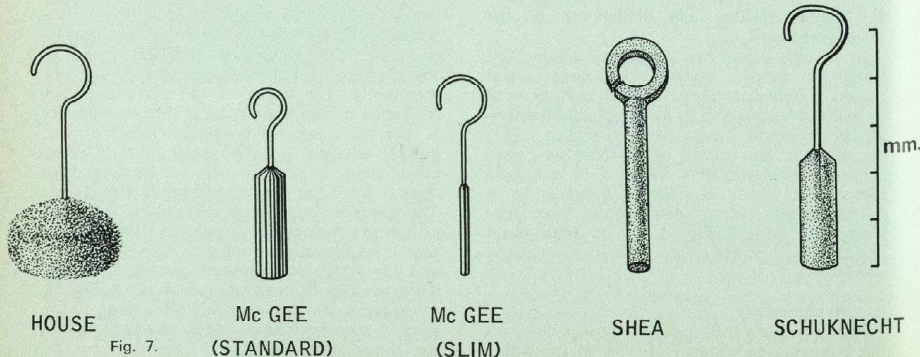


Fig. 7.

Prospect

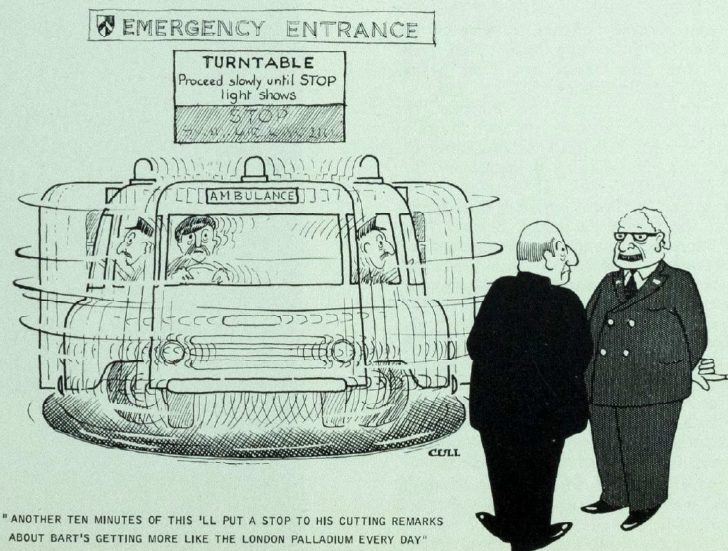
Now that the glare of publicity has been directed elsewhere perhaps it could be instructive to sit back and estimate how much Sir Francis Chichester really achieved.

Undoubtedly it is a feat of courage, endurance and strength of will to undertake and complete single-handed a voyage of such length and hazard In all fairness to Sir Francis this was all that he personally set out to achieve. His success has demonstrated to the rest of the world that the human-being is capable of sustaining alone all these qualities in defiance of the forces of nature ... It is, however, probably easier to face lonliness "alone", knowing that others through the medium of the Times and before that the Guardian are intensely interested in your activities, rather than being "alone in a crowd" when no one is interested.

Why did he do it? Why climb mountains? The attraction is largely that no one else has succeeded before. Chichester's achievement undoubtedly has meaning to Sir Francis himself. He has the satisfaction of knowing that he, as a man, is in possession of such strength and reserves. But when that man ceases to exist what is left of his achievement? Apart from the marginal benefits of increased knowledge of winds and currents, can one really purport that there has been benefit to mankind in general or to anyone in particular.

It seems a pity that what are undoubtedly phenomenal talents could not have been more productively employed . . . For despite these talents the rest of his life seems to have had as much or as little purpose as any one else's. However, the publicity will have been justified if the qualities displayed can inspire some of the younger generation to make use of these qualities in their own personalities and endeavour to master the elements such as drought, flood and earthquake which are directly menacing mankind.

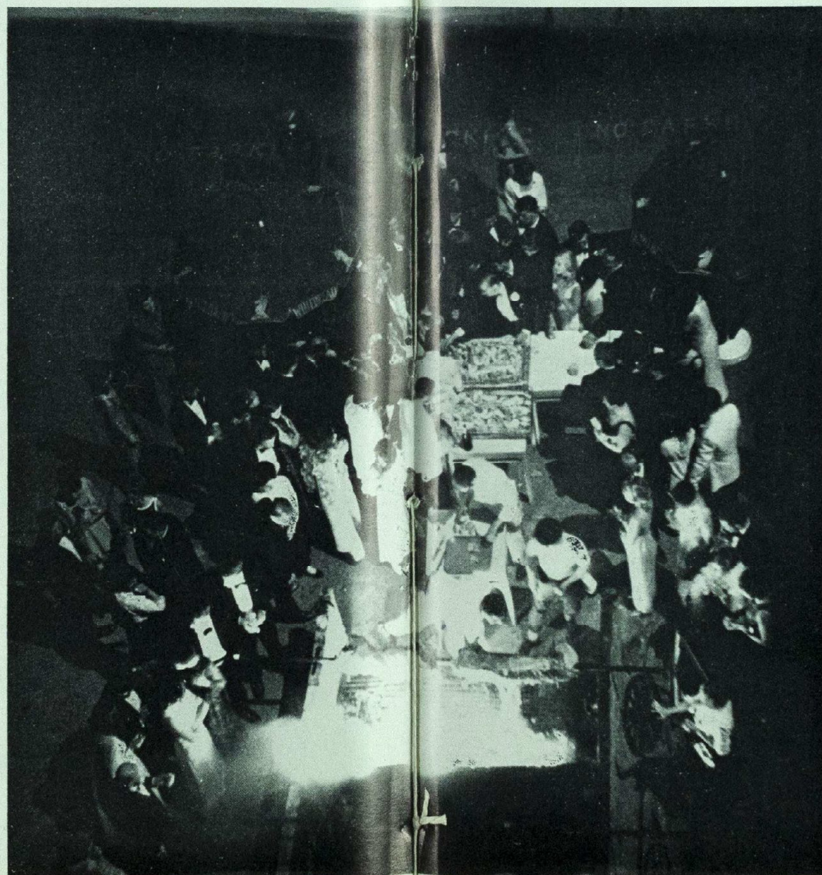
E.A.M.



"ANOTHER TEN MINUTES OF THIS 'LL PUT A STOP TO HIS CUTTING REMARKS ABOUT BART'S GETTING MORE LIKE THE LONDON PALLADIUM EVERY DAY"

BARBECUE BALL

by Peter Dady



The Fifth Annual Barbecue Ball (incorporating the View Day Ball) was held at Charterhouse on Friday June 9th.

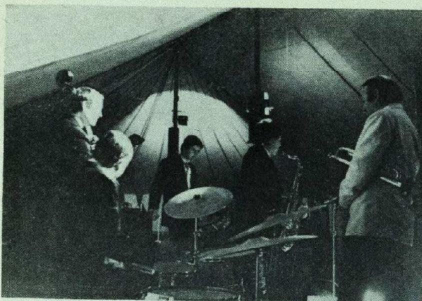
A welcome innovation this year was the abolition of the formal buffet supper, which last year caused some despondency, especially among senior staff by running out before they could get at it. It would seem that that hoary old ritual "Chicken and Ham" with attendant scrummage was not greatly missed and most people found the pre-Ball dinner party a much more congenial institution. Numerous and intelligently located bars made drinking a pleasure instead of an athletic endevour. It is hoped that the days of the West End Ball, where to get a drink requires the aggression of a Rugby League forward, the patience of Job, the true humbleness of soul to call a barman "Sir", with the riches of Croesus, to pay for that drink, are gone for ever. A special Champagne bar was selling bottles of Moet et Chandon as rapidly as some shops unload books which have been the subjects of succulent Court Cases.

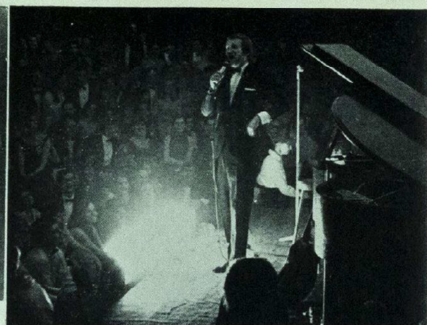
Until recently rubbish from children's comics remained on the pages of comics, including of course the popular press. All this has changed in the "swinging" mid-sixties, when these same illustrations, magnified fiftyfold, have become dignified with the soubriquet "Pop Art", which has rapidly outstripped the vast field of contemporary cliches to become the most hackneyed by a long head. That great clarion of American Democracy, Time Magazine, regularly runs headlines "Sock . . . Pow . . . Wham" referring of course to Batman, the leader of the genre, and our very own News of the World is never too busy safeguarding the morals of this great nation to headline "Boy Wonder in divorce case". If Batman is the favourite subject of Pop "Artists", then Union Jack must the second favourite. Several years ago the Union Jack was the British flag, today a suitable design to emblazon on "trendy" carrier bags, tomorrow an amusing lavatory paper? It is unfortunate therefore that a large proportion of the College Hall decoration for this year's Barbecue Ball should be Pop Art. Fortunately the Wine Committee handled the rest of the decor with some skill and originality, including an interesting display of redundant bicycle wheels and effective floodlighting of the lawns. Especially good was the rustic dray with beer barrels, parked in front of the refectory.

The eight noble beasts who died that we might have a Ball had been impaled antero-posteriorly and mounted in tandem on spits at 7 p.m. By 9.30 p.m. they were rotating slowly and cremating nicely over four fires, their last rites administered by a dedicated band of men and women impressively robed, girt about the waist with sufficient evil looking knives to equip any Gorbals street gang for a year. 12.30 a.m. saw the climax of the ritual, when the six swine and two sheep were carved and distributed in buns to the waiting multitude. Their flavour was excellent.

Indubitably the outstanding group of the evening was "Finders Keepers". Playing for the first time at Bart's this group impressed almost all of their audience. Insufficiently insanitary for the mass of the Great British record buying public to "identify" with, insufficiently bizarre to rate a television appearance as a promising new group, they have yet to appear in Court on a drug charge, one hopes that "Finders Keepers" will overcome each of these grave obstacles and achieve success, simply because they make a nice noise. Almost as good were the "Beachcombers" who were both competent and melodious. The "New Conchords" were above average. Humphrey Lyttleton is probably one of the most articulate jazzmen there is, unfortunately this only applies to his conversation. His music is far from eloquent and this goes for the rest of his band, with the notable exception of his Tenor Saxophonist who plays some fine modern jazz. Usually the Steel Bands at these Balls can be relied upon to produce a pleasant sound. Certainly the Steel section of the "Maestros" did produce a very pleasant sound, but there did seem to be some trouble in the Vocal department. The lead Vocalist bravely dissociating himself from his colleagues, found himself scrambling up one side of the tune and slithering down the other. His style, an unhappy mixture of Caruso and Sandie Shaw, his intonation nasal and slurred, the overall effect closing time in a Dublin Pub on a Saturday night.

There must be many who remember Mr. Percival's late, unlamented Television series, who awaited the Cabaret with some trepidation. Those who remembered the rough handling of the female impersonator at the Rugger Club Ball must have wondered how Lance Percival would fare at the hands of this, a much larger audience, ripe for a spot of Riot and Civil Commotion by the time the Star arrived, ten minutes late. It was a great relief to discover that Lance Percival could not only be amusing, but very funny. He rapidly brought his rowdy audience to heel. His material was traditional Cabaret, and as such was not sensational by way of originality, but his delivery and timing were faultless and his mimicry was superb, no male


Humphrey Lyttleton with trumpet.


Lance Percival with beard.

comedian who can imitate Eartha Kitt as convincingly as did Lance Percival can be bad. Rounding off his performance with one of his famous Calypsoes he left the stage to enthusiastic applause.

The Wine Committee were fortunate with the weather which remained fine and mild, but the undoubted success of this Ball owed little to luck and very much to the hard work of the members of the Committee, who gave up an entire week to the meticulous preparation of the Ball. The perks were minimal (free entry and a few free drinks). The Committee deserve the thanks of all who attended the Ball.

The Barbecue Ball ended as the dawn chorus started at 3.45 a.m. Couples departed to scattered beds. A drunken barman was gently restrained from clambering into the barbecue pit, doubtless trying self immolation in sympathy with the martyred pigs. The more determined gluttons ate more pork. A lady, squealing happily, long dress flying, rode the back of her friend's motorcycle. The Wine Committee began clearing up the mess.

Justin Baker — Secretary of the Wine Committee.

Man Ltd.

by Bart's Christian Union

Gloucester Hall was the scene of an unusual evening's entertainment on 23rd May, when members of the Bart's Christian Union, with rare enterprise, gave a public performance of their own composition, *Man Ltd.*, "a whitsun anthology of verse and song". The verse, and indeed nearly all that was spoken, derived from a number of outside sources, notably C. S. Lewis, Jeremiah, Shakespeare and St. Paul, inter alia. The songs included works by the Beatles and others and were performed with not unmixed success by a sombre cape-clad trio. The whole was selected and arranged by Ros. Leech and Philip Wood, and formed "a case presentation expressing dramatically the evolution of one man's thought and ideas".

We meet the hero Everyman (Philip Wood) at the start of his journey, adrift and beset with uncertainties. He seeks the Truth, like Galahad the Holy Grail. We follow his progress as he turns first to the pursuit of pleasure and wealth. Finding this but vanity he looks to religion and the established Church; but its message seems irrelevant and its traditions obsolete. Desperately he takes refuge in total withdrawal, isolating himself from the world, an island of experience. In the end he finds the answer in the story of the crucifixion of Jesus Christ (presented briefly with readings from the Bible and colour slides from the Passion Play at Oberammergau).

It is difficult to criticise a performance such as this. The message was unexceptionable, and conveyed with patent sincerity by all who took part. Nonetheless I at least was confused by the sequence of events and the apparent irrelevance of some of the illustrations to the theme.

A humanist might have complained that the pleasures of the world received indifferent advertisement, and that Everyman showed unusual perception in finding the answers to his specific problems in those Biblical excerpts that were chosen.

Judged as drama the entertainment was a little uneven. Much of the acting lacked confidence, and the singing was often unconvincing. But the readings from the Bible were nicely delivered, James Casson's Bishop was carefully thought-out and well portrayed, and Miss Jane Cantrell on the guitar was delightful. It was in the satirical pieces that the Company found its surest footing, for example the fatuous rendering of the psalm, which reminded me of my own favourite bad hymn:—

> Harpers I seem to hear,
> Harping on harps of gold.

(the words are seeking to describe Heaven).

Noteworthy also was Studdart Kennedy's fine poem, set in the words of one of the thieves at Calvary:—

> "It's God they ought to crucify instead of you and me,
> I said to the carpenter a–hanging on the tree."

In summary, the intentions of all concerned were admirably gallant and in my opinion encountered a fair measure of success. As for the performance, it was somewhat like the curate's egg.

Robin Williamson.

Bart's Hospital Music Society

The Creation

by Joseph Haydn

The Creation is an oratorio in three parts, for three soloists, full chorus and a large orchestra of two flutes, two oboes, two clarinets, two bassoons, one double bassoon, two horns, two trumpets (marked Clarini), three trombones, tympani and continuo (organ).

I wonder if there has been any man since its composition who on hearing the work for the first time could honestly say he disliked it. If he had heard a performance of the calibre of this one, I would be surprised to know that such a man existed. The work is so much the inspiration

of a devout man with a simple and abiding faith —each section seemingly more melodious and lovely than the last—that to sophisticated twentieth century ears it might seem positively naive, were Haydn himself not too great a master to permit this. It stands out as one of the purest gems of all music, a treasure whose lustre can never fail. One can only thank God that Darwin was not to live until a century later!

So much care and love and delight were poured into this effort by all concerned, that it may seem ungrateful to find faults, and such as there were are mere details, not to be set against the achievement as a whole.

It was performed in The Church of The Holy Sepulchre, Holborn Viaduct, an ideal venue for the music, though traffic noises filtering through the walls sometimes fleetingly distracted.

From the orchestral prelude "Representation of Chaos"—which can still astonish with its revolutionary harmonies and orchestration—it was at once apparent that the direction and playing were of a very high standard indeed. There was a tendency for the strings to be drowned at times, especially by the brass, but the higher registers of the wind sections were always clearly audible; a very important point later in the work, where Haydn depicts atmospheric conditions and assorted fauna in little musical tableaux.

The soloists represent three archangels; Raphael (Bass), Uriel (Tenor), and Gabriel (Soprano).

Raphael, sung by Mr. Frank Olegario, seemed to regard the birth of this planet as mere routine, and brought very little enthusiasm to the proceedings. But he possesses such a strikingly fine and mellifluous voice that one forgot these shortcomings in the pleasure afforded by so noble a sound.

Uriel (Mr. Edmund Bohan) was more involved in what he was telling us. His voice has a slightly nasal quality and he tended to rise to high notes with occasional ugly whoops, but in many ways he was the most impressive of the three. There was a heroic, exultant quality in his singing that was memorable.

Miss Anita Marvin, as Gabriel, was on this occasion at least, unequal to the demands of her colloratura passages. Her voice would sometimes fade away completely, and throughout it was evident that she was not on form. Yet of all the soloists, she perhaps gave the impression of being the most sensitive artist, and if she could manage to do so, it would be good to hear her sing again with the choir.

The soloists did not blend ideally in the sections for three voices.

The choir was predictably excellent; in this work they do not have quite so much to do as they have had in the past, and the choral sections are short and pungent. One of Haydn's most inspired moments comes in the passage "And He said, 'Let there be light' (p) . . . and there was (pp) LIGHT! (f. C maj.)" Here one really sat up and took notice, though it were possible to have wished for a more hushed prelude to the dawn—but I quibble!

In the fast fugual sections, for example, "Awake the Harp, the Lyre awake . . .", Mr. Robert Anderson, the conductor, occasionally let things speed up a little from his initial tempi. This was a pity, because it resulted in a certain blurring of the entries from the various sections of the choir. His beat was not, I think, always sufficiently clear in these passages.

But these as I say are mere details. I listened with a musician friend, who said afterwards that any professional group would have been glad to achieve so high a standard of performance.

The work was sung in the English version, and the words are so simple and beautiful, that in themselves they are a delight. But there are moments, particularly in some of Raphael's recits, when, in order to keep to the composers note values, the soloist must, like "The Gentleman from Japan, Whose poems never would scan," . . . try to cram as many words very quickly into the space of one short, little crotchet beat as ever he possibly can!" It seems to me that judicious use of a little poetic licence could easily obviate this.

Robert Anderson, speaking of future plans, advocated a Beethoven work next time. The obvious choice is the C major Mass, but I wonder if he might not consider the almost unknown oratorio, "Christ on the Mount of Olives". It is hardly ever performed, and would assuredly attract a great deal of interest from a very wide musical public. I would lay good odds that it would pay as well as any Messiah.

R. S. Thompson.

Rheumatoid Athritis

by H. Wykeham Balme

There is no miracle cure yet for rheumatoid arthritis, quick and decisive like Penicillin for pneumonia, so the disease, in the modern medical scene, is an unpopular one to treat. But if one adopts an old-fashioned attitude towards it and first thoroughly learns its habits and tricks, and what annoys it and what pleases it, one can learn to out-manoeuvre it, to tame it, even to coax it to go away; and even at the worst one can learn how to come to the best possible sort of terms with it. Frontal assault on it , as with an antibiotic, is not yet available: steroids, as a weapon, are far too prone to blow up in one's own face to be of much good, and are in no way comparable with, say, Streptomycin for tuberculosis; gold and the antimalarials are of limited benefit and frightening toxicity—rather like mercury for syphilis, perhaps.

Basically, the disease consists in inflammation —not beneficial, like the laudable pus when a staphylococcus is being restrained, but pointless, destructive, and persistent. If one could only eliminate the inflammation one would virtually get rid of the disease. It can, at times, be acute, severe, and painful, but for the most part it is subacute, granulomatous, almost painless, and remarkably easily overlooked. (Just how painless most of it is is rarely appreciated, but just try pinching some of the inflammatory tissue above the knee joint or between the second and third metacarpophalangeal joints in the next patient you come across and you will see what I mean.) This firm, gelatinous stuff, often mistaken for subcutaneous fat, has no feeling in it and is contemptuously disregarded by the patient as being therefore of no consequence. It is, never-

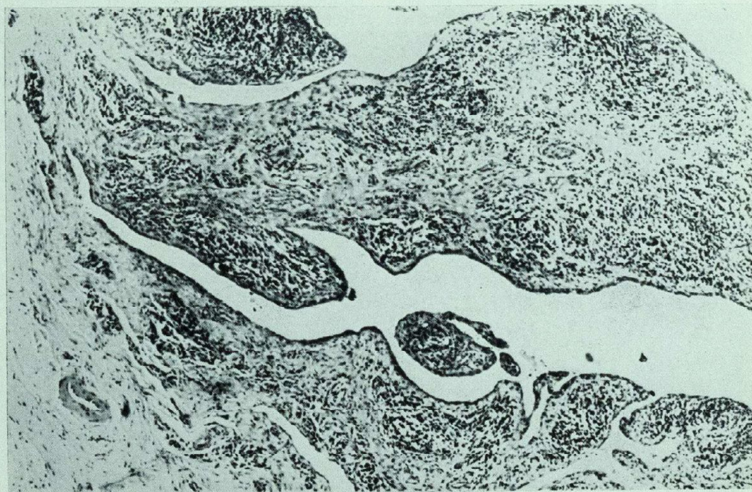


Fig. 1. Here the synovial membrane, which ought to be only one cell thick, has become infiltrated with lymphocytes. Innumerable villi like this project into the joint cavity secreting an inflammatory exudate into it.

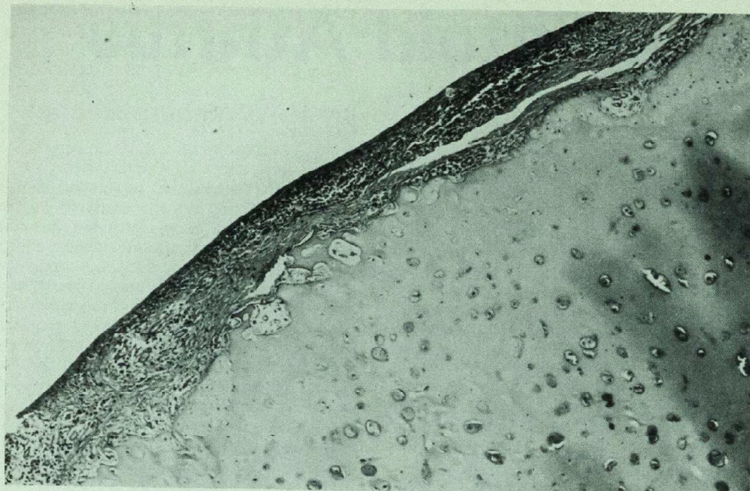


Fig. 2. Here the same inflamed synovial membrane has extended over the articular cartilage, and is already eroding it by proteolytic action. Such damage is permanent.

theless, the real enemy, for it is this that quietly destroys the tissues of the joint, and it is the partial destruction of the joint, rather than the inflammation in it, which causes the pain, the deformities, and the crippling.

The quiet destructiveness of the process is quite astonishing. The carpus may melt down to less than half its original size, the component bones fusing together and engulfing themselves within the hollowed out lower end of the radius. Metacarpal heads and phalangeal bases may each lose more than half their substance so that the fingers, foreshortened, waggle loosely on the hand and start drifting into positions of deformity that normal fingers could never acquire. Interphalangeal joints, hyperextended by deranged muscle pulls, disappear completely so that proximal and middle phalanges join together across where the joint used to be. The top of the tibia crushes under the weight of the body, with the ragged condyles of the femur burrowing into it. The tarsal joints, from being an exquisite engineering system of gliding surfaces, are converted into a gluey sticky mess wherein no cartilage glides, and the whole foot now screams in pain when weight is borne on it. The toes, like the fingers, lose much of their phalanges and metatarsal heads so that every time their extensors help to lift the foot off the ground they themselves are pulled into hyperextension and now project upwards inside the shoe, rubbing corns on their tops and doing nothing to protect the tender metatarsal heads from being ground into the floor when walking. Occasionally the hips are damaged too, and this wonderful joint, that in health frictionlessly takes a quarter of a ton per square inch without ever letting we mortals know it is doing it, then gives some of the most severe pain the disease is capable of.

Treatment is aimed at preventing these disasters occurring and is very much more successful than one might think, Naturally one likes to relieve symptoms, and analgesics are normally indispensable, but they do not constitute definitive treatment for the disease any more than cough mixtures constitute definitive treatment for tuberculosis; and, as with the latter, suppression of symptoms could bring its own snags, for it might well be quite dangerous to make these inflamed joints too insensitive to pain. Nor can steroids be looked upon as a proper treatment for the disease, for they probably only work by non-specifically reducing the patient's ability to get inflamed; and as the ability to do this is at times essential for survival, it is no wonder that, in ordinary doses, these drugs, over the years, carry a mortality of at least 5%.

Studies on the natural history of the disease have recently led to a revolution in treatment more radical even than that occasioned by Cortisone. One now knows that, of the million and a half or so in this country that either have it, or have had it, some 98%, or thereabouts, will either recover completely or have already done so, the explanation being that in the great majority the disease has been astonishingly mild, and never bad enough to go to a doctor about (just as well, if they do not wish to be poisoned by steroids!) Even those who, bad enough to consult their doctor, are also so bad as not only to be referred by him to Hospital but actually thereupon to be admitted to a precious bed, still have a two-to-one chance of complete or nearly complete recovery. These figures represent, quite simply, the hitherto unexpectedly strong natural tendency of the disease, given a chance, to disappear. Modern treatment, in a nutshell, consists in giving it this chance, and encouraging it to take it, knowing that the process of disappearance is bound to take months or years; the traditional treatment, still disastrously commonly applied, of massage, heat, exercises, and for-God's-sake-keep-going, we now know to have been the best way of annoying the disease, of keeping the inflammation active, and of greatly discouraging it at all from disappearing.

The disease is a slow-moving and cumbersome thing, but it is just as surely improved by rest as is any other inflammatory process. Rest is as essential for active rheumatoid arthritis as it used to be for active tuberculosis, and because we now know how favourable the prognosis of the disease is, given a chance, we now appreciate how well worthwhile it is to insist on adequate rest. It is like Rollier, Leysin, and the sanatoria all over again. Indeed some hospitals, like that at Black Notley, that used to specialize in the long-term care, along sanatorium lines, of tuberculous patients, now deal more and more with patients with rheumatoid arthritis and with considerable success.

Unfortunately the period of rest has to be very prolonged and must be enforced strictly. There is a constant temptation to ease up on it, especially if a job is in jeopardy or there are children to be looked after, but the long term aim of helping the disease to settle down before irreparable damage has occurred means that this temptation must normally be resisted. A patient with recent florid disease—say, less than one year —with multiple joint involvement, nodules, and ill with it, needs to be in bed for at least 23 hours per day for a couple of months or more. Inflamed knees and wrists are splinted, the feet protected by a cradle in the bed, and analgesics given regularly in order to promote proper rest. Slowly, over a period of weeks, the disease wanes; but if one persists with this strict rest for another few

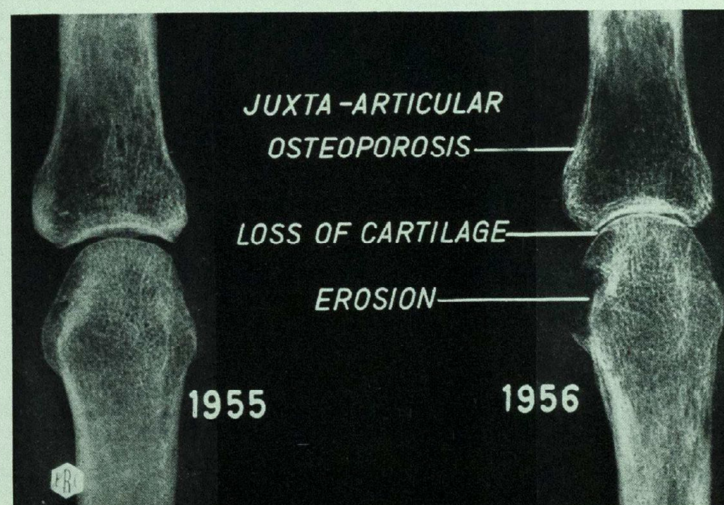


Fig. 3. The X-Ray appearance of a rheumatoid joint.

weeks before very slowly allowing increasing activity, there is a good chance that the disease will disappear completely, never to recur. But, as with tuberculosis, the tendency (germ? antibody? heredity? stress?) is still present, so the patient must continue to lead a sheltered life.

Fatigue and emotional crises are dangerously liable to start it all off again. Some cases, fortunately much in the minority, are so severe that they do not respond to rest alone, however strictly one applies it, and it is in these that one gratefully receives assistance from gold, anti-malarials, or steroids. The first two, in their mysterious and somewhat dangerous ways, curiously make the disease less active, and though they are not very potent they sometimes help greatly in turning the tide. Steroids, at even greater risk to health, act quite differently, by lessening the inflammation itself. In this, however, they are nothing like as effective as rest, and they are no substitute for it at all. One often sees the proof of this when a patient who has been put on them feels immediately more comfortable and as a result goes exerting himself a good deal more; he promptly relapses, for the extra exertion has quickly counteracted the anti-inflammatory effect of the steroids. He himself may well complain that the drugs have lost their effect, and unfortunately it is all too likely that his doctor may agree with him and raise their dosage further. Even if he does this, some of the inflammation will persist, but the pain becomes much less and the patient remains up and about, enjoying his fool's paradise whilst his joints are destroyed all the more quickly. Used in excess in this way, to the neglect of proper rest with splintage and simple analgesics, the steroid drugs worsen the ultimate prognosis of the patient, and at the same time burden him in addition with the problems of their own making—disfigurement, skin atrophy with bruising and ulceration, psychosis, diabetes, hypertension, cataract, osteoporosis and vertebral collapse, haematemesis, perforation, adrenal insufficiency, spreading infections, septicaemia and death. Philip Hench, who invented steroids and often wished he hadn't, had a very long acquaintanceship with the disease, and was most expert in its management; but he understood the dangers of steroids so well that he kept them down to a top maintenance dose of 10 mgms. per day of prednisolone for men and 7.5 mgms. per day for women. On the other hand, many patients—the majority of the longstanding ones—are not going to benefit very much from the theoretically ideal treatment of strict and prolonged rest, as permanent damage has already taken place. One's aims in these patients are therefore very limited, and a very modified sort of regime may be all that is called for. Jobs may need changing or made lighter, gadgets bought to ease the work in the home, relatives and friends made use of to take the children to school. Nevertheless, in general, it is still right to curtail the activities of these patients pretty ruthlessly, if one is going to secure maximum benefit for them. Splints are almost certainly going to remain necessary too.

One also sees very many mild cases, for whom no particular treatment is required as they steadily recover on their own. It is probably sensible to keep an eye on them in case anything starts to go wrong, but they can be reassured that this is definitely unlikely to happen as long as they avoid fatigue and do not over-use the affected joints. Again, there is every reason to use splints freely, even if they are only necessary for a few weeks. Quite often these mild cases have a strangely localised form of the disease, involving only one or two joints but persisting in them for months or years with an obstinate effusion and synovial proliferation. This inflammatory tissue may easily become half an inch thick in the case of the knees, and is quietly destructive, as ever. The patient may otherwise be quite well, have no other signs of the disease, and think little of it. In these, the mass of inflammatory tissue can be removed surgically—synovectomy—and the condition thereby literally cured. The patient, indeed, often feels all the better for being rid of the inflammatory and necrotic material. One would like to be able to do a medical synovectomy, say with cytotoxic drugs injected intra-articularly, and spare the patient an operation, but so far this is not really feasible. Intra-articular steroids certainly help, say half-a-dozen injections at weekly intervals, but are only of real value if used during a general regime of rest, when quite gross synovial proliferation will disappear surprisingly completely. If used by themselves they are far less effective, and are even dangerous, for they are all too liable to relieve pain too well and allow the patient to over-use the joint. The danger of this happening is so great that one no longer uses them as a means of keeping the patient up and about, but reserves them exclusively for those joints that are being properly rested at the time.

Surgical synovectomy is quite well worthwhile even in joints that are already a little damaged, but is probably valueless when much cartilage destruction has already occurred, and may even permanently increase the joint stiffness. Not enough is yet known about how surgery can in other ways best help some of the severe advanced

cases that have partially destroyed, subluxated or dislocated joints. Obviously it cannot restore them to normal, but it can often improve function enormously. Arthrodesis takes all the pain out of a joint, and the loss of movement, if already severely restricted, may not matter. Excision arthroplasties, e.g. of the hip at one extreme, or metatarsal heads at the other, may give much relief too. No doubt the fact that so much necrotic inflammatory tissue is removed at the same time is of benefit, for there may be a good cupful of it, and presumably the prolonged stay in hospital post-operatively helps too, but whatever the explanation, one is frequently pleasantly surprised to find that these rather sick people benefit even more from these biggish operations than one had expected.

When it comes to deciding about how to look after any individual patient one is guided by the general principles I have outlined, but, as ever in the practice of medicine the details of treatment matter just as much as the general principles do. The next paragraphs reflect my present personal habits in this regard; these are most unlikely not to change in the future, as they have done in the past, so do not follow them too slavishly for more than the next year or two.

To cure the disease. (Far more often possible than most people think, but obviously out of the question with many of the chronic cases attending hospital.) Rest in bed, as for tubercle; splints of Plaster of Paris later changed to back slabs and then to plastic; bed cradle; once daily gentle passive full movements to shoulders and fingers to prevent permanent stiffness. Anticipate three to six months.

To lessen the severity of the disease. Modified rest—twelve hours in bed at night and two in the afternoon. Plastic night splints for wrists and knees, possibly for use in the day as well. Occasional intra-articular hydrocortisone if the joint is rested and splinted at the same time—say 50 mgms. for a knee, 5 mgms. for a metacarpophalangeal joint. (Careful asepsis, but no antibiotic cover.) Modifications in the home and at work. Gold: 50 mgms. of sodium aurothiomalate intramuscularly weekly or fortnightly to a total of 600 to 1500 mgms.; each injection preceded by an inspection for gold rash, especially on the shins, and a test for albuminuria (and urobilinogen?), and each fourth injection by a full blood count with differential white count, platelet count, and E.S.R. The course stops directly any complication arises, and it slows down drastically or stops for a while directly the patient becomes really well.

Anti-malarials: (becoming obsolete because of the danger of permanent blindness from damage to the pigment layer of the retina), 200 mgms. of hydroxychloroquine sulphate t.d.s., for six to twelve months would be the usual dosage.

Steroids: (greatly over-rated). Prednisolone 10 mgms. daily for a man and 7.5 mgms. daily for a woman is top maintenance dosage; usually it is wise to work up to it from even smaller doses as 3 or 5 mgms. daily may give the required benefit. Dangerous to start with higher dosage as the patient will not tolerate its reduction. Only of real value when used to supplement rest and splints, and its effect is quickly nullified if there is any increase in activity.

To prevent joint damage. Rest; splints; adjustments of home and job; reduction of proliferative synovitis by intra-articular steroids; synovectomy.

To reduce pain. Splints are by far the most effective analgesic device. Soluble aspirin twelve tablets (4 grams.) or more per day—"three last thing at night, three first thing in the morning, and another half dozen during the day" is still better than anything else for most people. Phenylbutazone, erratic but sometimes good against more severe pain, 100 mgms. t.d.s., nearly always quite safe indefinitely. Indomethacin, still more erratic but sometimes better still against severe pain, 25 mgms. daily working slowly up to 200 mgms. daily; it sends some people very queer in the head. Anti-depressants are very often needed, and by restoring the pain threshold to normal effectively relieve pain miraculously; usually a reactive thing for which monoamine oxidase inhibitors such as Phenelzine 15 mgms. t.d.s. would be appropriate. Steroids are not analgesics and are not to be used as such, for the severity of the pain is in no sense a direct consequence of the severity of the inflammation, being far more often of mechanical origin.

Relief of stiffness. Morning stiffness, sometimes quite paralysing in severity, usually becomes manageable on high dosage of aspirin; otherwise, it is an added indication for steroids, as quite small doses, 5 mgms. at night, may improve it sufficiently, but it still takes very high doses to abolish it, so this should not be attempted. One aims for a grip strength of 100 mms. mercury, as tested on the sphygmomanometer.

Management of the patient. One must keep re-examining to detect new mechanical problems, such as incipient contractures. Keep reminding patients to do less, and if there is any tendency to obesity, to eat less. Tell them to have patience. Optimism is essential, and is fortunately usually justified. One must be on their side, and let them know it.

Charterhouse Forum

The Selection and Performance of Medical Students

by J. D. Hawkins

Selection of students for higher education is a very difficult matter, but with University education costing so much (an average of £1,061 per annum was contributed out of public funds per medical student in 1962-3, according to the Robbin's report) and with the great competition for University places, it seems extremely important that those individuals most likely to benefit from it should be the ones who are selected. At present their selection seems to be based mainly on three criteria—reports from a head-master and those who have known the candidate well; a personal interview with official(s) of the department where potential students wish to study; and A level grades. The first two are, of course, mainly subjective, but A level grades should provide a more objective measure of people's ability. It therefore seems of some interest to gather information about the A level grades obtained by students and their success in the 2nd M.B. examination. Although this is only an intermediate examination on the way to medical qualification, it is widely recognized as a major hurdle, and, in practice, the great majority of those who pass it go on to complete their clinical training.

Since the entry in October 1962 we have had fairly complete information about the A level grades of our students, and now that 3 years' entry of students have completed their 2nd M.B. courses it has been possible to make some correlation between A level grades and 2nd M.B. success. For this purpose, A level grades given in terms of letters (A-E) have been assigned numerical values (A=1, B=2, — — — E=5) and the total "score" for A level computed. Thus, the best possible score is 3 and the worst is 15. In some cases grades with numerical values have been reported so no conversion was necessary. Students for whom we have incomplete information have been omitted from this study. Because of small numbers with most individual scores, groupings of 2 or 3 adjacent scores have been made to give groups of reasonable size. The accompanying table shows these scores correlated with the number of failures in 2nd M.B. For comparison and completeness, an extra group, consisting of those who passed 1st M.B. at Bart's, is included. For this last category, no account has been taken of their A level performance since they form a group with a very mixed background and any rational sub-division would probably give a multitude of very small groups.

2nd M.B. failures correlation with A level scores.

A level score	*Number of students*	*One fail*	*Two fails*
3—5	14	1 (7%)	0
6—7	21	2 (10%)	1 (5%)
8—9	38	7 (18%)	*4 (10%)
10—11	48	13 (27%)	4 (8%)
12—13	41	14 (34%)	*4 (10%)
14—15	39	11 (28%)	†8 (20%)
1st M.B.	61	13 (21%)	7 (11%)
Total	**262**	**61 (23%)**	**28 (11%)**

*Includes one withdrawal after one failure.
†Includes three withdrawals after one failure.

It is apparent that the chances of failing 2nd M.B. once increase as the A level performance gets worse until, in the lowest groups, about one student in three is doing this. Those who have taken 1st M.B. at Bart's seem to compare roughly with students who have a score of 8 or 9 in their A levels (which is, of course, the arithmetic mean score). The total number of students who have failed twice (and subsequently withdrawn) is small and so differences in failure rates of those obtaining different A level grades are probably not significant in the statistical sense. However, there are again poor performances among students with poor A level grades. Thus it seems that there is some correlation between A level grades and failure rate in 2nd M.B., though it would obviously be foolish to reject all applicants with poor A levels without taking other factors into consideration. The aim of the 2nd M.B. course is to instill a knowledge of the methods and modes of thought of the basic sciences on which much modern medicine is founded, and the 2nd M.B. examination tends to be rather academic. Yet there are qualities needed in practising doctors which are not necessarily linked with high academic performance and which are probably very difficult to measure.

Two figures that emerge from these studies are rather disturbing—first, the high proportion of students being accepted, with very poor A level grades, that would be very unlikely to be acceptable in many Universities (including some provincial Medical Schools), and, second, the significant proportion of students with good A levels who fail 2nd M.B. at least once. This latter phenomenon may arise from the fact that A level grades are not always a very good guide to an individual's capabilities; they may be partly due to luck, or partly due to intensive teaching. In this connection, it may be significant that the Dental students taking the 2nd B.D.S. at Bart's have a much lower failure rate (12 out of 129 (9%) failed once; only 2 failed twice) than the Medical students taking 2nd M.B., despite the fact that the average A level grades of the two groups are not significantly different. The 2nd B.D.S. is, of course, at a lower standard than the 2nd M.B., but it is taken after only three terms, and the subjective assessment of the staff teaching both Dental and Medical students is that the former are of higher academic standard. An interesting difference between the two groups is that while the Medical students are predominantly from independent schools (about 70-80%), only about 30% of the Dental students come from such schools. Is it possible that smaller classes or other factors in independent schools produce better A level results?

Another factor that may tell against some students with good A level grades (as well as those with poorer ones) is the feeling of lack of relevance to medicine which is frequently levelled as a criticism of much of the work in the 2nd M.B. courses. There is undoubtedly some truth in this criticism, though it may be ill-informed, but one wonders if the self-discipline and ability to work at subjects which may seem dull and only marginally relevant to a future career may not be a desirable quality.

Are there any different objective criteria which could be used in student selection? In America medical aptitude tests are widely used, and it might be desirable to use them here in addition to the usual procedures for selection, so as to be able to compare their efficacy. It has recently been reported in the *Guardian* that scholastic aptitude tests will be given next autumn and in 1968 on an experimental basis to some sixth form candidates for University entry. It is surely encouraging that there should be some experiments along these lines.

Acknowledgements I wish to thank Mr. J. W. Cope for permission to publish this article and also Mr. I. M. Hill, Professor E. M. Crook, Dr. E. D. Wills and other colleagues for helpful discussions about it.

N.B.—The Charterhouse Representatives propose to analyse this year's Second M.B. results in the October Edition of the Journal. They will attempt to assess the effects of the extra term and the single annual sitting for the examination.

Penguin Reviews

LITERARY MASTERPIECE

Gulliver's Travels, by Jonathan Swift, price 5s.

This literary masterpiece was first published for Swift in 1726. Penguins have now brought it out in a paperback edition to join the other classics which make up the Penguin English Library. This is a growing range of a collection of English literary classics which have been published since the 15th century.

Although it is usually read in childhood it is a book which the adult might appreciate for the satire directed at his fellow human beings. An introduction by Michael Foot and notes on the text make this presentation a more enjoyable one than the one encountered as a compulsory book at school.

If you have not read these accounts or you failed to appreciate their deeper meaning at an earlier attempt, then here is a chance to do so at a reasonable cost.

I. D. Fraser.

DOCUMENTARY

The Doctors, by Paul Ferris. A Pelican documentary, price 5s.

Paul Ferris has completely revised this book which now appears in its first paperback edition. On reading through it one is impressed by the wealth of information and the diversity of sources from which it is derived.

Varying conditions of medical practice are described with colourful accounts taken "from Harley Street to the Welsh Valleys". Ferris liberally uses physicians' and surgeons' stories and experiences to press his own points about the differing qualities of British medicine. He writes of the inadequacies of some doctors and of the inadequacies and inequalities of the system under which many good doctors are expected to practice a high standard of medicine. One feels he is a little unfair in emphasising many disreputable aspects without, at the same time, shedding more light on the excellent work done by many practitioners under restricted conditions. This is particularly irritating in the chapter entitled "Very General Practice".

On the whole, however, his criticisms are well founded and his praise discreetly and properly placed. Those who have read *The City* and *The Church of England* by the same author will need no encouragement to read *The Doctors*. Those who have not but are privileged to practise medicine should take this fine opportunity to read the examination of the medical profession by a well-informed outsider.

A highly recommended book—an aperitif to many an "in" argument.

I. D. Fraser.

MEDICAL BOOKS

Selected Readings in the History of Librarianship, by John L. Thornton, 2nd edition. London: Library Association. 1966. Price 88/–

The author of this book is well enough known to those men and women at Bart's who have felt compelled, at one time or another, to use their library. He is perhaps even more widely known as the author of *Medical books, libraries and collectors*, recently issued in a revised edition, and of many articles some of which have appeared in this *Journal*. The book under review is also a revised edition, in this case of two books long out of print.

These **Selected readings** are from the works of men (not all librarians) who have had something interesting to say about libraries. Occasionally the extracts are too short, even bitty; but, as a general rule, they read well and are always supplemented with brief biographical

introductions. Three quarters come from the last two centuries and only six chapters have any direct connection with medicine. These bear on the lives of four medical librarians (MacAlister of the Royal Society of Medicine, Prideaux who was part-time librarian to Sir Henry Wellcome, Barnard of the London School of Hygiene, and Bishop of the Royal Society of Medicine and the Wellcome Historical Medical Library) and two medical men, one of whom, Sir William Osler, was the greatest clinician of his time, author of a famous textbook of medicine and creator of a magnificent library now housed at McGill University. It is a pity that the Osler extracts are not longer, but at the very least they should encourage medical students to turn to the **Aequanimitas** from which they are taken.

The other doctor, John Shaw Billings, was librarian of the Surgeon-General's Office in Washington from 1865 until 1895. After a short-lived, albeit promising, medical career in the Union Army, Billings devoted himself to building up a public medical library fit to rival any in Europe—and this task he accomplished marvellously well. The **Index Catalogue** of his library's collections amazes people today more perhaps than his own contemporaries, and it is now an essential part of any library where retrospective bibliography has to be done. Furthermore, his once humble library of fewer than 5,000 books has grown into the largest and most dynamic medical library anywhere in the world. What a pity it is that the extracts from his works are so distressingly and frustratingly short.

In another chapter we have a longer, more satisfying piece, about the Osler Library by a distinguished librarian of the Royal Society of Medicine. Sir John MacAlister, author of this piece, played a prominent part in amalgamating various medical societies into the Royal Society of Medicine. Nothing else quite comes up to MacAlister's contribution. We have Barnard explaining the ins-and-outs of his classification scheme (strictly for librarians) and Bishop describing the history of the Medical Section (a professional grouping of medical librarians). But Bishop wrote much and often about medical history, and one cannot help feeling that a livelier piece than this could have been selected without too much trouble. These are small criticisms, however, which should not discourage the reader who seriously wishes to learn about the literature of librarianship.

E. Gaskell

Modern Trends in Anaesthesia, Aspects of Metabolism and Pulmonary Ventilation. Edited by Frankis T. Evans and T. Cecil Gray. Published by Butterworths. Price 75s.

This is the third volume on Anaesthesia in the Modern Trends series and follows the pattern set by its predecessor in limiting the reviews to two aspects of the speciality in which there is considerable interest at the present time. The editors have gathered togethered a distinguished team of contributors who have written up-to-date accounts of their particular subjects. These assist the editors in their aim to bridge the gaps which inevitably occur in the standard textbooks between one edition and the next.

The two chosen subjects are Metabolism and Pulmonary Ventilation. At first sight these may seem an unusual combination for such a volume but they both have a particular application to the work of Intensive-Care and Respiratory Units in which anaesthetists are becoming increasingly involved. Few doctors now question that the substitution of artificial for natural pulmonary ventilation should be the responsibility of the anaesthetist, but it is only recently that anaesthetists have been asked to assist in the problems of artificial nutrition in the severely ill patient.

The first chapter gives a scholarly account of recent studies in metabolic aspects of anaesthesia. Despite the fact that Dr. Geddes presents a simplified concept of the basic biochemical background to carbohydrate metabolism the reviewer fears that this subject will continue to be a mystery to most clinical anaesthetists. Those who wish to be able to manage the metabolic problems that arise following resuscitation and during intensive care must obviously make an effort to come to grips with this subject. The chapter on the Respiratory Centres and their responses and that on the pharmacological aspects of the control of respiration are separated by practical reviews of work on pulmonary compliance and airway resistance, aspects of dead space, acid-base disorders and oxygenation.

There is a stimulating chapter by Professor Robinson on the choice of a ventilator, disapproving of standardization on one machine (a view contrary to that held in this Hospital). Dr. Bush has written an excellent review on intermittent pressure breathing in children. The problems associated with long term ventilation are assessed and some of the methods in use at the Alder Hey Children's Hospital (including the admirable Jackson Rees nasotracheal tube) are described. In a review of the problems of humidification Dr. Morgan gives a timely reminder of the advisability of humidifying the inspired mixture in patients undergoing prolonged surgery but he fails to mention the risk of infection with the condensor type of humidifiers.

The last chapter reviews the problems of artificial alimentation in an intensive therapy unit. Professor Steinbereithner gives a detailed account of the possibilities and limitations including an excellent section on the technical difficulties associated with long term intravenous infusions.

This book will be of great value to all anaesthetists. The reviewer would consider it is essential reading for F.F.A. candidates and certain sections will be of interest to Surgeons, Physicians and Paediatricians.

The book is attractively bound and well produced but at 75s. cannot be considered cheap.

R. D. Marshall

SPORTS NEWS

FIXTURES FOR JULY

Sat. 1—Cricket Club v. Jesters, Home. 2.30 p.m.
Sat. 1—Tennis 1st VI v. Guys, Home.
Sun. 2—Cricket Club v. Old Roans, Home. 11.30 a.m.
Wed. 5—Tennis 2nd VI v. City University, Home.
Wed. 5—Golf Club v. St. Thomas's (Chislehurst).
Sat. 8—Tennis 1st VI v. Westminster Hosp., Home.
Sun. 9—Cricket Club v. Past Players, Home. 11.30 a.m.
Wed. 12—Tennis 1st VI v. King's College Hosp., Away.
Wed. 12—Golf Club v. Middlesex Hosp. (Hendon).
Sat. 15—Cricket Club v. Incogniti, Home. 11.30 a.m.
Sat. 15—Tennis 1st VI v. St. Thomas's Hosp., Home.
Sat. 15—Tennis 2nd VI v. St. Thomas's Hosp., Away.
Sun. 16—Cricket Club v. Hampstead, Home. 11.30 a.m.
Sat. 22—Cricket Club v. Nomads, Home. 2.30 p.m.
Sat. 22—Tennis 2nd VI v. Guys Hosp., Away.
Sun. 23—Cricket Club v. Dartford, Away. 11.30 a.m.
Wed. 26—Athletic Club v. St. Georges Hosp., Paddington.
Sat. 29—Cricket Club v. Old Chomeleians, Home. 11.30 a.m.
Sat. 29—Tennis Club 1st VI v. Kings College Hosp., Home.
Sat. 29—Tennis Club 2nd VI v. Westminster Hosp. (Mixed), Home.
Sun. 30—Cricket Club v. Wimbledon, Away. 2.30 p.m.

TENNIS CLUB

29th April. **1st VI v. Queens' College Cambridge, away. Won 6-3**

Playing under variable weather conditions, the team did well to begin the season with a victory. The match gave an opportunity to assess the pairing which had been decided perhaps more on temperament than on ability.

The club is fortunate in having three strong couples, an important factor when the result of a match may be decided on the odd rubber out of nine.

Team: 1st Couple: C. Garrard (capt.)
J. Ussher
2nd Couple: J. Wenger
N. Ireland
3rd Couple: C. Hunt
C. Higgins

10th May. **1st VI v. London Hospital 1st VI, away. Won**

This game was a reversal of last year's result when we lost to London Hospital in the Hospitals' Cup semi-final.

Chris Garrard and John Ussher mastered the extremely slow grass courts to win their three matches and set a solid basis for this victory. Marcus Setchell, last year's captain, returned to play third couple with I. Sitwell.

2nd VI v. London Hospital 2nd VI, home. Won

Played on the beautifully prepared Chistlehurst courts the second VI continued last year's successful run with yet another victory. It gets increasingly difficult to find reasonable opposition for the second VI without arranging matches with first teams of other colleges.

15th May. **1st VI v. L.S.E. 1st VI, home. Inter-collegiate Cup, lost 5-0.**

This previously cancelled match was finally played on the waterlogged hard courts at Chistlehurst beneath threatening skies. The miserable conditions and a failure to settle on the slow hard courts proved our undoing and we failed to win a rubber. The first couple, playing some attractive tennis won their opening set against the opposing first couple, but loose play in the subsequent sets allowed their steadier opponents to clinch the rubber.

The second and third couples played well, but as the prospects of victory faded, their enthusiasm waned.

2nd VI v. City University, away. Won 8-1.

1st May. **Mixed 2nd VI v. Birkbeck College, away. Lost 5-1.**

22nd May (evening replay). **Hospitals' Cup 1st Round. 1st VI v. U.C.H. 1st IV. Won 5-1.**

The absence of our captain due to injury resulted in the promotion of Simon Smith from the 2nd VI. Despite the hard court, all three couples played good aggressive tennis. Julian Wenger and Marcus Setchell, playing at second couple did extremely well to beat the opposing first couple, an achievement which always demoralises the opposition.

The club plays either the Royal Dental School of Charing Cross in the quarter-finals.

Players that have represented the 2nd VI:

M. Spencer	D. Baugh
G. Danovitch	P. Hill
J. Davies	D. Marshall
R. Williamson	D. Lythe
D. Jack	I. Fraser

JUDO CLUB

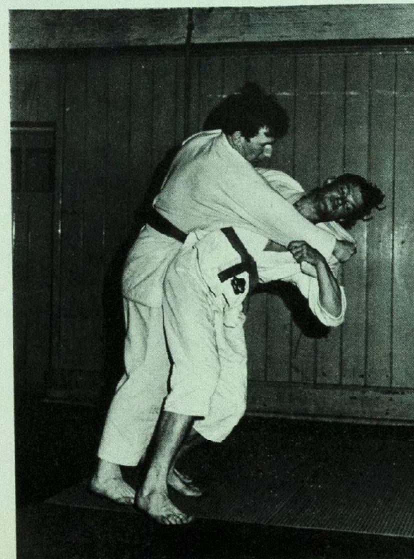
The club has won the Inter-hospitals cup again this year. The entry for the cup was very small—3 Hospitals, which was disappointing. But perhaps it is understandable since at least three hospitals felt that they had no chance of winning and so did not enter teams.

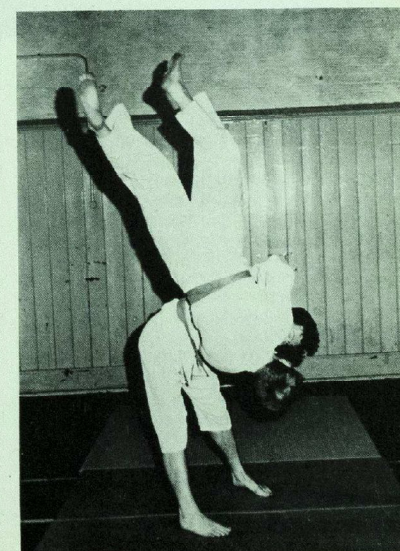
We fielded the following side and the results were as shown:—

Barts		*Mary's*	*U.C.H.*
R. Thrush	3K	W 10pts.	L −10pts.
A. Ruddle	3K	W 10pts.	W 10pts.
A. Boatman	2K	W 10pts.	D 5pts.
M. Clifton	3K	D 5pts.	L −10pts.
P. Clarke	2K	W 10pts.	W 10pts.
		WON by 40pts.	**DREW 25pts. each**

Barts		*Oxford Univ.*	*City*
J. Dearlove	4K	L −10pts.	L −10pts.
J. Davies	4K	L −10pts.	D 5pts.
A. Ruddle	3K	W 7pts.	L −10pts.
P. Clarke	2K	W 10pts.	D 5pts.
		LOST by 3pts.	**LOST by 20pts.**

MEMBERS IN ACTION





UCH lost to St. Mary's and so Barts won without dispute.

We were delighted to see our President, Mr. Todd with his wife and family, watching from the gallery and also supporters from the hospital.

Following the team event, was the individual event which Barts lost in the final. The winner was a UCH Brown Belt and although no decision was reached after extra time, the referee's decision went to the UCH man because of his superiority in the contest.

Martin Clifton has unfortunately been forced to retire from the mat due to injury. He will be missed in the team.

On 20th May we sent a four-man team to Oxford to fight the University and the City of Oxford. We did well against superior opposition. Two of our up and coming Orange Belts fought and with a little more experience they should go on to be useful contest men.

We were particularly pleased to do so well against the University and were very unlucky not to force an overall draw against superior grades.

A match has been arranged against Cambridge for October. One we must win!

P. D. Clarke

GOLF CLUB

24th May **v. Northants. Golf Club at Fleet; Lost 3-1**

This was a new fixture for the club and although only an afternoon match, was very enjoyable; it is hoped to make a whole day of it next year. The match was played as foursomes because the weather threatened to be bad but in fact throughout all the games it remained dry. Individual games were played off handicap.

Our first pair, David Grieve and Mike Bowen lost more or less to local knowledge, going down on the 18th by 1 down. Chris Booth and Angus Hoppe never really got going being soundly beaten by 5/3, and the third pair, Jon. Sadler (capt.) and Howard Rutherford went down 3/2.

Our one successful pair was the last, Richard Begent and Nick Packer, who, in the first ten holes, dropped only one or two strokes to par. This dynamic golf met with little opposition and the game was over at the 13th hole (seven up and five to play).

30th April; **v. Hadley Wood; Lost 5-3**

This year we played eight singles at the very attractive Hadley Wood Golf Club. Although we lost, it was a good day and we are most grateful to the Begents for the marvellous spread they put on for us before the game.

Our winners were Richard Begent and Howard Rutherford by 3/2 and 2 holes respectively. M. M. Bowen halved against a very good 2 handicap golfer and Jon. Sadler halved also.

Team:—M. M. Bowen, A. D. L. Hoppe, J. C. Sadler, R. H. J. Begent, N. Packer, M. Hares, R. E. Atkinson.

17th May; **v. R.D.H.** *X* **St. George's at Huntercoombe; Won 4-1.**

The thunderstorms fortunately lifted and we found Huntercoombe in excellent condition. David Grieve lost against a very competent opponent by 3/2 but the rest of the team won easily, Chris Booth and Howard Rutherford by 7/6, Jon. Sadler by 5/4 and Nick Packer by 3/2.

A. D. L. Hoppe.

BOAT CLUB

Crews:

1st VIII (Head of the River Crew)
Bow, C. M. Castleden
2 R. E. Franks
P. C. Cobb
N. J. C. Snell
B. I. Featherstone
P. A. B. Cheetham
B. D. Cutler
J. D. C. Martin
J. Brooker, cox

2nd VIII (Gentlemen)	3rd VIII
G. W. Libby	I. B. M. Stephen
C. R. S. Anderson	R. J. Horton
D. Parr	B. J. Close
R. H. Bentall	R. M. Wilmshurst-Smith
B. Moore	R. Henderson
J. K. Anderson	J. M. Jarvis
B. Grimaldi	M. J. Simmons
H. N. Whitfield	P. J. Houlton
J. N. Winner	M. H. A. Martin-Smith

4th (Sailing Club)	5th (Rugger Club)
M. Williams	S. Smith
E. Walsh	H. Scarf
B. Chapman	A. Mason
D. Stringer	M. Skidmore
J. Shaw	T. Fenton
R. Williams	G. Kavanagh
A. Wingfield	P. Durey
P. Smyth	N. Fairhurst
J. Walsworth-Bell	S. Davidson

Following a three-week break over Easter, the VIII was coached by Peter Brass and then by Dr. "Bill" Williams to such effect that we were able to look forward to the bumps with considerably more confidence than we had thought possible after the Head Races.

May 8-9-10. **The United Hospitals' Bumping Races**

Three fine evenings made conditions very pleasant and the 1st VIII rowed over each night, on the last, opening the distance between them and St. Mary's to some five lengths, to retain the headship. The Gentlemen's VIII, although bumped by the fast U.C.H. VIII on the last evening, again won the pennant for the highest second VIII. The 3rd VIII suffered a bump on the first evening but regained their position by making a bump on the Wednesday night, thus remaining the only third VIII in the first division. A collision and some inadequate umpiring robbed a keen Sailing Club (4th) VIII of a bump on the first evening. They rowed over on subsequent nights.

For the last few years the Rugby Club has boated a fast if not highly skilled crew, but this year's VIII proved a disappointment. Not only did they incur fines for absence at the start on two evenings, but were bumped after about ten desperate strikes at the river on the final evening.

13th May. **Allom Cup Regatta**

We again entered the 1st VIII for the senior event, but were unfortunate to draw the winners, Imperial College, in the first round. Though we proved to be their most substantial opposition we were beaten by a length after a rather uncontrolled row. Castleden and Snell sculled in the novice event, but did not survive their first rounds.

17th May. **May and Baker Cup**

This cup, presented last year for a race between Bart's and Guy's, was retained after Guy's, half a length down, had been disqualified about twenty strokes from the finish by a vigilant umpire—though we had been warned about keeping to our station during the race earlier in the race, we were in our own water when Guy's clashed with us.

The World Medicine Shield for 2nd VIIIs was retained by Guy's.

20th May. **Twickenham Regatta**

In the first round, we lost to the holders, King's School Canterbury, who were in turn beaten by Furnivall in the final. A Novice Coxed IV was also entered but could not row as we failed to get the cox to the start in time.

27th May. **Chiswick Regatta**

After a week's coaching by Nick Boyd, we had improved and disposed of Bedford R.C. and Kensington R.C. in heats but lost to Quintin by 1½ lengths and Imperial College by ¾ length in the final.

29th May. **Windsor and Eton: Junior-Senior VIIIs**

We had the misfortune to draw in the first round, R. M. A. Sandhurst, who went on to win the event.

J. Martin.

CRICKET REPORT

1st XI

The first round of the U.H. Cup was played on Tuesday May 9th against **King's College Hospital.** Hopkins started the day well by winning the toss and electing to bat on the traditionally placid Chislehurst wicket. After the loss of an early wicket, the Bart's innings soon recovered, Jones making a very useful 31 in his Cup debut, and Higgs scoring an attractive 65. The tail of the innings however, proved to be much shorter than it should have been, and the last 6 wickets fell for a mere 36 runs, the innings closing at 198.

The major disappointment of the day proved to be Bart's very poor performance in the field. Dropped catches and poor ground-fielding delayed the result until 3 minutes before play was scheduled to finish, when Baumber lightened the gloom by holding a spectacular slip catch to dismiss the last man, with King's still 57 runs behind.

Bart's

G. Purcell	c. Goodall	b. Doyle	4
R. Jones	c. Hoffman	b. Dodwell	31
R. Higgs	c. Goodall	b. Doyle	65
N. Griffiths	b. Kensit		38
P. Furness	c. Thomas	b. Kensit	20
D. Berstock	c. Cox	b. Doyle	22
G. Hopkins	c. Goodall	b. Kensit	1
P. Savage	b. Kensit		0
S. Baumber	Not out		1
E. Lloyd	c. Hoffman	b. Doyle	11
J. Shepherd	b. Bailey		3
		Extras	2
		Total	198

King's

141 all out
P. Savage: 3 for 28
D. Berstock: 1 for 24
E. Lloyd: 3 for 36
N. Griffiths: 3 for 33

The second round of the Cup was played on Thursday 18th May at Chislehurst when Bart's came up against the holders of the trophy, **St. Thomas's.**

St. Thomas's won the toss and elected to bat, but were very quickly in serious trouble thanks to some very much improved fielding and some hostile bowling from Savage and Rhys-Evans, playing in his first Cup match. This performance was maintained and Thomas's struggled to a total of 141, leaving Bart's four and a half hours in which to reply. This reply, however, was one which most of the Bart's side would very much like to forget, in which only Jones showed any resistance, batting well to make 22 out of a very dismal 62 all out.

Scorecard

St. Thomas's

141 (M. Read 44)
P. Savage: 1 for 42
P. Rhys-Evans: 2 for 43
I. Hann: 1 for 11
N. Griffiths: 4 for 32
E. Lloyd: 2 for 9

Bart's

62 (R. Jones 22)

Other Matches

30th April; **v. London House. Match drawn**
Bart's 154 for 5 dec. (S. Thomas 65).
London House 134 for 7.
19th May; **v. U.C. Oxford.** Rain.
13th May; **v. Southend. Match drawn**
Southend 170 for 7 dec. (E. Lloyd 4 for 50).
Bart's 112 for 5 (S. Thomas 72 n.o.).
14th May; **v. Hampstead. Match drawn**
Hampstead 50 for 0. Rain stopped play.

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20th May; **v. Chrishall.** Rain
21st May; **v. Romany.** Cancelled

2nd XI

United Hospitals Cup
Tuesday, 9th May v. **K.C.H. Won.**
Bart's 149 (I. Hann 38, P. Curry 28, D. Jefferson 26, D. Grieve 26).
K.C.H. 80
Thursday, 18th May; **v. St. Thomas's. Won** by 7 runs
Bart's 85, St. Thomas's 78.

Wednesday XI

3rd May; **v. Royal Free Hospital. Lost** by 65 runs
Royal Free 136 for 6 dec.; Bart's 71.
10th May; **v. Royal Veterinary College. Lost** by 29 runs.
Royal Vets. 127; Bart's 98.

P. J. Furness.

SAILING CLUB REPORT

Bart's v Hampton S.C.—Won 65¼-51¼

The second match against Hampton was held at the Welsh Harp in Fireflies. There was a light breeze and sunshine which gave perfect conditions for Team Racing.

At the start M. Williams left the fleet followed by M. Freeth. R. Chapman was unfortunately over the line at the start, but even after restarting he was in third place by the second mark.

The order remained unchanged for the remainder of the race.

Points: Bart's 24¼ *Hampton* 14.

In the second race we were not so lucky. One of the Hampton team made a very good start to leeward of the fleet and led for the remainder of the race, which proved to be far shorter than had been anticipated and the positions did not alter, Bart's finishing second, third and sixth.

Points: Bart's 19 *Hampton* 20¼.

The teams now retired for an excellent tea, after which a third race took place. Hampton were forced into a losing position and held there throughout by some very competent team manouvres.

Points: Bart's 22¼ *Hampton* 17.

Team: M. Williams, R. Chapman, M. Freeth. Miss J. Walsworth-Bell, Miss L. Chapman, Miss J. Gould.

Bart's II v St. George's I—Won 31¼-27¼

A second team proved to be more than a match for the Georges team in the blustery conditions that prevaled at the Welsh Harp. In the first race M. Freeth finished first with J. Browett second. B. O'Farrell and one of the opposition retired after capsizes.

Points: Bart's 20¼ *Georges* 16.

The second race saw only four starters as the two crews who had capsized in the first race were rather wet and cold. This time the Georges team finished first and fourth. M, Freeth came in second and J. Browett third.

Points: Bart's 11 *Georges* 11¼.

Team: M. Freeth, J. Browett, B. D. O'Farrell. Miss G. Petty, Miss K. Porter, Miss J. Gould.

Hospital v College

As last year there were two preclinical and two clinical teams.

Hospital I: M. Freeth, T. Lepard, J. Browett. Miss G. Petty, R. Markham, D. Brough.
Hospital II: D. Jackson, P. Coburn, M. Redfern. M. Knott, Miss J. Cantrell, Miss N. Dent.
College I: M. Williams, J. Shaw, R. Downe, Miss J. Walsworth-Bell, Miss P. Harris, Miss S. Rowntree.
College II: R. Chapman, B. O'Farrell, M. Rowntree, S. Copeland, Miss J. Begg, Miss J. Gould, Miss P. Benison.

Hospital I v College II

In both of these races R. Chapman finished an easy first followed by M. Freeth. In an effort to take third place in the first race M. Rowntree hit J. Browett and had to retire, thus allowing the Hospital to finish second, third and fourth in each race.

Result: Hospital I 42 *College II* 35½.

Hospital II v College I

Here the only notable event was the untimely capsize of M. Williams in the first race. Otherwise the College both started and finished well in front of the Hospital team in both races.

Result: College I 44½ *Hospital II* 30.

Hospital I v College I

It was decided to have only one race for the final as most of the College team were due at the

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Bumps. This proved to be the Hospital team's salvation, as all of the College team were over the line at the start and did not hear the recall gun. One of the Hospital team was also over and so only two boats finished.

Result: The Hospital beat the College by 17¾ points to O! !

United Hospitals Bumping Races

The dinghy sailors combined with the "Blue Water" sailors to produce a sailing VIII for the Bumps this year. In fact all but one of the crew were oarsmen and he fitted in very well after only one practice.

On the first day the crew were very jubilant as they thought they had bumped the Westminster crew, but there was a mix-up at the start with George's across the river and it was disallowed.

On the following two nights the crew rowed over and were consequently exhausted at the finish.

United Hospitals Burnham Open Meeting

The club in all entered seven boats for the meeting. The races were on a handicap system and the best two out of three races counted towards the trophy. The first day provided quiet racing with light winds and the second day a fresher breeze with a period of torrential rain.

J. Shaw in an Enterprise won the trophy for the weekend and R. Chapman came fourth in a G.P. Other entries were:

M. Williams, National 12; M. Rowntree, Firefly; D. Jackson, 5.0.5; M. Freeth, Firefly; A. Newman, Enterprise.

Barts I v London II—Lost 34¼-38¼

The occupation of our first and second teams with exams caused a rather scratch team to represent the Hospital in the first round of the **Guinness Cup.** In the first race the team were all late at the start through no fault of their own and consequently came in fourth, fifth and sixth. In the second race M. Freeth knocked out one London boat prior to the start and another on the first reach. A. Eley led round the first two marks but was knocked out as well in a port-and-starboard incident. Bart's finished first and third but lost overall.

Welsh Harp Open Meeting

In a force 5 wind, M. Freeth won the single-handed trophy by managing to stay vertical for the whole race unlike the other fourteen starters.

R. Chapman in a G.P. was among the many who had an unwanted bath at the meeting.

Sherrin Cup

Racing for this trophy took place in Enterprises at Burnham on Bank Holiday. Two boats entered from the college. J. Shaw won the trophy for the Hospital very convincingly. M. Williams capsized in a freak thunder storm and retired. J. Salt and M. Freeth crewed.

M. J. H. Williams.

SWIMMING CLUB

The Annual General Meeting of the Swimming Club was held on 24th May with Mr. George Ellis in the chair. M. Knight was elected Captain, and R. Jolly, Secretary. Various proposals were discussed including one that we should have an Annual Dinner this year. Attention was drawn to the club's good record in both U.H. and U.L. leagues, and the U.H. knockout tournament, in which we reached the semi-final. Doug Sheira was commended for his regular appearances for the University Swimming team, for which he was awarded a half Purple. Rick Jolly has been awarded a team Purple for Water polo.

It was also suggested that regular training sessions be held each week by the club and it was pointed out that the University ran an excellent waterpolo session every week and very few people had been making regular use of this. A Colours Committee was formed, and it decided to award Colours to Doug Sheira and Paddy Weir. Paddy Weir was also elected Charterhouse representative.

We have matches arranged this month against Westminster Bank and St. Mary's.

R. Jolly.

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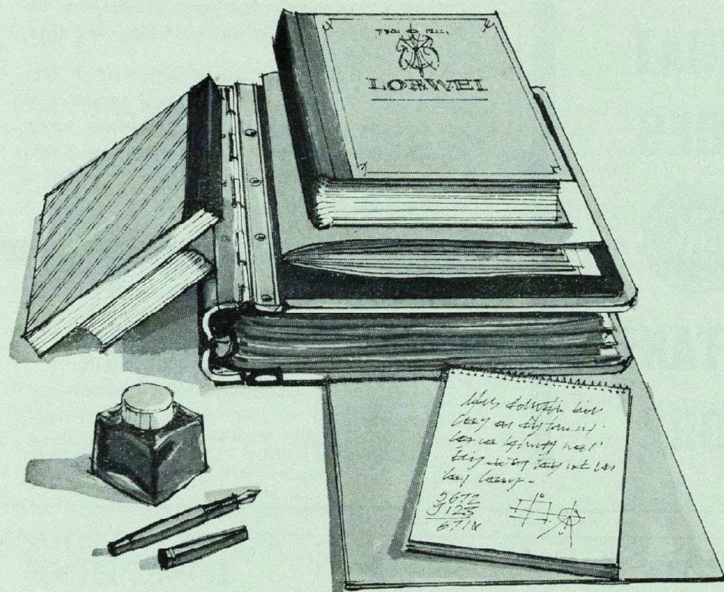

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References
1. *Arch. Derm.* (1962) **86**, 608.
2. *Lancet* (1964) **i**, 1177.

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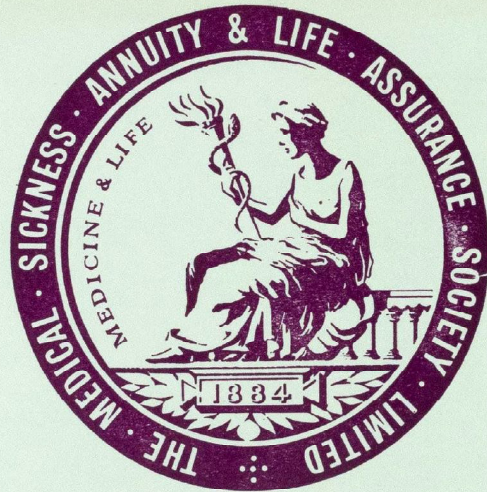

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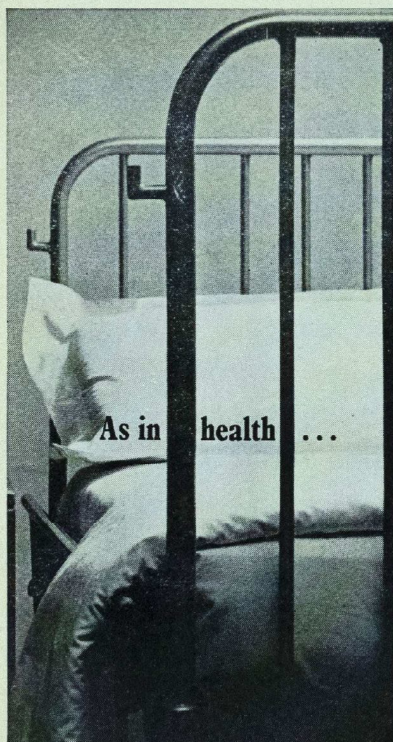

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B.M.A. CONFERENCE

Last month saw the 135th B.M.A. conference grind its way through an agenda crammed with a record number of motions (most of which were, in fact, rushed through on the last day in a scene which must have been something like Beecher's on the first lap of the Grand National). Just how representative the conference is has been questioned during the past year by the establishment of The Junior Hospital Doctors' Association (J.D.H.A.). The Conference hall must have thundered with rage when a hundred consultants simultaneously read the J.D.H.A.'s pamphlet "On Call" trumpeting that the B.M.A. was acting in collusion with the Ministry in such a manner as to misrepresent their cause. However the responsible breasts must have been soothed, for a motion was passed that the B.M.A. would like talks with the J.D.H.A., providing that their Chairman, Dr. Briggs, disavowed the "On Call" publication. This he later did by telephone and now the B.M.A. will learn how their *bête noir* bleats.

Fully representative or no, the conference at least recognised and considered many of the most pertinent problems, even though the National Dailies snapped up the human interest topics like the motion which insisted on eyetests for school crossing patrolmen.

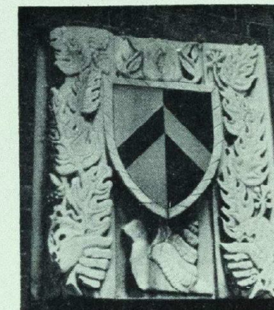
On drug addiction the conference heard several astute voices proclaim dismay at the rising number of housewives addicted to Amphetamines, however a clear statement by the profession to guide possible legislation was not forthcoming. A motion was passed stressing that the drugs should be covered by schedule I, but an hour later the conference *volte faced* and rescinded their motion, leaving observers greatly perplexed. Appropriately little noise was made about Cannabis and the problem of narcotic addiction was rightly given greater stress. Dr. Lawrence Abel applied the time honoured scientific technique of hypothesis and experiment—he proposed that the weak link in the distribution chain of Heroin was the drug pedlar and quoted American evidence in support of breaking its life cycle at this point. Apparently sentences for "pushers" were stepped up astronomically in Ohio and the result, he claimed, was the virtual elimination of Heroin addiction. The argument sounds eminently plausible, even though it might be claimed that the Ohio pedlars merely moved their place of business to less vigilant cities. Moreover the success of a similar application in this country is made more likely by the fact that English pedlars are largely addicts ensuring their own supplies. Gaol for them, with the concommittant withdrawal of drugs, would presumably have added deterrence. What also emerged from the conference was the realization that the proposed establishment of "centres", to bring the addicts into the open, was hardly a discouragement to the black-market non-addicted pedlars reported to be arriving in the country, and that more important was the development of withdrawal clinics.

PATHOLOGICAL UNREST

Sympathy must be extended to those now taking the Pathology course. Several letters have been received by the Journal, and, although too late for publication in this issue, their subject matter is obviously of immediate relevance. The letters complain of the inadequacy of the course, shortened from six months to three so that the reorganised clinical course can begin with a fresh timetable in October, and the abyssmal working conditions prevalent during this period of maximal pressure. The windows of the pathology lecture theatre have been skilfully sealed for the Winter's heating system, but unfortunately the air conditioning does not seem up to the task and temperatures of 86 and 88 have been reported on successive days. The Ram is veritably on the altar.

LETTERS TO THE EDITOR

SNAIL PACE MEDICINE?



Sir,—I do not recall ever seeing in the Journal a reproduction of the sculptural plaque on the Medical College Hall of Residence at Charterhouse. I enclose a recent photograph. Presumably the snail symbolises the slowness with which accurate knowledge is gained both by the student, and by the discipline of Medicine itself. Perhaps someone else could identify the plants; presumably they symbolize the drug heritage of Medicine.

Yours faithfully,
BRIAN McGRATH,
27 Arundel Gardens,
London, W.11.

4th June, 1967

"THIS SMOKING BUSINESS"

Sir,—Many of your readers must, like me, be in a state of confusion and bewilderment about this smoking business.

Of course it all began with Sir Walter Raleigh in the days of good Queen Bess, and, though King James took a poor view of it, it has gone on ever since.

During the Crimean war they ran short of pipes and started rolling up tobacco in pieces of paper, and the cigarette was born.

Since then untold millions have been consumed. In two world wars they have been showered on our armies by the Royal Family, by countless philanthropic bodies and, indeed, were issued as part of the army ration. Lord Montgomery, though a non-smoker, is said to have scattered cigarettes from his jeep in North Africa. Presumably today he would be accused of spreading a foul and fatal disease among the gallant eighth army. The Secretary General of the Red Cross has recently written that no less than 1,500 million have been sent by the B.R.C.S. to the troops and prisoners of war. If the anti-smokers are right what happened to all the lung cancer cases which must have resulted, for we seem to have heard little about it before the early sixties when the present campaign began? Did our physicians and pathologists fail to diagnose them or did they simply not happen?

The origin and cure of most of the devastating diseases to which the flesh is heir—typhoid, plague, tuberculosis, malaria and the rest—have been the result of scientific research of great men whose names are household words. Can there be some mute inglorious Manson, some self-effacing Pasteur, Lister or Koch shyly disclaiming his epoch-making discovery in a cloak of anonymity? Even in Queen Victoria's day some laboratory work must have been done. Did not C. S. Calverlay write "Cats may have had their goose cooked by tobacco juice, why then deny its use . . . ." or is it all just a question of ARITHMETIC?

Presumably all the data regarding tobacco sales, prevalent disease and hundreds of other subjects are available to the general public in government and official publications. Is there any reason why some enterprising young journalist, let loose among the files with his slide rule and adding machines, might not have reached the same conclusion as the scientist? or, alternatively, he might have discovered that the disease was due to Diesel fumes, petrol lighters, motor cars or even washing machines! His popular newspaper would then come out with the banner headline "DOES TOBACCO CAUSE CANCER?" The scientist would however talk in a different language and would have written "There is some evidence to show that

tobacco contains some hitherto unidentified carcinogen which is a not inconsiderable aetiological factor in the formation of neoplasms of the bronchial tree" which comes to exactly the same thing!

Will somebody please explain why the tycoon enjoying his corona-corona is looked upon with tolerance and why the dear old vicar puffing away at his old pipe as he prepares his Sunday sermon is regarded with affection while the man who wraps the same tobacco leaf in a piece of paper is a miserable dope addict to be held up to public execration?

There is a large difference between the cigarette of today and that of yesterday. When I first contracted the habit in the very early years of the century one had to *smoke* a cigarette i.e. take an occasional puff to keep it going as one does at a pipe or cigar and how we used to laugh at the very daring young woman unsuccessfully *trying* to smoke! If the present day cigarette is put down it smokes itself in about five minutes. Can it be that something has been added to the cigarette of today which is the cause of the trouble?

Let us hope that the day may not be far distant when a further edict may be issued to the effect that "there is good reason to believe that the sense of well-being engendered by the moderate indulgence in the tobacco definitely outweighs the undoubtedly deleterious effects resulting from its abuse." "Or as Miss Marie Lloyd so aptly put it "A little bit of what you fancy does you good."

Yours faithfully,
Major-General R. E. BARNSLEY,
R.A.M.C. Historical Museum,
Keogh Barracks,
Aldershot.
Hants. 20th June 1967

"TOGETHER WE CHOSE A . . . ."

Sir,—Following the car rear window stickers is to me more informative than reading the daily papers.

I read with interest who has a tiger in their tank, note with alarm the increasing toll of bullet riddled windows and wonder at what nationalistic pride prompts those who "Support Rhodesia" and "Stand by Israel". The latest, may I bring to your notice, appeared on the back of a dirty, battered, pre-war saloon. Amidst hundreds of stick-on bullet holes was a dismal little tattered banner with the slogan "We stood by Egypt."

Yours faithfully,
P. R. JORDAN,
Abernethian Room,
Bart's Hospital,

13th June, 1967
(N.B.—Real name no Political, Religious or Geographical pun intended).

Engagements

MORSE — MASON. — The engagement is announced between Dr. F. G. Morse and Mrs. M. P. Mason.

PAGAN—ROULSTON. — The engagement is announced between Dr. William Hugh Pagan and Miss Fiona Margaret Roulston.

REES — KIPLING The engagement is announced between Brian I. Rees and Sara Elizabeth Kipling.

Marriage

BEDFORD-TURNER — HAWKINS. — On July 8, Christopher Mark Bedford-Turner to Shelagh Beatrice Hawkins.

Births

BEARDWELL. — On May 31, to Julie (née Hazzledine) and Dr. Colin Beardwell, a son (Edward Andrew Frederick).

CHONG.—On June 3, to Janie and J. Kenneth Chong, a son.

DUDLEY.—On June 7, to Dawn (née Russell) and Dr. Nicholas Dudley, a daughter (Justine Patricia), sister for James.

GREEN.—On May 20, to Sheila (née Minns) and and John Green, a daughter (Emma Louise).

RAWLINSON—On June 9, to Ann (née Maccoll) and Dr. Keith F. Rawlinson, a daughter Caroline Emma).

Deaths

BARNES.—On June 17, Dr. Francis Gregory Lawson Barnes, M.R.C.S., L.R.C.P., D.P.M., M.B., B.S. Qualified 1921.

CHAMBERLAIN.—On May 1, Dr. L. P. B. Chamberlain, M.R.C.S., L.R.C.P., aged 63. Qualified 1931.

HARKER.—On May 13, Dr. M. J. Harker, M.A., M.B., B.Chir., F.F.A.R.C.S., aged 68. Qualified 1925.

LANDER.—On June 18, Dr. Harold Drew Lander, M.R.C.S., L.R.C.P., aged 82. Qualified 1911.

PRALL.—On June 2, Dr. Samuel Reginald Prall, B.A., M.D., M.B., B.Chir., M.R.C.S., L.R.C.P., I.M.S., aged 76. Qualified 1915.

QUICK.—On May 23, Mr. H. E. Quick, B.Sc., M.B., B.S., F.R.C.S., aged 84. Qualified 1906.

Appointments

The title of Professor of Bacteriology has been conferred on Dr. F. W. O'Grady in respect of his post at St. Bartholomew's Hospital Medical College.

The title of Professor of Embryology has been conferred on Dr. T. W. A. Glenister in respect of his post at Charing Cross Hospital Medical School.

Dr. Paul Turner has been appointed Reader in Clinical Pharmacology at St. Bartholomew's Hospital Medical College.

Dr. J. W. Harris has been appointed Reader in Anatomy at the Royal Free Hospital School of Medicine.

Awards

University of Oxford

A D.M. degree has been awarded to J. G. Widdicombe.

University of Cambridge

M.D. degrees have been awarded to D. A. Chamberlain and L. J. Chalstrey.

An M. Chir. degree has been awarded to H. B. Stallard.

Royal College of Obstetricians and Gynaecologists

A Fellowship has been awarded to E. A. Alment.

Birthday Honours List

The following honours were awarded in the Birthday Honours List:

Harold Jackson BURROWS, M.D., F.R.C.S., Senior Surgeon in Orthopaedics, St. Bartholomew's Hospital. *C.B.E. (Civil)*

Henry Martyn McGLADDERY, M.B., F.R.C.S., D.T.M. & H., Surgeon, Lady Templer Hospital, Kuala Lumpur. *O.B.E. (Civil)*

John James Barclay HOBBS, M.B., F.R.C.S., Squadron Leader (now Wing Commander), R.A.F. *M.B.E. (Military)*

Change of Address

Dr. A. B. Anderson to 23A, Chaucer Road, Cambridge. Tel.: Cambridge 53099.

Dr. and Mrs. Cecil Horder, Dr. Patrick Horder to Spiggie, Briar Patch Lane, Letchworth, Herts. Tel.: Letchworth 3282.

Dr. A. R. Macdonald to Monk's Ridge, Burrows Lane, Gomshall, Guildford, Surrey. Tel.: Shere 2162.

NOTICE

It is proposed to start a monthly column giving times and venues of departmental lectures and seminars open to students. Secretaries are asked to address such information to the News sub-editor.

August Duty Calendar

Sat. & Sun. 5th & 6th.
Prof. Taylor
Prof. Scowen
Mr. Lettin
Dr. Jackson
Mr. Cope

Sat. & Sun. 12th & 13th.
Mr. Ellison Nash
Mr. Badenoch
Sir Ronald Bodley Scott
Mr Lettin
Dr. Boulton
Mr. McNab Jones

Sat. & Sun. 19th & 20th.
Mr. Ellison Nash
Dr. Black
Mr. Manning
Dr. Cole.
Mr. Dowie

Sat. & Sun. 26th & 27th.
Mr. Badenoch
Dr. Hayward
Mr. Manning
Dr. Gillett
Mr. Fuller

Physician Accoucheur for August is Mr. D. Williams.

Ars Longa . . .

A new monthly column of criticism by Bart's men with a guide to coming events.

Music:

During the summer months, the Festival Hall tends to give up the struggle, and provides us with the "Festival Ballet" continuously. This year they are doing some fairly advanced stuff, though, of course, there are still productions of The Swan Infested Lake and The Sleeping Beauty for Ma, Pa and the kids.

However, at that well-known wrestling arena, Albert Hall, there are the Proms, now by far the most exciting musical festival in the world —in probably the worst acoustics. During August, almost every concert has something worth hearing, but two items stand out—on the 18th, Liszt's huge Faust Symphony gets a rare performance under Colin Davis, and on the 23rd, Berlioz's "Grande Messe des Morts", with Sir Malcolm on the baton.

And on some Sunday evenings, there are the Kenwood House chamber concerts—which, in their own way, are as near to perfection as any institution in London.

Opera and Ballet:

Once again this year The Royal Opera House, Covent Garden, is producing two cycles of Wagner's "Der Ring des Nibelungen" in September and October.

As those familiar with the work will know, this is an excellent opportunity of seeing the complete cycle, so rarely performed as such. Booking has been open since mid-July but tickets for individual performances or the whole cycle are still available.

Sadler's Wells Opera, having done away with 'the Season', are presenting, from August 9th, in addition to a number of revivals, two new productions—Mozart's "The Magic Flute" and Gluck's "Orpheus and Eurydice". All opera is performed in English and tickets are often available at the eleventh hour.

Also in Roseberry Avenue, at their headquarters, The Western Theatre Ballet, which have had such notable success recently, stage productions in the modern idiom; their next performance—"Sun into Darkness", music by Malcolm Williamson—is on October 10th.

From time to time films of operatic productions are shown at The Queen Elizabeth Hall on the South Bank; details are obtainable from WAT 3191.

Theatre:

The Promise. Fortune Theatre

One is not exactly treading on quicksands unknown to buy tickets to see Judi Dench in any play, and even though the *Daily Mail* trumpets "a new and moving experience" it is not novelty that "The Promise" hangs on, but on a standard of acting and directing of rare excellence. Aleksei Arbuzov's play about two boys and a girl forced into the inevitable triangle by the sheer problem of body temperature during the seige of Leningrad in the last war and their subsequent twenty years of ping-pong, is possibly not the most original theme. Yet the play, in its refreshingly different setting, is entirely convincing and one is bewildered to find oneself identifying with such stubbornly Russian characters. What the dialogue must lose in translation is effectively veiled by the brilliant performances given by Judi Dench, Ian McKellan and Ian McShane.

A memorable play which will be off to Broadway in the all too near future.

Regents Park Open Air Theatre

If the weather and yourself agree that the evening should be spent out of doors, then a visit to Regents Park might well prove a surprisingly good idea. The park at night proves a really romantic setting, there are excellent refreshment tents serving "chicken in the basket", strawberries and some memorable Lager, as well as a play for which reasonably priced seats (deck chairs) are always available up to the last moment.

The play being performed at the time of writing, "A Midsummer Night's Dream", is directed with, what some may feel is an appropriate (for this play) unapologetic abandon and lack of pretention. Perhaps it was the National Theatre's production of "Much Ado . . . " that awoke the producer to the realisation that audiences enjoy watching actors enjoying playing their parts. If the play to follow on July 12th, "Cyrano De Bergerac", is performed with equal vigour and enthusiasm it will make for fine entertainment.

Cinema:

Onibaba (X)—Cameo Moulin

Shindo's totally convincing, beautifully photographed dramatization of an old Japanese folk legend. Some of the most movingly erotic scenes that can ever have been filmed melt somehow without a jolt into the barbarity of the villagers' Darwinian fight for survival. By far the best film on in London. Avoid supporting unsupported Nudie "in glorious colour" at all costs.

The Gospel According to St. Matthew (U)—Paris Pullman

Surprise, surprise this is a magnificent film shot in black and white in Italian by a communist as a tribute to Pope John! Authenticity is the keystone of the film's excellence and the centurions look adequately ill-fed and mercenary to carry out any number of crucifixions a day. The sound track is taken largely from the original text, and the English sub-titles owe much to the King James version. A must for all "Robe" haters.

Stranger in the House (A)—Rank General Release

A tautly constructed thriller—drama centering around a retired alcoholic lawyer finding a shot youth in the attic of his home and the somewhat bizarre investigations he makes. Recommended.

Masculin-Feminin (X)—Cameo Victoria

Of his latest film "Masculin-Feminin" Jean-Luc Godard says it might equally as well have been called "The Children of Marx and Pepsi-Cola". The film has little or no plot; rather there is a series of minor incidents; boy meeting girl, girl making record, man shooting woman, three girls in a flat and so on. The film reads like a photographic album. Each of the fifteen sequences is preceded by a number which flashes on the screen to the sound of a gunshot. If this sounds rather confusing, it is. Essentially Godard is trying to probe the lives of the "new generation" and does so by following the actions of a bunch of Parisian kids. He uses an almost newsreel technique. There is no cinematic gimmickry here; no slow motion dancing or distorted images, in fact the presence of the camera is so unobtrusive that at times some of the dialogue sequences seem to have been caught completely off the cuff.

The main characters in the film are played by Jean Pierre Leaud, Chantal Goya and Isobel Duport. The acting is superb. Leaud, as Paul, has a mine of facial expression which is a delight to watch. Chantal Goya plays Madeleine, a girl who works on a magazine and whose ambition is to be a pop star. Paul only wants Madeleine to sleep with him and eventually succeeds by sharing a bed with Madeleine and her flatmate.

The Vietnam war and birth control, illegal in France at the time, are topics which frequently recur throughout the film. There is no mention of drugs and the characters, by English standards, seem incredibly unhip, as opposed to "Blow Up", a recent film of Antonioni. Inexplicable scenes of violence, reminiscent of earlier Godard films, and strange cut-aways of milling crowds in a department store or along a pavement are interspersed between long stretches of straight dialogue. Sometimes Godard uses an interesting technique of transfering from one dialogue to another while we still see the first two speakers. For a moment the new dialogue sounds absurd until we are reorientated visually.

Masculin-Feminin is a must for those with no inherent dislike of "nouvelle vague", sub-titles, or black and white.

Contributors: Brian Briggs, Richard Markham, Roger Rolls, Richard Staughton and Richard Thompson.

Department of Psychological Medicine

At the last meeting of the Department of Psychological Medicine, Dr. J. Trevor Silverstone gave an account of a small epidemiological study of obesity he had undertaken in two general practices in the London area. The prevalence of obesity was surprisingly high; 18% of the men in the sample and 25% of the women were more than 30% above their ideal weight. Obesity was more prevalent among the older age group and among those of lower socio-economic status. It was found that the group in whom obesity was most prevalent were women over the age of forty who were in social classes (IV) and (V).

Somewhat contrary to general expectation, although in keeping with previous work, psychiatric and psychological disability was no more common among the obese than among those of normal weight.

Dr. J. Trevor Silverstone

Abernethian Society

Thursday, 4th May:
Canon Edward Carpenter, "People in a technological age."

The topic seemed fascinating and indeed Canon Carpenter, a Dean of Westminster, certainly had some interesting thoughts for those at the evening meeting.

A profound philosophical thinker, the Canon reminded us all of our very real duty to the personality, and that in a time when technological advance was paramount we must never allow ourselves to forget this. It was a pleasure to all to be reminded of some very basic philosophical concepts and all felt most refreshed by the Canon's clarity. Many interesting questions followed. Mr. John Griffiths proposed a vote of thanks and closed an enjoyable meeting.

Thursday, 25th May:
Dr. William Sargant, M.A., M.B., B.Chir., M.R.C.P., M.R.C.S., D.P.M.

"The mechanism of conversion and brainwashing."

Before the lecture, the President dealt with the election of officers for the coming year.

This was the last lecture of the Society's year and certainly proved a most exciting one. The lecture theatre seats about three hundred but some members unfortunately had to stand.

It soon became obvious to all the audience that Dr. Sargant's lecture was a very fine piece of original scientific research. This was no surprise to those who had already read his book.

With the aid of films, slides and sound recordings Dr. Sargant showed how various tribes and communities could, by using astonishingly similar methods, become entranced and then be in a very susceptible state for conversion or brainwashing. Examples were taken from all parts of the world, including the London "scene"!—all original research collected by Dr. Sargant and his wife. A most interesting lecture.

Question time proved very entertaining. Professor Linford Rees then reminded us how lucky we were to hear this splendid work and thanked Dr. Sargant, on behalf of us all, for coming and giving us such an excellent evening.

Gerald Libby.

Centenary

of Sir Thomas Lauder Brunton's classic publication:

"On the use of Nitrite of Amyl in Angina Pectoris"
July 1867

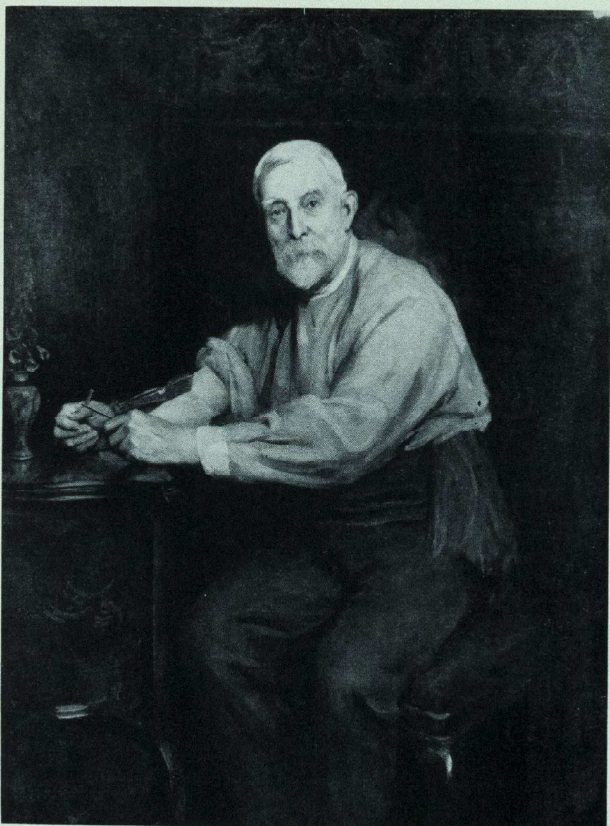
Sir Thomas Lauder Brunton 1844-1916

by John L. Thornton
Librarian

Edinburgh features prominently in the history of medicine, and several of the eminent medical graduates of that City have travelled south in order to extend their activities, to seek fame and fortune, or to share and improve their knowledge. Prominent among those who have come to Bart's was Thomas Lauder Brunton, an outstanding research worker, teacher, pharmacologist and advocate of physical education. Lauder Brunton distinguished himself as a student and was actively engaged in research from the time he qualified, contributing extensively to medical periodicals. He was the author of several books, some of which were translated into French, German, Italian, Spanish and Russian, and he was mourned by a host of friends after a life-time of painstaking investigation into numerous problems, some of which have advanced little since his death.

Thomas Lauder Brunton was born at Bowden, Roxburghshire, the third son of James and Agnes Brunton, his father being sixty-seven and his mother thirty-seven at the time of his birth. James Brunton farmed at Hiltonshill, and Agnes having died when Thomas was only four, the father brought Thomas up in a religious atmosphere which was reflected in his later life. Privately educated at first, Thomas then went to Edinburgh University, where he graduated M.B., C.M. with honours in 1866, B.Sc. in 1867, M.D. with a gold medal in 1868, and D.Sc. in 1870. In 1867, while House Physician to Edinburgh Infirmary and President of the Royal Medical Society, he published his classic paper in *The Lancet* (1867 ii, pp. 97-8) indicating that amyl nitrite would relieve pain in angina pectoris, and would also lower the blood pressure. This article was reprinted on several occasions, and appears in *Cardiac classics* by F. A. Willius and T. E. Keys, 1941, pages 561 to 564.

In 1868 his M.D. thesis was published as *Digitalis, with some observations on the urine*, London, Edinburgh, and includes observations made during numerous experiments made upon himself. A copy in the Medical College Library, bound with several other of his reprints, formerly belonged to James Matthews Duncan, another eminent graduate from Edinburgh who came to Bart's.



Herkomer's Portrait of Sir Thomas Lauder Brunton, which now hangs in the Great Hall. On his right arm is a Marey Sphygmograph for recording variations of pulse wave on the radial artery. In the vase is a foxglove from which Digitalis is extracted.

(Photo courtesy of Illustration Department).

The connection between Lauder Brunton and Matthews Duncan is confirmed by the fact that the National Library of Medicine at Bethesda houses seven volumes of "Manuscript notes of lectures attended by T. Lauder Brunton", indicating that he attended lectures on materia medica by Christison; on midwifery by Duncan and by Simpson; on the practice of physic by Haldane and by Laycock; and on organic chemistry by Playfair. The location of these volumes at the National Library of Medicine (formerly Surgeon General's Office Library) is probably explained by the fact that Lauder Brunton was a great friend of John Shaw Billings the librarian, and made numerous gifts to that Library. Also in 1868 Lauder Brunton was awarded the Baxter Natural Science Scholarship, and he made a lengthy tour of foreign medical centres including Vienna, Berlin, Amsterdam and Leipzig, where he made many friends. He also toured in Egypt, Syria and southern Europe.

The year 1870 saw Lauder Brunton's appointment as Lecturer on Materia Medica and Pharmacology at Middlesex Hospital, but a year later he came to Bart's, and from 1871-1875 was joint lecturer with Frederic Farre. Lauder Brunton transformed the subject from botanical expeditions and the study of dried herbs into experimental investigations of the

pharmacological properties of the drugs. His lectures were attended not only by students, but by teachers from other schools. In 1874 he became Editor of *The Practitioner* and continued for many years to contribute extensively to its pages. He was also elected a Fellow of the Royal Society when he was only thirty years of age. Lauder Brunton served on the Council of the Royal Society from 1882 to 1884, and was a Vice-President during 1905-6.

In 1875 Lauder Brunton was elected Assistant Physician to St. Bartholomew's Hospital, and the National Library of Medicine houses a twenty-nine page booklet entitled *Testimonials in favour of T. Lauder Brunton, candidate for the office of assistant-physician to St. Bartholomew's Hospital*, London, 1874. He was not elected full Physician until 1895, and when he resigned owing to illness in 1904, he was appointed Consulting Physician. In 1886 he had served on the Commission reporting on Pasteur's treatment of hydrophobia, and three years later he went to India as a member of the Hyderabad Chloroform Commission.

Sir D'Arcy Power gives the following description of Lauder Brunton:

> "As a lecturer he met with complete and well-deserved success, both at his medical school and on more public or official occasions. It will be observed that his best books were the outcome of collected lectures, and those that are not so, where they are not merely popular disquisitions, conformed to the lecture style. He was always able to make his subject interesting and easy to follow, and yet he was very thorough, while he would illustrate his points, whether simple or complex, by example, experiment, or anecdote. Punctuality with him was a watchword, and simultaneously with the hand of the clock pointing to the lecture hour the figure of Brunton appeared at the door of the theatre, and almost before he had arrived at the demonstration table he had completed a rapid summary of the previous lecture, so that his audience might be able to follow the thread." (p.5).

Sir D'Arcy Power had been associated with Lauder Brunton for many years, and his obituary notice of his former chief contains a wealth of information, including the following passage:

> "My first introduction to Sir Lauder Brunton was in the long vacation of 1877, when I was an undergraduate at Oxford and he needed someone to help him in the series of experiments subsequently published in the thirteenth volume of these reports under the title 'On the Albuminous substances which occur in the Urine in Albuminuria.' His laboratory was a cupboard opening out of the materia medica section of the Old Museum. The cupboard was lighted dimly by a dirty skylight. It contained a few shelves, a cold water supply, a sink, and one Bunsen burner. There was hardly room in it for my master and myself, and when visitors came, as they often did on the hot summer afternoons, the interview had to be conducted in the Museum. Much good work was done in this den, for in addition to the albuminuria research Sir Joseph Fayrer was dealing with snake venom and Cash with the physiological effects of digitalis, and here Brunton himself laid the foundations of experimental pharmacology which he lived to see firmly established as a science. At this time he was living at 50 Welbeck Street, having just moved from 23 Somerset Street, where he long had rooms with Ferrier, his fellow-student and life-long friend. Milner Fothergill, another University chum, was a daily visitor. The trio was remarkable, for each in his own way was doing pioneer work of the highest character and destined to bear good fruit. Of the three, if Fothergill was the least renowned he was the most wonderful in appearance, for he weighed 23½ stone and prided himself on his eccentricities. It was his mission in life, he said, to educate his two highly gifted scientific friends, down to a level at which they could earn a livelihood by their profession, and had he lived he would have rejoiced to see that his teaching was successful." (pp. 3-4).

Lauder Bruton had been elected M.R.C.P. in 1870, and six years later he became a Fellow. He was Examiner for the Royal College of Physicians from 1880 to 1900, Censor 1894-5, and also delivered the Goulstonian Lectures in 1877, which were published as *Pharmacology and therapeutics; or, medicine past and present*, 1880; the Croonian Lectures, 1889, printed as *An introduction to modern therapeutics . . . On the relationship between chemical structure and physiological action in relation to the prevention, control, and cure of disease*, 1892; and the Harveian Oration, 1894 published in the same year as *Modern developments of Harvey's work*. He was President of the Medical Society of London in 1905 and delivered the Lettsomian Lectures there in 1886. These were included in *On disorders of digestion, their consequences*

and treatment, 1886, reprinted in the same year and in 1887, 1888 and 1893. He was examiner in materia medica and pharmacology at Edinburgh, Oxford, London and Manchester, and was a member of numerous scientific societies at home and abroad. Many universities bestowed honorary degrees upon him, and in 1900 Lauder Brunton was knighted. Nine years later he was created a baronet.

In 1879 Lauder Brunton married Louisa Jane Stopford, and they had two sons and two daughters. The second son, Edward Henry Pollock Brunton, qualified in medicine, but was killed in France in 1915. The elder son, James Stopford Lauder Brunton went to Canada, and became a geologist. He presented this portrait of his father to the Hospital, where it is displayed in the Great Hall. Painted by H. von Herkomer, it shows Brunton in his shirt sleeves conducting an experiment on himself, and provides a contrast to the other formal paintings.

The writings of Thomas Lauder Brunton were extensive and widely scattered in various periodicals, but many of them were collected together into books. He excelled as a lecturer, and his printed lectures reflect his ability to command attention and to inspire his audience. In addition to the above-mentioned publications he was the author of the following books, and also contributed the section on Digestion and Secretion to Burdon-Sanderson's *Handbook for the physiological laboratory*, text and plates, 1873: *Tables of materia medica. A companion to the materia medica museum*, 1877, with a new edition in 1883; *The Bible and science*, 1881, which reflected his strictly religious upbringing; and *A text-book of pharmacology, therapeutics and materia medica*, (etc.), 1885, which was translated into several foreign languages, and went into a third edition in 1887, with reprints in 1891 and 1893. The first edition of this had been prepared and advertised some fifteen years before actual publication, but Brunton was constantly experimenting and revising and eventually he re-wrote the entire manuscript. D'Arcy Power was given the task of checking all the references, which occupied his spare time for three months. Brunton's *Lectures on the action of medicines. Being the course of lectures on pharmacology and therapeutics delivered at St. Bartholomew's Hospital during the summer session of 1896* was published in June 1897, reprinted in August and December of the same year, and in November 1898, while a reprint with an enlarged index was published in October 1901. This book was translated into several languages, and a copy bearing the imprint New York, London, 1899 was found in 1954 in an old log cabin near Farncomb Hill, Colorado, where it had apparently been abandoned since about 1902. J. B. Hume wrote an interesting note on the volume, which is now preserved in the College Library.

A collection of Lauder Brunton's papers and addresses, including one given at the International Medical Congress in Moscow in 1897, was published under the title *On disorders of assimilation, digestion, etc.*, 1901, reprinted 1904, and thirty-nine of his articles covering research work accomplished from 1865 to 1883, were reprinted as *Collected papers on circulation and respiration. First series, chiefly containing laboratory researches*, 1906. The preface to this contains much autobiographical material, and the volume is dedicated to David Ferrier "my chum for three years, and my friend for more than thirty." The second series, *Clinical and experimental*, was published in 1916 and is dedicated to the memory of Sir Joseph Fayrer and to J. Mitchell Bruce. It contains sixty-eight previously published papers, some written jointly.

Therapeutics of the circulation. Eight lectures delivered in the spring of 1905 in the Physiological Laboratory of the University of London, 1908, went into a second edition in 1914, and was followed by *Collected papers on physical and military training* published a year later. This contains thirty-three articles written in support of the National League for Physical Education and Improvement which Brunton had helped to found in 1905. He foresaw the outbreak of war with Germany, and his emphasis on physical fitness for the youth of this country, his interest in school hygiene, the boy scout movement, the cadet brigade, and in physical education in general was a major contribution towards preparation for the conflict. This aspect of Brunton's work was emphasized in a paper by Fielding Hudson Garrison, who stressed Brunton's work on the physiology of exercise. Lauder Brunton had many friends on the Continent, and the outbreak of hostilities caused him great distress. His wife had died in 1909, his son Edward was killed in 1915, and in a short note of farewell written to D'Arcy Power he wrote: "I am going to join Ted." Thomas Lauder Brunton died at De Walden Court, London on September 16, 1916, and was buried with his wife in Highgate Cemetery. Lengthy obituary notices appeared in most of the outstanding medical journals, and he left unsettled estate valued at £28,151. He left much more than that. The memory of a rather frail figure, a prolific writer, a keen traveller, constantly experimenting to improve his knowledge and to share it with others. A man devoted to his profession, which he enhanced by placing it on a sound scientific basis. He laid the foundations upon which modern pharmacology has been built, and his pioneer efforts in the face of difficulties should be an inspiration to his successors.

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Lauder Brunton Clinical Pharmacologist

by Dr. Paul Turner

Reader in Clinical Pharmacology

Lauder Brunton came to London in 1870 as Lecturer on Materia Medica and Pharmacology at the Middlesex Hospital, and then was appointed Lecturer on Materia Medica and Therapeutics at St. Bartholomew's Hospital in 1871. Clinical pharmacology remained one of the primary interests in his life, and he wrote several textbooks of pharmacology and therapeutics together with many original papers on the action of drugs.

He was responsible for the teaching of clinical pharmacology and therapeutics to the clinical students, and his course of lectures delivered during the summer session of 1896 were published as "Lectures on the Action of Medicines." It is evident from this book that his teaching was liberally illustrated with anecdotes, many of which give him a humorous commentary on everyday life of the end of the 19th century. A favourite story was concerned with the cough linctus prescribed according to the St. Bartholomew's Hospital Pharmacopoedia containing tragacanth powder and tincture of hips, which was a thick viscid liquid supposed to work by adhering to the fauces and reducing irritation there. This linctus had to be made thinner, and Brunton thought less effective, because it was discovered that a large number of children came to the out-patient department complaining of cough and were given the linctus which they then promptly sold to an old women in Smithfield who gave them each a penny and made jam tarts with it!

It is, perhaps, difficult to realise how much therapeutics has changed since Brunton's day. Few drugs in use now had been discovered then, and most of the preparations about which he spoke have been rendered obsolete. Much of his teaching was concerned with diet, exercise, massage, cupping, bleeding and counter-irritation. "There are various recommendations," he wrote, "which a doctor gives to his

patients . . . One of these is work for those who will not take it; another, rest for those who cannot get it; yet another is restraint of the appetites." His was the time of introduction of phenacetin, amidopyrine and salicylates as antipyretic and anti-inflammatory agents. The plasmodium had just been identified as the agent responsible for malaria, and its life history was being elucidated to give a rational basis for the therapeutic use of quinine which had already been the treatment of choice for more than 200 years. Cocaine had recently been introduced and its therapeutic applications were excitingly varied, albeit hazardous. Anaesthesia was still in its infancy, and the indications and risks of nitrous oxide, chloroform and ether were still being learnt by experience.

Lauder Brunton was a proficient animal pharmacologist as well as a clinician, and enjoyed demonstrating pharmacological principles by animal experiment during his lectures. His most important contributions to medical knowledge, however, were the result of observations on drugs in patients and in himself, and these must undoubtedly be his work on digitalis and on nitrites.

At the age of only 24 years, he obtained his M.D. (Edin.) with Gold Medal, for his thesis *Digitalis, with some observations on the urine* which was subsequently published as a monograph.

Digitalis was widely used at that time in the treatment of a variety of diseases including tuberculous haemoptysis, epistaxis, pneumonia, malaria, epilepsy and syphilis as well as in oedema and ascites of different causes. Its mode of action was quite unknown because the physiology of cardiac contraction had not yet been elucidated. It was not until 1893 that Kent and His discovered the atrio-ventricular bundle which furnished an antomical basis for the conduction of the cardiac impulse, and the sino-atrial node was not known till at least ten years after that. Brunton, like other physiologists of his time, believed that the autonomic ganglia which can be shown in the wall of the heart controlled and co-ordinated its contractions, and that they could be inhibited by vagal, and stimulated by sympathetic influences. Two schools of thought existed concerning the action of digitalis. One thought that its main action was through the vagus and sympathetic nerves, while the other believed that digitalis had a direct effect upon the "cardiac ganglia". From his own observations in animals, Brunton suggested that digitalis had a direct action on the myocardial tissue, but that this was small and relatively unimportant. Its main action was through the vagus to slow the heart, and the sympathetic to increase its force of contraction. We now know, of course, that the latter effect, an increased force of contraction is due to a direct action upon the myocardium. Brunton also claimed that digitalis causes contraction of the small arteries, and this has subsequently been confirmed. The effect is more easily demonstrated in normal subjects than in the presence of congestive heart failure. He was well aware of the symptoms and signs of digitalis intoxication. For several months he took increasing doses of the drug and experienced its anorectant effect, abdominal pain, vomiting and diarrhoea, impaired mental ability and visual disturbances. He also noted the onset of irregularities of pulse in patients with digitalis intoxication and his thesis includes a striking recording of the pulse wave in such a patient who obviously had atrial fibrillation induced by the drug, which returned to sinus rhythm 3 or 4 days after stopping it. This was before the age of E.C.G. machines for making such a diagnosis. He noted the onset of occasional ectopic beats as an early sign of overdose, followed by atrial or ventricular tachycardia as toxicity progressed. He observed ventricular fibrillation in animals, and thought that it was largely due to sympathetic stimulation. This is of particular interest, because when specific beta-adrenergic receptor blocking drugs were recently introduced they were found to reduce or abolish digitalis-induced arrhythmias, which suggested that these might be adrenergically mediated. However, it is now thought that this effect is due to quinidine-like properties of these drugs and not to their beta-receptor blocking action, and Brunton was almost certainly wrong in his view, although he did admit the possibility of a direct action on the cardiac muscle. He recognised that digitalis is a general tissue poison, and that in animals it reduced muscle power generally, in high doses. He was very interested in the diuretic action of digitalis measuring his own urinary output, its content of urea, phosphate and chloride for considerable periods of time. From his own observations he concluded that digitalis has a diuretic action in fluid retention due to congestive cardiac failure, and that it may sometimes have such an effect in normal subjects. Larger doses, however, produce vomiting and diarrhoea so that a negative fluid balance is induced and the urinary output falls. Still larger doses, by impairing cardiac output reduce renal blood flow and suppress urine production. This summary

cannot really be improved upon today, except to say that recent work demonstrates a direct diuretic action of digitalis on the renal tubules, but its significance at therapeutic doses is uncertain.

Brunton's second major contribution to therapeutics was his paper in the Lancet on July 27th, 1867 on the use of amyl nitrite in angina pectoris. Contemporary treatment for this condition had consisted of rest and bleeding, with administration of brandy, ether, chloroform or ammonia, but these were generally considered unsatisfactory. In 1859, Guthrie noted that the recently-discovered amyl nitrite caused flushing of the face, throbbing of the carotids and acceleration of the heart's action. Gamgee, a colleague of Brunton found that it reduced the blood pressure in animals and man, and these observations led Brunton to use it in a severe case of angina pectoris. He found that "on pouring from five to ten drops of the nitrite on a cloth and giving it to the patient to inhale, the physiological action takes place in from thirty to sixty seconds; and simultaneously with the flushing of the face the pain completely disappeared." From observation of pulse rate and pressure he noted that as an anginal attack developed the pulse and respiration rate and blood pressure increased. As the nitrite was inhaled the pulse slowed and became fuller, blood pressure fell and respiration rate slowed. Following Brunton's classical paper other nitrites such as sodium nitrite, propyl nitrite and isobutyl nitrite were found to have similar effects. However, although their action developed rapidly, it was transient and short-lived. Glyceryl trinitrate provides somewhat longer action, although it is still shorter than is desired. Despite the introduction of many so-called "long acting" coronary vasodilators, the effectiveness of the agents introduced by Lauder Brunton has not been bettered, and their exact mode of action is still not entirely known.

While his work on digitalis and amyl nitrite deservedly held pride of place amongst his research projects, he pioneered other measures as well. In the belief that the pancreas was intimately involved in diabetes, he administered tablets of pancreatic extract to diabetic patients, but naturally without success. The reason for this failure, he rightly concluded, was that the active principle "is one of those which become changed in the intestinal canal or during absorption; and if one is to obtain any definite result it must be administered by subcutaneous injection." He claimed to be the first to administer raw meat to cure disease. Having failed with pancreatic extracts in diabetic patients he gave raw meat with similar lack of success. He also gave raw beef marrow to

To the Royal Medical Society
with the authors compts

ON THE

USE OF NITRITE OF AMYL IN ANGINA PECTORIS.

By T. LAUDER BRUNTON, B.Sc., M.B.,

SENIOR PRESIDENT OF THE ROYAL MEDICAL SOCIETY, AND RESIDENT PHYSICIAN TO THE CLINICAL WARDS OF THE ROYAL INFIRMARY, EDINBURGH.

[*Reprinted from* The Lancet *for July* 27, 1867.]

Reproduction of the reprint of Lauder Brunton's paper which he sent to Edinburgh.

patients with pernicious anaemia, but with what success is not really indicated. However, it may be that these original ideas played a part in the development of raw liver therapy in this condition.

Bruton anticipated future progress on several occasions. He was convinced of the importance of adrenergic activity in mediating the effects of nicotine, and in particular suspected release by nicotine of catecholamines from the adrenal gland which had yet to be demonstrated. He taught that analgesic drugs act at various levels of the central nervous system, the narcotic analgesics such as morphine acting centrally while drugs such as salicylates and phenacetin have a more peripheral effect. It is interesting how relevant these observations are in our present controversies in these matters. He foresaw the introduction of the decimal system into prescribing. In 1896 he wrote "The decimal system has not yet come into general use in prescribing in this country but it is sure to come by-and-by," and in anticipation of this he devised a dosage scheme for children based on the metric system, rather than Young's method which by any standard must have been extremely complicated.

There were many things which Brunton taught that we know now to be erroneous. He used potassium bromide freely and denied that there were risks in "pushing" it. He considered that digitalis was a "tonic", it "braces up the vessels, and prevents the drowsiness during day and sleeplessness during the night." He believed in the value of bleeding and the application of leeches. For example "in inflammation of the liver they may be applied over it or to the anus, and in meningitis behind the ear." As an anti-pyretic he preferred "the old-fashioned febrifuge mixture made up of acetate of ammonia and spirit of nitrous ether" to modern drugs like phenacetin!

Nevertheless, Lauder Brunton was one of the first clinical pharmacologists. He believed that man must be his own experimental animal, and he used and devised all sorts of apparatus to study drugs in man. In times like this when complex electronic apparatus permits accurate study of reaction times it is salutary to read Brunton's work on "Apparatus for Measuring the Speed of Thought," where by means of a pendulum and levers he was able to detect the effect of alcohol, and other drugs on central function.

Although enormous advances have been made during the past 100 years, Lauder Brunton's opening remarks in his M.D. thesis on digitalis strike a contemporary note. "As we review the rapid progress made within late years by physiology, pathology, and other departments of medical science, and compare it with the slow advance of therapeutics, we experience a growing dissatisfaction with our present empirical method of treatment, which, consisting as it does, in the mere tentative administration of drugs without a definite knowledge of their action, must necessarily retard progress . . . Turning from this unsatisfactory method, we begin anxiously to look for one of a more rational character, which shall be based not only on a knowledge of the changes induced by disease, but on a minute and accurate acquaintance with the action of the remedies which we prescribe for its cure."

The Lauder Brunton Centenary Symposium on Angina Pectoris

Edinburgh 21st April 1967

by John Sills

The history of the Royal Medical Society, which organised this symposium is intimately connected with the history of the medical faculty of Edinburgh University. The first Professor of Medicine in what was then called the Town's College was appointed in 1685, but it was not until 1726 that the Faculty of Medicine was established. In 1734 six students of medicine began to hold informal meetings at which they discussed dissertations on various medical subjects written by themselves. This was the start of the Medical Society and it was formally constituted in 1737 with ten members. The record of members is complete, for upon joining the Society each member has to sign the Obligation Book and the Society is in possession of the series from the foundation to the present day.

At first the Society met weekly in a local

tavern under a President appointed for each occasion, but in 1741 when the Edinburgh Royal Infirmary moved to a new building the Manager granted the Society the use of one of the vacant rooms for their meetings. By 1776 the membership had grown so much that the Society opened its own premises and in 1778 King George III granted the Society its Royal Charter, which is proudly and prominently displayed in the Society's present premises.

During the 78 years spent in their first premises the Society flourished and many of the distinguished men of the day gave first intimations of their potential while undergraduate members of the Society. In 1854 the Society moved again and remained in premises in Melbourne Place until 1965 when development of the area made a move necessary. At present the Society is housed in Hill Square, Edinburgh adjacent to the Royal College of Surgeons of Edinburgh. There is room for some 40 members in the present meeting room, but for larger meetings the Society has the use of rooms in the Pfizer Institute and for important occasions such as the Symposium reported here they are granted facilities in the College of Surgeons. Ladies were not admitted to the Society until 1965.

Thomas Lauder Brunton's association with the Society began in 1863 when he went up to Edinburgh University and joined the Society signing the Obligation Book on 20th November, 1863. He was immediately appointed to the Finance Committee, which suggests that he may have made a strong impression at the very outset. He was fined for non-attendance at two early committee meetings but later records show that the committee decided that a "cold" and an anatomy class were reasonable excuses. In 1865 he was elected Secretary of the Society and in 1866 after his success in the M.B., C.M. examinations he was elected to the Senior Presidency of the Society. Throughout his undergraduate career he had, besides his clinical work and his activities in the Royal Medical Society been carrying out studies on two drugs; mercury and digitalis. The former researches were published in the form of a dissertation to the Society in 1865 and the experiments on digitalis formed a basis of his book on "Digitalis with some observations on the urine," which was published in 1868.

One month after being elected Senior President he was appointed in 1867, Resident Physician to the University Clinical Wards, and during the following six months he made the observations on the effect of amyl nitrite on Angina Pectoris which were commemorated at the Symposium.

The Symposium was really the brain child of Sir John McMichael, who was himself one-time Secretary to the Society, but the organisation was carried out by the Society, which was supported and encouraged by members of the staff of the Faculty of Medicine, whose Dean, Professor K. W. Donald, was once Chief Assistant to the Medical Professorial Unit at Bart's under Professor R. V. Christie.

The theme of this conference was "Angina Pectoris" and the Society had succeeded in gathering together an impressive number of world authorities on the subject To orientate the Conference with regard to Lauder Brunton and Angina Pectoris two of the undergraduate members of the Society presented papers as a preliminary. Robin Hunter's dissertation on Lauder Brunton has already been abstracted earlier in this report and much of the content also comes into the contributions of Dr. Turner and Mr. Thornton, but Miss Alison Leach's paper on the "History of Angina" contained some interesting points.

Miss Leach traced the history of the documentation of Angina from the original definitive account by Thomas Heberden in a paper delivered to the Royal College of Physicians in London in 1768 entitled "Some account of the disorder of the Breast." Early observations on the pathology of Angina were communicated to Heberden by one Dr. Wall of Worcester whose case turned out to be a case of Calcified Aortic Stenosis and Dr. Edward Jenner of Vaccination fame suggested that changes which could well have been atheroma, in the walls of Coronary arteries were associated with Angina. By the early years of the nineteenth century it was fairly well established that coronary arteries were necessary for full function of the heart and there were theories put forward by Allen Burns, Professor of Anatomy at Glasgow University, that coronary artery insufficiency was responsible for ischaemia of the heart with the consequence of angina. Heberden himself believed that spasm of the heart muscle was responsible for the pain. Lauder Brunton thought it was due to vessel spasm, while others were in favour of the theory that it was due to irritation of the heart nervous elements. In 1867 Knoknagel suggested that the symptoms were due not to primary heart disease but to secondary factors comprising generalised arterial spasm and in 1876 Hannah reported the first coronary thrombosis diagnosed in life and confirmed at post

mortem examination. It was interesting to hear that it was only in 1880 that the first accurate description of a myocardial infarction was published by Vigerdt, and in 1912 Herrick indicated that the sudden occlusion of a coronary artery was not always fatal.

If the opinions as to the cause of angina were diverse during this period the treatments were equally so, and Lauder Brunton was really the first man to produce any effective treatment when he described the use of amyl nitrite a treatment that is still used today.

After this historical orientation there followed the first of a set of four papers devoted to the pathophysiological aspects of angina pectoris. Dr. W. F. M. Fulton of Glasgow described some studies on the anatomy of the coronary arterial circulation and collateral channels, visualised by post mortem injection of radio-opaque material into the coronary arterial system. He showed that cardiac ischaemia depended upon insufficiency of coronary out-flow in relation to myocardial needs and that the extent of structural damage and hence the differing clinical syndromes of myocardial infarction and angina pectoris depended as much on the distribution of blood through collateral channels in the heart muscle mass as upon the extent of obstruction of the arteries on the heart surface.

Dr. J. Russell Rees of the Westminster Hospital then presented a survey of his work on dynamic aspects of collateral blood flow in the coronary artery system of dogs. Dr. Rees occludes branches of the coronary arteries by ligation or by blocking with a catheter tip and by techniques using radio-xenon is able to study the blood flow through the area distal to the occlusion which is a measure of the state of the collateral circulation. If the vaso-dilator drug dipyridamole is administered the degree of vaso-dilatation of these collateral vessels may be measured. He had found that in experimental myocardial infarction collateral channels are maximally dilated in the first hours after occlusion and that as new channels open up on successive days the vessels become less dilated. Collateral blood flow varies with systematic blood pressure so that a reduction in flow is likely to follow the hypotension of shock and large doses of barbiturates, while the administration of pressor drugs is accompanied by an increase in collateral flow. Dr. Rees also referred to the actions of glyceryl trinitrate and suggested that the effect might be more than a simple vaso-dilatation and involve reduction in the myocardial oxygen requirement.

Dr. Richard Gorlin of Boston, U.S.A. was the next speaker and he outlined work done in his laboratory in which the metabolism of the human myocardium was studied by simultaneous sampling of blood by catheter from the coronary sinus and the arterial system. He discussed the findings relating to oxygen uptake and lactic acid production and how they might change under different conditions and with the action of glyceryl trinitrate and stated that in his opinion the effects of this drug were due to actions at the arteriolar rather than arterial level of the coronary vasculature. In the final paper of the pathophysiological session Dr. Ottar Muller of Oslo described his work on the effect of exercise on pulmonary capillary venous pressures in patients with coronary heart disease. Signs of impaired left ventricle function are most easily provoked during stressful situations and attacks of anginal pain. The actual mechanism of the impairment were not clear but could well be due to such other haemodynamic parameters as systolic ventricular pressures and the stroke volume. After a period of informal discussion on the papers the Conference adjourned and met again later on in the evening in the Hall of the Royal College of Physicians of Edinburgh for a formal dinner to honour the memory of Lauder Brunton and celebrate the centenary of his observations on the actions of amyl nitrite in angina.

The Conference Session the following morning was devoted to papers dealing with aetiology, diagnosis, prevention and treatment of angina. Professor Jeremy Morris of The London Hospital presented the first paper on "The Modern Epidemic," in which he discussed the methods of the various studies which had suggested that such factors as stress, raised blood pressure and high blood cholesterol levels were of importance in the aetiology of both angina pectoris and myocardial infarction. He also emphasised the importance of these conditions socially and economically and in his closing words wondered if as there were now some well established types of men who were liable to develop ischaemic heart disease, there were hopes of preventive action. Unfortunately at the present time one of the difficulties was lack of proving data, and so the next step would have to be properly conducted trials . . . this question he left for the next speaker Dr. Michael Oliver of Edinburgh to discuss, in his paper entitled "Is Angina Preventable?"

Dr. Oliver took four of the more accepted aetiological factors; hyperlipidaemia, hypertension, cigarette smoking and physical inactivity and considered each with reference to prevention of ischaemic heart disease. Cigarette smoking, which was more closely associated with myocardial infarction than with angina pectoris would, he concluded, be difficult to control as the effects of the reports linking the habit with lung cancer upon the public taste have shown. As he considered the association to weight a less well documented association and less easy to assess, and because the publications to date reporting the prognostic value of treating hypertension present with pre-existing ischaemic disease were rather discouraging, he suggested that any attack on the prevention of ischaemic heart disease should aim at prevention of the premature onset of the disease by attacking hyperlipidaemia. Hence if hyperlipidaemia of one form or another was an aetiological factor it could be studied with long term clinical trials, and Dr. Oliver then proceeded to describe a trial of the lipid depleting drug Atromid-S (Clofibrate), which he and his colleagues were undertaking to find out if the drug had any preventive action.

In the penultimate paper Dr. G. C. Freisinger of Baltimore, U.S.A. described some of the objective methods of study employed at the Johns Hopkins Centre, Baltimore, to determine whether an individual with subjective chest pain was suffering from angina pectoris or not. Although he saw many patients with typical angina pain, which had the three characteristics of relation to effort, substernal location and visceral character, he found that there were many patients with pain that was possibly ischaemic in origin and others with pain, whose origin could not be posivitely related to the myocardium from the history alone. One of the techniques used in evaluating patients with chest pain is that of exercise electrocardiography, the patient exercises on an escalator (the bicycle being outmoded) and a twelve lead electrocardiogram is taken. Specific E.C.G. changes such as a square, a down sloping ST segment depressed more than one millimetre are taken as evidence of myocardial ischaemia. The second technique is that of selective coronary cine arteriography, which outlines the coronary vascular tree in vivo and demonstrates not only obstructive lesions of the arteries but also the degree of collateral vessel formation, and Dr. Freisinger expressed the hope that studies with this latter technique might in the future improve our ability to prognosticate and thus lead to a better understanding of the natural history of ischaemic heart disease.

The final paper on "Prognosis in Angina Pectoris" was given by Dr. C. F. Borchgrevink of Oslo. He reviewed the literature on the subject and reported that his own experiences in a controlled clinical trial of the prophylactic effect of anticoagulant therapy seemed to indicate that long term anticoagulant therapy had some part to play in the prophylaxis of angina. In conclusion, however, he pointed out how difficult it was to predict the course of the condition in individual cases, but that in general there was a fifty per cent chance of a ten year survival; while the prognosis was independent of age, severity, and duration of symptoms the chances were reduced by such factors as hypertension, cardiac enlargement, an abnormal ECG or co-existing heart lesions, such as valvular disease.

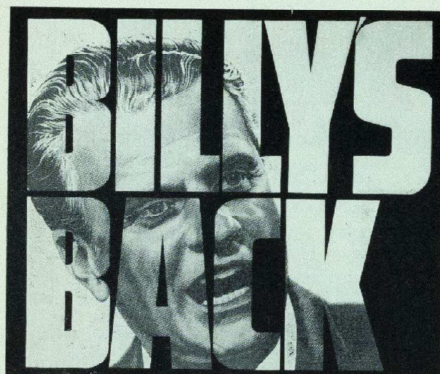
As a conclusion to the Conference there followed a Panel Discussion. This dealt with questions from the floor and among the subjects covered were the uses, even today, of short acting nitrites, the role of long acting nitrates, propranolol, and anticoagulant therapy. Also touched on was the question of surgical treatments such as internal mammary artery implantation or disobliteration operations to increase the blood supply to the myocardium.

Then after a short closing speech by Sir John McMichael the Conference, which had been so stimulating and interesting, was suddenly over.

On reflection it is perhaps an indication of the greatness of Thomas Lauder Brunton that today the only therapeutic attack on angina which is universally accepted is with the short acting nitrites. And full and comprehensive though the conference was, one came away with the impression that there was still much work to be done before all the mysteries of angina and its particular relationship to myocardial infarction could be resolved. Indeed this quotation from a dissertation read to the Royal Medical Society in 1800 by one A. Lawler is appropriate even today; "Angina Pectoris has seldom been completely cured, yet still we must not despair as in time we may arrive at its true cause and administer effectual remedies."

I should like to take this opportunity of thanking the members of the Royal Medical Society for their help and hospitality and the Medical College of St. Bartholomew's Hospital for granting me the privilege of attending this Conference.

I should also like to acknowledge the help I have received in preparing this report from A. J. Ruff, Esq., of Geigy Ltd.



by Peter Dady

Preceeded by an awesome barrage of advance publicity Dr. Billy Graham, Scourge of the Godless, launched his second British Crusade in two years, at Earl's Court on Friday June 23rd.

Posters have, for more than a month, proclaimed the (presumably) Glad Tidings of this second coming in so short a time. Probably this news is no surprise for many, for at the end of his last visit the American 'Hot Gospeller' pledged his return, presumably to tackle any intractable sin which he was unable to treat during his last campaign. True to his word at the appointed hour Dr. Graham, with a small band of disciples, manifested himself to his waiting public. Tuesday night, when I attended the show, Earl's Court and two ajoining auditoria, equipped with closed-circuit television, were crammed to capacity, while some thousand frustrated souls milled around outside. Linked by landline to twenty-eight provincial centres, the evangelist had a huge potential of redeemable sinners.

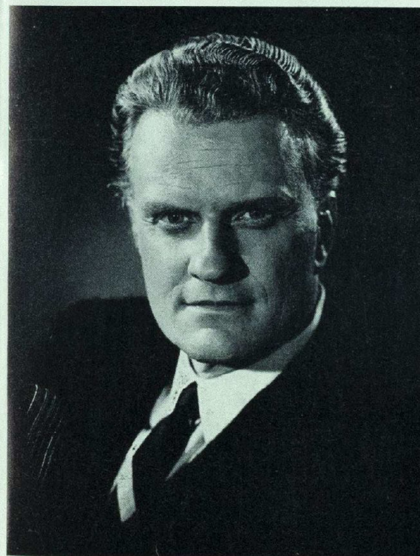
One of Dr. Graham's acolytes set the ball rolling with a short prayer, a very good prayer, lacking the grandiloquence and bombast which so frequently make communal prayer a ritual to be intoned but not necessarily understood. This high standard was maintained in all the prayers used in the service. Communal hymn singing followed, the huge audience conducted, with considerably more enthusiasm than skill, by a member of the Graham entourage. The value of massed song has long been recognised as an adjuvant to emotion, hence the fervant 'Abide with me' from a largely athiest crowd at the F.A. Cup Final.

Suitably receptive we awaited a revelation, apparently to be furnished by an American gentleman, who bounced onto the rostrum exuding more bonhomie than a politician about to kiss a whole maternity homeful of babies. Perhaps it is rather unfair to cast aspersions on this speaker's sincerity, which if anything but genuine, undoubtably merited an Academy Award. The message was clear and simple, hire of Earls Court with twenty-eight provincial auditoria is by no means cheap, not to mention a million dollars spent on purchase of 'prime' viewing time on American television, for which somebody has to pay. Hard on his heels there followed an English Gentleman who, clutching nervously at his club tie, told a joke of venerable antiquity, and invoked the spiritual authority of the gospels to add gravity to his appeal for funds, quoting from the Bible 'The Lord loveth a generous giver'. It is refreshing to note this area of agreement between the scriptures and so many individuals and organisations. Stewards then passed among the congregation with collecting bowls. Commercialism was a recurrent theme and throughout the evening various speakers produced various goodies obtainable 'free' from the Graham Organisation in Minneapolis by dispatching a maximal contribution to the campaign fund.

Two singers then sang for us, a lady and a gentleman. They chose two fine examples in the Religious-Folk Music style and both gave good, professional performances. Mr. Cliff Richard professed alarm at having to follow two such talented performers, but was prevailed upon to sing a pleasant little Yuletide number. Not only did Mr. Richard sing, but also gave testimony of his belief, which apparently makes his work much more enjoyable, a revelation indeed to those of us who have thought that the popular branch of the musical profession was notably impious, the chief joy for practitioners in this field being financial. It was, however, impossible to detect any insincerity in Mr. Richard's faultless little discourse, and I am sure his avowed intention of leaving Music for Teaching will win him widespread applause.

In an atmosphere of tense expectancy Dr. Graham strode to the rostrum and began his address. It was soon obvious that here was a superb orator. Eyes narrowed to slits, voice beautifully controlled, and gestures wonderfully expressive, Dr. Graham is one of the great public speakers of this time, possibly the

greatest since Hitler. Unfortunately, as with most great public speakers his appeal is emotional, not rational, logic does not appear to lend itself well to fine words and eloquent pauses. Those of us looking for a carefully constructed argument, leading step by step to a logical conclusion, were disappointed. Dr.



Dr. Billy Graham — Evangelist

Graham had chosen the subject of 'Youth' for his theme, a subject which has been exhaustively discussed, especially since the advent of the Sunday Colour Supplements. He did, however, have at least one rather interesting theory, concerning the current neurotic obsession with Youth, that is that this phenominum is a fulfillment of Joel's prophecy that 'Their young men shall see visions', a rather dubious premise when most of the visions seen by the leaders of the juvenile cult seem to be drug induced. Not quite what the prophet had in mind, I think. Statements like 'There will be no peace on earth until all men turn to God' sound a little hollow when the leaders of established churches seem to compete with each other in bellicosity. Our own Archbishop 'Bomb Rhodesia' Ramsey and America's leading Cardinal, and 'Hawk,' Spellman spring readily to mind. Ironically among the most ardent advocates of peace are the 'Hippies' of California, who were berated roundly for Godlessness.

Dr. Graham terminated his dissertation with the customary invitation to his audience to 'Come forward for God.' Many decided 'for God', the vast majority of them young, probably on average sixteen years of age, and it is difficult not to wonder if perhaps some of these were not swept forward on the flood tide of emotional oratory without perhaps having made any real decision for themselves.

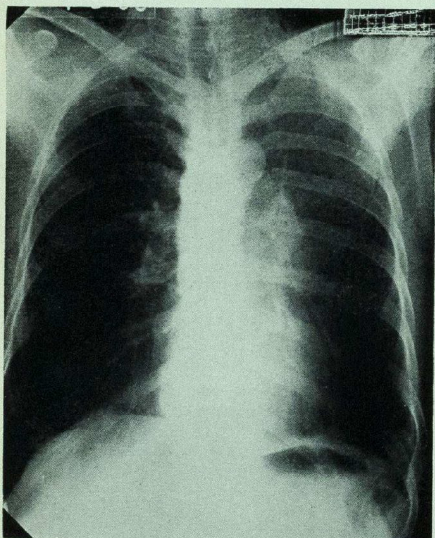
As the thousands left their seats to come to the front of the hall an American aide, *Sotto Voce*, invited the American television to 'Invite friends and neighbours round to view with you the next transmission, brought to you by the Billy Graham Organisation'. Perhaps we have seen and helped finance a new American social institution, which will one day become part of the national heritage, along with the neighbourhood Barbecue or Clambake.

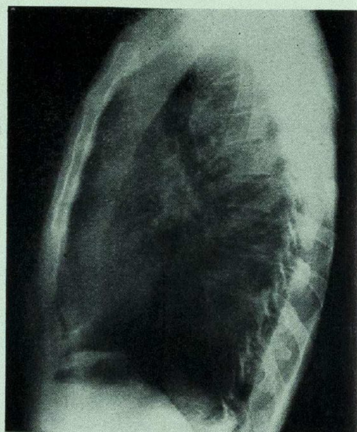
Outside Earl's Court demonstrators handed out anti-Vietnam War material.

Dr. Billy Graham reads the Scriptures

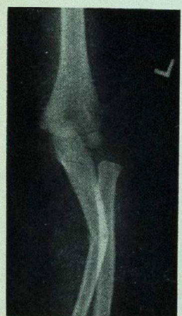
Diagnosis by J. R. Griffiths.

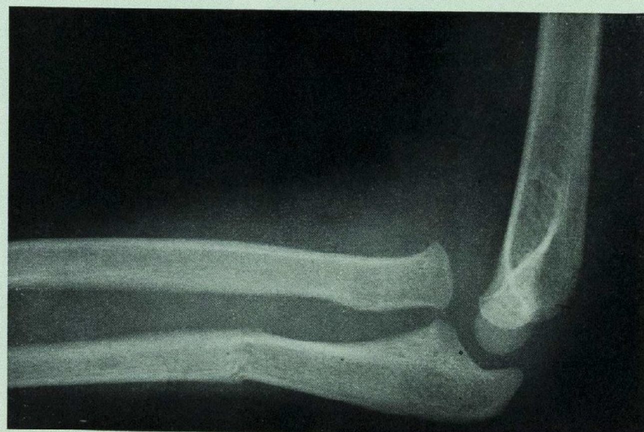
a. A. These are the films of the chest of a 64 year old man.





1. What is the likeliest explanation of the opacity in his left lung field?
2. What complications have arisen?
3. What were the patient's most probable presenting symptoms?





b. 1. Diagnosis?
2. Treatment?

Answers on page 321.

Stylytes

On fait moderne quoi?

"Now you are a really useful member of a team." Poor little chap. *"What you do counts."* How disillusioning to find that he is eminently dispensible. *"On a Surgical Firm the student makes a real contribution."* This amounts to an extra pair of hands in the theatre and endless blood sampling. Even in casualty—medicine at first hand—the work is immediately and justifiably duplicated by the House Officer. Time is saved by doing stitch-ups, and the student's presence allows the House Officer time to eat. This is not unreasonable, students could not sensibly be given more responsibility. Safety demands that their work be checked. None the less, although he is here only to learn and not to actively administer treatment, it is a pity that so many of the students' duties should entail doing work that could quite well be left to the porters: collecting X-rays, fetching notes, carrying specimens to the laboratories.

The dilemma of medical education, is the problem of training students for responsibility, without allowing them any that might jeopardise the patients' safety. In most cases the two are incompatible. The answer must surely involve an appreciation of the desirability of fostering personal responsibility in place of professional. This requires both a reassessment of teaching methods and a greater involvement of the students in teaching. A step towards this is to make the knowledge demanded of students more profound, and their presentation of this knowledge more professional.

How much can be expected from a student on a Ward Round in the early afternoon, when the patients under discussion have only been admitted since mid-day? Are ward rounds by themselves really the most effective vehicles for Consultant's teachings? Are the demands on the students really adequate? Often their scope is far too ambitious. Can eight or more patients be comprehensively taught upon in two hours? This often requires no more than a basic appreciation of the history and physical signs by the student and allows only the briefest dissertation by the Consultant. Under the present conditions this is almost without exception inevitable.

Whilst it is impracticable to go as far as the B.M.S.A. and advocate the installation of "Student Tutors", students could play a more demanding role if a system of Seminars were introduced. The Consultant performing the role of chairman of a series of discussions in depth on previously selected patients. This system would allow perhaps a half an hour for students to present a comprehensive survey of the case, from angles, pathological, clinical, radiological, aetiological, and any others of relevance. The Consultant might guide both this presentation and ensuing discussion along the channels that he considered most productive. This system would in no way remove any emphasis from the examination of patients in the wards, but would allow a more intensive study of the topic by the student, putting greater emphasis on his appraisal of the situation. And rather than relying on the Consultant for information that with a minimum of ingenuity he could discover for himself, it would encourage him to develop that sense of inquisitiveness so important to the Medical Practitioner.

Baghdad Rats

by Colonel W. C. Spackman

A further extract from Colonel Spackman's Reminiscences. Colonel Spackman, an old Bart's man, served in the Indian Army.

In previous numbers of the *St. B.H. Journal* I have recorded some of my adventures as a Regimental Medical Officer with an Indian Regiment in the First World War—the terrible Battle of Ctesiphon (*March* 1966) and the subsequent Fall of Kut after its five months siege (*November* 1964). We then had to undertake, as prisoners of war, in our emaciated condition, riddled with dysentery and various deficiency diseases, and driven on by a callous Arab escort, the long desert march into Anatolia in the tropical heat of May, June and July 1916. Very few survived the ordeal and I was one who did. My friends still regard me as "indestructible".

I also recorded (*March* 1965) my romantic voyage in the reverse direction down the Tigris on a kelek (raft) from Mosul to Baghdad so hopefully under a promise of repatriation.

I now show how these bright hopes were doomed to cruel disappointment, leading to my second journey north and a further two years incarceration in a prisoners-of-war camp in the mountains of Central Anatolia.

On reaching Baghdad on my raft at the beginning of December, I was taken to see Cassim Bey, an Arab officer in charge of the P.o.W. depot, a man with a reputation for homosexuality and other venal vices but not hostile to the British. He examined my papers and accepted in principle that I was to be sent down river for repatriation as soon as it could be arranged. So far so good.

After this interview I was given accommodation in a house overlooking the Tigris, on the right bank, just above the point where a railway siding ran from Baghdad Railway Station to a small wharf, a distance of about half a mile. In this house also were two or three Kut men, British, detained in Baghdad for various reasons and perhaps half a dozen others captured subsequently.

I found myself again the only British officer in the place, but there was also an Afridi officer of the Indian Army who was suspected of accepting privileges from the Turks for political subversive purposes. I found him enjoying a good deal of unexplained liberty and wearing a version of a Turkish officer's headgear. This cap he promptly discarded on my arrival and resumed the proper kulla and safa he should have been wearing. Cassim Bey professed to be surprised that I declined to share a room and feed with him. He proved to be a thorough nuisance to me later on when we met again under conditions of great adversity, expecting

me, already exasperated with him, to make smooth his path when it was all I could do to keep myself going.

In the same house were a number of wretched Russian prisoners captured on the Persian front. We rarely saw them but sometimes heard them at night singing their songs and choruses, their deep Russian voices booming and echoing up from their cellar below us. They had with them a little Lieutenant named Alexis, a sad sensitive man, formerly a schoolmaster in the Ukraine. He knew rather less French than I did and we exchanged one or two surreptitious but unimportant notes. Later on, at the time of the fall of Baghdad, we met and had a serious conference. He died on the march up country that followed the Turkish evacuation of Baghdad, being the subject of tuberculosis and, like so many others in no sort of condition for so severe a physical undertaking.

I was most thankful to find among the British P.o.W.s a soldier named Lawrence Eyres. He had been an undergraduate, in fact a scholar, at one of the Oxford colleges and had enlisted at the outbreak of the war and gone through the siege as a private of the Dorsets. He had been kept back in Baghdad by the Turks for clerical duties with the prisoners of war. He became a schoolmaster in a well-known Public School in England.

Unlike me, he was a most ascetic character, but I found him an amusing and intelligent compatriot to talk to after so many days and I got him appointed nominally as my orderly. On this footing he was allowed to come and talk to me whenever I wanted, and each night we had great contests of chess and bezique, and he taught me the Nile patience which has often solaced me since. At other times and in other moods we read from my sole literary treasure, Riddell's copy of the Oxford Book of Victorian Verse.

On the opposite bank of the Tigris was the Hotel Tigris (later the Hotel Maude) to which I was allowed to go about twice a week to dine, guarded by a posta, crossing the river in a boat. Eye diseases were extremely prevalent and it happened that the boatman I employed was one of the very few with more than one eye so he was called some Arabic name meaning "the two-eyed boatman"!

The hotel proprietor was one Zia, a grand fellow who always treated me excellently. Whilst my posta sat outside, I would go into Zia's office where he gave me "mezzeh" before dinner, lettuce, bits of cheese, celery washed down with raki. As the latter is very strong and was liberally dispensed, I was glad to find it produced no ill-effects provided I took plenty of lettuce at the same time! Zia used to give me bits of news, with due regard to any Turks who might be present: "the weather down river was good" or "there had been a bad storm in France" to indicate how the war was going. His sympathies were clearly with us.

I found Eyres involved in a scheme to escape; he had made friends with local monks and nuns who were trying to arrange certain essential contacts for him. I was not much interested personally at first, though I advised and encouraged him as best I could. I still had the Turks' assurance that I would be sent down for transfer across any day "soon". In fact, I actually got my papers signed for the "very next steamer" when, a week before Christmas 1916, General Maude started, after months of inaction, his methodical atack on the Turkish positions astride the Tigris south of Kut, and so my chances of repatriation were first postponed and finally faded out altogether. I then began to take a practical interest in the question of escape, but as I had not given any parole I was closely guarded the whole time.

Akbar

It was about this time that Akbar turned up in Baghdad. He had been servant to one of the officers of the 48th, an engaging young Mohammedan the mess sometimes used as a relief cook and he was not restricted to a specific employment as are the Hindus with their caste system, by which, however, you can always find "the man for the job", be it as a false witness in the courts or to carry out a murder. In India it was almost impossible to rise above your station of birth. We had, however, a young regimental "sweeper", doomed only to do the dirtiest and most degrading tasks, who took his chance when it came. Throughout the campaign he had shown most unusual energy and cheerfulness in his distasteful work and made himself widely liked and relied upon though still a sweeper. As a P.o.W. by his enterprise and initiative while working on the railway construction programme our men were engaged upon, he raised himself to a position far above that which he could have reached in India.

But the opportunist whose story I want to record was this man Akbar. When in May I had remained in Mosul, as I have related, Akbar proceeded west on the road to Ras el Ain with the others and was lost in that land I was always trying to picture.

At Mosul, the blazing summer settled down inexorably, and throughout the afternoon man and dog lay and endured, the beggar and the

pariah sharing the scanty shade of a mud wall, whilst I in my small room at the hospital shared the heat and some of the flies lying somnolent and perspiring on my reed mat.

On such an afternoon in that August, the entrance, after a quiet but persistent knock of Akbar into my room did not excite a welcoming smile, especially as I saw him attired in a German follower's uniform, his pagri replaced by a dirty white peaked cap with the little concentric coloured disc in front.

But Akbar's knowledge of me was based on old experience, and the rapid production of a large and fragrant plum-cake saved him from being flung out. Obviously, I thought, here was an occasion for less summary treatment: plum-cakes in those days were not mere luxuries, they were miracles! If Akbar and I must part in anger, it would be hard if that cake and I must part in sorrow as well.

"Akbar, what is all this? Have you too joined the multajis, the deserters?"

"Your honour knows that I hate the Germans. They are only pigs."

"What are you doing then in this rig-out?"

"The desert is a bad place," with a wave towards the west whither our hungry and ragged army had been driven—"many are dead, more dying from lack of food and care. A man must get back to the English south of Kut before winter or die in misery over there. My Germans are going to Ravandooz to fight the Russians. It is better to ride back with them and wait one's chance than to run away as a poor starving hai to be robbed and beaten by Arabs or perhaps caught and hanged by the Turks. The Germans know that an Indian is the best cook for them between Stamboul and Singapore, so I have charge of their kitchen. Allah in his mercy has given them but a poor intellect, and—pointing to the cake—they sleep in the afternoons".

I received several brave cakes from Akbar in Mosul and enjoyed them the more knowing whence they came. Then I heard that the Duke of Mecklenberg's Machine Gun Mission had departed for Ravandooz, and Akbar's visits to me ceased abruptly.

A New Cook and His Story

One day in the following December, after my return to Baghdad by the kelek, I was having tea in my room in the P.o.W. house, wondering if and when I should be sent down river. This led me to think of Akbar and to speculate on his fate and fortune in the months that had intervened, and it seemed almost natural that just then an Arab urchin should bring me up a note, which read:

"I have heard that your honour is in Baghdad. I am in prison, can the protector of the poor get me out? Akbar."

This set me quite a problem. Doubtless, thought I, knowing master Akbar, he had been cast into prison for some good and sufficient reason, and who am I, a fellow prisoner of war, that I can beg him off?

I had to approach Cassim Bey whom I knew was vain and ambitious and wished to stand well with the British in case of Turkish disasters. He was a native of Baghdad and subsequently deserted to us.

I went to his office next day, and after the routine coffee and polite enquiries about health, he asked me what was the news, i.e., what did I want?

"Oh, Cassim Bey," I said, "I am in such a plight. My cook has been taken ill, and there isn't another at the prisoners' depôt!"

"Aman! aman! effendim, neh yapalam (what can I do)?"

"There is only one man in Baghdad," I replied, "powerful enough to help me, now that Vali Bey and Khelil Pasha have gone down to Baghaila with Herr Grossmann Pasha, and that is yourself—or perhaps the Gendarma Commandant might help me."

Now Cassim and the Chief of Gendarmes were sworn enemies.

Whereupon Cassim bestirred himself, and having some hold over the prison governor (or for some quid pro quo, always a possibility), he induced that official to deliver up Akbar, and Cassim sent him over. The outcome was that my cook (whose illness was, of course, fictitious) regularly received the benefit of Akbar's well-known repertory of story-telling, in the vein of Scheherezade, and was occasionally allowed to make me one of his famous plum-cakes.

The roof of our house after dinner, with a moon over the river and a gentle breeze blowing among the palm tops, was an appropriate setting for Akbar's yarn, he facing the moon and a bottle of raki rather nearer him than me, sitting in a deck chair. How much of his story is fact and how much borrowed from one of his famous tales I am not prepared to decide, but it ran on these lines.

"Yakob was a simple man and, of course, he would have got me hanged if he had had the brains, poor fool. He did not know that I had run off with some of the Germans' maps and papers and, being a Christian, he believed me when I told him I was a poor harmless date-seller. So we went into partnership, and I shared his hovel in the ruins of Kut town, I taking the more protected side, under the wall, for the British shelled and bombed us almost daily, and Yakub lay like dead with fright. Allah is merciful and just!

"The maps and papers were hidden in the ground under my mat, also some money I had to buy food for the Germans when I ran away. I had a poor pilgrim's cloak and turban in my kit, and these were all I needed for disguise to make my way down to Kut by way of Kirkuk and Hillar."

All this I could well believe, or most of it, for poor naik Wali Dad of the Sappers and Miners, who was afterwards recaptured and most severely dealt with for trying to escape, made his way from the Amanus mountains to Baghdad dressed only in a gunny bag! I saw him arrive, after his journey of 700 miles.

"In Kut", Akbar resumed his tale after a brief interval for refreshment, "I bought a stock of dates from an Arab merchant, and Yakob and I used to go down to the Turkish trenches and sell them to the soldiers. Of course we used to get beaten and driven off, but on quiet days the chaoush would let us trade if we gave him a good lump of dates for himself. I used to wander for miles over the Turkish position pretending to be a bit mad, selling dates and cigarettes and hashish, and all the time trying to see how to get across to the British trenches. The river was low so it wasn't difficult to get about, but one day I went a bit too far and a Turkish officer sent me back to Kut where I was put in prison. Yakob came to see me there and brought me some food and my bedding. I told him the English were going to shell the town and he should have my side of the hut where he would be safer. A poor dull man, mashallah! who believed me about the shelling. Also he did not guess that the hut would be searched. They found the German maps under the wall, under Yakob's mat. That is why they hanged him that evening and only sent me to prison in Baghdad. Allah Kerim!"

Akbar did not seem ashamed of this shocking treachery. He had learned to survive by his wits and it was useless for me to argue with him. When Baghdad fell to the British in March and we were all bundled out north again with the Turkish army in retreat, I lost sight of him, but I feel sure he survived, and in less discomfort than most of us!

Escape?

By now I had a few friends in Baghdad but, as the only British officer, was closely guarded. Even permission to visit Cassim's office was not easy to obtain, though I was allowed on certain days to go and dine at Zia's, where I was always waited on by Thomas the head waiter, even if the place was full of German and Turkish officers. I knew there were many Christians and Jews who would favour a British regime, but they dared not display their sympathies openly. One day I was brought a bottle of wine I had not ordered. I asked no questions but noticed a Baghdadi wearing a fez who was being served by Thomas with just the same red wine as he had brought me. This man caught my eye in the large mirror just ahead of him (he had his back towards me) and raised his glass, I did the same. It was in such cautious gestures that one came to recognise possible helpers. I learnt that this man owned a house and garden on the right bank on the southern outskirts, and it was to this fruit garden, enclosed in its high mud wall, that I hoped to make my way if, at a suitable moment, the opportunity arose to give the slip to my guard. Here again I was to be frustrated as I shall relate later.

Eyre's escape scheme with the nuns ran into difficulties as the "friendly" sheikh who was to be the intermediary blew first hot and then cold according to the turn of events as reported by the desert "grape vine", and as I had by then pretty well written off my chance of transfer, he and I began to think of other ways and means dependent on our own efforts to replace those of the convent.

General Maude's army was still held up a hundred miles to the south and there were several other Turkish positions in between, with a lot of military comings and goings by river and by desert tracks which would make escape just then almost impossible. For the same reason Eyres persuaded me to abandon the idea I conceived, after a rather hospitable dinner at Zia's, of making off in the boat after throwing the guard and boatman into the river. He pressed the extra point that they might be drowned!

We did go as far as to work out a scheme for getting out of our house at night via a window and a wall, even trying the effect of a bottle of raki on a night-watchman on the railway siding below us which we should have to cross: he soon got drunk and dozed off. In fact, one night we had a rehearsal, climbing over the wall and back again; I still remember how my heart was thumping with excitement. After this we were confident we could slip away into the date groves and gardens when the right moment arrived, i.e. on some dark night as soon as the British had got a bit closer up. We knew they had crossed the Tigris at the Shamran bend and had started the series

of actions which would bring them nearer almost daily. Khalil's forces were fighting rear-guard actions all the way back and we had little inkling as to just how far the British had got. We had been strictly confined to our house following a British air raid when we were thrilled to see a number of our 'planes come over and drop bombs, some near the citadel and others on the railway yards quite close to us. The bombs were not large and did little damage, but produced a sensation in the ancient town out of all proportion to their military effects.

Then suddenly on the morning of the 28th February, we saw a regular fleet of small and large boats, and the great round and capacious guffas, like huge porridge bowls, making their way across the river to the wharf right under our noses where there was a siding leading to the railway station, and all heavily laden with Germans of the administrative branch, with quantities of kit and baggage.

We watched with growing excitement, for it was obvious that the run had started and that our own moment for putting our escape plan into operation was upon us. I managed to send some kit, including my two lovely saddle bags, over to the American Consul, our good friend Mr. Brissell, but only just in time. Eyres and I determined to attempt our escape that night, taking advantage of the confusion around the wharf, but alas! a strong guard arrived in the afternoon and we were all taken away across the river and thrown all together, including the dozen Russians, into an innermost dark and dismal room inside the citadel, a regular old-fashioned fortress with enormous walls and iron studded gates.

Light was provided by a couple of smoky oil lamps and I alone had been allowed help with the small amount of personal kit and bedding I brought with me from the P.o.W. house; the others just had what they could carry, a blanket or two, a change of shirt and a share in some toilet articles. We were brought some food and allowed, under escort to go, one by one, to the primitive and stinking latrine.

During the night Alexis came to me and said some of his Russians wanted to make an escape attempt by overpowering our guard, two or three Arab soldiers at the room door. We held a council of war about this and I must say we all felt pretty desperate. We could easily have dealt with our guard, but the Russians would probably have killed them. They would almost certainly have no keys to the main gates, and we were in the innermost enclosure of this citadel, with armed guards at key points (properly so called) who would have no scruples about shooting us down if we had killed our guards. I persuaded the Russians that a better opportunity might easily present itself later for an individual attempt or a collective one.

Missed Opportunity

Looking back, I think the moment should have been as we were being marched across the boat-bridge at dawn next morning, to have jumped into the river and swum for it. This bridge was, however, at the very top end of the town and even if one was not shot in the water there was every chance of being recaptured during the long day before darkness might come to hide one. I got so far as to develop trouble with one of my boots and took it off to look for a "stone", but being the only British officer was under special guard and I soon got a jog from the butt of a bayonetted rifle and chased on after the others.

So our desolate little company was herded out of Baghdad and off on the Mosul road again, with not even the prospect of a lift by rail as far as Samara. We halted a while at Kazimain, beside the glorious mosque, and here I succeeded in developing alarming symptoms and getting myself sent back to a hospital in Baghdad. The doctors were sympathetic but I failed to convince them that I was ill. Next, I argued that as I was sent down from Mosul for the express purpose of being liberated, I should be allowed to stay with the American Consul. The hospital authorities could not admit that Baghdad was about to fall, in fact no decision to abandon it had as yet been taken, and I had with me no papers about my repatriation. All argument failed, and on the evening of the 2nd March I was sent over to Baghdad railway station to go to Samarra once more. Exactly eight days later, on the night of the 10th/11th March, 1916, the Turks withdrew and the city was occupied by the British on the 11th!

Darkness was already falling when I arrived with my two guards in the marshalling yard at the station, where beside the passenger train in which I was to travel there was an assortment of open trucks on parallel lines. It was a scene of much confused activity and noise, lit by flares and pressure lamps on posts. Arabs, Turks and Germans, in uniform and without, were working like slaves but without much orderliness loading trucks in the sidings for the evacuation which was clearly expected. I was wearing a khaki burberry and a rather battered topee, both rather anonymous articles

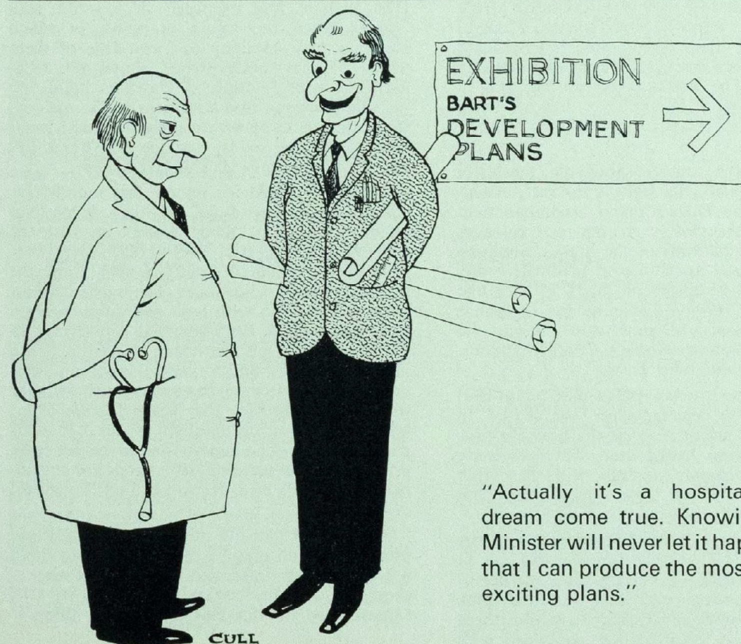
of attire among the dimly lit groups of people around I thought: "if I could just manage to elude my guard for a brief minute, I could slip off into the darkness of the mud-walled lanes and palm gardens, swimming down the river by night and lying hidden by day, and so reach FREEDOM!"

Foiled!

My guards took me to the train and put me into an empty compartment, one remaining with me whilst the other went off. I chatted in "kabba turkcha" with my guard who seemed a friendly fellow. The train was not expected to start till dawn of the 3rd and about midnight I expressed a need to visit a latrine. It is the universal and commendable habit in the east to use water for ablutions on these occasions. I took the precaution of earlier drinking all the water in my water-bottle and as my guard and I made our way towards the station latrine, I shook the bottle and handed it to the Turk with the request that he would go and fill it at a stand-pipe nearby. How my heart beat at that moment! Would he or wouldn't he? He hesitated, and I pressed a piece of silver into his hand. After a moment's hesitation, while my hopes were desperately balanced, seeing the excitement in my eyes I was unable to conceal, he siezed me by the arm and shouted to me to come back to the train. I tried to shake him off, but others quickly surrounded us and I was dragged back to my compartment and locked in.

Even today, as I motor along a familiar stretch of road, I say to myself—"If that night I could have got unobserved from here—to here—what a wonderful and exciting week I would have had!"

After this, they were more than ever on their guard, and when at dawn the train steamed north, every mile taking me further from the advancing British, my chances of escape seemed gone for ever, and I huddled miserably in my corner, dumb in tears of rage and frustration, disappointment and despair.



"Actually it's a hospital planner's dream come true. Knowing that the Minister will never let it happen, means that I can produce the most fabulously exciting plans."

Jazz record review:

One of the most encouraging aspects of Jazz in Britain at present is the recent resurgence of "Big Bands," which culminated in the revival of John Dankworth's band at Ronnie Scott's Club in May. The discipline of the big band arrangements and the need for concise thinking in the construction of a solo limited to a couple of choruses are thought by many to be essential in the apprenticeship of any musician who hopes to make his name in jazz. Due mainly to economic reasons there have been few big bands operating recently and so this resurgence should provide valuable experience for the many talented players around in Britain today.

During the formative years of jazz, the big bands were the centres of progress in musicianship and provided the outlet for the more sophisticated minds, who were prepared to advance from the styles of New Orleans. Three of the greatest of these early bands can be heard on "Great Big Bands" (Music for Pleasure MFP 1085). The tracks were all recorded in 1933 and the bands featured are those of Duke Ellington, Benny Carter and Fletcher Henderson.

The Ellington tracks show the masterful hand of the Duke; the style is instantly recognisable and the Duke's piano accompaniment complements the closely written reed passages and the riffing patterns of the brass. "Sophisticated Lady" still an Ellington favourite today is one of the best tracks on this L.P. with fine solos by long serving Ellingtonians Lawrence Brown and Barney Bigard. Also among the personnel are Johnny Hodges, Cootie Williams, Harry Carney and Juan Tizol.

Benny Carter is by trade mainly a reed player, and his arrangements are biased in favour of this group, leaving the brass to provide the harmonic background. The lush reedy sound of this band contrasts with the other bands and there are good solos from Chu Berry and Teddy Wilson.

The third band, Fletcher Henderson's is perhaps the most interesting for one can see in some of the tracks, e.g. "Night Life" the beginnings of the "swing" style that was to become the hallmark of Benny Goodman within three years. The band recorded here contained such men as Henry "Red" Allen and Coleman Hawkins. The arrangements are more balanced than those of Carter and are more complex producing an integrated background for the soloists. This record is a fascinating collection of historic tracks which while being of interest in the academics of the arrangements make very good listening.

The Fletcher Henderson band featured in the Big Band record turns up on another new release from Music for Pleasure, Vintage Hawk MFP 1128. There are five tracks by this orchestra and the emphasis as implied by the title, is on the solo work of Coleman Hawkins the grand old man of the tenor saxophone, who manages to maintain his contemporaniety still today. The tracks on this LP are varied and even include four recorded in London with Stanley Black (no less!) on piano, in which Hawkins plays well up to form. One of these tracks "Honey-suckle Rose" shows the technique of improvisation as Hawkins builds up his solo from the first statement of the melody. In all the tracks Hawkins improvises with great facility and the set is, like the Big Band LP, another harmonious slice of jazz history.

The final record for review this month is a collection of recordings by the singer Nat "King" Cole (Nat "King" Cole sings with the Nat "King" Cole trio, MFP 1129). They were made before Cole decided to split from the trio to become a solo singer. The music features Cole at the piano with bass and guitar accompaniment and is complimented on several of the tracks by such musicians as Willie Smith (alto sax) "Stuff" Smith (violin) and Juan Tizol (trombone). Cole's singing comes over with the warmth and intimacy that was a feature of his later career, but the highlight of the LP is his piano playing. The superb Tatum based style, produces some majestic solos and his accompaniment to his own "vocal refrain" is a model of economy.

This record like the other two is totally unpretentious, and may be recommended to those not particularly interested in Jazz, and also to those aficionados rather perplexed by the vagaries and the discords of the "new thing."

John Sills

MEDICAL BOOK REVIEWS

Surgery

Demonstrations of Operative Surgery, by Hamilton Bailey, E. & S. Livingstone, Third Edition, 1967. Price 50s. 431 pp., 485 figs.

This book is described as a manual for general practitioners, medical students and nurses. It outlines the main steps in most of the standard surgical operations, both general and specialised. It is profusely illustrated, many of the figures being taken from other works by the same author, such as the excellent "Emergency Surgery", well known to most surgical registrars.

A few criticisms should not detract from the value of this book. Many of its readers will be working in university teaching hospitals, where specialised operations are tending to displace more routine procedures; they will look in vain for most peripheral vascular operations, repair of a cleft palate and the delicate modern operations in the middle ear. There is no reference to central sterile supply and it is stated that the minimum time for boiling instruments should be ten minutes. In the description of cholecystectomy there is no mention of operative cholangiography, a step which many surgeons now consider essential and figure 152 looks suspiciously as though both the common bile duct and the hepatic artery have been ligated. Circumcision by the Australian bone-forceps technique is described; this has occasionally produced serious accidents. Photographs of a particularly gory thyroidectomy are shown and there is no description of exposure of the recurrent laryngeal nerves.

A number of distinguished surgeons have contributed to this undoubtedly useful book.

Martin Birnstingl

An Introduction to Surgical Haemodynamics, by Felix E. Weale, M.S., F.R.C.S. 128 pages, illustrated. Published by Lloyd-Luke (Medical Books) Ltd., London, 1966. Pirce 25s.

Mr. Weale is to be congratulated on condensing material from a large number of contributions on haemodynamics into one small, readable, practical and excellently illustrated book. Like a cartoon, a simple and revealing diagram demands an exhaustive knowledge, and there are many such diagrams in this book, each one illustrating and clarifying the text and so imprinting the message on the reader's mind.

More and more arterial reconstructions for stenoses, aneurysms, arteriovenous fistulae and effects of injury are being done so that a knowledge of haemodynamics, shortly, clearly and succintly presented, as is the case in this book become essential for the vascular surgeon. Not only the text but also the extensive bibliography will be of the greatest assistance to anyone engaged in investigations of blood flow in different circumstances. The section of viscosity I found interesting and viscosity is an important factor to be considered in arterial surgery.

This book will have, I am sure, a wide appeal, and is one which should be on the vascular surgeon's bookshelf. Its careful study may help to improve results in this difficult field.

Peter Martin

Psychiatry

City Psychiatric, by Frank Leonard. Published by Four Square Books. Price 5s.

This book is about the treatment of the mentally ill in the United States. In view of the gravity of the subject, the lurid design of the cover is tasteless, involving a picture of an ill-attired female patient and a claim to "mercilessly reveal the sinister secrets of public mental wards". It is a pity, and perhaps points to one of our own problems, that the publisher must use such a presentation to attract the public's interest in the problems of mental health.

Nevertheless, the content of the book has more merit. The author has had consderable experience of mental hospitals and social psychiatric work, which he has put to good use in describing a typical week's events in a public psychiatric receiving hospital of a large American city. It is the account of one compassionate administrative assistant's attempts to improve the lot of his hospital's inmates despite the intransigent hospital management and his own personal problem of alcoholism. Presenting hospital life in a series of fragmentary incidences and using a bleak prose, Mr. Leonard well illustrates the brutality and lack of love and hope that results from overcrowding and understaffing, and he describes vividly the lower depths of human degradation and despair which results from such a situation.

Although a book aimed for an American public, it does contain something of relevance for a British public, for it provides a catalogue of the evils of institutional, non-voluntary treatment and may act as a stimulus to general interest in furthering research and improving the public's attitude to the mentally ill.

Edward Walsh

Dermatology

Skin-irritant and Sensitizing Plants found in India, by P. N. Behl and R. M. Captain with the assistance of B. M. S. Bedi and S. Gupta Published by the Department of Dermatology, Irwin Hospital and Maulana Azad Medical College, New Delhi Pp. XXII and 179. is. 157 and two plates in colour.

The investigation of eruptions due to plants (phytodermatoses) is often difficult, clinicians usually being bereft of adequate botanical knowledge and botanists not being easily available for collaboration. We can therefore welcome this new book which, whilst it applies chiefly to work in India, is so well stocked with information that it has its uses in many countries including England.

The monograph consists of four parts: The Introduction is a useful compilation about the problems of phyto-dermatoses, then there follows several lists of plants which may be inculpated in several types of employment and finally a useful list of the irritant parts of each plant (e.g., dermatitis caused by Garlic is more likely to be caused by exposure to the juices and the cloves, whilst with Cow Parsley the whole of the plant may be inculpated). Then follows 160

pages on the actual hazards: each is introduced under its common English name, thereafter the botanical and the vernacular names are given, followed by a botanical description and notes on the geographical distribution of the plants, their chemical constituents and the dermatoses which they can produce. The book ends with a list of references, a glossary of botanical terms and three separate indices (of botanical names, popular names and vernacular names).

Your reviewer has little botanical knowledge and cannot comment on the accuracy of the botanical information given, but if as he believes most of it is accurate, this is one of the most important, interesting and useful books which have been contributed to Dermatology by our Indian colleagues in recent years. It is hoped that a copy will soon be available in the Library.

R. M. B. MacKenna

Cardiology

Clinical Cardiology, by Velva Schrire. Published by Staples Press. 2nd edition. Price 70s.

This is a very good and up to date textbook of clinical cardiology. The emphasis is on bedside diagnosis rather than on specialized procedures such as cardiac catheterisation and angio-cardiography. The author's lucid style of writing makes for easy and enjoyable reading. Physical signs in particular are well described, with many excellent illustrations to supplement the text. The chapters on electrocardiography and arrhythmias are, however, disappointing. A few of the statements in the book might well be challenged, but it would be impossible to avoid all controversy in a work so full of facts. It contains considerably more than would be required by candidates for the M.B. examinations. A helpful bibliography is provided for further detailed reading.

Douglas Chamberlain

Lighter reading

"The Medicine Men" by James Balfour. Published by Hutchinson. Price 25s.

"The Medicine Men" is the third novel to leave the extraordinarily untalented pen of James Balfour, a real life Surrey G.P. The somewhat elusive plot is an attempted exposition of the degrading depths to which medical men have sunk.

The narrator is Drew-Dawson, a medical student at the fictitious City Hospital, whose general apathy about life penetrates all of his activities except one. Thus all that we hear of him concerns his bizarre "affairs du coeur".

Dr. Parr, the hero of the story, is a blundering hypochondriac whose knowledge of medicine is practically non-existent, but who is such a bedside charmer that even as a student the patients insisted on his opinion before consenting to an operation by the Professor of Surgery. Our villain is Dr. Parker, the very cold and competent surgeon, happy only when removing something—anything from one of his underprivileged patients.

The theme is a rather hackneyed one, duplicating at a somewhat lower literary level and with less efficacy, any of Richard Gordon's "Doctor" books. At one point in the novel, Balfour, through Drew-Dawson, says of himself, "It is an extraordinary thing, in those days (his student days), and these days come to that, how few people pay the slightest attention to what I say."

I have similar sentiments regarding your writing, Mr. Balfour—only it isn't extraordinary.

Hilary Gordon

The Everyday Miracle, text by Axel Ingelman-Sundberg and Claes Wirsen, photographs by Lennart Nilsson. Published by Allen Lane The Penguin Press. Price 42s.

There is often ignorance about the beginnings of a baby, its development and eventual birth in the minds of those who have had no formal medical education. Knowledge on this large subject is sometimes very confused having been built up on inadequate education at school, hearsay and the occasional article in a woman's magazine or on some television programme. Curiosity begins in childhood and unless satisfied can lead to embarassment and shyness when the subject is encountered in later life.

The Everyday Miracle, originally a Swedish publication, has been translated for the American and British markets. Nilsson's wonderful photographs formed the basis for articles in *Life, Woman's Mirror* and *Paris Match*—each a sell-out edition.

Wirsen is the histologist and embryologist and his notes and diagrams occupy the first half of the book. He has packed a great deal into a small space and one feels that in places he has been too brief to do justice to the topic and that a knowledge of at least "O" level biology would be useful for a fuller understanding. This is a small criticism of an otherwise excellent section liberally illustrated with photographs and diagrams.

The remainder of the book follows through with the pregnancy and is seen through the eyes of the obstetrician, Professor Ingleman-Sundberg. The purpose of each part of the examination is explained and reasons given for any other investigations in relation to the progress of the pregnancy. His advice will naturally be of prime interest to the expectant mother but is not laboured to the extent of boring the uninvolved reader. The writer concedes that practices such as natural childbirth courses and the presence of the father at delivery are not universally accepted in this country.

This book is designed for the lay reader yet cannot fail to be of interest to those in the medical profession. The ideal recipients of this book might be the young couple expecting their first child. However since it is scientifically and clinically accurate and up to date it will serve as a source of reliable information to adults either for their own education or for the education of their enquiring children.

Considering the content and the use of high quality paper which gives superb reproduction the book is modestly priced.

I. D. Fraser

SPORTS NEWS

CRICKET CLUB

June started on an unhappy note for the club with a sound thrashing from **Putney Eccentrics.** The Eccentrics, batting first, scored 180 runs for the loss of 9 wickets, with strong "moral" support from the inimitable Lionel Francis on the boundary who was seldom without the company of a full pint of the beer which Sir Francis Chichester took round the world with him. Bart's reply to this total was rather a lamentable one, namely 84 runs all out, but the side did its best to forget this afterwards by drinking several toasts to Sir Francis.

Unlikely as it may seem, the Barbeque Ball brought about a remarkable change in the fortunes of the club. On the following morning, Bart's faced the **"Crickets"** with sore heads and little hope, so it seemed, of staving off imminent defeat. In struggling to a total of 124 for 4 declared, Bart's only appeared to have one player who had successfully ridden the storm of the night before, Graham Purcell, who scored a very stylish 64 not out. However, another man was to rise out of the depths; Phil Savage, thrusting aside all distasteful residues of the night before bowled his way to the incredible figures of 9 for 13, and the "Crickets" were summarily dismissed for 56.

The next day, Sunday 11th brought **Blackheath,** one of the strongest fixtures of the season, to Chislehurst. Blackheath, batting first, scored 202 all out, Doyle Husband claiming 8 wickets for 44 runs. Left 150 minutes in which to better this total, Bart's again defied all odds and scored the required runs for 5 wickets in 135 minutes, Doyle Husband displaying his sobriety by scoring 64 runs.

On Saturday 17th, Bart's maintained their run of success by beating **Old Tauntonians** by 31 runs. Bob Jones gave the performance of the day, scoring 63 runs.

Sunday 18th heralded the annual pilgrimage to **Horlicks.** Bart's batted first, and were soon struggling due to some poor batting by the early order, coming in to lunch with a meagre 64 for 5 on the board. After lunch however, the situation changed dramatically. Paul Curry fighting the effect of two Horlicks tablets he had inadvisably taken with his lunchtime beer, went on to score a magnificent 93 not out, out of a total of 202 all out. Horlicks were then dismissed for 101, thanks to some good all round performances in the field.

6-a-Side Tournament

This was to be held at Chislehurst on 24th June. It proved to be an exercise in how to make the best of a bad afternoon. The pitch looked beautiful. The teams had arrived together with some of our American guests. The spectators had arrived. But so had the rain.

The players, confined to the pavilion, watched the blackboard outside displaying the draw, slowly get washed clean. So while the rain flowed over the cricket squares outside, the beer flowed inside. However, the rain dried up before the beer and since cricket was now out of the question, a lively international game of football was held. Thus the afternoon was not a complete wash-out for everybody.

P. J. FURNESS

Fixtures for August:

Saturday 5th Parkfield A.2.30.

Sussex Tour

Sunday 6th Ferring A.2.30.

Monday 7th St. Andrew's, Burgess Hill A.2.00.

Tuesday 8th Rottingdean A.2.30.

Wednesday 9th King Edward VII Memorial Hospital, Midhurst A.2.30.

Thursday 10th Barcombe A.11.30.

Friday 11th Seaford A.2.30.

Sunday 13th Hill End Hospital A.2.30.

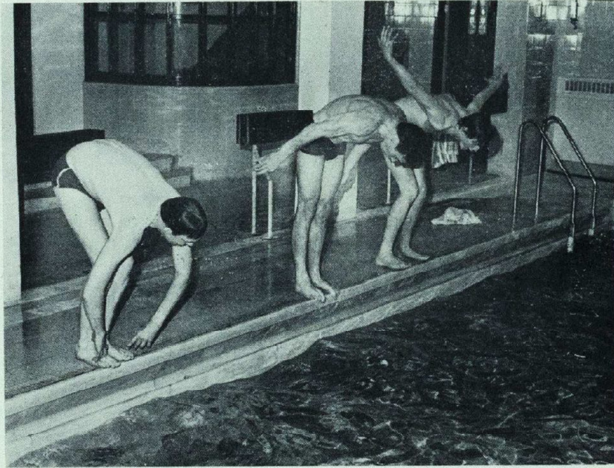
Essex Tour

Saturday 19th Clavering A.2.30.

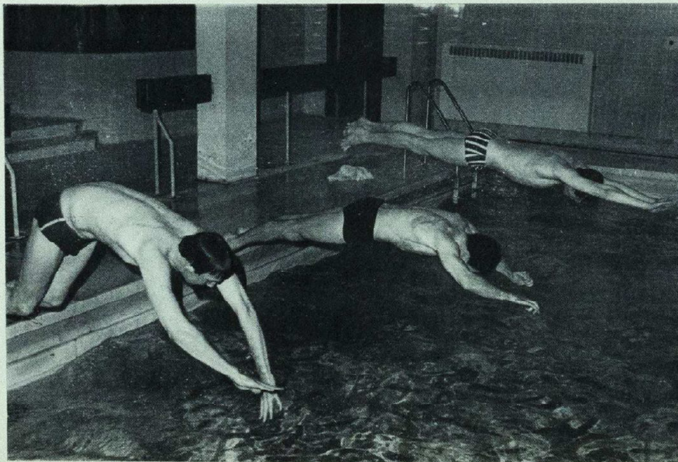
Sunday 20th Arkesden A.2.30.

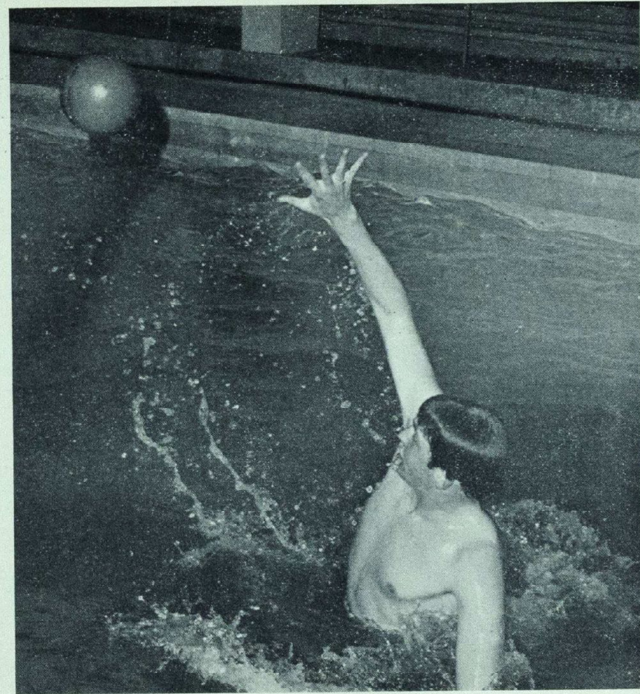
Sunday 26th Harpenden A.2.30.

MEMBERS OF THE SWIMMING CLUB TRAINING:



Coburn, Shearer and Kadleigh practising starts.





Shooting for goal!

ATHLETICS CLUB

After the appearance of a small number of athletes at the University Championship at Motspur Park, where Brian Scott again gained a place in the London team, our first outing was a match against **Milton Abbey School** in Dorset. Although the Bart's team eventually won, the result was in doubt until the last two events and full credit must be given to the School athletes who, urged on by keen and vociferous supporters, managed to contain older men for so long.

Our sprinters performed well and were unbeatable, John Scarr, the Cambridge blue taking the two shorter events, while Scott and Sutton provided one another with opposition for first place in the quarter. John Brooks took both the mile and steeplechase; during the latter, Thompson once again amused the crowd by falling in the pond. John Coltart was not as fit as usual and was beaten in the half mile. Although handicapped by using heavier implements than the boys, our throwers did well except for disaster in the discus; special mention must be made of Keith Rawlinson's last effort in the Javelin, an event which he won: a nonchalant no-throw, it cleared 190ft., which would have been Keith's best, and which suggests that if he had the time for practice, he could go far in this event.

Tour Party: B. Scott, C. Sutton, R. Thompson, J. Coltart, P. Kitchener, J. Scarr, R. Jolly, P. Jordan, K. Rawlinson and J. Brooks.

The United Hospitals' Championships were held at Motspur Park on Saturday June 3rd on a sunny afternoon. The track was near perfect and the Bart's athletes were inspired to perform at their best, both on track and field so that we were only beaten by Guy's (112 points) and The Royal Free (79), coming third with 69 points.

No one from Bart's won an event, but we took more places than usual. In the field events, Graham Mees took third place in the shot, and is bound to improve on this in future years. Russell and Miller tangled with the Pole Vault and with coaching could gain us some valuable points in this difficult event. We were very grateful to Keith Rawlinson who travelled with his wife from Southend to take 3rd in the Javelin. On the track, Brian Scott was 2nd in both the Hurdles events. John Brooks also had two 2nd places, in the Steeplechase and the Mile. His performance in the latter, where he put up a time of 4 min. 37 sec., was disappointing only in that he lost to an inferior runner: he will not make this mistake when he has gained more experience. Tony Breeson was 6th in the 100 yards and Chris Sutton took a similar place in the Half Mile; Sutton's time of 2 min. 12 sec. was bettered when he brought us into second place in the Medley Relay in 2 min. 4 sec., in which event we were finally third. Robert Thompson was 4th in the 3 Miles, 5th in the Steeplechase and 6th in the Mile, and we finished the day with 6th place in the sprint relay.

Centenary Dinner

The Centenary dinner of the United Hospitals Athletic Club was held on 3rd June at the Cafe Royal following the Championship at Motspur Park. A reasonable meal was followed by the main attraction of the evening, the speeches, which, to suit the occasion, were, at least to some listeners, somewhat long-winded. Dr. Bannister, in the chair, opened to send our good wishes to our absent President, Sir Adolph Abrahams, who was very ill, and then continued with a history of the club, reading several extracts from past minutes books. The Captain and Secretary got through their speeches and the presentation of trophies very rapidly while Mr. Quist of the Royal Free told us some funny, if somewhat restrained, jokes. Harold Abrahams gave the best speech; he commenced by informing us that he had timed the previous speeches with his stopwatch, announced the times and hoped that he would not take so long himself. He thanked us on behalf of his brother for our good wishes, and, amongst other passages, read an extract from "The Times" relating to the Bart's sports day in 1909 at Winchmore Hill, when his brother set the record of 10.2 sec. for the 100 yards; this still stands today. Apparently, said "The Times", the weather was perfect, the crowd in advance of 1,000, the ladies present viewed the sport from carriages drawn up around the track, and the standard of athletics was high, as was expected from the hospital; alas, how times have changed. Mr. Abrahams concluded with a list of international and Olympic achievements by U.H. men, in which the name of Bart's came well to the fore.

The thanks of the club were offered to Chris Sutton, who organised a successful dinner.

We have had three domestic matches, the first of which, against **Lloyds Bank** on May 18th was a wash out: our four athletes participated there in a strenuous 20 minute relay event.

On June 8th we could only muster a total of four athletes for the match against **Pearl Assurance, Northern Assurance, Midland Bank, Royal Exchange and Old Whitgiftians** at New Malden, and we finished in last place. It is disappointing that some members neither turn out for certain fixtures nor take the trouble to tell the Secretary of their proposed non-attendance: if this state of affairs continues, we shall soon lose all our fixtures. In the match in question, Scott, Thompson and Kitchener were last in all the sprints, but redeemed themselves in the longer distances. Scott ran his best ever Half in 2 min. 9 sec. for 3rd place in the 'A' event and Kitchener took a similar position in the 'B' race. Thompson was 2nd in the Mile in 4 min. 43 sec. on a sluggish track, while our best performer was Rick Jolly who won the Javelin (132ft. 5ins.) and who was 2nd in the Weight (35ft. 0¾in.).

Our third match v. **Westminster Bank** on 24th June was successful both in attendance and performance. We did well on the track and held our own in the field so that we won the fixture by 41 points to 35. We were admirably entertained after the match, as usual.

Results:

100 yds.: 1 Sutton, 10.9; 2 Jackson, 11.2.
440 yds.: 1 Sutton, 54.3; 3 Wood, 59.7.
880 yds.: 1 Brooks, 2:11.8; 3 Kitchener, 2:13.8.
2 Miles: 2 Thompson, 10:28.0; 3 Brooks, 10:34.0; 5 Field, 11:26.0; 7 Kitchener, 12:54.0.
Shot: 2 Jordan, 30.1½; 3 Sutton, 28.7½.
Discus: 1 Jordan, 82.10½; 4 Kitchener 56.10.
High Jump: 3 Sutton, 5.0; 4 Jordan.
4 x 110 yds. relay: 1 Bart's., 49.4.

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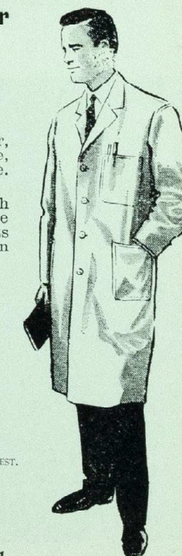
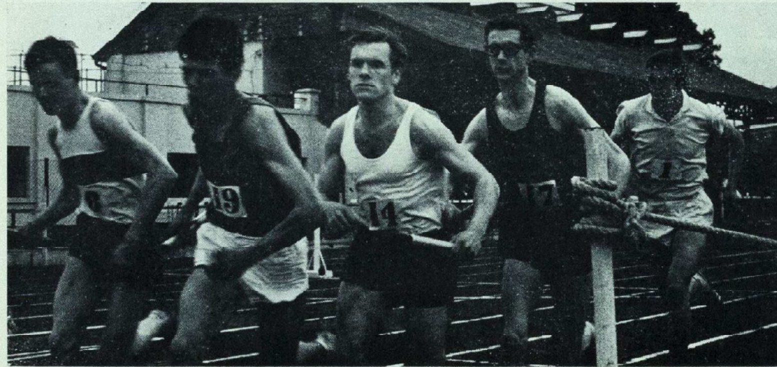
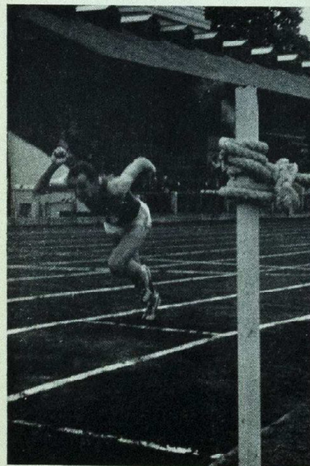


Sports Day

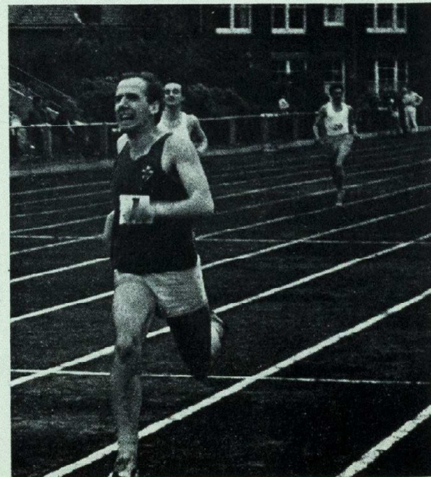
Sports Day was held on 24th May on the wettest Wednesday available. The track at Chislehurst was soaked, and the runners badly cut up Laurie White's beautifully kept turf. Conditions for track and field athletes alike were difficult in the extreme and, not surprisingly, no startling performances were put up. Thanks must go to the athletes and spectators who braved the rain, and not least to Dr. Francis and his efficient team of judges who stood out in the rain, without reprieve.



Chris Sutton (No.1.) in the Medley Relay



Brian Scott Starting . . .



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throughout the afternoon, and to the Dean and his wife who suffered a very cold and wet three hours waiting to present the prizes. Of the athletes, Graham Mees, Brian Scott and John Brooks were outstanding amongst the prize winners, and Mees was awarded the President's Cup for the best all-round performance. The same people won the Inter-firm competition, this time calling themselves "Midder & Gynae".

Results:

100 yds.: 1 Scarr, 10.4; 2 A. Breeson, 10.9; 3 S. Smith, 11.0.

220 yds.: 1 B. Scott, 25.5; 2 A. Breeson, 25.8; 3 C. Sutton, 26.2.

440 yds.: 1 B. Scott, 56.8; 2 C. Sutton, 57.0; 3 R. Lambert.

High Hurdles: 1 B. Scott, 18.2; 2 J. Coltart, 22.6; 3 P. Kitchener.

Half Mile: 1 J. Coltart, 2:13.4; 2 D. Tunstall-Pedo, 2:15.0; 3 R. Thompson.

Mile: 1 J. Brooks, 4:48.8; 2 D. Tunstall-Pedoe, 4:52.8; 3 R. Thompson, 5:10.0.

3 Miles: 1 J. Brooks, 16:49.6; 2 R. Thompson, 17:4.6; 3 D. Tunstall-Pedoe.

Shot: 1 G. Mees, $35.3\frac{1}{2}$; 2 J. Stevens, 34.8; 3 S. Smith.

Discus: 1 G. Mees, $89.0\frac{1}{2}$; 2 J. Stevens, 89.0; 3 C. Grafton, $83.1\frac{1}{2}$.

Javelin: 1 S. Smith; 2 R. Jolly; 3 J. Stevens.

High Jump: 1 G. Mees, 5.0; 2 S. Johnson, 4.9; 3 B. Scott, 4.8.

Long Jump: 1 S. Smith, $18.4\frac{1}{2}$; 2 D. Jefferson, 18.2; 3 G. Mees, 17.9.

Triple Jump: 1 S. Smith, 39.0; 2 C. Sutton, $37.8\frac{1}{2}$; 3 G. Mees, 37.2.

Staff Handicap 100 yds.: 1 Dr. Francis; 2 Dr. B. Davies; 3 Mr. Aston.

Cricket Ball: 1 G. Mees; 2 S. Smith; 3 B. Jones.

Egg and Spoon: 1 J. Coltart; 2 R. Brearley; 3 Miss R. Shankland.

4 x 220 relay: 1 Midder and Gynae, 1:49.6; 2 Veterans; 3 Mops and Sops.

Inter Year Competition: 1 Midder and Gynae, 94 points; 2 1st year-2nd M.B., 81; 3 Mops and Sops, 69; 4 Veterans (Stevens and Tunstall Pedoe), 50; 5 Clerks and Dressers, 40; 6 2nd year-2nd M.B., 28; 7 Kids and Specials, 10.

R. S. THOMPSON

RIFLE CLUB

Full Bore Events at Bisley
Pafford Cup

As usual, Bart's entered two teams for this competition and, despite the adverse conditions, both teams shot very well. At the end of the 200 yd. shoot the "A" team were 2nd and the "B" team were 4th, two points behind. At 500 yds. the wind was very troublesome, and was very quick to show up those who had had little experience under such conditions. Once again the "A" team finished 2nd to Imperial College, this year by only two points. The "B" team were unable to maintain their earlier position and finished the day in 7th place. This, however was sufficient to beat both the Westminster and St. Thomas's "A" teams.

U.L. Individual Championships.

Unfortunately, only three people were able to enter for the Championships this year, but the quality of the shooting made up for the lack of quantity. For most of the day, the conditions were very good, but at 600 yds. the wind made life awkward for the unwary or inexperienced with the result that there were several spectacular crashes.

Results.

1st C. J. Sedergreen, 99 ex 105.
3rd C. I. V. Franklin, 98.
21st S. G. Crocker, 89.

C. J. Sedergreen also won the 200 yd. range prize after a tie shoot.

In the team competition Barts were first with a score of 285 ex 315 which was four points ahead of U.C. who were 2nd.

Armitage Cup and U.H. Individual Championships.

These two events are shot concurrently, and both our teams were in fine form and shot excellently under very good conditions.

The 200 yd. shoot was quite exceptional with only one member of the two teams dropping below 33 ex 35. We finished the shoot with the "A" team 1st and the "B" four points behind at 5th.

The 500 yd. shoot was less spectacular, but saw the "A" team still in the lead, and the "B" team a few places higher having made the highest score at that range.

At 600 yds. the "B" team did very well and again made the highest score at this range, which was sufficient to pull it up into 2nd place on aggregrate behind the "A" team.

Results.

Armitage Cup—1st Barts "A" 382 ex 420. 2nd U.C.H. 378. 3rd St. Thomas's 367.

"B" teams—1st Barts "B" 380 ex 420.

Individual—1st G. D. Tuckwell Barts "B" 100 ex 105. 2nd C. J. Sedergreen Barts "A" 99. 3rd C. I. V. Franklin Bart's "B" 99.

G. D. Tuckwell also won the 500 yd. range prize with a score of 34 ex 35.

The results so far this season have been most encouraging, and we are hoping for some further success when we try to retain the United Hospitals Cup in the Imperial Meeting.

C. I. V. FRANKLIN

TENNIS CLUB

The Cambridge Tour unfortunately had to be cancelled this year. The pressure of exams, especially 2nd M.B., meant that only two regular 1st team players were available.

Saturday 17th June **v. University College "A" VI; Won 5-4.**

Both University College and ourselves fielded "A" teams and this resulted in a closely fought match. The 1st couple played well to win their three rubbers.

Sunday 18th June **v. Guy's Hospital 1st VI; Lost 8-1. Semi-Finals, Inter-Hospitals Cup.**

The score unfortunately does not reflect the closeness of this encounter, but the effects of lack of practice ultimately told. Guy's played extremely well and we wish them luck in the final.

Team: C. Garrard (Capt.), J. Ussher, A. Edelston, C. Higgins, J. Wenger, N. Ireland.

Several matches have had to be cancelled recently due to the inability of our opponents to raise teams.

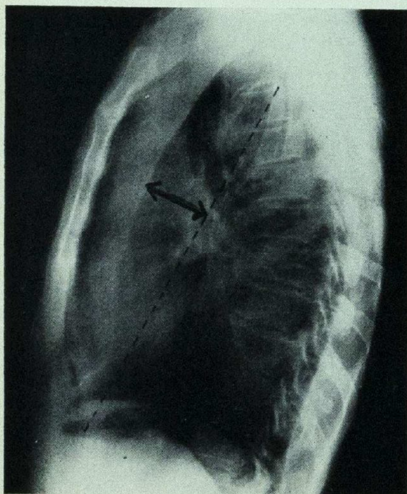
C. GARRARD

THE SPORTS SUB-EDITOR WOULD BE MOST GRATEFUL IF ALL FUTURE CONTRIBUTIONS FROM SECRETARIES WERE SUBMITTED IN TYPESCRIPT.

answers to diagnosis

a.

1. The opacity is from a squamous cell carcinoma of the bronchus. A neoplasm is by far the commonest cause of a shadow of this type, in the lung field of an elderly man especially if, like this patient, he has smoked 20-30 cigarettes daily for 40 years.



2. The left upper lobe has collapsed (atelectasis) because of the occlusion of its bronchus, and the lower lobe has over-inflated to occupy the apex. Note the decreased number of blood vessels in the left field and the haze in the left upper field. The left hilum has become laterally convex. In the lateral film the collapsed upper lobe and lingula form a tongue-like shadow lying anteriorly. The posterior margin of this lies well forward of the expected line (dotted) of the interlobar fissure which normally runs between the lower, posterior edge of T4 and a point on the diaphragm 1.5 inches behind the sternum.

Bronchiectasis has occurred distal to the occluded bronchus.

3. The patient presented with a four month history of dyspnoea (the collapsed lobe), two episodes of haemoptysis (the neoplasm) and a cough with sputum (the brochiectasis). He underwent pneumonectomy two years ago and has since shown no signs of recurrence of his tumour.

b.

1. This child has fractured the ulna and *also* dislocated the radius forwards (it should articulate with the capitulum of the humerus).

2. Reduce the dislocation as well as the fracture!

I am indebted to Dr. Simon for advice, and permission to publish these films.

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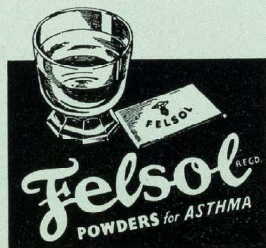

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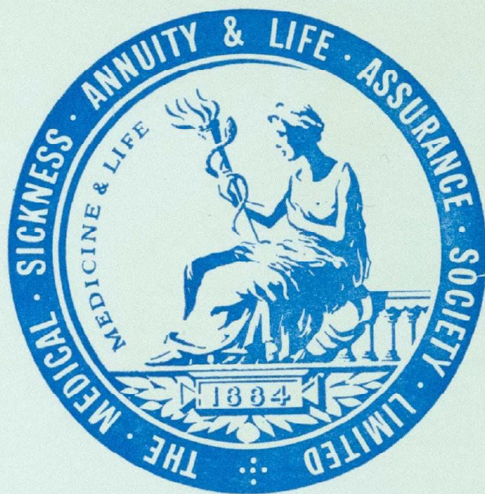

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References
1. *Arch. Derm.* (1962) **86**, 608.
2. *Lancet* (1964) **i**, 1177.

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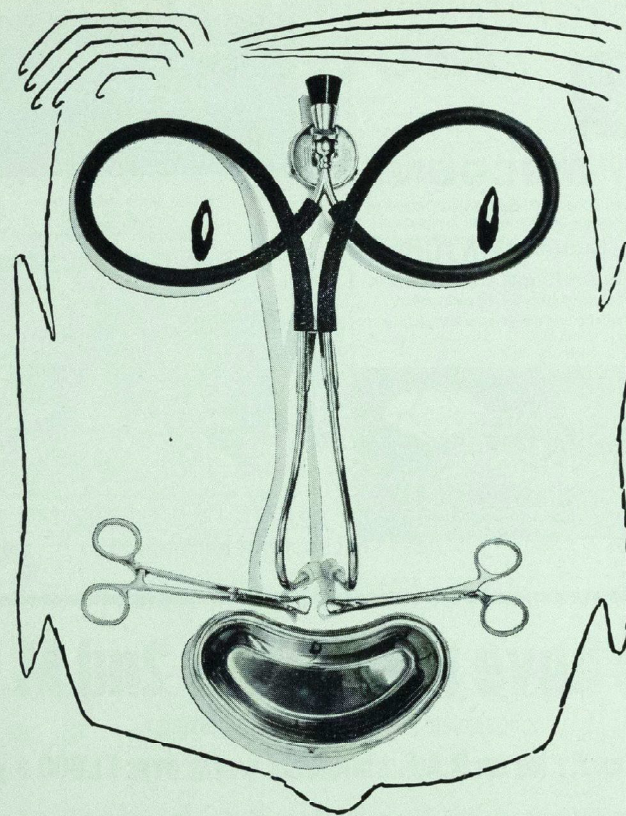

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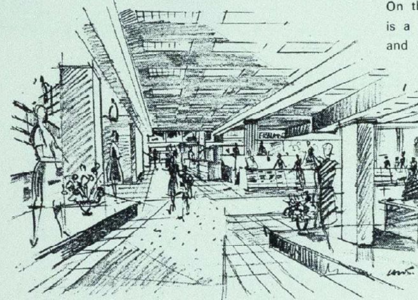

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