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SAINT BARTHOLOMEW'S HOSPITAL JOURNAL

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Editorial

As winter draws in, the nights get longer and the days colder, and everyone wonders how many electricity cuts and gas leaks will disturb the peace that is the British household over Christmas. There is the thought of endless relatives and tedious Christmas cocktail parties. The newspapers will be giving startling coverage to the number of motor accidents over the holiday period, and the pros and cons of British Standard time. Yet despite all these major upsets, there will be crumpets over the fire on dark afternoons followed by bumper Variety Shows on television in the evening.

The sad thing is that by the time this *Journal* becomes printed and distributed the cyclone disaster in Pakistan will have been forgotten. All that will be remembered will be a number, the last estimation of the death toll as reported in a particular newspaper before it was given the page-eight-column-ten treatment, ousted by the sacking of Lord Hill from the Post Office. This is what modern communications is all about. Except for a few old chestnuts such as the Bomb and the Common Market which drag on for years, with seemingly no progress made, most items become history after a very short time has elapsed. The follow-up phenomenon, so important in Medicine, is almost unknown outside it, the pre-occupation with the present being all-important. Although for eleven days the moon Astronauts filled every news bulletin and dominated the newspapers, not very many people can even remember their names now. The Medal of Honour merely takes its place beside the photograph of College on Graduation day, and all is forgotten.

Another feature of Modern Society are the attacks on our sets of values, spotlighted recently by the Government who one week donated £200,000 to Pakistan, then a week later announced it was trying to raise over ten times as much to prevent a Velasquez painting from leaving Britain. Although no one can deny it would be a great pity to lose it, surely the price is so high that this is one occasion when the National Gallery must give way to American wealth and save its money for some other project.

LETTERS

ANTIQUE OPERATING THEATRES

51 Sloane Street,
London, S.W.1.

Dear Sir,

Dining with a Bart's Consultant recently I accompanied him when he was called to an emergency at the Hospital and, hoping for a whiff of nostalgia, I stayed to watch the operation.

What an anti-climax on entering the theatre which I can best describe as a museum.

Apart from the anaesthetist's oscilloscope which failed to function I was unable to discover a single new piece of equipment or change in the fabric of the suite since the time I was a student ten years ago. The whole atmosphere was of shabbiness with cracks in the floor and obsolete electrical wiring. A housewife might well have felt some concern at preparing food under such circumstances.

This theatre, which I assume is typical of others in the main surgical block does not begin to compare with any others that I have seen in London Teaching Hospitals or elsewhere for that matter. What must visiting surgeons think?

One wonders how any surgeon operating under such circumstances can claim to have given his patients the full benefit of modern medical science. I should also like to ask if it is possible to sterilise instruments properly in these theatres?

Yours sincerely,

JOHN IND.

St. Bartholomew's Hospital,
London, E.C.1.
2nd November, 1970.

Dear Sir,

Thank you for showing me Dr. John Ind's letter about the Operating Theatres. I am sorry he has forgotten all the work that has been done in these Main Operating Theatres for the last 40 years.

We like to think that the manner of operating is often more important than the glamour of the new theatre filled with toys.

I can assure Dr. Ind that we have been trying to get new theatre suites for many years now and I can also assure him that the sterilisation, although possibly old fashioned, is still satisfactory.

I will be delighted to take his gallbladder out in Theatre E anytime he wishes and I will guarantee that he will make an uninterrupted recovery with no complication attributable to the theatre.

Yours sincerely,

E. G. TUCKWELL, M.Ch., F.R.C.S.

JOBS

Fairmount, ND 58030.

Dear Sir,

I read in our daily paper that a number of your doctors are looking for places to settle outside of England.

I live in a small town in North Dakota and at the present time we do not have a doctor. Our town has a completely equipped clinic. It is 15 miles from a large hospital. A good hunting and fishing area. It is composed of young and old people that you would find in an agriculture community.

Fairmount has a high school (12 grades), a community centre for our senior citizens, and plenty of local recreation. We are only 15 miles from a Junior College and Trades School.

If you have a doctor that would be interested in coming to our clean fresh state of North Dakota, please contact me and I will give him all the information he would desire.

Our last doctor made $37,000.00 the last year he was here.

Yours sincerely,

HARRY T. WAITE,
Postmaster,
Fairmount, ND 58030.

STUDENT'S UNION LETTER

19th November, 1970.

Dear Sir,

At the A.G.M. on 29th October I said that I had proposed to the Dean that a Staff/Student Committee be formed; this Committee has now been accepted by the Dean. At a meeting earlier in the day the Council decided that the Teaching Committee should function from within the Union Council and express its views as Union views through the Staff/Student Committee. To render these ideas functional a change in the Constitution was needed so that six of the ten members of the Teaching Committee would be Year Representatives from the Union Council. This meant that Year Reps. could not be elected until an amendment to the Constitution had been passed; nominees were warned of their new responsibilities and an E.G.M. was arranged for 17th November.

Only *thirty* people were present at the E.G.M., but due to a flaw in the Constitution we were able to pass the Amendment (as posted). Since a quorum was not present Year Reps. could not be elected; I do not intend to hold further meetings in the hope that a quorum may result. The Executive, consisting of Mr. J. O. Robinson, P. Millard, Miss E. Mansi, J. Wellingham, N. Fairhurst and D. Edmondson, will therefore be responsible for all union activities this year. That this situation can exist is intolerable since (a) Year representation will be minimal (b) The Teaching Sub-Committee will have only four of its ten members (c) The Staff/Student Committee, as it stands, will have only three of its four student members. In order to have a functional "Council" I shall co-opt certain students.

I feel that things have been running too smoothly at Bart's for many years and this has led to gross apathy—Clubs get their grants without trouble and the Cocktail Parties are usually very good! On a tangent with this the record of the Union/Teaching Committee has been so poor in achieving any advances that most students consider their Union to be ineffective and a waste of their time. The "social" image of the Union Council in the past has led to complacency, ineffective discussions and total disregard of student opinion by many of the senior academic staff.

Barts has many "social" clubs which function extremely well providing areas of contact which completely over-ride any Staff/Student division—these clubs are "part" of the union. But, the other "part" of the union must be prepared to tackle a problem or two and be seen to disagree with Staff where necessary. Ideally every member of the hospital and college should belong to both "parts."

Several changes have been made in the last few weeks, for which the Dean deserves our thanks.

1. Random allocation to firms.
2. Re-convening of the Curriculum Committee.
3. The Chairmen of the S.U. and Teaching Sub-Committee have been invited to be members of the Curriculum Committee.
4. Agreement on the formation of a Staff/Student Committee.

N.B. Certain senior Staff have inferred that the last changes in the Curriculum were arranged by the previous Secretary to the Sub-Dean since consultants could not agree on times to meet to discuss changes etc.; other perhaps more reliable sources say that this is not true. Even to hear a rumour such as this should make any thinking non-apathetic student (all thirty of you!) see red.

PAUL MILLARD,
Chairman of the Student Union.

Announcements

Births

CHARLTON—On October 29, to Jennifer (née Price) and Clive Charlton, a son.

PHILLIPS—On October 29, to Jennifer (née Thompson) and Dr. Simon Phillips, a son.

Engagements

DIEPPE—STADWARD—The engagement is announced between Dr. P. A. Dieppe and Miss E. A. Stadward.

KNIGHT—HOYLE—The engagement is announced between Dr. M. T. N. Knight and Miss D. L. Hoyle.

SALT—SULLIVAN—The engagement is announced between Dr. John C. Salt and Dr. Brigid D. Sullivan.

Deaths

SOLTAU—On November 13, Henry Soltau, M.R.C.S. Qualified 1912.

Appointment

Mr. D. B. Moffat, F.R.C.S., of U.C. Cardiff has been awarded a personal chair in anatomy.

FINAL F.R.C.S. DAY-RELEASE COURSE
(3rd February to 21st April, 1971)

Mr. McColl will be running the next Final F.R.C.S. Course on twelve consecutive Wednesdays between the hours of 9.45 a.m. and 5 p.m., commencing on Wednesday, 3rd February.

Application forms and further details may be obtained from Miss Machan, Assistant to Mr. McColl, in Room 4 of the Finance Block (Hospital extension no. 7258).

DIARY OF EVENTS FOR JANUARY

December 21st
Service of Nine Lessons and Carols in St. Bartholomew's the Less at 5.30 p.m.

December 25th and 26th
Ward Shows on the Hospital Wards after lunch.

December 29th and 30th
Pot Pourri at the Cripplegate Theatre at 7.30 p.m.

December 31st
Pot Pourri at the Cripplegate Theatre at 5.30 p.m.
Tickets for the Pot Pourri are available from the Hospital Library.
Pot Pourri Party at Charterhouse Square after performance.
Tickets for party are available from the Hospital Library price £1.

January 12th
Bartsfilm. Physiology Lecture Theatre, Charterhouse Square at 9.15 p.m. Members 1/-. Non-members 3/-.*

January 13th
Pre-clinical Spring Term commences.

January 16th
Boat Club Hop. Charterhouse Square.

January 19th
Bartsfilm. Physiology Lecture Theatre, Charterhouse Square at 9.15 p.m. Members 1/-. Non-members 3/-.*

January 21st
Lunch-time lecture, Clinical Lecture Theatre at 1.15 p.m. "London in Verse" by Sir John Betjeman.**

January 25th
Harvey Society Meeting, Pharmacology Lecture Theatre, Charterhouse Square at 5.45 p.m. "Acupuncture" by Mr. Rose-Neil, Clinical Director of the Tyringham Naturopathic Clinic.

January 26th
Bartsfilm. Physiology Lecture Theatre, Charterhouse Square at 9.15 p.m. Members 1/-. Non-members 3/-.*

January 30th
Judo and Drama Clubs Hop. Charterhouse Square.

* Due to hiring agreements the Journal cannot print the titles of the films. However lists of the forthcoming films are posted on notice boards in the Hospital and at Charterhouse Square.

** Coffee will be served 15 minutes before lectures. Tickets for admission are available from the Clerk's Office; please collect tickets as theatre only holds 160 people and in the event of numbers exceeding this, ticket holders only will be admitted.

Bartsfilm is on the road again

The Bartsfilm programme is now under way for this year, and first of all we would like to thank Dave Wilkinson and his chosen few friends who organised the Club last year and have given us much help about hiring films for this year. With films ordered already up until May next year the membership is 10/- with subsequent 1/- admission charge (non members 3/-). We hope to erect a large Cinemascope screen soon, and from last year's profits purchase some new speakers to improve the sound quality. On the Committee of 8 there is a Nurses Representative who is responsible for publicity among the Nursing Staff, who have supported the Club last year and have given us much help about even greater attendances from the Students at Charterhouse.

Due to hiring agreements it is impossible to print the dates and corresponding titles in the Journal, but the following will be appearing throughout the year;

Poor Cow
Lucky Jim
For a Few Dollars More
The Comedians
The Night of The Generals
Twisted Nerve
One Million Years B.C.
Gambit
Quatermass and the Pit
Far From the Madding Crowd
The Mercenaries
The Guns of Navarone
Casino Royale
This Sporting Life
Every Home Should Have One
The Virgin Soldiers
Dr. No
In the Heat of the Night
Never on Sundays
Hombre
Zorba the Greek

All films begin at 9.15 p.m. on Tuesdays, and are shown in the Physiology Lecture Theatre in Charterhouse Square. Notices of Forthcoming titles are posted up around the Hospital and Medical School, and we look forward to seeing you in the near future.

I. D. Weller

BART'S DINNER

On 12th October, 1970, a dinner for old St. Bart's men resident in the Nottingham area was held at the Stocks Club. This is a small exclusive dining club near the Quorn hunt country and as we had the exclusive use of the club the evening was made more enjoyable.

About 14 old Bart's men with wives attended and the toast of St. Bart's was proposed by Dr. Johns, late pathologist to the City Hospital, Nottingham. Dr. Johns qualified in 1913.

It is hoped to make this dinner an annual affair. Should any old Bart's men who may have been inadvertently omitted and who wish to be informed of any future event please contact Dr. Jarratt of Colston Bassett.

W. Hunt.

BART'S FINALS RESULTS

University of London

The following candidates were successful in the Third (M.B., B.S.) Examination for Medical Degrees dated 16th November, 1970.

Honours

Brooks, Nicholas ...	Medicine; Surgery.
Huskisson, Adrienne ...	Medicine; Applied Pharmacology and Therapeutics.
Sutcliffe, Simon	Surgery.
Tubbs, Hugh	Applied Pharmacology and Therapeutics.

Pass List

Almeyda, Jenifer
Andrews, Heather
Badham, David
Bangay, Paul
Barnham, Michael
Bartlett, Peter
Battye, Ian
Begg, Jane
Bintcliffe, Ian
Blake, James
Bowen-Roberts, Peter
Breeson, Anthony
Britton, Mark
Brodribb, Peter
Burman, John
Copeland, Stephan
Craig, David
Davidson, Anthony
Davies, David
Dieppe, Paul
Dunckley, George
Elliot, Michael
Flatman, John
Froggatt, Clive
Hamilton, William
Hammersley, Stanley
Hardy, Fiona
Hayward, Roger
Hemphill, Barry
Hunt, Christopher
Hyde, Geoffrey
Isaac, Andrew
Jarvis, Christopher
Johnson, Andrew
Johnson, Norman
Kidd, Graham
Lambert, Robin
Lawrence, David
Leverton, William
McIntyre, Keith
Mackinnon, Jacob
Madson, Michael
Marsh, Philippa
Matthews, David
Moynagh, David
Navin, Marcus
Newman-Taylor, Anthony
Nixon, Christopher
O'Carroll, Timothy
Paterson, Ian
Radcliffe, Grant
Redden, Jonathan
Reddington, John
Rennie, John
Renton, Nicholas
Robinson, Diana
Rodgers, Richard
Rotblat, Frances
Rymer, Michael
Salt, John
Scarffe, Howard
Shaw, John
Simpson, Peter
Solley, Anthony
Stewart, Mairi
Stewart, Mark
Sullivan, Brigid
Taylor, Kenneth
Ussher, Jonathan
Vandyk, Edward
Vanhegan, Gillian
Vanhegan, John
Wager, Alison
Wagner, Nicholas
Waller, Thomas
Whitehouse, Simon
Wickes, Charles
Williams, David
Williams, Michael
Wilmshurst-Smith, Catharine
Winner, Jonathan

THE PATIENT

It's amazing how physicians love to be proved wrong, or to be presented with an insoluble case for their deliberations. It's as if they take some sort of masochistic pleasure in standing at the end of the bed and saying, "Hmh, we'll see," and things like that, and admitting, standing confidentially by the X-ray machines that they don't know what's wrong, but further tests are, of course, necessary. It's all on the National Health, and even the most obscure diseases are worth following up when you're not paying. And so, with all our modern tests and techniques, there's very rarely a case which has everyone puzzled.

When one arrived, I, of course, got lumbered with it. I was doing a locum for a Dr. Canning at the time, who was a good doctor and a pleasant chap, but he had referred to the ward for tests a young housewife of 25, whom he'd seen in outpatients. She'd come with a letter form her G.P. who said that she'd come in for a routine check up, and whilst he hadn't been able to find anything definitely abnormal, he had felt something wasn't quite right, and so he had asked for hospital advice. And Dr. Canning had seen her, and he wasn't sure either, and so at the bottom of his notes he'd put, ? gut, ? heart, ? nervous. And I had to decide what to do.

She was a pretty girl, pleasant but not stunning, quite intelligent. She had one child, a boy, and a loving husband from what I could make out, and they had a decent little house in a nice area, and the husband had a good safe job. She didn't smoke, and drank occasionally, and took nothing but the odd aspirin. She wasn't really complaining of anything at all; she didn't think there was anything wrong to speak of. Oh, she had had 'flu last Christmas, and an upset tummy when they'd been to Spain the year before, but that was all as far as she could remember. Yet, as a doctor, I felt there was something wrong. I put her down for all the tests and investigations I could think of. The registrar nearly had a fit on the spot when he saw my list, but when he had examined her, he agreed, there was something that didn't fit somewhere, and so he let the tests go through.

When the tests started to come back, we pounced on them avidly. They were all within normal limits. When Dr. Canning came round he was very worried. "There's only one thing to do," he said. "Call for Sir Walter."

Sir Walter came onto the ward surrounded by his retinue. He heard our story, of the feeling of something not quite right. Then he went to the patient and talked to her and examined her for 20 minutes. Then he came back to us, and wrote on a piece of paper. He turned to us, "Some of you ought to go outside a hospital occasionally," he said. He went out of the ward.

As soon as he had gone, we looked at the paper. On it were the two words,

ABSOLUTELY NORMAL.

Autolicus, Nov., 1970.

WHAT WERE YOUR FIRST REACTIONS TO . . . ?

by T. H. Turner

"Help!" "Where am I?" "Shocking!" "I don't know really!" Thus, in round, rich language, came the expressed first thoughts of this year's 1st M.B. These were no shallow reactions based on the newness and strangers all around; these were solid opinions, reached after three weeks of bombardment and resistance, thrust and counter thrust, in the battle to keep your head while lectures, practicals and tutorials piled up in solid phalanx day after day after day. . . .

"People kept to themselves." "Just a little disorganised!" "I don't know, why?"—Were they really a mass of solitary people drifting around amidst total disorganisation not knowing what they were doing? Others were more pragmatic, — . . . "Too many forms to fill in—and always the same!" . . . "I enjoyed the first two days." (Lectures began on the third day.) Ah yes, that Monday and Tuesday so long ago; barging to the front of the registration queue, muttering the magic formula—"1st M.B."; shyly trailing around trying not to look too novitiate. Addresses by Dean, Doctor, and Student's Union—"We are a right-wing college," waking you with a start from the daydream about those odd-looking jars you saw in the Anatomy Museum. Beware of drugs and the Slippery Slope. Then tea in that marvellous upper room (what was its name now?) followed by club representatives hawking their delicacies to a bewildered throng. Then Wednesday, and the first pangs of fear. "Depressing." . . . "Am I doing the right thing?" . . . "Just another place." . . . "I really don't know." The mixture is the same as before; people still don't know what they're doing; but now, along with the solitary and the disorganised, depression and neutrality have joined the fray. But stop! stop! put an end to anxiety. Everyone still looks sane. Perhaps several pairs of eyes are just a little darkly shaded. "Is it true the Air Pollution Unit stops all day for the Chemistry practical?" ask people with hope in their voices. "Yes, Yes!" cry the Most Hopeful (with the hint of a glint in their eye).

But in four weeks time there's—oh yes, to be sure there is—there's an *Examination*. Aaaagh! Sound the retreat; everyone else plays games and drinks in the pub, but we, the absolute bottom of the Six-year pile, what do we do? "I don't know really," comes the refrain. Should we leave it here?

"Upper Class" mutter mutter, "Masculine atmosphere" burble burble, "Insular and narrow-minded; an enclosed society;—really great for studying Medicine" mumble mumble; but everyone smiled at being asked.

INTRACRANIAL TUMOUR IN A MOTHER & SON

by E. D. DORRELL, M.R.C.S., L.R.C.P.

This is an account of cerebellar haemangioblastoma occurring in a mother and son. There follows a discussion on the family incidence of Lindau's disease, an association of lesions of which the cerebellar tumour is the most significant.

Case 1

M.R. aged 34 years—first developed symptoms at the age of 32 years and was admitted on 1.12.62 after six months of worsening headache and vomiting occurring initially in the mornings; unsteady gait and blurred vision came later. It was two years previously during her second pregnancy that she had similar symptoms of headache and vomiting which resolved on the delivery of her child. Examination showed bilateral papilloedema, a fine nystagmus on looking to the right and some ataxia of the right arm and leg.

The skull X-ray showed the dorsum sellae to have no cortex on its anterior surface, indicating raised intracranial pressure, and a ventriculogram revealed the lateral and third ventricles to be dilated; the aqueduct was kinked sharply forward and displaced forward and to the left, giving the appearance of a right cerebellar space occupying lesion. The Hb. was 11.8 Gms. per 100 ml. After the ventriculography a right suboccipital craniectomy was made. In the right cerebellar hemisphere a solid vascular tumour was found overlying a small 15 ml. cyst. A complete removal was achieved and histology proved the tumour to be a haemangioblastoma. She did well after the operation and remains fit after eight years of follow-up.

Case 2

J.R. aged 12 years—the son of the above patient was admitted on 8.10.69 complaining for six months of increasing nausea and vomiting and pain in the back of the neck. He had nystagmus, mild ataxia of the left side and a head tilt to the left. There was no papilloedema and the fundi were normal. The haemoglobin was 13.4 Gms. per 100 ml. with a PCV of 42. Skull X-ray was normal. A left vertebral angiogram, Fig. 1, demonstrated a displacement of midline structures to the right and stretching of all the vessels in the left cerebellar hemisphere away from a centrally placed cyst. In relation to the posterior inferior border of this cyst was a small intensely opacified nodule of haemangioblastoma.

A left suboccipital craniectomy was effected allowing 35 mls. of clear yellow fluid to be tapped from a cyst in the left cerebellar hemisphere. Reflection of the dura exposed a scarlet nodule 13 mm. in diameter in the wall of the cyst. The tumour was resected, Fig. 2, and histology confirmed the diagnosis.

Discussion

Cushing and Bailey (1928), divided the blood vessel tumours of the brain into two groups:

1. Angiomatous malformations.
2. Angioblastomata—or true neoplasms of blood vessel tissue containing angioblastic cellular elements and almost always confined in the brain to the cerebellum. They may be cystic or solid and are associated with lesions in the retina, spinal cord and viscera.

The first patient presented as an isolated cerebellar haemangioblastoma but seven years later her son was found to have a similar tumour. As no retinal or visceral lesion was discovered in the mother, the diagnosis of Lindau's disease was inappropriate until this hereditary element was provided. Bradford (1948) observed that a family history of a similar tumour is probably far more common than a concurrent haemangioblastoma in the same patient. Neither was an angiomatous retinal tumour seen in case 2, but as Lindau (1930) pointed out, this may be of microscopic size and escape ophthalmoscopic detection. Fluorescine however, would help to uncover these minute abnormal vessels. Jesberg, Spencer and Hoyt (1968).

At each craniectomy, a small solid vascular tumour was found overlying a smooth-walled cyst. Section on both occasions revealed fine vascular spaces in between which were endothelial cells and pseudoxanthomatous or foam cells containing lipid. The blood vessel nature of this tumour was demonstrated with reticulin stains. Thus the neoplasm is of mesodermal origin, in spite of the frequent presence of glial tissue, which, according to Lindau (1926), develops due to reactive gliosis. Polycythaemia does occur with these tumours, but no evidence was found for this in either patient.

In 1872 Hughlings Jackson wrote up the post-mortem findings in a case with a cerebellar cyst on the outer part of which was a highly vascular tumour, the size of a shilling. The patient had presented with headache and double "optic neuritis". Her sister had died four days after a seizure, never regaining consciousness.

It was Treacher Collins in 1894 who provided the first definite evidence of a familial tendency in this condition, later substantiated by pathological evidence. In a brother and sister of a family of eight, three eyes became blind and painful requiring enucleation, and showing, on histological examination, tumours made up of plexuses of numerous thin-walled blood vessels and in them, cystic spaces. 1904, Von Hippel called this growth of the retina angiomatosis retinae, and one of the cases he described was found at autopsy to have vascular tumours in the cerebellum, cauda equina and petrous temporal bone.

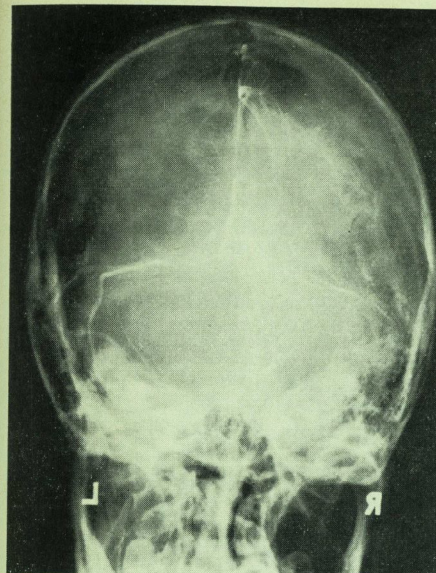

FIG. 1

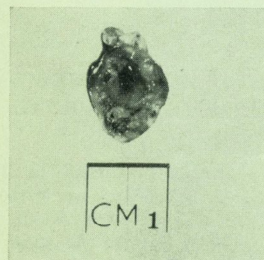

FIG. 2

It was not until 1926 that Lindau in his famous monograph, noted the repeated coincidence of angiomatosis retinae and cerebellar haemangioblastoma, and that they were often associated with other central nervous system and visceral tumours. He also observed a familial tendency.

Lindau's disease is transmitted by a dominant heterozygous gene well illustrated by Bird and Krynauw (1953) in their report of an Afrikaan who, with two wives, produced fifteen children, six of whom had a manifestation of the disease. Unfortunately, the father's mode of death was unknown. Penetrance is however, incomplete and generations are missed. In the ninety members of a family studied by Christoferson and Gustafson (1961), only 12 per cent. in four generations were affected, whereas approximately 20 per cent. should be if the dominant gene were fully penetrant. Nor is there any evidence of sex linkage. Genetic anticipation appears frequently in pedigrees reported in the literature, Melmon and Rosen (1964), Wright (1969), and is present in the family described here.

A history of Lindau's disease in a relative of a patient with a posterior fossa space-occupying lesion, is of tremendous value in diagnosis, but the incidence of a family history in isolated cases is difficult to assess. The early confusion in classification of blood vessel tumours, the lack of histological verification and problems in tracing and proving affected members of the family makes it an unrewarding task. However, Lindau (1930) reckoned the incidence to be 20 per cent.; Usher (1935), reviewing 119 cases of angiomatosis retinae, found 22.68 per cent. had a family history of Lindau's disease, but his series contained several members of families affected. This percentage is therefore higher than it would be if drawn only from isolated cases. Stein, Schilp and Whitfield (1960), only produced one patient, 4 per cent., with a hereditary story out of 25 cases of intracranial haemangioblastoma, while Norlan (1941), only found one pair in a series of 42 (2.4 per cent.). It would seem that the incidence of a family history in isolated cases is under 20 per cent.

It is interesting that the mother complained of headache and vomiting during her second pregnancy two years before the onset of symptoms that led to surgery; they disappeared with the birth of her child. This phenomena has been recorded in the literature on several occasions, notably by Wright (1969), Robinson (1965), and Bourdillon and Hickman (1967). The latter describe a patient whose visual acuity deteriorated while pregnant and who was later found to have angiomatosis retinae.

During pregnancy, the circulating blood volume increases by 25 per cent. to 30 per cent., which is not all accounted for by the placenta, Donald (1966), and the higher oestrogen levels cause salt and water retention; the maximum increased cardiac output is reached between the 26th and 29th week. As a cerebellar haemangioblastoma is a very vascular tumour, often combined with a cystic component enclosed within a rigid cranium, it seems likely that these circulatory changes would account for the worsening or commencement of symptoms during pregnancy. Also the blood viscosity is lowered, which would increase the liability of oedema formation and haemorrhage from the abnormal vessels in the retina and hence reduce visual acuity in a patient without papilloedema from a cerebellar lesion.

Summary

Two cases of cerebellar haemangioblastoma are reported, occurring in a mother and her son. Both tumours were successfully resected and both patients continue to do well without any sign of recurrence or further manifestations of Lindau's disease.

There is a short discussion on the hereditary factors involved and the aggravation of symptoms or presentation of the disease during pregnancy.

I wish to thank Mr. J. E. A. O'Connell for his assistance with this report and Dr. G. du Boulay and the Photographic department for allowing me to reproduce the photographs.

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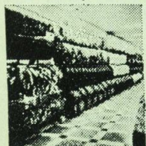

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CHRISTMAS WITH THE DYAKS

by Trevor Hancock, B.Sc.

Saratok is a small town much like many others in the Second Division of Sarawak, on the northern portion of the island of Borneo. The small bazaar, a parade of Chinese-owned wooden shops, was built on stilts, and the heavy rains of landas had changed the ground beneath into a quagmire. At each end of this main street a track led along the banks of the sluggish muddy river to the Malay kampongs, small villages of neat brightly-painted stilt houses, crowded close to the river that was their bathroom, toilet, and main road. All around, the jungle cloistered them, a sea of greens slashed by a livid orange-red scar, where the only major road in the country, un-metalled and still under construction, cut across a ridge, as it had to many times in its passage between the two major cities. Overhead the sky was heavy with clouds, for this was landas, the rainy season, and everywhere the ground was thick with mud, the great jungle dripped and steamed.

Early on Christmas Day I met Andy, a fellow V.S.O., in the bazaar. After a breakfast of sweet, sticky cakes and coffee made with condensed milk, we set off up the new road in the school Land Rover, to spend Christmas with some of his Dayak pupils, whose ancestors had been amongst the most renowned and feared pirates and head-hunters in the world. Ten miles out of town we were met by some of his pupils, and leaving the Land Rover, we set off along a well trodden path into the jungle. After ten minutes, we rounded a bend to see the longhouse at the top of the rise ahead, or at least one end of it. Leading up from the ground to the entrance, some twelve feet above, was a small log with notches cut in it, which served as a ladder. This is easy enough to ascend, but quite another matter when descending after enjoying the unrivalled hospitality of the Dayaks.

On climbing the ladder we found ourselves in the roumai, a communal living space running the length of the longhouse, in this case about 75 yards, and traversing half the width, about 25 feet. The roumai is where most longhouse life is carried on, entertaining guests, holding dances and other ceremonies, winnowing and threshing the rice harvest, or simply living. Along the outside runs a verandah, where thatch is made and kept, crops are sun-dried, and hunting, fishing and farming implements are kept. The remaining half-width of the longhouse is sub-divided down the length into individual family rooms, bileks, with cooking places along the outside wall. The number of rooms, and thus the length of the longhouse, varies. This one had 21 rooms, which meant that roughly 150 people were living communally under the same roof, not particularly large by Dayak standards, but big enough.

This was a rich longhouse, newly built with well fitting planks of belian, a very hard wood found sparsely deep in the jungle. The bileks, into which we were invited for food, were brightly painted and many of them had carpets and large richly covered beds. The best china was proudly displayed in cupboards, and even a few transistor radios were to be seen.

As this was a Christian longhouse everybody was wearing their best clothes, the women in their graceful brightly printed sarongs, the men in dark trousers and open-necked white shirts, though nobody wears shoes in the longhouse; these are removed and left at the door. As always, we were welcomed gracefully and led to the centre of the roumai, where we sat eating sweet rice cakes and drinking hot sweet tea, surrounded by an inquisitive and friendly group. At the front sat the old men, smiling and nodding at us, showing their few remaining teeth in mouths stained black by many years of chewing the bitter betel nut, and thrusting upon us still more sweetmeats, drinks and pungent cigarettes made from local tobacco and wrapped in nipah leaf. Next to us sat the secondary school pupils, acting as interpreters when needed. The women, although emancipated by Asian standards, preferred to sit at the back, where they chewed a variety of betel nut which made their mouths appear blood-stained, or smoked the same evil smelling cigarettes, as they talked in low voices, or just sat and watched us. Children were everywhere, the elder ones sitting very solemnly with their elders, the young children in the care of the elder girls, or playing happily. Occasionally they risked a peek at these strange visitors, but if we looked at them or spoke to them, they drew back with a shy, embarrassed smile, to the amusement of all.

About three in the afternoon, a neighbouring longhouse came visiting, which provided what little excuse is necessary for the Dayaks to engage in dancing, drinking and general celebrations. Andy and I were escorted back outside, where the men, women and children of the visiting longhouse were waiting. We were given a splendidly embroidered hat to wear, and a very beautiful old parang with an inlaid silver handle, that had doubtless taken its share of heads in its time. Bearing these, we all formed up into a parade, and to the accompaniment of gongs, drums and ribald encouragement, we re-entered the longhouse behind the visiting tuai rumah (headman) with the rest of the visitors, from the oldest to the youngest, following. As custom demanded, we walked, or in some instances staggered, down the roumai, stopping at the door of each bilek to receive a drink from the family. Most of these were glasses of Hennessey cognac or arak, a semi-lethal

A Heavily-Tattooed Dayak Playing the Gongs

Photographs by R. Collister

A Group of Young Dayak Girls

rice-spirit, and a number gave us beer or tuak, a delicious but potent rice wine. As there were 21 doors, and it would have been gross bad manners to have refused to drink, we were all much happier by the time we reached the end, and the headman and his wife, who seemed to think that their position of eminence required them to drink twice as much as anyone else, were practically incapable of supporting each other by the end. Their condition provoked howls of laughter from hosts and guests alike, as did the condition of those who attempted to leave the line prematurely, but were gently replaced by their hosts.

Soon after this, we had to move on to the next longhouse, as it was getting dark, but the dancing and drinking still continued. We made our way precariously down the log ladder and back to the Land Rover, and with our heads spinning, drove a further five miles down the road, to be met by another group of students. By now it was dark and we had only torches and a fitful moon to light our path. This longhouse was about two miles back in the jungle, and part of our journey entailed crossing 250 yards of swamp on a series of tree-trunks which had been felled end-to-end to provide a path often only nine inches wide and eight feet above the swamp, and totally devoid of hand-holds. Stone cold sober and in broad daylight this would have been a daunting trip, but in our condition and with the moon hinding behind the clouds it was hair-raising. We would not have made it at all were it not for the Dayaks' marvellous sense of balance, though even so it took us 15 minutes. (I was told later that our giudes were capable of crossing in a couple of minutes.)

Having successfully negotiated this, we quickly arrived at the longhouse. This was quite a contrast to the previous one, being old and obviously poor. It was built in the same style, but principally from bamboo, which creaked and shook as we walked on it. We were again entertained on the roumai, surrounded by all the inhabitants, their dogs, cats, and cockerels (prize birds carefully cared for inside the longhouse, and much prized for their fighting ability, which is the Dayaks' national sport). Below us in the muddy ground beneath the longhouse, pigs rooted and snorted. Again we were given food and drink, and again we were the focus of an interested group, more inquisitive than at the previous longhouse, since European visitors to this remote longhouse were rare. All the inhabitants came to stare, some of the girls quite beautiful though dressed in the rough black sarongs which were such a contrast to the finery of the girls at the other longhouse. Most of the old women wore their sarongs in the traditional topless style, and the men wore the cool cotton sarongs.

But the most distinctive thing about this non-Christian longhouse was that, whether by accident or design we never found out, they had chosen Christmas Day to hold a ceremony to ask the rice-spirits for a good harvest for the new planting. In the middle of the roumai were a number of wicker baskets containing rice and other plants, surrounded by beautifully woven straw mats, and tended by a very ancient lady with wrinkled breasts and the usual betel-nut stained red mouth. Around this, for ten hours solidly from 9 p.m., four men half-walked, half-danced, chanting and periodically banging the large staves they carried on the floor. Soon after we got there, a very curious ceremony called "combing the pig" took place. A line of five people formed up; at the front was a man wearing a beautifully embroidered sarong and jacket, and carrying the longhouse emblem, an intricately decorated hand-woven blanket carried on a stick; a second man carried a vicious-looking spear, and behind him came three women bearing food and a pot of tea as offerings for the spirits, and most important of all, the hand-carved comb. After parading round the longhouse and leaving the offerings around the baskets of rice, they went out onto the verandah, and taking a pig from its specially constructed cage, they carefully combed it. The pig didn't seem to take too kindly to this, but then perhaps he knew that he was to be sacrificed soon after, and his liver examined for omens by the witch doctor.

Because of the chanting and banging of staves, it was nearly impossible to sleep, and the rest of the night passed in talking, drinking, eating and enjoying the purely male pastime (in the Dayak culture) of dancing to the infectious and primitive rhythm of the longhouse band of drums and gongs. So it was that two bleary-eyed, half-drunk V.S.O.s staggered thankfully to greet the dawn of Boxing Day, and to regret the passing of a most unusual Christmas.

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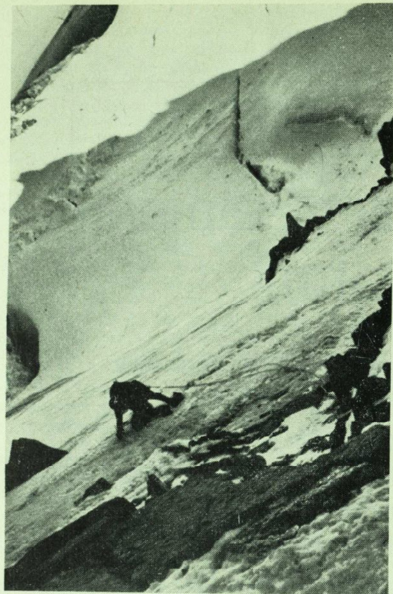

FOUR STEPS TO THE SUMMIT

The north buttress of the Aiguille du Chardonnet above Chamonix.

Photographs by David Gundry

THE CARCINOID SYNDROME— A CASE PRESENTATION

by Gareth Davies, B.Sc., and John Lumley, F.R.C.S.

The first description of the carcinoid tumour is generally ascribed to Lubarsch (1888) who distinguished it from an adenocarcinoma of the ileum. In 1890, Ranson noted that it was a metastasising tumour and in 1907 Oberndörfer coined the term "karkinoid," stressing its malignant appearance despite a seemingly less aggressive clinical course. Oberndörfer, however, believed the tumour to be benign and thought it of limited clinical significance. Between 1914 and 1928, Masson demonstrated that both carcinoid tumour cells and the cytoplasmic granules in the Kultshitzky cells in the Krypts of Lieberkuhn reduced silver salts and he postulated the argentaffin cell of origin of the tumour. More emphasis was at this time being placed on the morphology of the tumour than on its clinical presentation. Cassidy (1930, 1934) described the features of the Carcinoid Syndrome whilst being totally unaware of its relationship to the tumour.

In 1952, Biörck, Axen and Thörson reported a case of jejunal carcinoid with associated hepatomegaly, cyanosis, right-sided heart lesions and skin involvement, thus establishing, for the first time, a relationship between the clinical findings and the presence of a carcinoid tumour. It was suggested by Thörson that 5-hydroxytryptamine (5HT), which had been isolated from the argentaffin cells of the carcinoid tumour might be responsible for the clinical features. Shortly afterwards, increased levels of 5HT in the blood of patients with carcinoid tumours were demonstrated as well as increased urinary excretion rates of the chief metabolite of 5HT, namely 5-hydroxyindole acetic acid (5HIAA).

Inevitably, despite evidence to the contrary, all the features of the syndrome were ascribed to an excess of 5HT as illustrated by the doggerel of Bean (1958).

"This man was addicted to moanin'
Confusion, oedema and groanin',
Intestinal rushes, great tricoloured blushes,
And died from too much serotonin."

In fact the typical carcinoid flush cannot be produced by 5HT and this active amine only accounts for a small part of the syndrome, possibly the diarrhoea and cardiac lesions. More recently, an increase of other pharmacologically active substances such as bradykinin and prostaglandins (PG) has been demonstrated. Both these substances can produce the flush, the wheeze and the diarrhoea, but in all probability all three substances, and other as yet unidentified compounds produce the full clinical spectrum.

Williams and Sandler (1963) reviewed tumours arising in sites other than the small intestine which had been reported with similar clinical and biochemical findings; many of them were not argentaffin tumours. Some representatives of this group were found to produce 5-hydroxytryptophan (5HTP) a precursor of 5HT and these authors grouped such tumours according to an embryological classification. Table 1.

The prime manifestations of the "Classic Carcinoid Syndrome" are now regarded as flushing, diarrhoea, wheezing and cardiac disease. However, in any given case such symptoms may present in so many different ways, that Sjoerdsma and Melmon (1964) have coined the descriptive phrase the "Carcinoid Spectrum."

CASE PRESENTATION

The patient, a 45-year-old housewife, was admitted onto the Surgical Union on 18.8.70 with a known diagnosis of the Carcinoid Syndrome. She was complaining of swollen painful legs, flushing attacks, diarrhoea and wheeziness. The history had started eight years before when she first noticed periodic inappropriate flushing of her face; over the next four years the flushing spread to involve the whole of her body. She was otherwise well until two years ago when she started to have diarrhoea; she experienced the passage of watery motions two to three times per day. Four months prior to admission, she began to feel generally unwell. She complained of wheezing, particularly during flushing attacks which commonly occurred with epigastric pain after ingestion of food. One month later, her legs became swollen, tender and painful. She had lost half a stone in weight during this period.

On examination, she was florid, flushed, disorientated and extremely agitated. She was not clinically anaemic or jaundiced. The J.V.P. was raised 10 cm; the pulse was 80 beats/minute with an occasional ectopic beat. Blood pressure was steady at 130/80 mm.Hg; there was bilateral leg and sacral oedema; the second heart sound was loud and single and there was a pansystolic murmur. An irregular liver edge extended across the upper abdomen and down as far as the umbilicus.

INVESTIGATIONS:

The diagnosis was first made at the Essex County Hospital in June, 1970, where the patient's urinary 5HIAA was found to be 460 mg/24 hours (normal 2—10 mg/24 hours). Renal function, as assessed by blood urea, electrolytes, urinalysis and I.V.P. was normal. Chest X-ray revealed an enlarged heart, an elevated right hemi-diaphragm and small pulmonary vessels. A liver scan showed uptake in a large liver with multiple large cold areas consistent with gross metastatic infiltration of the liver.

MANAGEMENT:

The patient was transferred to the Medical Unit for assessment and treatment of right heart failure, flushing and diarrhoea. She had right ventricular hypertrophy, and signs of tricuspid incompetence and pulmonary stenosis. Intensive diuretic therapy on frusemide and slow K resulted in the J.V.P. falling 7 cm. and elimination of the oedema.

Since there is some evidence that the diarrhoea may respond to 5HT antagonists, methysergide was given for a short while but with little benefit and apparent worsening of the mental confusion. It was withdrawn and the diarrhoea controlled with codeine.

As there is also evidence that flushing attacks can be produced by the administration of adrenaline, cheddar cheese and alcohol, and that the release of pharmacologically active substances from the tumour may sometimes be adrenergically innervated, the effects of ∝-adrenergic antagonists were tried. Initially, intravenous thymoxamine was infused and then oral phenoxybenzamine was given 10 mg. t.d.s. Dramatically, the flushing attacks became less frequent and then stopped altogether.

The patient's general condition improved so that an operation could be contemplated. A laparotomy was perfomed on 21.9.70. A small primary carcinoid tumour of the mid-ileum with a chain of nodes running to the pre-aortic region was found. The liver contained multiple large and small metastases, mainly in the right lobe, as predicted by the liver scan. The primary lesion was excised with a wedge of mesentery. The liver substance was pulsating due to tricuspid incompetence, and haemostasis proved extremely difficult. A right hepatic lobectomy was performed and a large metastasis was excised from the left lobe. The remaining raw area was packed with a flavine swab which was left in situ and led to the exterior. Infusion of angiotensin was required throughout the operation in an attempt to prevent hypotension; the effects of the commoner sympathomimetic pressor drugs in this situation would have been blocked by phenoxybenzamine and they were not used. Despite the angiotensin infusion the patient became profoundly hypotensive, the systolic pressure falling to

Table 1.

THE CHARACTERISTICS OF CARCINOID TUMOURS DERIVED FROM DIFFERENT EMBRYONIC DIVISIONS OF THE GUT

	Foregut	Midgut	Hindgut
Histological structure	Tendency to be trabecular ; may differ widely from classical pattern	Characteristic	Tendency to be trabecular
Argentaffin and diazo reactions	Usually negative	Positive	Often negative
Association with the carcinoid syndrome	Frequent	Frequent	None
Tumour 5-H.T. content	Low	High	None detected
Urinary 5-hydroxyindole-acetic acid	High	High	Normal
5-H.T.P. secretion	Frequent	Rare	Not detected
Metastases to bone and skin	Common	Unusual	Common

Williams, E.D. and Sandler, M. (1963). Lancet, 1, 238.

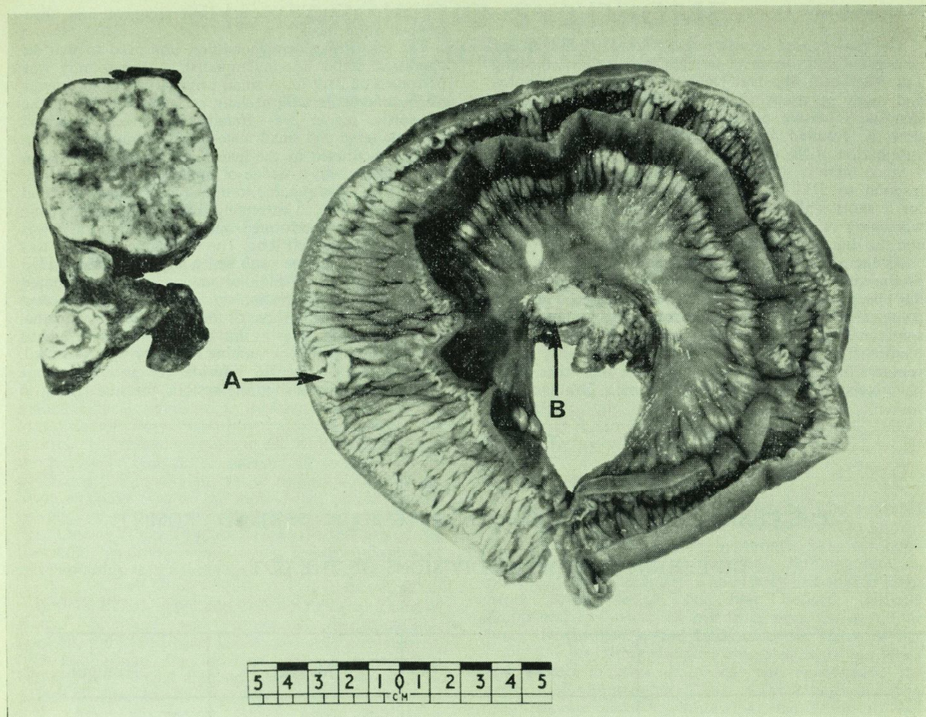

PLATE I. Primary carcinoid tumour and liver metastases.
A. Primary ileal tumour.
B. Mesenteric metastatic nodes.

between 40 and 20 mm.Hg. with no recordable diastolic pressure. She was transfused 19 pints of blood and 18 pints of clear fluid during the operation.

The main problem post-operatively was the patient's inability to produce urine. Her general condition seemed to be improving twenty-four hours post-operatively, but her serum creatinine rose to 3.7 mg% and K^+ rose steadily. Resonium enemata and intravenous glucose and insulin were given in an attempt to lower the K^+ but it rose to 9.3 mEq/L and the patient arrested and died on 24.9.70.

POST-MORTEM FINDINGS

Plate I shows the primary ileal tumour and liver metastases. At one end of the loop there is a small yellowish nodule 1.3 cm. in diameter. It is well circumscribed but non-encapsulated. Microscopically, the tumour appeared to have arisen in the mucosa of the ileum and extended through the serosal surface. Plate II shows the typical appearance of a carcinoid tumour consisting of discrete clusters of cells lying in a delicate connective tissue stroma. The liver was infiltrated with necrotising metastases. Plate III shows the appearance of the pulmonary valve cusps which are densely fibrotic and stenosed; there is also marked fibrosis around the valve which has caused contraction of the heart tissue. The tricuspid valve edges were nodular and thickened; the right atrium was dilated and there was evidence of endocardial thickening. Microscopically, fibrous deposits were present on the luminal surface of the internal elastic lamina which was covered by apparently normal endothelium.

The kidneys showed evidence of acute tubular necrosis, probably the result of the prolonged operative hypotension.

DISCUSSION

PHARMACOLOGY

5HT is the anabolic end-product of tryptophan metabolism, tryptophan being an essential amino-acid. Ninety-nine per cent. of that ingested is directed towards protein and niacin synthesis, less than 1% being metabolised to 5HT. The first step in synthesis is the hydroxylation of 5HT to 5HTP, this is rate limiting and occurs in normal and carcinoid tissue; therefore, increased 5HT production in carcinoid tumours is not

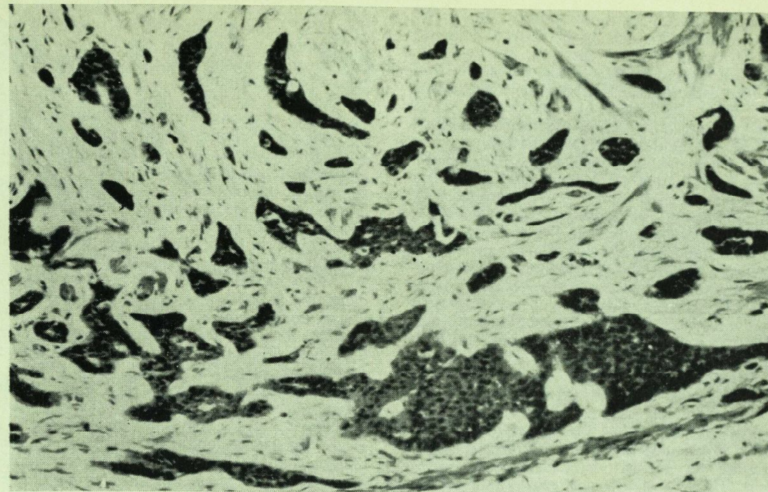

PLATE II. Histological appearance of a carcinoid tumour showing discrete clusters of cells in a delicate connective tissue stroma.

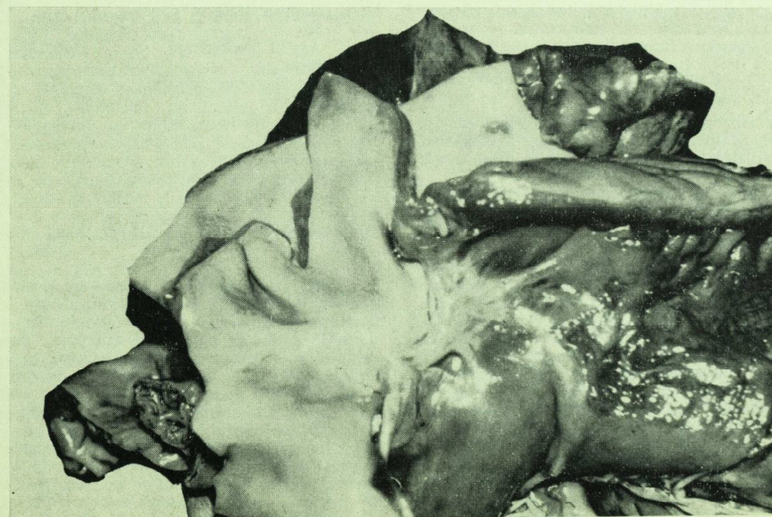

PLATE III. Opened pulmonary valve showing fibrotic, stenosed cusps.

due to increased function of individual cells, but rather to a greatly increased number of normally functioning cells. 5HT is stored in blood platelets, brain and intestine and is destroyed by monoamine oxidase in liver and lung. The end-product, 5HIAA, is excreted in the urine.

Intravenous infusion of 5HT increases intestinal mobility, tone and intra-luminal pressure and results in abdominal cramps, nausea, vomiting and diarrhoea. The current belief is that 5HT plays a neuro-humoral role in gastro-intestinal muscular activity, probably by stimulating cholinergic nerves distal to the submucosal ganglia, or by vascular control of the gastro-intestinal tract, or by a combination of both.

5HT is also a severe bronchial muscle and pulmonary vessel constrictor. It decreases renal blood flow by constricting the afferent glomerular vessels. Injected intravenously, it causes hyperpnoea in normal subjects.

Until 1963, it was generally accepted that 5HT was released intermittently into the circulation and produced the flush. It was also assumed that flushing could only occur if the tumour was drained by veins of the systemic system, since portal venous 5HT is destroyed by monoamine oxidase in the liver. Therefore, for an ileal tumour to produce the syndrome there must be liver metastases or extensive secondary lymph node involvement. There is now strong evidence that 5HT contributes little to the flush:—

1 Severe, induced flushing attacks occur in the absence of elevated urinary 5HIAA.
2 It has not been possible to demostrate elevated 5HT or metabolites in either blood or urine during spontaneous flushes.
3 Intravenous infusion of 5HT has not been shown to consistently produce flushing in normal or carcinoid patients.

The Kinin peptides are highly active pharmacological substances

KININOGEN ——→ lysyl Bradykinin
Kallikrein ↑ ↓ ← amino-peptidase
BRADYKININ

Kininogen is an active ($\alpha-_2$) globulin present in plasma and lymph. Kallikrein is present in an inactive but readily available form in plasma and is in an active form in saliva.

Infusion of synthetic bradykinin into normal and carcinoid subjects produces typical facial flushing and hypotension (Oates *et al*, 1966). Hepatic metastases have been shown to contain kallikrein in large quantities. Brady kinin-induced flushing may, however, not be the whole story since Oates found no detectable rise in kinin blood levels in two patients who exhibited severe flushing attacks. Bradykinin also has a stimulating effect on smooth muscle of bronchi and intestine and may thus be implicated in the attacks of asthma and diarrhoea. Spector and Willoughby (1964) have implicated bradykinin as an agent capable of altering endothelial permeability and initiating inflammatory reactions with proliferation of fibrous tissue.

Excess Histamine has also been demonstrated in many patients with the syndrome, in particular those with gastric tumours; increased levels of imidazoles appear in the urine. Some patients presenting with diarrhoea, flushing, abdominal colic and facial telangiectasis without definite evidence of a carcinoid tumour or systematic mastocytosis have been shown to have elevated blood and urine levels of Histamine. Facial skin biopsy in carcinoid patients has shown an increase in the number of mast cells containing a kallikrein-like enzyme. 5HT causes release of Histamine which in turn releases catecholamines.

Sandler et al (1968) have shown evidence of the occurrence of prostaglandins in amine-peptide secreting tumours and Williams *et al* (1968), demonstrated relatively high concentrations of prostaglandins in tumour tissue and blood from patients with medullary cell carcinoma of the thyroid. This tumour seems to bear a morphological and biochemical relationship to the carcinoid tumour and also shares with it the important clinical feature of diarrhoea; the thyroid tumour also contains increased amounts of 5HT. Prostaglandins may play an important role in the aetiology of the diarrhoea. Bergström *et al* (1959) infused prostaglandin E_1 into human subjects and found flushing to be a constant feature. It also produces severe migraine-like headaches, a prominent sympton in bronchial carcinoid.

CLINICAL FEATURES

Table 2 illustrates the main clinical features in a group of patients as compiled by Thörsen (1958). Diarrhoea, flushing and wheezing have been discussed above. Cardiac lesions occur in 50% of patients with the syndrome but are rarely seen in the absence of liver metastases; they are late manifestations of the disease. Tricuspid incompetence is the most common valvular lesion, and non-valvular lesions include the existence of a hyperkinetic state where there is an increase in carciac output, a decrease in A—V Oxygen difference, an increased stoke volume and a decreased peripheral vascular resistance.

TABLE 2
Clinical features of the Carcinoid Syndrome

Number of cases	77
Sex	48 M, 29 F
Age at presentation	18-80 M, 33-80 F
Flushing	74
Intestinal hypermotility	68
Oedema	52
Heart lesions	41
Asthma	18
Arthralgia	6
Pellagra-like skin lesions	5
Peptic ulcers	5

THÖRSON, A. H. (1958). Acta. Med. Scand., *161*, Suppl. 334, 1.

Valvular and endocardial lesions are predominantly right-sided. The left heart is infrequently involved, usually occurring in a patient with either a patent foramen ovale or pulmonary carcinoid. There does seem to be a definite correlation between an increased serum 5HT and a generalised fibrotic process seen in carcinoid. The changes indicate active formation of young collagen, and plasma cells and lymphocytes are scattered around the blood vessels. Bananas contain a high concentration of 5HT and are the stable diet of certain African tribes. Davies has shown a definite increase in the incidence of endomyocardial fibrosis in such tribes, a condition which certainly mimics that of the carcinoid heart. Large infusions of 5HT into animals have failed to produce these lesions. 5HT-rich blood is also in contact with the hepatic veins, but they show no such change. Urinary 5HIAA is similar in patients with carcinoid irrespective of whether cardiac lesions are present or absent. Bradykinin does have a fibrosing action and it has been demonstrated that there is a decrease in kinin levels from the hepatic vein to the peripheral vessels in the syndrome.

It is likely that these lesions are due to a combination of factors, amongst the most important being the repeated distension over many years of the structure of the right heart, and local 5HT action causing fibrosis and platelet deposition. Altered tryptophan metabolism is also associated with hypoproteinaemia and hypovitaminosis causing a lowering of tissue resistance to trauma in association with a low blood concentration of oxygen and a high carbon dioxide concentration found in the right heart.

Pellagrinous features are believed to be secondary to niacin and protein deficiency. Sixty per cent. of ingested tryptophan may be diverted to form hydroxyindoles. A less common feature of the syndrome is personality change—a prominent symptom in the present patient. Much work has been done on the effects of 5HT on the C.N.S. but dementia and hallucinations occur too infrequently in carcinoid patients to make these disorders an integral part of the syndrome.

DIAGNOSIS

The "Classical Carcinoid Syndrome" is not difficult to recognise; but individual signs and symptoms presenting on their own may be the sole clue to the diagnosis. Differential diagnoses which must be considered are:—flushing: may be menopausal in origin, may be associated with vasomotor instability or decreased oxygen saturation; diarrhoea: may be associated with acute or chronic gastritis or functional gastro-intestinal disease; paroxysmal dyspnoea and wheezing: are common symptoms of bronchospastic disorders; hepatomegaly and cardiac valvular lesions: may simulate rheumatic heart disease.

The diagnosis is made:—

1 By the presence of increased urinary 5HIAA. A value over 40 mg/24 hours being diagnostic.

2 By the adrenaline provocative test. Between 0.6—5 micrograms are injected into patients complaining of spontaneous flushing. The diagnosis is positive if the flush is reproduced within 45—90 seconds after injection, accompanied by tachycardia and hypotension.

Where there is evidence of widespread metastases in a patient with apparent benign disease, the possibility of a carcinoid tumour should always be considered.

TREATMENT:

1 **Surgical:** The treatment of choice is complete removal of the primary and any metastases. Resection of large metastases, particularly in the liver, does give temporary relief, and because of the slow growth of the tumour, liver resection should be attempted whenever possible. Operation is not without hazard, hypotension being a major problem; administration of anaesthesia alone may provoke both hypotension and bronchoconstriction. Fluid therapy is not without risk since it may increase right heart failure and the antidiuretic action of 5HT may further delay excretion.

2 **Medical:** If surgical excision is not feasible, then the treatment must, of necessity, be symptomatic. Since a raised 5HT level is the hallmark of the disease, 5HT antagonists may be administered. They do not, however, decrease tumour size or alter blood or urinary levels of 5HT metabolites. Restriction of dietary intake of tryptophan has proved unhelpful. Methysergide is commonly used but is only effective in controlling diarrhoea.

Phenoxybenzamine is used to control flushing for reasons already given. α—methyl dopa has also been found to improve flushing probably by inhibiting catecholamine release from tumour tissue.

Heart failure and oedema should be treated in the usual way, but no known agent is, as yet, capable of preventing the cardiac lesions.

3 Radiotherapy and chemotherapy:

Carcinoid tumours are generally resistant to X-irradiation; few favourable results have been obtained.

Chemotherapy involves the infusion of cytotoxic drugs, such as nitrogen mustards, purine antagonists and methotrexate; results have been poor in these series but more encouraging results come from the infusion of 5-fluorouracil and cyclophosphamide. Effective therapy reduces liver size but produces a rise in urinary 5HIAA and initially an excerbation of symptoms indicating tumour cell destruction and release of toxic metabolites.

CONCLUSION:

Many questions still remain unanswered. What is the aetiology of the heart lesions? What is the identity of the other substances secreted by the tumour? Is adrenergic innervation the main method of release of vasoactive kinins? What is the aetiology of the less common clinical manifestations of the syndrome? Further study of this disease will undoubtedly render much benefit towards the understanding of many, as yet, unknown physiological and pharmacological principles.

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ET IN ARCADIA EGO

Introduction:

The light splashes on the waxed leaves. Spinning off,
hurled by the wind, it echoes on the dusty stone
and worries the shadow. Slow moving air
pulses the tree, its branches reaching. Never finding.
Its knuckles arch and clench the grey below,
standing, vulture on prey, wings quivering. Gripping
sad rock, carved and gutted by an age of such moons.
With the falling wind, the tree breathes more slowly
and holds its pride of shadow near— blue
against each eye of light. Soft with each stir.

Monologue:

Cut the sky gently dear moon. And allow
a cold light while I walk. Do not run
to hide behind a crest while the hanged-man
shadow in the boughs ices my skin.
I walk from sun and through the dawn mists
into sun, where wind alone flickers candles
and brushes hair. Where my name is known.
Do not hide so quickly, or push shadows further
to the east. Stay, look from the tower
of the mountain, form an eye from a circle
and guide my way through sorrow thorn.
I wore a ring, but now I walk on dust
and crusted blood. My shadow hides no ground
and only memories give me form. The love
that was is but a bitter goad. A flint
beneath my feet. Wait before you blur
the mountain grass, and see my journey pass.
Raise a wand of light in sadness for our parting.
Leave the night gently, dear moon, before
you wane in sorrow for our meeting.

Conclusion:

Wind raises and flutters leaves once curled
in silence. Darkness gathers near roots and upwards
blurs a rippling gust. The scudding sudden shower
pocks the dust-laid path, wetting the sting
of the wind. And passes. The moon casts
a shrinking glance upwards and is lost.
Tree, alone, struggles with the wind in silence.
A shroud of mist gathers, searching, near
the earth. The sun breaks, spewing blood but suddenly,
and finds the cool grey shadows in the west.

TEIFION W. DAVIES.

PRO DEO REGE

The halfmoon carves a sudden branch coldly
near the waters' edge. Black and bare from the void.
The frightened clouds still run to mingle black with black;
their movements edged with silver. Tree, like people,
bend before the rushing particles of time. Windheld.
Drifting leaves turn slowly near our faces, breaking
dust to concrete, near our feet. The dipping treefingers
lean heavily: cracking the glow of streetlights
which dapples our merging forms.
An edge of rain skirts our slowly moving bodies.
Suddenly we run, a heartbeat apart. Hair on the wind.
The startled leaves swirl and suck about our feet.
Figures blur with fenceposts as we run. Passing traffic
streaks the darkness unnoticed. We reach the small bridge
gasping, laughing. We hang together seeking shadow.
Closely damp. The languid dreamcrest waves shudder
over smooth sand to their high, gripping the distance.
The run and splutter chokes the rainrock, fringed white
beneath a waxing moon. Again the naked trees
lose their forms in darkness. The brown leaves float.

TEIFION W. DAVIES.

GRASS SKIING a personal appraisal

By I. D. Bunker

They were nowhere to be seen, could this be the right place? A whirring sound gently wafted round Parliament Hill; did they whir? I quickened my pace through the golden trees dripping their autumnal leaves and whirring resolved into rattling. There they were, twenty grass skiers snaking down the hill, and, horror, at the top a silhoutted crowd of about two hundred sat, lay and stood, watching and burst into laughter when anybody fell.

Having paid my dues I collected a pair of ski boots and grass skis. The grass ski resembles a caterpillar tracked roller skate with the tracks protruding at front and back making the assembly about eighteen inches long. The tracks are made of a band of nylon and run on roller bearings which are attached to the tracks in a plastic encasement. These bearings run on the metal rails of the ski chassis. They are attached to the ski boots primarily, it seemed, by being hammered to fit, and only secondarily by the nylon straps. Now came the great moment, I tripped over walking to the start of the run.

Summoning all my strength I heaved on the sticks and started rumbling off down the hill. The rumbling turned to a rattling, the turf flew by underski, people turned to blurred images. Chosing a bump to turn on I found the skis did not slide sideways as snow skis do in a turn, but by exaggerating the movement I turned nevertheless. How does one stop? Snow ploughing (or grass ploughing!) is impossible, as is the skid stop, both being dependent on the skis sliding sideways and dissipating energy by displacing snow. The lakes at the bottom of the hill were approaching fast as I turned and turned until, facing up the hill, my speed gradually declined until I stopped. Sweat dripping from my brow, I started herringboning up the hill (easy on grass skis due to their short length). The art it seems is thus dependant on exaggerated movements and having enough speed to perform them. One thing that struck me was that far fewer people were falling over than one sees on the ski slopes. After a half an hour I was getting used to the skis, making use of bumps to jump on and slaloming down through the poles. Two hours later as the sky glowed red behind the Post Office Tower and the sun set I felt satisfied, enthralled, and absolutely exhausted.

Grass skiing is bound to catch on—all you need are grass skis, boots, sticks and a hill. This is an all year sport, whereas snow skiing is a Winter sport and water skiing is a Summer sport. A pair of skis at £20 is fairly expensive for the individual but not for a club. Bearing in mind a good pair of snow skis costs £60 without bindings, grass skis are relatively cheap. Grass skis are ideal for getting in form for snow skiing and have a great advantage over dry ski runs in that they can be used anywhere, whereas the dry ski run is fixed. They are also a sport in themselves, a challenge to nature, and mastering a hill on grass skis will probably take over from having a round of golf on Sunday afternoons. You never know.

Book Reviews

Doctor in Chains. By George Moreton. London, *Howard Baker,* 1970. 251 pp. 35s.

The pseudonym George Moreton conceals the identity of a Bart's man who entered the College as war broke out, but interrupted his pre-clinical studies to join the R.A.F. While training in the States he spent his spare time in a hospital, gaining knowledge which later proved useful. Returning to England, the author was shot down during a bombing raid over Germany, and spent several years as a prisoner-of-war. This book is largely an account of his experiences during that period. Much of his time was spent assisting the medical staff in the primitive conditions of the hospitals in these prisoner-of-war camps, and he was eventually giving anaesthetics and conducting operations. An M.B.E. Military Division for medical services in a prison camp must be a unique distinction for an unqualified person, but the author returned to Bart's, qualified and eventually settled down in general practice.

This book is not to be confused with the *Doctor* series, also written by a Bart's man. It is not funny, and the author is not an experienced writer, some of the sentences being particularly difficult to construe. It is very repetitive, and rather overloaded with gory details, but it is obviously a true record of a man's war-time experiences. It is extremely difficult to recall events of thirty years ago, and the Dean (Sir Girling Ball) "with a thin long beard" must surely be a figment of the imagination. However, this makes a change from memoirs of generals based on official sources, and delineates in full detail the horrors of prisoner-of-war camps, the inhuman treatment meeted out to prisoners, and recalls something of the effect of war on mankind in general. Many of us have forgotten, or choose not to remember, events which took place between 1939 and 1945. This book serves to remind us, and to warn a later generation, of the results of man's inhumanity to man.

JOHN L. THORNTON.

ST. BARTHOLOMEW'S HOSPITAL

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PENGUIN MODERN POETS 16

It was once said that if Keats had not died so young poetry would have been the natural form of literary expression of the 19th century, and men such as Hardy would never have written in prose and therefore assisted in raising the stature of the novel to its present overwhelmingly dominant position in literature. As it is, poetry is viewed with a peculiar brand of ignorance, suspicion and doubt which may well have its origins in a schoolboy inheritance: i.e. that schoolmasters used poetry simply for exercises in the practice of criticism, and presented the better known poets together with Shakespeare at an age and on a level that made appreciation impossible. Perhaps modern poetry has simply broken away from the traditional as the cubists did in art and nobody has bothered to notice. The decline in interest in poetry is a great pity, especially as the decline in the number of poets has probably weeded out many of little ability, and left only those with a strongly positive and individual approach to the form.

Some of the works of all three poets in this Penguin edition are a sheer delight to read, speak or listen to. It is sometimes difficult to conjure all that Jack Beeching is attempting to convey in one go, but his imagery is very good, and his use of words extremely tidy, concise, and full of vitality. Occasionally he lapses into a cleverness of phrase which reminds me of some of the toys in Heal's children's department which though beautiful to look at have really lost all the simplicity they are trying to preserve:— such a line as "perforating pain—more brilliant than hellish chocolate masking white ice-cream". Women, love, and death are his major themes and I found him the most enjoyable of the poets included.

Harry Guest who has spent the last four years in Japan, is much more gentle in pace. There is a quality about his verse, the blending of his words, that hits the senses like the changes in colour, tones, movements that occur in the immediate aftermath of a heavy storm giving way to the peace of a spring evening in the open country. Matthew Mead, the last of the poets, I found the least imaginative and he never quite seemed to let his language dominate his ideas. At 5/-, this is a bargain in enjoyment.

M. C. White.

An Introduction to Ward Management. (Published: Blackwell Scientific Publications. (Price 35 shillings).

Elizabeth Hardman's book "An Introduction to Ward Management" is well laid out and presented, and easy to read. It is an informative book, if a little biased towards the Royal Free Hospital, but the newly qualified staff nurse would find it a useful guide to problems of administration she would not have encountered during her training.

It also gives useful general information on the nursing profession which few nurses know about.

In all, it should prove a useful reference book if one applies it to one's own hospital.

Susan Broadey (*Sister Heath Harrison*).

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M.S.

Bart's Sport

BART'S RUGBY

Bart's v. Old Alleynians. Home

This was one of those games most of the team would like to forget. Fielding a weakened side and playing uphill against a very strong wind Bart's did well to restrict their opponents score to two penalties and a try in the first half, due in no small way to good tackling in the backs. In the second half Bart's did everything wrongly; so intent were they on scoring that passes were thrown wildly, scoring chances missed, and a multitude of minor infringements stopped them from getting into top gear. Eventually Mick May kicked two penalties, Nick Packer came into the line to score a try, and Mick May converted it putting us into the lead 11-9. At this point Bart's foolishly considered the game all over bar the shouting, but the Old Alleynians had other ideas and having kicked their way up the field were quickly awarded a penalty in front of the posts and we had lost 12-11. After the previous week's performance against Sidcup this was a very disappointing result, and shows that there is still a great deal of work to be done.

Cornish Tour, 1970

This turned out to be a great success both on and off the field, and was certainly enjoyed by all the participants. After a day's journey down to the hotel in Falmouth on the Friday, the first game took place on Saturday afternoon against Camborne R.F.C. Playing in Cornwall is always an experience, if only because the crowd watching the game is invariably hostile to the visiting teams and openly voices its disfavour. After an interesting first half Bart's were 8-nil up through tries by Laidlow and Martin, one of which was converted by Peter Rhys Evans. In a very close fought second half Camborne gradually wore down our defences and eventually won by 12-8.

The second match of the Tour against Falmouth R.F.C. is always something of a novelty because it is an evening game played under the Falmouth floodlights, and these are hardly up to Old Trafford or Chelsea standard. Rumours that each of the 14 lights had 60 watt bulbs were denied by the Secretary, but during the game the visibility is decidedly murky. Just to confuse matters Falmouth always play in black shirts and shorts so their players are apt to appear from nowhere like ghostly shadows. Another feature is that a high kick ahead disappears into the stars at the apex of its trajectory, a considerable hazard for the waiting full back.

Bart's fielded its strongest side, with Mark Britton and John Carroll in the second row, and the scrum as a whole played very well indeed, far better than they had all season. Simon Smith opened the scoring after an excellent loose ruck had been won by the Bart's forwards, and Peter Rhys Evans converted from the touchline. This was the only score in the first half, but early on in the second Carroll threw himself over the line for our second try. Falmouth then replied with a goal to make the score 8-5, but after a very tense and enjoyable game the final whistle blew with no further addition to the scoring. The match was followed by an amusing evening in the bar, and we owe our thanks to the members of Falmouth for making it so enjoyable.

After a very subdued journey, the 90 odd miles to Torquay on Tuesday, we faced Newton Abbot on a cold, blustery Wednesday afternoon.

Playing with the wind behind in the first half Bart's scored 11 points through tries by Lambert and Laidlow (2), one of which was converted by Rhys-Evans. At times during this game Bart's looked as if they were at the end of a 10 week, 20 game tour rather than one lasting just a week, and except for a few occasions never really exerted themselves. Early in the second half Newton Abbot scored a penalty goal, and visions came to mind of our draw here three years ago when we had led 11-0 at half-time. Fortunately, however, Lambert scored a try almost immediately, Rhys-Evans converted it, and the game was all over. In the last few minutes Newton Abbot scored a good try on the wing but by that time it was too late. Final score; 16-6.

Tour Party

Forwards:

N. Fairhurst, N. Best, S. Sullivan, P. Cottrell, J. Carroll, M. Britton, G. Aitken, T. Fenton, O. Else, D. Davies, A. Mason.

Backs:

J. Wellingham, G. Brain, M. Martin, R. Lambert, R. Griffiths, P. Rhys-Evans, S. Smith, J. Laidlow, N. Packer.

Record so far: Played 13, won 10, lost 3. Points for 160; Against 108.

BART'S FOOTBALL

2nd XI Report

The 2nd XI began their season on October 10th by entertaining U.C.H. 2nd XI at Chislehurst in a friendly game. Our opponents proceeded to give us a lesson in good football, and ably assisted by several own goals and some slack defensive play from us, managed to reach double figures without reply. We suspected that our opponents were giving some 1st XI players a pre-season outing, but we do not offer this as an excuse for our poor performance and it was very heartening to hear so many players asking about the next game immediately after such a disastrous start to the season.

v Middlesex Hospital 2nd XI—Home

In our second game we met the Middlesex in another pre-season friendly. Anxious to make amends for the previous week's errors we started well, but in their first advance into our penalty area our opponents took advantage of poor covering by our defenders and scored a very "soft" goal. After this early setback we settled down and executed several excellent moves, switching quickly from defence to attack and unsettling their defence. During this period of heavy pressure we went ahead 2—1 with two well taken goals from Janusz Kolendo and Richard Franklin. However, just on the stroke of half-time our opponents broke away and levelled the score.

The second half was unfortunately a repeat of our first game, slack defence and a couple of own goals allowing Middlesex to romp away, winners by 6—2.

v Middlesex Hospital 2nd XI—Away

A week after our defeat at home we faced the Middlesex again, this time on their ground. On a bitterly cold afternoon we started well forcing our opponents back into their penalty area. Their defence held firm during this opening fusilade, marshalled by their centre back, known affectionately to his team-mates as "Ada". Then, however, history began to repeat itself yet again. Middlesex began to control midfield and gradually to pressurise our defence. Two quick goals plus two gifts from our defenders and suddenly we were 4—0 down. Nevertheless we fought back and went close to scoring. We pulled one back before half-time, scored from close range by Janusz Kolendo, who minutes previously had had two shots blocked by a very agile Middlesex goalie.

After the interval Bart's defence played well in the opening stages, Eric Noren being outstanding. The forwards too had their moments, Dave Thompson and Chris Lynch being very unlucky not to score with fine efforts. Middlesex, playing with the wind, took over gradually and we were fortunate to concede only one further goal in the latter stages of the game. Final score 5—1.

In spite of these poor results, the enthusiasm of our players has not waned and it is very pleasing to see the large numbers of players attending training sessions.

P. Morrison (Capt.)

SAILING CLUB

The sailing season started at the Welsh Harp on Wednesday, 4th November, with a match against St. Mary's. This was the first of the U.L. league matches, of which there are seven during the Winter. It was an unspectacular day for the Bart's team of Roger Chapman and Pete Meade, crewed by Tom Moore and Claire Wilson-Sharp. The first race was won convincingly by Mary's. The second race was more successful, with Pete Meade coming first, Roger Chapman third, and one of their boats retiring. We had high hopes of winning the match, due to a protest from the first race. However, it was rejected on a technicality, because no protest flag was flown, and Mary's won the match.

Wednesday, 18th November: v. St. Thomas's

This match was sailed in heavy rain and moderate winds. The Bart's team was: Tom Moore, Penney Quilliam, Roger Chapman, Claire Wilson-Sharp.

The first race was won by Bart's, with Roger Chapman first and Tom Moore fourth. This was encouraging, since St. Thomas's had two of the U.H. team sailing for them. We started well in the second race, but some very fine team racing by St. Thomas's took them to the front, and they won the match by a narrow points margin.

Tom Moore.

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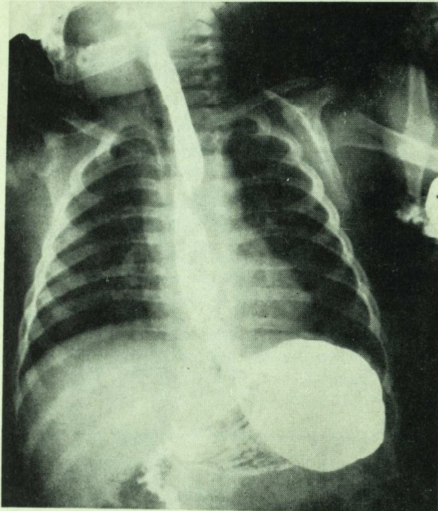
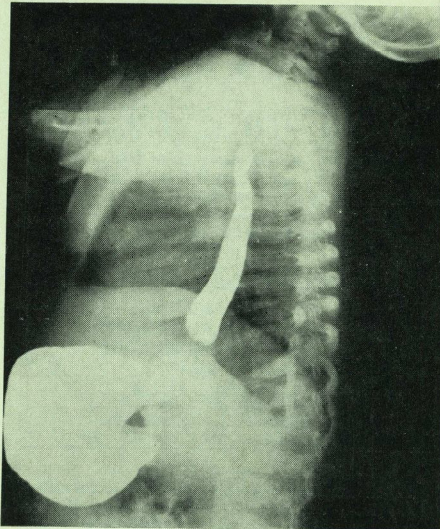
SPOT THE LESION

By Charles Hinds





Questions:

a. The patient was a 10 month old child who had suffered from attacks of vomiting since birth. The barium meal shown was done; what is the diagnosis?

b. What treatment would you advise in this case?

a. Aberrant right subclavian artery.

b. Surgery is advised in symptomatic patients with radiographic evidence of tracheal or oesophageal compression. This consists of dividing the aberrant vessel at its origin from the aorta and ligating it. The blood supply to the arm is maintained by the numerous anastomoses in the shoulder region; as the patient is young the blood vessels easily adapt to accommodate the increased blood flow.

NOTE—All material for the February Journal should reach the Office, Typed, not later than Tuesday, December 29th.

SAINT BARTHOLOMEW'S HOSPITAL JOURNAL

Founded 1893. Vol. LXXV No. 2

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Editorial

Another Hospital Christmas has come and gone. Will there be another like it? The Ward Shows and Pot Pourri survived a last-minute attempt at cancellation. But it is now well known that it was only the lateness of the attempt that led to its frustration. The whole subject of future Ward Shows is to be reviewed in the early part of this year by a high-level committee of the Hospital. This is a very controversial subject and passions become easily inflamed when one of the most popular events in the Hospital is threatened. What is the case for calling off the Ward Shows? If they do appreciably delay patients' recovery throughout the Hospital, as the Chief Nursing Officer (Matron), their main opponent, has suggested, then certainly they must be closely investigated and curtailed. But the evidence so far produced to support this case, a solitary letter was rather flimsy.

On the other hand, it seems obvious that many, many patients derive great enjoyment from the Shows—and indeed many people from surrounding areas who might otherwise spend a lonely Christmas at home, come into the Wards to join the fun. A letter from a patient in Garrod over Christmas, printed later in this issue, shows what she, and others in the Ward, felt about the Shows. Perhaps if any particular Ward Sister felt that there were gravely ill patients on her ward, around whom it would be in dubious taste to present bawdy shows, then she might wish to refuse entry to the students' shows. This would obviouly be acceptable, because the welfare of the patients must come first. But to ban the Shows in principle when needful exceptions and compromises can be made seems to us to be ludicrous. Anyone who is actually on the Wards over Christmas can vouch for the widespread enjoyment that the Shows bring.

And patients are not the only people in the Hospital over Christmas. The nursing staff, from sisters down to the newest nurse, welcome the strolling players and their boisterous good spirit with open arms. Administratively, Christmas Day and Boxing Day may not be the most smoothly-oiled days in the Hospital year, but the Hospital is surely an organisation run for and by people, not impersonal machines, and as many as possible should be able to enjoy themselves in the season of good cheer.

This is an issue which must be openly discussed and the columns of the Journal are open to the expression of all shades of opinion. We hope to be able to print an interview with the Chief Nursing Officer at a later date, and in the meantime anyone associated with Bart's past or present is welcome to write in. We believe that we speak for the overwhelming majority when we say that the Ward Shows should continue as a central feature of the Hospital Christmas.

LETTERS TO THE EDITOR

TODD REPORT

95 Harley Street,
London, W1N 1DF.

Dear Sir,

I wish I could share the Dean's optimism about the effects of the Royal Commission's proposals on medical education, and perhaps I might comment on some of the points he makes in your December issue.

Dr. Malpas states that "it is a basic tenet of the report that more students should be taught in a more stimulating way" and he goes on to assert, though he does not explain how, this will be achieved in a multi-faculty College. To a simple fellow like myself the prime requisite of stimulating teaching is to have stimulating teachers and, alas, there are never enough such folk. Putting all the medicos from Bart's and the London in a multi-faculty college in the East End can surely, of itself, do nothing to make the teaching any better. Doubtless there are powerful economic arguments for such an arrangement but do not let us deceive ourselves about its possible educational value.

A frequent criticism of teaching in the basic subjects is that it tends to be divorced from clinical Medicine. Older members of the Bart's staff will recall that the anatomy department was formerly situated alongside the west block, whilst physiology and biochemistry departments were adjacent to the "White Hart". In those days it was not uncommon for members of the clinical staff to visit "the rooms" to refresh their knowledge of anatomy. The movement of the preclinical departments to Charterhouse Square, though providing a magnificent site, was felt by many to have deprived both the Hospital and the Medical College of the former opportunity for close liaison. But to remove all those departments to a still more remote site would be the last straw at a time when the basic sciences were never more relevant to Medicine.

A joint academic paediatric unit based on Hackney could certainly be welcomed as providing an opportunity for students to study this subject in relation to a populous working-class community. But I think that the dean is misleading when he states "the teaching resources of Great Ormond Street . . . will become available for students". The resources of Great Ormond Street are more appropriate to the training of paediatricians than medical students. Such resources are already heavily, and rightly, committed to postgraduate teaching and research.

One very important field in which a tremendous amount could be done to improve clinical teaching is by much wider use of regional hospitals. In such places student can get the richest of clinical experience in the shortest possible time. Many of these hospitals have good medical centres and libraries, indeed the teaching facilities are often better than those which exist in the central London undergraduate hospitals: the student has the added advantage of being resident and learning his Medicine by total immersion. The only possible snag is that the University has to pay the Department of Health for the expenses of student accommodation; but the teaching, like much of that in the medical schools, is done for nothing.

Your editorial in the same issue complains that nobody could be persuaded to express opposition to Todd proposals. It is possible that the flood of reports in the last two years on various medical subjects explains, if it does not excuse, the inarticulate torpor of some of our colleagues. I have found much to disagree with in the Royal Commission's proposals but I must not occupy more of your valuable space. To me the nubbin of Todd's philosophy lies in paragraph 197 of the report which states "We cannot emphasise too strongly that the undergraduate course in Medicine should be primarily educational. Its object is to produce not a fully-trained doctor, but an educated man who will become fully qualified by postgraduate training". I submit that it is a load of rubbish to suggest that in some six years of medical training we cannot produce a useful practical doctor. The good student is capable of taking a good deal of clinical responsibility and should be encouraged to do so. Undue reliance on prolonged postgraduate training will simply slow down the tempo of pregraduate work and make much of it even less stimulating than it is at present.

Yours faithfully,

REGINALD S. MURLEY.

95 Harley Street,
London, W.1.

Dear Sir,

I was astounded to read in your Editorial that some of my colleagues were afraid of expressing an opinion contrary to the views of the Todd Commission in relation to our Medical College. When I ceased to be Dean I was told by a colleague whose view I respect that I had one major failing—that was that I believed that what my colleagues agreed in a committee they were prepared to support in practice! I did indeed trust the verdict of a College Committee and though some of its decisions and those of the College Council are made on a majority vote, this does not stop individuals expressing a contrary view, nor does it free them from their responsibility of supporting the Dean in carrying out the decided policy of the College. Unfortunately between the University Grants Committee and our own College Council there is the huge unwieldy and unpredictable machine of the University administration. In my experience College policy decided locally has little or no effect on the ultimate decisions of the University of London or the University Grants Committee. During my tenure of office and during that of my successor Mr. J. W. Cope, pressure was brought to bear to accept more students each year. As everyone knows the present intake has risen to a record 140. In anticipation of this huge intake the College has dissipated a good deal of its effort in obtaining teaching facilities in other hospitals. The pipe dream of a new pre-clinical school in a multi-faculty college in the East End cannot be justified if the intake now between Bart's and The London is reduced to 200 gross—which we believe to be the new policy of the U.G.C.

A few influential people in the University of London have successfully stymied efforts of our Medical College and Hospital to rebuild the museum block and the clinical school, temporary accommodation for which was to be provided in Cock Lane. The plans for this building were in an advanced stage. No one has the courage to press policies which are contrary to those of the University. It may well be that things have already gone too far for St. Bartholomew's Hospital and Medical College to maintain their independence as an undergraduate school, and they must look to the prospects of postgraduate training, particularly the higher training in various specialities, to maintain their greatness. If people tell an individual he looks ill and asks him what is the matter, sooner or later he feels sorry for himself and falls sick! Too many people are knocking the Medical College and the Hospital at the moment saying that it has no future, that it has no district and doesn't pull its weight particularly in providing Regional services. This political side of the hospital's problems will not be sorted out until new legislation to set up Area Health Boards has been formulated. In the meantime let all those who have views express them. The present course being plotted by the University of London on the recommendation of the Todd Committee is a very uncertain one.

No stone must be left unturned to prevent the high standards of our pre-clinical school and the excellence of the hospital training being subordinated to academic theories.

Whatever policy is finally imposed upon our Medical College, it behoves everyone to support the Dean and the Council in what is going to be a very difficult period of transition. It is, nevertheless, surely healthy to have diverse views expressed?

Yours faithfully,

D. F. ELLISON NASH.

STUDENTS' UNION

Abernethian Room,
St. Bartholomew's Hospital,
London, E.C.1.

Dear Sir,

The Ward Shows this Christmas seen to have been enjoyed by patients, students and nurses alike, as they have been in the past and will be in the future. After the shock of a sudden refusal, two weeks before Christmas, to let the Ward Shows be performed on the Wards it was decided eventually that we should be allowed to entertain the patients. Reasons for this sudden initial refusal are difficult to come by; however, we are told that the future of the Ward Shows is to be discussed within the next two months. It is to be hoped that when these discussions take place, facts will be considered and that those who wish the Shows to be stopped for "medical" reasons will make their reasons known openly. Students should realise that there are several Consultants who wish the Shows to be stopped, it is not simply the Chief Nursing Officer versus the Rest.

It is worth recording that the Gloucester Hall stage was offered to us as an alternative site for a Christmas Show in place of Ward Shows—however, for the last year the Drama Society has been refused permission to use this stage for its plays.

The Drama Society recently staged a play written by Paul Swain, The Mirror and The Star, with such success that it was selected as one of six plays (selected from sixty) to be performed during the N.U.S. festival in Southampton.

A new item on the social calendar before Christmas was a Wine and Cheese party for both students and nurses held in the H.A.R. The S.N.A. worked hard to make this a great success with about 250 people being present. The S.N.A. and Students' Union have decided to hold at least two such parties each year.

John Wellingham, Bruce Noble and Barbara Apleby are at present considering ways in which the Union Council can keep students up to date on activities within the Union. Any simple practical suggestions should be sent to them as soon as possible.

The Minutes of the Union Council meeting held on 19th January are displayed on Union notice boards.

PAUL MILLARD,
Chairman, Students' Union.

Abernethian Room,
St. Bartholomew's Hospital.

Dear Sir,

After the farce of the Extraordinary General Meeting of the Students' Union in November, feelings of concern about the whole image of the Students' Union have been expressed. The question of publicity and public relations must necessarily also come under review.

Student interest has waned considerably to the point where only 30 people turned up to this E.G.M. This would appear to be in contrast to the present high feelings in the student body with regard to teaching and recreation. This is unfortunate, because the present Students' Union Council has built and is building a respected and strong positon of liaison with the administration. The mainstay of the link has been the establishment this year of the student—staff committee. This Committe is comprised of four staff and four student members, and must meet within one month of either body summoning it.

Every year the student body meets to elect its representatives to the S.U. Council. These representatives, who because of the low numbers at the E.G.M. were co-opted by the Chairman and not elected this year, are drawn from the pre-clinical and clinical students. These students, two from each year, are the immediate links of the individual student with the administration, because the representative can sit on the Student-Staff Committee when dealing with problems relevant to the students, by whom they have been elected. The problems raised by the students with their reps are discussed by the S.U. Council and passed to the relevant committee for active investigation and amplification, and if

requiring administrative decision are presented by the chairman of the relevant committee to the student-staff committee. To maintain these hard-won channels of contact it is important that the students provide their representatives with ammunition for their guns.

A common complaint has been the lack of feed-back from the S.U. Council. It is our opinion that by actively and constantly informing the student body of the activities and projects within the council, that student interest might be rekindled. We think this whole problem of feed-back should be considered and the writers would like to hear of any other ideas and schemes, apart from those sketched below.

We will be proposing at the next meeting of the S.U. Council on January 19th that:

1. The *Journal* should be used more often by the S.U. as a means of communication.

2. This could take the form of quarterly reports of Union and Council meetings. The subjects of the reports should be presented in an informal but accurate manner.

3. The content of the reports should include the subjects presented, the findings of the committees, including the results of numerical surveys, and the action taken on the matters raised.

4. Because of the time lag between submission of an article and its publication in the *Journal* a more immediate form of contact is sought. One answer to this would be to make precis of the minutes of meetings readily available in the cloakrooms. Full minutes will still be posted on all the Union notice boards.

We invite the suggestions, views and criticisms of your readers on these matters.

Yours sincerely,

JOHN WELLINGHAM and BRUCE NOBLE,

(Members of Union Council).

Department of Anaesthesia,
St. Bartholomew's Hospital.

CATHETERISATION OF THE SUPERIOR VENA CAVA

Dear Sir,

May we beg your indulgence to make an addendum to our article on superior vena caval catheterisation in the November 1970 issue (St. B.H.J., (1970), 74, 363).

Since that article went to press we have had the opportunity of trying out the pre-sterilised disposable "Drum cartridge catheter" manufactured by Abbott Laboratories Ltd., of Queenborough, Kent (figure 1) for catheterisation via the veins of the ante-cubital fossa.

The catheter stiffened by a stylet is coiled within the drum to the left of the picture. The 14 gauge needle is exposed by opening the hinged needle guard and introduced into a vein in the usual way. The 28 inch (70 cm.) catheter is advanced by turning the drum in the direction of the arrow: we have found that, provided a vein of suitable size is available, it is not only posisble to introduce the catheter through the medial veins of the arm as recommended in our article but also through the cephalic vein across the top of the shoulder, which we suggested was often difficult because of the restriction at the clavipectoral fascia. After the catheter has been advanced for the required distance the needle is withdrawn and encased in its guard, while pressure is maintained on the puncture site. The long stylet is then withdrawn and the intravenous infusion attached in the usual way.

May we also draw attention to the misprint in our article under the heading "Precautions in all techniques" on page 366? The first sentence should begin "If *infection* is to be avoided"—not "if *injection* is to be avoided". We apologise for our careless proof reading.

We are again indebted to the Department of Medical Illustration for the figure.

Yours faithfully,

G. B. RUSHMAN.
ANN FERGUSON.
T. B. BOULTON.

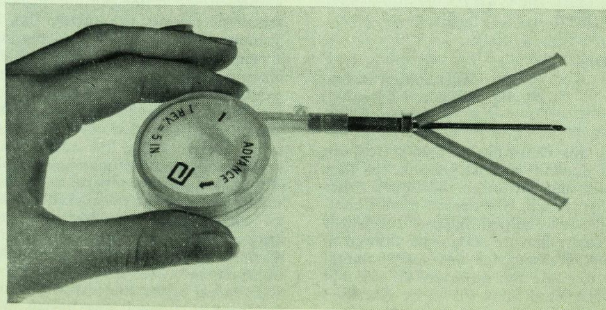

FIGURE 1.

A MYTH ?

I clerked for Dr. (Sir Wilmot) Herringham in 1905 when Dr. C. F. Hadfield, afterwards one of our anaesthetists, was House Physician. He told me the following story:— a nice old woman used to come to the Hospital regularly. She did not seem ill but asked for her medicines to be repeated. Rep. Omnia 14 days. One day the Casualty Physician was not busy and he thought he would see what medicines she really needed. One of them was Gee's Linctus. But as she had no cough, he struck it out. The old lady was disturbed at this action but still more so when the Dispenser refused to give her the Gee's Linctus because it had not been ordered. She repeated that she must have the Gee's Linctus and could not be pacified. Evenutally she returned to the Casualty Physician. Seeing how upset the old lady was he treated her sympathetically and tried to discover why she insisted she must have the Gee's Linctus. Eventually she disclosed that she did not take the linctus but used it to flavour some small pies which she made and which were much appreciated by her neighbours and added to her income.

The story I was told ends at this point. If the incident occurred, the Casualty Physician might have refused her pleas and so damaged her reputation and income. Or he might have consulted Sister Surgery, Miss Armitage, a strict disciplinarian with a heart of gold. Or the Steward, Mr. Watkins whose portrait hangs in the office. He was always most helpful to the house physicians who had difficulties in the disposal of patients. He again would probably consult the Clerk to the Governors, Mr. Thomas Hayes, who had only recently come to the Hospital. He was always most courteous and most understanding of hospital problems. He was a great ally of mine when I eventually reached the staff. If therefore the incident ever occurred I expect they would have found some way of helping this old patient and so preserve her reputation.

GEORGE GRAHAM, B.A., F.R.C.P.

FOOD PARCELS FOR OLD PEOPLE AT ST. MATTHEW'S

The Occupational Therapists would very much like to thank everyone for their gifts, which were much appreciated at St. Matthews, as seen in this letter from the Occupational Therapist there:

"I want to thank all the staff of St. Bartholomews Hospital who have given so generously to provide parcels for patients and ex-patients, who are living alone this Christmas.

On behalf of the people who will receive the parcels, I want to thank you for the thought and care which prompted these gifts. They are all so acceptable to people living alone. By the way, the baskets tied with white ribbon, we thought were delightful.

Thank you for organising the collection, and for packing the parcels, and sending them to St. Matthews. I can assure you they will be sent to people who really need them."

THE TRUTH ABOUT OLD AGE

Sometimes one sees the expression in writing—"Serenity of Old Age." This is absolute nonsense. Old Age is nothing more than a six letter word curse.

The physical state deteriorates so that it is difficult to get out of a chair, and one looks for the shortest way across the room to obtain an object. A man is lucky if he does not suffer from arthritis, but he may have attacks of "Rheumatism" which cripple him for several days.

His "taste buds" are lost so that all foods are alike, and "he eats to live" and no longer "lives to eat." It is difficult to realise what this means until it has been experienced. Standing without holding on to a piece of furniture is difficult.

Realisation of one's Mental Degeneration is almost more distressing. Lapses of memory for a word or name when writing a letter is very distressing.

As the old man in *Punch* said—"Sometimes I sits and thinks and sometimes I just sits"—more often the latter.

It is a mistake to remember happier days when my wife and I travelled a great deal, this only makes the present worse.

It is difficult to concentrate enough to read for any length of time.

There is little doubt we live too long in these days. Sleep, 16 hours out of the 24, is the only compensation.

MALCOLM DONALDSON, B.A., F.R.C.S.

ST. BARTHOLOMEW'S HOSPITAL JOURNAL

The annual Subscription to THE JOURNAL is only £1.50 per year £2.50 post paid anywhere in the world). Perhaps you know someone who would like to become a subscriber.

Further information may be obtained from:

The Assistant Manager (Subscriptions),
St. Bartholomew's Hospital Journal,
St. Bartholomew's Hospital,
London, E.C.1.

EAST LONDON

Sooner or later, during training at Bart's, medical students are likely to find themselves living in either digs or flats in East London. During this period, students cannot help but look around their immediate surroundings and become aware of the enormous social problems of this area, which, welfare state or not, we are unlikely to solve for many a year.

Unfortunately, the medical course is hard work, and therefore most people prefer to save their leisure for relaxing hobbies. So we gain a name for being uninvolved and apathetic, while in reality we are probably far more aware of the problems than many other sections of the community. At last there is an organisation which understands that students can only offer limited time for voluntary social work, and sees the student world as a vast reservoir of skills and manpower.

O.S.C.A. (Organisation for Student Community Action (East)) now provides a number of projects which require only a short-term involvement by people with the right skills or in adequate numbers. These projects reflect the needs of the society in which we live. Each project is started because of a request from a local authority, welfare organisation, or individual who by living in that area understands where help will be most appreciated.

There are many fields in which help is needed, some practical others theoretical, some requiring brain work, some needing only physical strength, but for everyone with any time to spare there are opportunities.

At this time help is needed in conducting surveys in East London which explore the worlds of the newly blind, the very old and the teenage population.

From the survey on the public's attitude to the newly blind and, the newly blind's attitude to the public, it is hoped to produce a booklet that will be truly helpful in answering the everyday problems of somebody who suddenly due to accident or disease find themselves in this situation.

From the other two surveys it is hoped that facilities that will be used can be planned and built, instead of the sad lack of interest in present facilities prevailing. The old have few facilities, and the young, or at least 85 per cent. of them in East London, ignore the facilities offered. This waste of public money in producing unwanted facilities must be stopped if we are ever to have the facilities we really need.

By offering 4 or 5 evenings' work spread out over a reasonable time you could help to carry out these surveys.

Of special importance to the medical student is the help being offered to various organisations to work with drug addicts and alcoholics. This work is by no means unsatisfactory and unrewarding, and those volunteers who find this angle of social welfare appealing, will I think find great interest in dealing with these people. St. Botolph's Crypt would welcome volunteers for evening work with vagrants and St. George's Men's Care Unit need help in providing evening meals and a club for the homeless to get together, discuss their problems and find help among each other.

There is also scope for helping mentally and physically handicapped, old people and illiterates with their own particular problems.

If all this seems rather day to day in the life of a medical student then how about offering help with decorating and gardening to old or recently widowed folk. Also, but only for the very fit, men are needed to help in the building of children's playgrounds so please, all those healthy young men of the rugger team, offer just one or two evenings' work on this project, I'm sure its training value would be enormous.

Finally, young handicapped people need escorts around London. You can offer to do this once or more as you wish, but believe me your help will be very appreciated.

If any of these projects interest you, please contact either Jane Knowles, Preclinical Cloakroom, or Miss Nell Image, East London Field Officer, O.S.C.A., Union Building, Malet Street, W.C.1E 7HY.

Garrod Ward,
St. Bartholomew's Hospital.

Dear Sir,

Speaking as one of your reluctant guests during the Christmas season, I would like to take the opportunity to thank all the staff who made my enforced stay with them such a memorable and happy one. I can't tell you how much the nurses and doctors together did to raise all our spirits, despite our being separated from our families.

For my part, I think it was a privilege as well as a pleasure to witness the unselfish and unsparing efforts of all the staff at Christmas time.

I understand there is some move to stop the antics of doctors and nurses and the shows they put on for the patients. In my view this would be a tragedy. I considered the ward shows to be witty, gay and a tonic to us all—an incalculable benefit to us all. If these unselfish staff were prevented from doing such good work in the future, it would be a scandal.

If the feelings of the patients are to weigh in any consideration, they will certainly go on. Thank you very much indeed for a wonderful Christmas, and may I wish you all a very Happy New Year.

Yours faithfully,

Mrs. F. HAWKINS.

D.Q.C. CLUB

Some people may be wondering about the appearance over the last few months of a tie, bearing the letters "D.Q.C."—one nurse, mis-reading this, thought: 'Isn't that sweet, having a tie with Doc on it!' But in fact, as many already know, the letters stand for Delayed Qualifications Committee, which some of us are required to see from time to time.

The idea of forming a club for those who had to go before this time-honoured band of gentlemen was formulated by a group of-er-revellers in a well-known local hostelry. It was decided then to restrict membership of the club to those people who saw the D.Q.C., after having certain difficulties with their 2nd M.B., but who did eventually pass. After all, when you are selected to join a club by the Dean, Sub-Dean, and all the professors, you deserve some kind of honour! This selection committee left us with such stalwart club members as the renowned Oliver F. Else, who had a 'spot of bother' four, or was it five? times; but who has happily now returned to the Royal and Ancient Hospital.

So, having formed a club, we needed an aim: the obvious choice, considering why we *had* to join, was a social aim. A committee of seven Club members was set up to run the Club and organize various activities. So far we have had a very successful cocktail-party—so we were told—and an even more successful Dinner. By the time this article goes to Press, we will have organized a Ward Show; and, I hope, organized 'something special' for the night nurses.

Future plans include a mystery tour, and when finances permit, a hop with a difference. These events will be open to all students.

To those 'Elders' of Barts, by which I mean those who qualified in the last 809 years, and who also had some trouble with their 2nd M.B., we would be extremely pleased to hear from you, or see you—the Rutland being the nearest pub to the Hospital.

Also, to those of you about to take the plunge, don't get worked up when you take 2nd M.B. Any advice on how to 'falter' will be on show in College Hall bar every night!

Duncan Jefferson
Chairman D.Q.C.

Announcements

Birth

MILLARD—On November 25, to Paul and Christina (née Graham), a son, Thomas.

Engagements

CARRUTHERS—MEDVEI—The engagement is announced between Dr. Richard Stuart Carruthers and Miss Victoria Mary Medvei.

BROOKBANKS—FAWCETT—The engagement is announced between Mr. Colin F. G. Brookbanks and Miss Pepita F. M. Fawcett.

MASON—SADLER—The engagement is announced between Andrew M. Mason and Miss Jane R. Sadler.

Marriage

HILTON—POLUNIN—On December 11, Dr. Andrew M. B. Hilton to Miss C. Natalia Polunin.

Deaths

BOURNE—On December 4, Dr. G. Bourne, F.R.C.P. Qualified 1917.

DAVIES—On November 21, Dr. E. W. Davies, M.R.C.S. Qualified 1924.

FINNEGAN—On November 25. Dr. J. D. Finnegan. M.R.C.S. Qualified 1940.

STANLEY—On November 24, Mr. E. G. Stanley, M.R.C.S. Qualified 1910.

Change of Address

Mr. and Mrs. Ivor M. Robertson's new address is Roshven, 3, Hollymead Road, Chipstead, CR3 3LQ, Surrey. Telephone Downland 55155.

Dr. J. G. Knill-Jones' new address is 9 Crown Road South, Glasgow, W.2.

The new address of Dr. A. Hilton is Lockwood Court, Knoll Road, Godalming, Surrey.

The new address of Dr. and Mrs. Walter Levitt is 10 Old Square, Lincoln's Inn, London, W.C.2. Telephone 242 3892.

During 1971, the address of Dr. and Mrs. John Stevens will be The Groote Schuur Hospital, Observatory, Cape Town, S. Africa.

Announcements

University of Oxford. The degree of M.Ch. has been conferred on Mr. Harvey White.

XI Decennial Club

The 36th Annual Dinner of the Eleventh Decennial Club will be held in the Great Hall on Friday, 30th April, 1971; this is a reversion to the custom of holding the dinner on the third Friday after Easter. Notices will be sent to members in March.

M. L. MALEY, C. K. VARTAN, *Hon. Secs.*

DIARY OF EVENTS FOR FEBRUARY

February 2.

Lunch-time Lecture, Clinical Theatre at 12.15 p.m. "Photography" by Mr. W. D. Tredinnick, Department of Medical Illustration. Bartsfilm. Physiology Lecture

Bartsfilm. Physiology Lecture Theatre, Charterhouse Square at 9.15 p.m.
Members 1/-. Non-members 3/-.

February 9.

Bartsfilm. Physiology Lecture Theatre, Charterhouse Square at 9.15 p.m.
Members 1/-. Non-members 3/-.

February 11.

London Medical Group Lecture at Charterhouse Square, 5.45 p.m. "Should we talk about Dying?" by Professor John Hinton M.D., M.R.C.P., D.P.M., Academic Department of Psychiatry, Middlesex Hospital Medical School.

February 12.

Lunch-time Lecture, Clinical Lecture Theatre at 1.15 p.m. "Medical Care in Developing Countries" by T. B. Boulton E.R.D., F.F.A.R.C.S., Consultant Anaesthetist.

February 13.

Tennis and Sailing Club Hop, Charterhouse Square.

February 23.

Bartsfilm. Physiology Lecture Theatre, Charterhouse Square at 9.15 p.m.
Members 1/-. Non-members 3/-.

February 27.

Swimming Club and Ladies' Clubs Hop, Charterhouse Square.

March 1.

Harvey Society Meeting. Pharmacology Lecture Theatre, Charterhouse Square at 5.45 p.m. "Genetics and Intelligence" by Mr. James Shields, Senior Lecturer at the Institute of Psychiatry, Maudsley Hospital.

March 2.

Bartsfilm. Physiology Lecture Theatre, Charterhouse Square at 9.15 p.m.
Members 1/-. Non-members 3/-.

SENIOR HOUSE OFFICER

EMERGENCY & ACCIDENT DEPARTMENT

APPLICATIONS ARE INVITED for the post of SENIOR HOUSE OFFICER in the EMERGENCY & ACCIDENT DEPARTMENT. The post is for six months only and dates from 1 June, 1971.

Applications should reach the Clerk to the Governors by Friday, 12 March, 1971, and forms are available from the Medical Staff Office.

J. W. GOODDY,
Clerk to the Governors.

OBITUARY

GEOFFREY BOURNE 1893-1970

Geoffrey Bourne, who died on 4th December, started his association with Bart's fifty-eight years ago by winning an entrance scholarship in arts. He won the Kirkes and Brackenbury Scholarship, the Skynner, Burrows and Bentley Prizes, the Lawrence Research Scholarship and a Rockefeller travelling fellowship. He retired in 1958 from the hospital—though not from private practice—after forty-six years during which he was respected and loved for his devotion to Bart's. Not content with this he started a further number of years in which he collected the data for an excellent book, "We Met at Bart's." Those who were fortunate enough to know him personally will deeply regret his passing and to these will be added all those who have read this book. Nobody associated with Bart's should have failed to read it. It is a fascinating account of the personalities at Bart's over more than fifty years and contains many humorous anecdotes. The book shows how much affection he had for Bart's. This in turn explains how he himself was held in such esteem by his associates.

Numerous scientific papers testify to Geoffrey Bourne's interest in the advancement of Medicine and in particular Cardiology. He started the Cardiographic Department and was taking electrocardiograms when the apparatus was large and difficult to use. In fact the Medical Block was wired so that the electrocardiograms could be taken without the patient leaving the ward. Before his retirement he had built up a large Cardiological Department with modern equipment. He was an early member of the British Cardiac Society and continued to attend their meetings to the time of his death.

Geoffrey Bourne's interest in teaching will be remembered by the many students who were fortunate enough to be taught by him. His book "The Principles of Clinical Pathology in Practice" (1929) testified to his interest in teaching. His interest in the students themselves was constant and he was particularly interested in the JOURNAL, of which he was Chairman of the Publication Committee at one time. In his teaching he believed that diagnoses were made by logical thinking rather than feats of memory and he helped the students develop their faculties of deduction. His musical ear was a help in the teaching of auscultation.

The patient's point of view was never forgotten by Geoffrey Bourne and he was much loved by his patients, some of whom he continued to see up to the time of his death. His book "Heart Disease" in Duckworth's Modern Health series was written to help the lay person understand heart problems and at the same time avoid unnecessary anxiety. One aspect of such anxiety related to air travel; he had a particular interest in this and he was in fact appointed Cardiological Adviser to the British Overseas Airways Corporation.

Outside the field of medicine Geoffrey Bourne had wide interests. His book "Return to Reason—an Essay in Political Diagnosis" showed his desire to guide humanity along pathways of sanity. He was a gifted musician and painter and an enthusiastic fisherman. He loved his cottage in Sussex where he spent almost all of his free time for forty-eight years. For much of this time it had no road, no electricity, and no telephone. Here some of his closest friends were privileged to visit him, including Dr. and Mrs. Paul White. At this cottage he kept a diary of the events of nature and the history and personalities of the district, and at the time of his death he had just completed a book about this aspect of his life, using the diary as a basis.

In the United States he made many friends, and during the year of his Rockefeller fellowship he initiated the creation of the Horseshoe Club, which brought about the first exchange of hospital residents between England and America. The club is now a flourishing organisation and has done much to promote Anglo-U.S. fellowship among medical men. It was also during his initial stay in America that Geoffrey Bourne married Margherita Cotonio of New Orleans, who died in 1952. In 1953 he married Patricia McCready who has helped him to enjoy every aspect of his wide interests. Not only was she helping with the latest book but she played a large part in writing "We Met at Bart's." She will have the sympathy of all his Bart's associates and the gratitude of all those who have read the book.

Geoffrey Bourne's affection for Bart's can best be shown in every page of "We Met at Bart's." It would be fitting to end with his own words in the last sentence when he describes the hospital as "an institution that had given me countless blessings, no regrets, wonderful friends, and a professional experience beyond price."

B. G. W.

SPEMBLY CRYO-MEDICAL EQUIPMENT

BIOLOGICAL STORAGE

The BIOFREEZE unit, initially designed for the preservation of human skin has been further developed exploiting its versatility as a basic unit in the preservation of all other tissues. The unit has been found invaluable in the preservation of lymphocytes used as a reference panel for Histocompatability typing. Simple to use and safe in operation, the BIOFREEZE uses liquid nitrogen as a cooling medium to provide an automatic programme controlled cooling rate from ambient temperature down to −150°C. An accurate trace of the cooling rate is indicated on a standard chart recorder. Where rapid freezing is essential, the FAST FREEZER, a multi-purpose simplified system is available for immersion, vapour freezing and droplet freezing techniques.

Liquid nitrogen laboratory storage vessels and frozen storage tanks are available and pressurised liquid nitrogen vessels for the convenient transfer of liquids for applications requiring controlled freezing facilities.

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The well established range of ophthalmic cryosurgical instruments have been supplemented by additional models to cater for the broad spectrum of surgical applications.

The Amoils T.C.C.10 control system with Series 4 and Series 7 probes provide configurations suitable for E.N.T., spinal cord, vasectomy and gynaecological treatment.

For Neurosurgery the T.C.C.20 control system is available. Urological requirements are met by the T.C.C.30 system.

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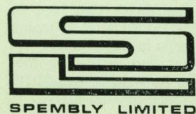
The St. Peter's renal hypothermia system consists of flexible pads cooled by the Joule-Thomson principle for use during stone removal operations. The cooling rate and coil temperature are controlled by a pressure regulator. The coils cool very rapidly, reaching 7°C in a few seconds enabling the average kidney to be cooled to 23°C in 8-10 minutes. This provides the surgeon with an extended examination and manipulative period up to 90 minutes in a bloodless field.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BURNS FEATURE

For the past few months Bart's students have been visiting Queen Victoria Hospital, East Grinstead, which has one of the foremost Burns Units in the world. The following articles are written by some of the staff there.

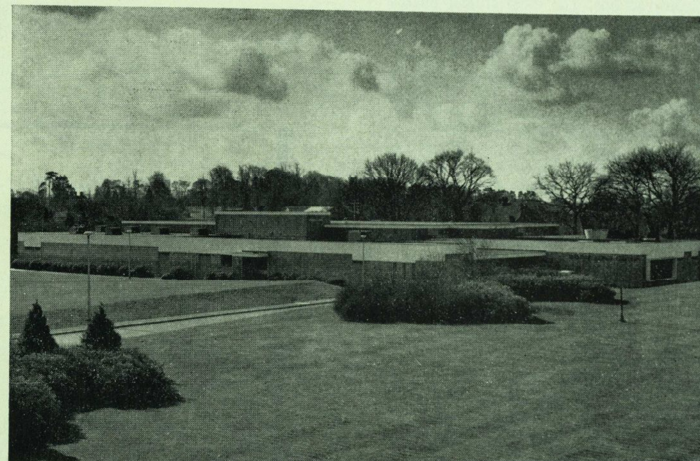


FIGURE 1. The McIndoe Burns Unit at the Queen Victoria Hospital, East Grinstead.

Introduction

When Mr. Michael Hackett first suggested that Bart's students should spend several days at the Burns Unit at Queen Victoria Hopital, East Grinstead, I was of course most enthusiastic about his plans. As there is no Burns Unit at Bart's the students receive little or no tuition on this subject. A practical way of remedying this deficit is to send them to a Burns Unit elsewhere for a period of several days to see a variety of different burns problems dealt with by experts. Clearly this kind of experience is not only good for students but inevitably benefits the teachers. One of the great joys of teaching is that it is a two-way process and the students question "Why don't you use lyophilised skin in this case?" may introduce the teacher to a recent advance which had escaped his notice. Increasing one's horizon in medicine by travelling to other medical centres has long been recognised as a great benefit to the medical profession. When one stops learning one should probably consider retirement.

We are grateful to Mr. Jayes and his staff, particularly to Mr. Hackett for making possible these regular monthly visits of five Bart's students to the Burns Unit. I joined one of these visits myself a few months ago and had a very enjoyable and instructive three days. I very much hope that this venture will continue and increase.

IAN MCCOLL.

THE EAST GRINSTEAD METHOD OF BURNS TREATMENT

by Mr. M. HACKETT, F.R.C.S.

In this country 10,000 people are admitted to hospital each year and 1,000 people die because they are burned. These patients present as complex a clinical picture as is met in surgery. The problems involved range from biochemistry to psychiatry, from immunology to intricate surgical reconstructions. The most critical phases of treatment come in the first few days, often before the patient can be admitted to specialised units and it is therefore imperative that people who are most likely to have to deal with badly burned patients initially should understand what is immediately required. These people are usually junior hospital staff. If the criteria for good initial treatment of a severe burn are

1. Accurate assessment
2. I.V. therapy
3. Urinary catheter for hourly urine estimation
4. PCV and haemoglobin measurement

one would be surprised how many burned patients are admitted to Burns Units with treatment which is other than ideal even though they may have been seen by surgical hierachy.

There are many opinions as to how serious burns should be treated, but there is no doubt that with any of the standard methods, which are basically similar, the prognosis of a burned patient depends on the speed with which the initial treatment is instituted and the amount of attention that can be given to the patient by the medical and nursing staff. This is a good reason for direct admission or early transfer of badly burned patients to a burns centre. No seriously burned patient should be treated in a general ward if it can be avoided.

The following is an account of the methods employed at the Burns Centre at East Grinstead and is divided into resuscitation and the treatment of the burn wound.

Resuscitation

There is a wide difference beween the response of individual patients with regard to the amount of fluid they lose following a burn and no formulae nor hard and fast rules will give an accurate assessment of the intake required to maintain a normal circulating blood volume. The various formulae used are a guide to how much fluid to give initially. The patient is then carefully monitored for assessment of response and correction of amount if necessary.

Within four hours of burning the patient should have received:—

$$\frac{\text{\% burned area (assessed by rule of 9) x wt. in kgs.}}{2}\ \text{ml. plasma}$$

(See Figure 2 for rule of 9).

On admission:—

a) A drip is set up (in a child with more than 10 per cent. burn or adult with more than 15 per cent.; more than 25 per cent. burn set up central venous pressure line).

b) The patient is weighed. The amount of fluid required in the first four hours *since the burn* is assessed.

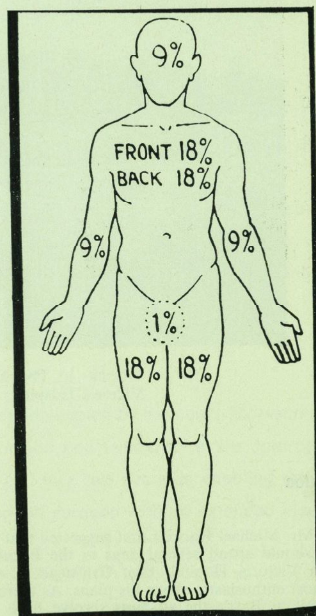


FIGURE 2. "Rule of nine" method of estimating burned area.

N.B. It is the area not depth which is important in calculating fluid replacement.

c) 20 ml. of blood is taken (when the drip is set up) for assessment of haemoglobin, haematocrit, cross matching, serum electrolytes, plasma proteins and blood urea.

d) In the case of a patient with more than a 25 per cent. burn a urethral catheter is set up and connected to an infants giving set to facilitate hourly measurement of urine output. Catheters should be removed as soon after the resuscitation phase as is practicable.

e) Aural, nasal, oral and anal swabs (for bacteriological culture) are taken, as well as swabs from the burned areas. Since infection of burns is often autogenic the results of these cultures can be useful for combating impending infection.

f) Routine antitetanus and antibiotic therapy is commenced.

Further fluid replacement depends largely on the condition of the patient. Careful observations should be made to assess the effect of the treatment already given and if necessary reduce or increase the intravenous infusion. It should be remembered that:—

Restlessness

High Hb. % and Haematocrit values

Urine volume below:

8 ml. per hour for a child below 2 years,
25 ml. per hour for adults
and roughly age x 2 for mid-childhood years.

mean dangerous under-replacement and

Falling B.P.

Rising pulse

mean even more severe under-replacement. As a rough guide the patient is likely to need:—

% burned area x weight in kgm. ml. of fluid

in each of the periods—time of burn to 8 hours, 8—24 hours and 24—48 hours. Caution is, however, used when planning for patients whose burns exceed 30 per cent. of the body surface. It is then safer to base the total estimated fluid required on a maximum of not more than:—

Body weight in kgm. x 100 ml.

This figure is only exceeded on quite definite indications that the patient still requires more fluid but CVP estimations can be very useful here.

Type of fluid used:

Although burn oedema and blister fluid contain less albumen than normal plasma, because of albumen loss, the catabolic needs of the patient and relative freedom from complications plasma is alone used to maintain the blood volume in the absence of indications that electrolyte replacement is necessary in addition.

Blood: In the case of deep burns, for each ten per cent. of deep burn a pint of blood is given within 48 hours of the injury. This replaces the same amount of plasma from the calculated requirement.

Metabolic requirements: The average daily requirements of patients of various ages for normal metabolism are shown in the following table:

wt. in Kgm. ...	5	7	9	13	18	24
ml.	700	1000	1150	1300	1400	1500
wt. in Kgm. ...	30	40	50	60	70	
ml.	1700	1800	2200	2600	3000	

The appropriate quantity of fluid is given by mouth every 24 hours but if this is not possible it is added to the intravenous requirements in the form of 1/5 N. saline and 4.3% dextrose salution. The patient is also encouraged to take as much of a high calorie substance such as Hycal from the day of admission as they can. It is thought that this does help to diminish the weight loss often sustained by patients. Urine volume is measured hourly, and specimens saved for serial comparison of colour, sediment and specific gravity. Early haemoglobinuria in a large burn is not uncommon and may not be serious provided that the urine flow is adequate. Haemoglobinuria after the first 12 hours is serious and may be an indication of massive R.B.C. destruction. Large blood transfusions may be required to deal with this situation and R.B.C. fragility studies should be done.

It is important to note that very deep or charred burns are quite often associated with renal failure and very early excision should be carried out. Electrical burns are particularly deceptive with regard to depth and expert advice should be obtained very early with these or where a deep lesion is suspected. (Fig. 3).

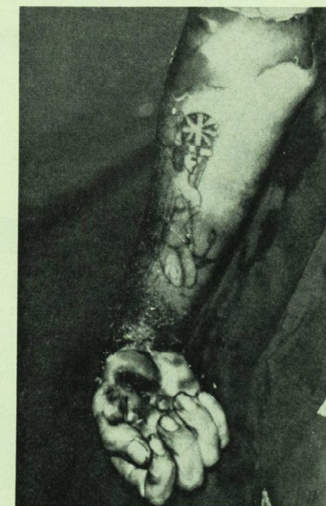
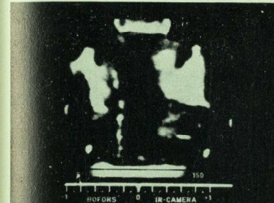


FIGURE 3. Patient sustained multiple burns including cubital fossa (above) which thrombosed the brachial artery and caused a Volkmann's ischaemic contracture. The patient was anuric from time of admission till death in spite of dialysis for 14 days.

GUEST/BOFORS Infra-Red Camera

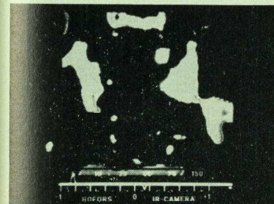
Medical Application on:
Burn Injuries

The following 4 thermographs determine the depth of the burn



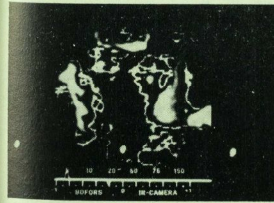
1

Greytherm—Dark is cold.
Light is warm.



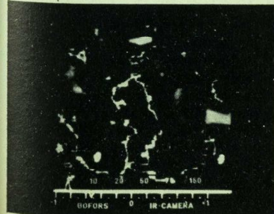
2

Isotherm shows warmest areas —i.e. unburned skin outlined in white.



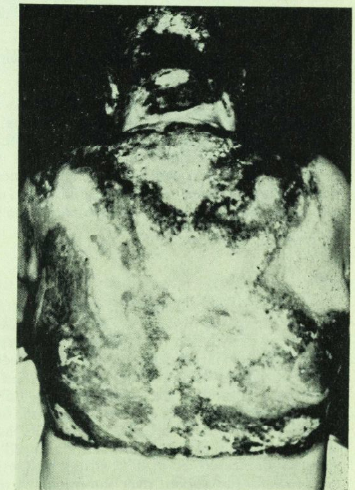
3

Isotherm 1.75°C colder — deeper burns shown in white which are partial thickness.



4

Isotherm 1.5°C colder still shows deepest burns which are full thickness.



The above picture shows a patient with burns of an indeterminate depth.

For further details please contact:—

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Burn Wound Treatment

The wound is first cleaned with Savlon and all dirt and easily removed dead epithelium removed. This procedure is carried out under Penthrane (vide infra) analgesia as are other early procedures. Where possible burned areas are treated by exposure in warm air with a humidity of about 50 per cent. Full thickness burns are covered with Sulphamylon cream but no topical application is used otherwise. Circumferential burns of digits and limbs which are full thickness usually require longitudinal incision to prevent vascular embarrassment. Circumferential burns of the trunk which impair respiration may require the same treatment and occlusive dressings over a thick layer of Sulphamylon cream may be required for circumferential lesions.

Special areas:—

Face is exposed and the eschar allowed to harden but a very careful watch must be kept on the eyelids as these may contract and lead to corneal exposure and ulceration. It may be necessary to graft the eyelids virtually as an emergency.

Ears are cleaned and liberally covered with Sulphamylon cream.

Hands. Initial treatment is individual tulle and gauze to the fingers, bulky dressings of the "boxing glove" variety and high elevation. The palm of the hand is seldom desloughed early but the dorsum should be either grafted within the first few days if necessary or alternatively exposed so that mobilisation may begin early. In either event early movement is the aim.

Perineum is best exposed.

Pain

Pain in the early stages of a burn is often not as severe as may be imagined. The full thickness burn because of destruction of nerve endings is usually pain free though partial thickness areas can be very painful.

The initial cleansing procedures are carried out under Penthrane; after this the patient usually only requires a mild analgesic together with a tranquilliser or hypnotic. Narcotics are seldom necessary especially as the burn eschar forms and if the patient is not allowed to become mentally distressed. So at first, strong analgesics may be used to help the patient over the initial 24 to 48 hours but seldom after that.

From the time that a patient enters the unit a particular effort is made by the whole staff to gain the patient's confidence and befriend him. It has been found that calling a patient by his first name often helps in this respect and also by carrying out any procedures expeditiously and with as little discomfort as possible. An explanation of what is to be done and why also often allays the psychological stress which is a big feature of a severe burns case.

General Treatment

That dead tissue which is liable to become infected should be removed as soon as possible is the surgical principle on which subsequent East Grinstead treatment is based. Before the tenth post-burn day excision of as much full thickness burn as possible is undertaken. This would appear to be the logical procedure but it is only because of special facilities that this can be done safely.

Having a skin bank, an accurate blood loss machine and a method of estimating the depth of a burn are marked advantages. The patient prior to surgery is examined using a thermographic camera. This measures the infra red emission from the skin and thus the temperature and blood supply. In a full thickness burn the blood supply to the skin is destroyed and its temperature is lowered by $2\frac{1}{2}$ to 3°C. Using a system of colour filters to record the temperature differences over an area, a coloured contour map can be obtained of the depth of burn in an area. Thus the superficial and moderate partial thickness burn can be left and the deep partial and deep burn excised. (Fig. 4).

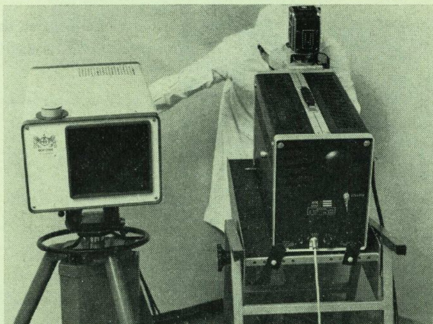

FIGURE 4. View of thermographic camera as seen by patient.

Having mapped out the areas to be excised the dead skin is removed usually at the level of the deep fascia and at the same time as much autograft as is possible is removed from the patient. This is done about the seventh post burn day thus the debilitating period of waiting for the slough to separate which is so often associated with infection and a sick patient is avoided. To be able to carry out these very major procedures speed of execution with a minimum of blood loss and accurate replacement at the time is necessary. To facilitate this a team of surgeons and nursing staff large enough for the occasion is essential. For example if two limbs are to be dealt with, at least two experienced surgeons with assistants are required. To minimise blood loss when limbs are desloughed, it is done under tourniquet control and in areas where this cannot be done the size of the procedure is limited by blood loss. Whatever the procedure a strict limit of one hour of operating time is set, in order not to exhaust the patient. Obviously blood must be lost, but if it can be replaced accurately as it is lost, the effects are minimal. This is done with the help of a blood loss machine in which all blood stained material from the operation are washed during the procedure. The fluid is filtered and passed across a photo electric cell and calibrated for the patients pre-operative haemaglobin. Thus there is a constant reading of the patients blood loss as it occurs during surgery and it can therefore be rectified at the time. In view of the large amount of blood that can be lost and the liberal use of swabs and drapes at operation the volume of items to be washed is a problem which is solved by the use of a standard washing machine adapted to the photo electric cell. The value of this method, which is accurate to 2 per cent., is seen when the experienced members of the operating team are asked to calculate the blood loss. When three opinions are asked for there is often a variation of 100 per cent. The aim is for the patient to leave the theatre within 10 per cent. of his pre-operative haemoglobin, which can be done with the aid of an accurate blood loss machine. It is especially important to keep the haemoglobin and blood volume within reasonably normal limits in burned patients. To err on the low side is to delay healing and encourage sepsis, whereas overtransfusing we believe tends towards thrombotic and embolic phenomena as well as the risk of overloading the circulatory system. This is especially true in children and old patients who form a large percentage of our patients.

When the dead tissue has been removed the question now arises of how to fill the defect created. The amount of autograft that can be taken is limited in a severe burn and the patient must therefore be tided over until further crops of autograft can be taken from the donor sites. By the use of two kinds of allograft this problem can be solved. The first allograft is lyophilised skin; this is cadaver skin taken within three days after death and put through a freeze drying process during which it is sterilised with ethylene oxide. It is stored in nylon bags and can be kept easily in a drawer and when reconstituted with saline it resembles recently cut skin and performs many of its functions. For example, the water vapour barrier is restored, the protein loss in wound exudate decreased and the threat of sepsis is averted; also it relieves the pain of an open wound and thus permits active physiotherapy allowing important early mobilisation. In order to use viable skin more economically lyophilised skin is put on the raw areas at operation and left for four or five days. If, for some reason, such as haematoma formation or infection, the skin take is poor all that is lost is the lyophilised skin. If the "take" has been good then when the allograft is removed an excellent recipient site is left on which viable skin graft is virtually bound to take. Lyophilised skin can also be used to speed up healing in partial thickness burns and to help remove infection if it has occurred in raw areas. (Fig. 5).

The other kind of allograft is typed viable skin. This is removed from the cadaver within sixteen hours after death and stored in liquid nitrogen having been gradually frozen at a rate of a degree a minute. The donor is "tissue typed" and thus a skin bank is established. The object is to place as well matched skin as possible onto a burned patient after deslough, knowing that in a severely burned patient this may remain intact for up to three months and thus enable more autograft to be taken as the donor areas heal. So we see the burned patient having had his dead skin removed; the raw areas are first covered with lyophilised or dead allograft which after five days is replaced by a combination of viable auto- and allo-graft. The point is that early in the history of the burn the majority of the dead tissue has been removed and replaced by a functional skin. Further grafting procedures may be necessary but often only one more and this is done within the three weeks that are usually necessary for a burn to deslough spontaneously. The advantage at the second operation is that the patient is in fact no longer in the serious burn category as the amount of burned skin has been radically reduced. So using this method of treating the burn wound by early excision, the patient who has sustained even a large burn can be completely resurfaced with living skin within a month of his burn and thus avoid many of the complications which have come to be expected in this type of injury.

FIGURE 5. Patient covered with lyophilised skin prior to grafting with viable auto- and allo-grafts.

From what has been said it is obvious that frequent dressings will be required and these, to a greater or lesser extent, are always painful, and nothing is more demoralising for the patient and also the staff than to contemplate a series of these unpleasant incidents. This is avoided by the use of Penthrane (methoxyfluorane). The drug is breathed through a "whistle" or mask and has the advantages of no dependence problems, an amnesic as well as an analgesic effect, the patient is co-operative and the administration can be started at any time during a procedure without any premedication or preparatory starvation. It is acceptable by the patients with a high degree of predictability of effect, there is no interference with feeding problems, no injections involved and the recovery period is short. Its use fits in well with a fundamental principle of the unit that physical or mental pain in a burned patient should be cut to an absolute minimum.

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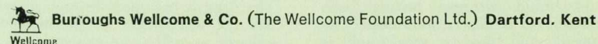

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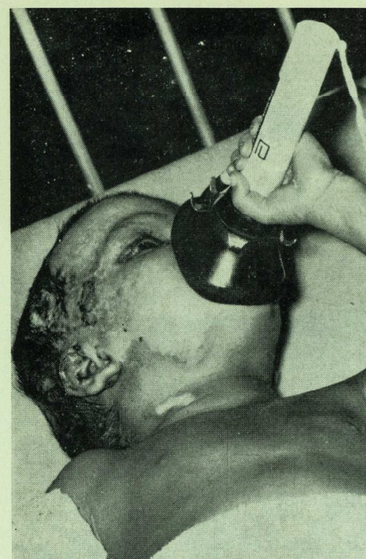


FIGURE 6. Child preparing himself for burns dressing by using a Penthrane analgiser.

Two other points of the routine treatment at East Grinstead are well worth noting. The first is the use of a polyvalent vaccine against Staph. aureus and Ps. Pyocyaneus, two of the most dangerous bacteria commonly found in the burn wound. This is another method of reducing the chance of infection which for so many years has been the eventual cause of many deaths.

Secondly the use of insulin and glucose therapy follows on work by Hinton et al. at the Burns Unit in Birmingham. The object is the treatment or prevention of the "sick cell syndrome." This is a condition which may arise usually during the third week post burn and is characterised by the patient first gradually becoming disorientated, quickly followed by an electrolyte disturbance in which the serum sodium falls and the serum potassium rises. The patient becomes gradually comatose, starts to hyperventilate and dies.

The theory advanced to explain these events is that the patients become resistant to their own insulin and therefore carbohydrate metabolism and subsequently other metabolism becomes disorganised. Eventually the individual cell becomes "sick", the cell membranes become inefficient and potassium is allowed to leave the cell while sodium is retained. Rather than try and correct the electrolyte imbalance directly the metabolic defect is treated. This is followed by an improvement in the electrolytic picture. An empirical regime of 50 ccs. of 50 per cent. glucose plus 6 units of insulin is given intravenously in five minutes each hour for six hours out of 24. Often a diuresis occurs in about 24 hours and the regime must therefore be accompanied by a high fluid intake. Also the potassium is returned to the cells rapidly, often to the extent that potassium supplements may be required so careful electrolyte observations must be made.

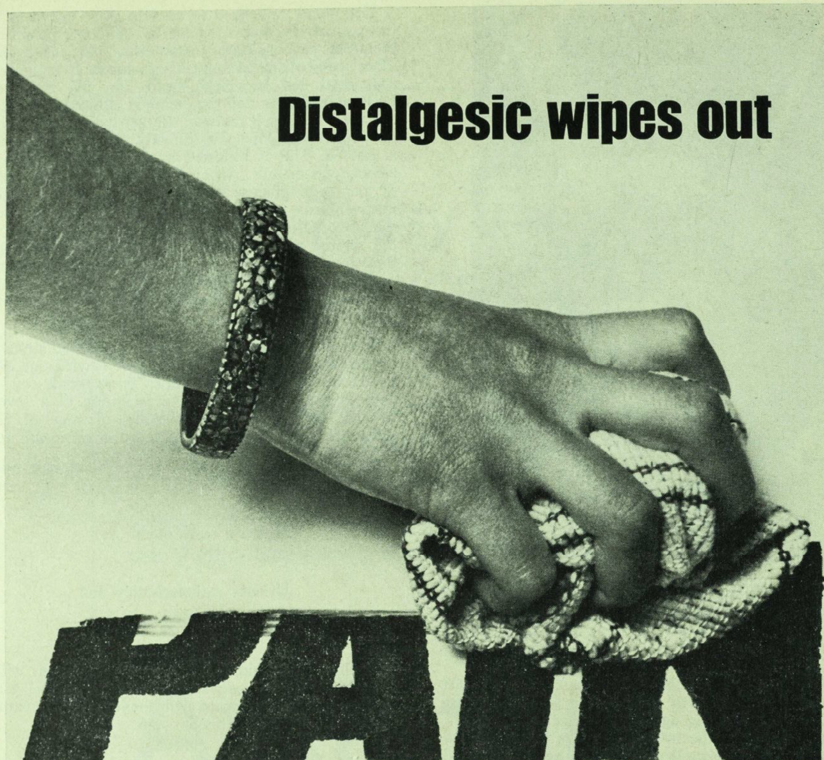
It is easily seen that only in specialised units can such involved treatment of burns be carried out. However, the object of this paper is to point out that without early and efficient resuscitation of a severely burned patient the effectiveness of any of these advances is either seriously reduced or of no use at all.

If the criteria mentioned earlier, which are worthy of repetition, i.e.

accurate assessment
I.V. therapy
Urinary catheterisation and
P.C.V. and Hb. estimations

are fulfilled, morbidity and mortality in burns will be reduced. It is the responsability of all medical practitioners who are concerned with the immediate treatment of a burn to see that this happens.

Mr. Hackett is a Marks Research Fellow at the Queen Victoria Hospital, East Grinstead.



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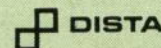

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IMMUNOLOGY IN BURNS AND ITS INFLUENCE ON TREATMENT

By Dr. M. French, M.B., B.S.

The important point about the immune system in burned patients is that its function is impaired. The exent of this immuno-depression is becoming well defined. There is depressed cell-mediated immunity (delayed hypersensitivity) to tuberculin and to skin grafts, and a diminished primary antibody response. The mechanisms which lead to this immuno-depression are poorly understood and require systematic investigation—they will not, therefore, be discussed in thi article.

Practically, the immuno-depression is important in two ways:—

(i) Increased susceptibility to infection.
(ii) Decreased ability to reject incompatible skin grafts.

Infection

Burned patients forcefully demonstrate that the body's natural resitance, or innate immunity, to infection depends greatly on the barrier presented by intact skin. Local infection of eschars and burned areas denuded of skin is very common and is mainly due to auto-infection. However, local infection can easily lead to systematic bacterial invasion in these patients because of their immunodepression, resulting in septicaemia and metastatic infections such as meningitis.

Infection is combated in four ways:—

(1) Skin cover is restored as soon as possible;

(2) A temporary barrier to local infection is used before the skin is covered. The three best ones at present are Sulphamylon cream, silver nitrate solution and lyophilised (freeze-dried) skin;

(3) The use of killed vaccines of Staphylococci and Ps. Aeruginosa to stimulate increased active immunity to the two most dangerously infective bacteria. Statistical proof of the effectiveness of this immunisation is difficult to obtain but it is a logical way of trying to diminish systemic infection;

(4) General supportive measures (barrier nursing, adequate intake of calories, etc.).

Skin grafting

Immunodepression leads to a prolongation of allo-graft survival in burned patients. The increased survival time is proportional to the percentage of body surface burned in experimental animals. In man the survival is further prolonged in patients who are severely ill as a result of their burn. Patients with severe burns have few areas from which autograft can be taken in order to cover the skin deficit left by the burn. The repeated cropping of autografts takes a long time to produce sufficient skin to achieve full skin cover. It has long been thought that the mortality and morbidity of burns would be reduced by producing early skin cover. Of the several materials used—viable allografts (skin from other persons), lyophilised skin (non-viable allograft) and xeno-graft (skin from another animal species)—allografts are the most suitable since once they "take" they assume the functions of normal skin. Lyophilised skin has the advantage that it can be removed from cadavers up to 72 hours after death and is therefore fairly readily available. It also acts as an excellent barrier to infection and prepares a good bed for subsequent grafting with viable skin. Xenografts tend to be rejected rapidly and also often introduce infection.

For these reasons the use of viable allografts required further study to investigate how they should be used. It was first established that in burned mice graft survival time was increased by diminishing the degree of incompatibility between graft and recipient. In order to understand how this finding could be applied to man, it is necessary to understand something about human histo-compatibility antigens. The most important system, and the only one to be considered here, is termed HL-A. In practice, each individual possesses 4 out of a possible 20 or more HL-A antigens on the surface of most of his cells, including skin. It is possible to determine which antigens are present by using the corresponding antisera, a procedure normally called tissue typing. Lymphocytes are prepared from peripheral blood and incubated with antiserum and complement and are lysed only by antisera to antigens present on the cells. When donor and recipient are compared, between O and 4 donor antigens will be found to be incompatible. Minimising this incompatibility (i.e. antigen matchng) has already been shown to increase the percentage of successful kidney grafts in man, the percentage being proportional to the number of incompatible donor antigens present.

Matching requires a selection either of donor material or of recipients. For kidney grafts the best-matched recipients are selected from a panel of patients receiving repeated haemodialysis. However, since it is possible to store viable skin in liquid nitrogen, it is preferable to select optimal donor material for any one burned patient. Typing of donor material is performed on peripheral blood taken post-mortem from skin donors who have been dead for less than 16 hours. After this time the lymphocyte viability is too low to enable typing to be performed.

A series of burned patients have been grafted with both well and poorly matched skin. The result showed a highly significant prolongation of survival of the well-matched over the poorly-matched grafts. Survival was longest (6-13 weeks) in the patients who were severely ill and in those with the largest areas of burn—the very patients who most urgently require skin cover. It was also found that grafts whose surival was prolonged

suffered slow and chronic rejection. If alternate strips, 2 cms wide, of autograft and allograft were used, creeping replacement of the chronically rejecting allograft by adjacent autograft occurred. This removed the need for further autografting of these areas.

In summary, immunodepression in burns leads to an increased susceptibility to infection and particularly to systemic infection. This unfortunate consequence is to some extent compensated for by the fact that skin graft survival is prolonged. This finding has been developed into a practicable method of producing earlier skin cover in patients with severe burns by the use of alternating strips of autograft and well-matched allograft. These two aspects of immunodepression are interrelated since infection will prevent the successful take of skingrafts. (This problem can be largely overcome by prior grafting with lyophilised skin which is removed 5 days later and replaced by viable skin.) On the other hand, early skin cover removes the portal of entry of the bacteria which can cause systemic infection.

Dr. French is a Research Fellow at The Blond Laboratories, Queen Victoria Hospital, E. Grinstead.

THE BURNED PATIENT A NURSING PROBLEM

K. FITZPATRICK,

In the treatment of a severe burn the nurse has more responsibility than in any other type of serious illness. Therefore it is important that she has a special understanding of the burns problem.

The patient is most at risk in the first few weeks after the injury and though treatment may need to go on for years the initial management is the most important.

Burned patients are usually frightened and need to be reassured, therefore every effort must be made towards making the patient feel that he is cared for by individuals who are genuinely interested in him.

The parents of infants and young children are often distressed and have feelings of guilt that they have not prevented the accident. This makes it difficult to obtain a history. A courteous, friendly and informative approach and cups of tea usually wins their co-operation.

To deal efficiently with the numerous problems that occur, a burns nurse must be competent in the management of:—

- Intravenous therapy
- Urinary catheters
- Positioning of the patient
- Care of tracheostomy
- Antibiotic therapy
- Naso gastric feeding
- Dressing techniques
- Care of grafts
- Care of donor sites
- Care of the eyes
- Oxygen therapy

and should fully understand the following:—

Pain

Treatment of severe burns is accompanied by some pain and physical discomfort which persists over a long period though the pain is less severe than is generally supposed and often the patient cannot distinguish between pain, discomfort and emotional tension—the nurse must realise that the patient needs relief from pain but also relief from fear. In patients whose emotional needs are neglected regressive behaviour may occur, e.g., moaning, complaining and demanding but if all the complaints of the patient are treated with narcotics he may rapidly become an addict. The routine should therefore be to make sure that the emotional stress is dealt with if necessary by tranquilizers or sedation and the pain by analgesics of gradually increasing strength until the appropriate one is found. It must be borne in mind here the susceptibility of burned patients to peptic ulceration.

Cross Infection

The prevention of bacterial contamination of the burned surface is very important because infection and septicaemia are the main dangers to patients with extensive burns who survive the shock phase. Therefore all staff working in a burns centre should have routine nose and throat swabs and be pathogen-free. Personnel with sore throats, colds and skin sepsis must not be assigned for duty.

It is advisable to wear a disposable paper cap or washable cotton turban to cover the hair to prevent the shedding of lose hairs on the burn wounds. A clean gown and mask should be worn for each procedure. Used gowns must not be hung up since the bacterial count increases.

A high standard of cleanliness is necessary for the whole building and equipment.

Strict barrier nursing is carried out from the moment that the patient enters the Centre and sterile bed linen and aseptic techniques must be used.

Nutrition

Nutrition is a great problem in burned patients and often only skilled nursing care can answer it.

A high protein, high calorie intake is necessary every twenty-four hours and it is the responsibility of the nurse to make sure that the patient takes the full amount. Supplementary feeds of Complan with Glucose, eggs and cream added, and Hycal are necessary between meals, as the aim is a daily protein intake of 2-3 gm per kilogram of body weight together with 50-70 calories per kilogram. Daily vitamin supplements are necessary as follows: Ascorbic Acid, Multivite, Vitamin B Forte and Iron as prescribed by the doctor.

The surgeon, nurse and dietitian collaborate in planning a diet containing foods that the patient likes and excluding those he dislikes, but it helps to explain to the patient the importance of adequate nutritional intake.

When tube feedings are used the patient should be observed to ensure that gastric dilatation does not occur and the feeding apparatus must be changed between each feed to minimise the amount of bacterial contamination, also the patient's stomach must be given a rest period without feeds usually from midnight to 6 a.m.

The nurse has a special role in the promotion of the patient's well being and must avoid attitudes of callousness as well as over-solicitude. If a nurse is unstable emotionally she will tend to react to a patient's complaints with one or other of these extreme modes of behaviour. The good nurse manages to be kind, but firm and it should not be supposed that a kind friendly warm and sympathetic approach is incompatible with firmness.

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The nurse must inspire the patient to help himself as a most important principle in recovery is demonstrating to the patient that he can function independently. This can be accomplished by having him feed himself and even though this may be quite difficult and slow at first, it is good physiotherapy and if he manages a few spoonfuls the first time, he must be encouraged subsequently. The remainder of the meal may be given by the nurse because ill patients tire very quickly in the early days.

These practical points are worth noting. All initial procedures should be recorded in detail because replacement therapy during the first three days may be complicated. Therefore the nurse must maintain accurate and detailed hourly records of intake and urinary output, temperature, pulse, respiration, central venous pressure and blood pressure.

The estimate of the amount and type of fluid required is based on these records, especially the output of urine in mls. per hour, specific gravity and urinalysis so they are very important.

The nurse is responsible for adjusting the rate of administration of intravenous fluids in accordance with the doctors orders.

To be certain that the patient is treated speedily and efficiently all that is needed should be immediately to hand. The following is a list of the things which are routinely needed for the admission of a bad burn.

Masks, gowns and gloves.

Trolley with:—

Intravenous giving set plus plasma. Venous cutdown tray. Venous pressure manometer. Several syringes, 20 ml., 10 ml., 5 ml., 2 ml. Intramuscular and hypodermic needles. Laboratory test tubes.

A portable transfusion stand.

Trolley with:—

Catheter pack and urinary catheter, Foley, balloon type.

Urimeter.

Laboratory specimen bottle—Universal container.

Trolleys with:—

Instruments, towels, and dressings for wound toilet.
Savlon Solution, Ringer's Solution.
Bacterial swabs.
Dressing materials, gauze, cotton wool Jelonet, Sofra Tulle, crepe bandages.
Oxygen and suction apparatus.
Tracheostomy set.
Naso-gastric tubes.
Eye tray.
Clinical thermometer.
Stethoscope.
Receptacles for soiled dressings, gowns, masks, towels, etc.

The method of local treatment is usually either exposure or occlusive dressings. If occlusive dressings are required they should extend 3-4 inches beyond burn margins. It should be absorbent to keep the wound surface dry and thereby inhibit the growth of bacteria. The dressing must be bulky and applied with even compression. The material placed next to the wound should not macerate the tissue or damage the remaining viable epithelium. Because of the tendency of the dressings to stick to burn wounds and because of the pain and tissue

trauma associated with removal of the dressing, the first layer should be non-adhesive, e.g. Sofra Tulle or Optulle.

If exposure is to be used the following points about specific areas are of interest.

Burns of the Face and Head

These are usually characterised by gross oedema during the first forty-eight hours. The eyelids swell and the patient is unable to see. This is a normal occurrence which is of short duration and should be explained to the patient and his relatives. The head of the bed should be elevated and the head of the patient placed on a sheet of sterile polyurathane sponge.

All burns of the face must have close examination of the eyes. Burns of the eyelids occur frequently when the face is burned. Usually the eyelids close by reflex action and protect the eyes, therefore burns of the sclera and cornea are rare. Routine eye care is very important when the oedema subsides in about seventy-two hours, e.g. four hourly antibiotic opthalmic ointment (Chloramphenicol Applicaps). Every effort must be made to prevent infection and maintain corneal cover and prevent corneal abrasions.

In full thickness burns of the eyelids the chief danger is rapid contracture of the eyelid skin and exposure of the cornea and ulcer formation. Eyelid grafting will be necessary early.

Scalp

In burns of the scalp it is often necessary to cut off the hair and remove singed and loose hair.

Neck

There is a tendency for the head to fall forwards on to the chest causing contact of the burned surface. This should be prevented by placing the patient without pillows on a roll of sterile polyurathane foam so that the neck is extended. The patient must be encouraged to maintain this position using sandbags or small pillows to prop the side of the head. With deep burns tracheostomy may be necessary.

Nose

The crusts may be removed daily using forceps. Sterile applicators with liquid paraffin makes this easier to do and enables the patient to breathe through the nose.

Lips

These tend to crack and to cause discomfort and irritation to the patient. They must be kept clean. It is advisable to use drinking straws for oral fluids. If disposable drinking straws are inadequate then a Portex sterilisable "straw" is available. Sterile Vaseline, sterile liquid paraffin softens crusts and prevents traumatic removal.

Axillae

The principle need is to keep the burned surfaces apart to dry with arms elevated to prevent contracture. In small children this can be achieved by using a crucifix splint.

Since skin grafting is an integral part of the treatment of a bad burn it would seem appropriate to say a little about the care of skin grafts.

Grafts may be treated by dressings or by exposure.

Dressings (Sterile)

The grafts are covered by a layer of tulle gras (paraffin gauze) applied in large sheets which fix the grafts in position and prevent them slipping around while the outer layers of dressings are applied. The dressing is completed with layers of gauze and best quality white cotton wool and crepe bandages.

Change of Dressings. The time of the first change of dressings depends on the amount of infection and the nature of the organisms present. If the grafts have been applied to firm healthy granulating areas then the dressings may be left in situ for five to seven days. If pus forms then the dressings must be changed earlier (third day) and if gram-negative organisms are present then the dressings must be changed frequently thereafter.

The wound is toileted using Savlon Solution 1 per cent. followed by Ringer's solution and any loose pieces of graft which have overlapped or not taken are removed using sharp fine scissors and McIndoe dissecting forceps. To prevent pulling off the grafts, impregnated tulle e.g. Sofra tulle may be placed next to the grafts and the dressing completed in layers as before. The use of sterile crepe bandage ensures a comfortable dressing which will stay in place.

If the wound is very infected then daily dressings may be ordered using Solution Eusol and Paraffin—Dakin's Solution. Antibiotics sensitive to the organisms may be used topically in the form of impregnated tulle, e.g. Genticin, Sofra tulle, or antibiotic powders or antibiotic creams.

Nursing Care of Grafts by Exposure

It is now generally known that a graft will *take* as long as it is not mechanically displaced or lifted off its bed by haematoma or pus formation. Heavily infected areas are best nursed by exposure. Gram negative organisms thrive in the dark moist and warm conditions under the dressings and the grafts will float off, in a sea of pus. The patients may be nursed exposed on sterile polyurathane sponge so that their position may be changed and grafted areas will not come in contact with bed linen.

Areas which do very well are neck and face grafts, buttocks and trunk and any area which the patient does not lie on, e.g. exposed grafts on buttocks, back, trunk and posterior thighs if patient can tolerate lying prone for a period of up to fourteen days.

Patients who have exposed grafts over large areas need expert nursing care so that the patient may be handled without disturbing the grafts. Patients requiring grafts to buttocks and thighs should have an enema or evacuation of bowel content before the grafts are in place and if possible no bowel movement after operation for five days. This is very difficult to achieve with very ill patients who often have loose stools and wound toilet is extremely difficult.

Daily toilet of exposed grafts is necessary to keep the wound clean.

The nursing of a severely burned patient is an extremely arduous but rewarding task. It calls for the use of all the skills acquired in one's nursing training as well as developing an insight into the human needs of a patient whose whole life is affected by his illness. This is particularly true of young children who form a large proportion of the patients treated.

Sister Fitzpatrick is the Departmental Sister of the McIndoe Burns Unit at the Queen Victoria Hospital, East Grinstead.

A BURNED PATIENT'S VIEW

The following are the observations of a 62-year-old stoker who sustained a 45 per cent. full thickness burn.

He fell into a furnace and was pulled out on a safety line, but his rescuers were unable to get him away from the furnace for 40 minutes. He was treated in a peripheral hospital initially and then was transferred to the East Grinstead Burns Centre where he was treated for ten weeks.

"My early recollections of the accident are very hazy; I do remember that I was surprised that there wasn't more pain. When I got to my first hospital the pain began to come on and I noticed that the doctor and nurses didn't agree what should be done and seemed to be arguing. It was in a small room and there was a lot of noise. I knew I was badly burned and I began to think that it didn't matter if I lived or didn't. I wasn't worried. People kept asking me questions which I couldn't be bothered with.

"When I was transferred to the Burns Unit I began to get more confidence. Everybody seemed to know what they were doing and I began to feel as though I could fight. Everybody was friendly and because they called me by my first name I felt part of the family.

"I was pleased that I was in a room by myself as I couldn't have put up with someone else in with me. I just felt peaceful. What was most important was that my wife was staying in the same building and I knew I could see her if I ever got very sick.

"I don't remember very much about my big operations but I used to look forward to the dressings because when I had the whistle (Penthrane) I felt as though I had had five big gins with no hangover.

"The worst thing I remember out of my time in the Unit was a nurse coming in one day with a trolley and starting to peel some of the scabs off my legs. This just seemed to hurt more than anything else. The injections depended very much on which nurse gave them but they were never too bad.

"It is hard to tell about the Unit; there were so many little things that, put together, helped, such as the way the doctors and nurses talked to me and gave me confidence in them, the good food, the fact that everyone was kind to me. Anyway all I can say is that I am grateful for all the work that was done for me."

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BARTS DRAMA

THE MIRROR AND THE STAR

by PAUL SWAIN

There was great interest and enthusiasm surrounding the Bart's Drama production this year. Perhaps it was because this was the world premiere of a play by a Bart's student, perhaps because the audience were re-termined to make the best of the draughty old Gym at Charterhouse (why are Bart's Drama, of all people, not allowed the use of the stage at Gloucester House?). At any rate, there was a sense of occasion amongst the audience before the lights went up.

Most people seem to have enjoyed the play considerably, although none seemed to know why. One felt, a little uneasily perhaps, that, having been blasted with such high-powered material for so long, and having had to concentrate so hard, it would have been an admission of defeat to say that one had not yet received some pleasure, even if one had to admit a slight lack of comprehension. It was certainly a difficult play to absorb, and I must confess that, sitting in the front row, I felt at the end that I had just watched a super-size cinerama production at the very front of the cheapest seats, and the desire to refocus my eyes and accustom my spinning mind to normality again was not as easily attained in the cold air outside as I had hoped.

The play is concerned with the ballet-dancer Nijinsky, relating the development of his schizophrenic condition to Freud in an effort to be cured. This theme maintains the structure of the play; but in between, these characters explore the wider concepts of madness; the mad, their doctors, their fellow humans, and the attitudes of each of these groups to one another. The scenes enacted—often by Nijinsky himself—are true samples, taken from the writings of a wide range of historians and medical men, traversing the history of Psychiatry to the present day.

There are some aspects of the play that are superb and, naturally enough, others that are far from it. The most important fault was the length—the first half could have been shortened by about half an hour. The reason for this, particularly in the last twenty minutes of that half, was that there was not enough light relief to contrast with the heaviness of the main theme of the play. This is an essential ingredient for a play of this kind, where one's concentration naturally tends to fluctuate, and there were several occasions ideally suited for comedy. I found myself consciously egging the actors on in any parts that promised of some humour, only to be disappointed on the whole by the weak climaxes these scenes supported. Furthermore, some of the small scenes, though relevant to the subject of madness and interesting to the audience, were repetitive and therefore of dubious dramatic value, however well staged. They could have been cut without unbalancing the structure of the play. The script itself is far too long to be stage-able in its entirety, and much of it was cut in the course of production, but the total organisation of material is very good and the fascination of the theme always keeps the play alive. Freud's was a rather negative and listless characterisation perhaps intentionally so as he is the observer and correlator above all else. As psychiatrist he is there to listen to the patient and is bound to be the more passive part. But he seemed too constricted somehow and, regardless of whether this was an attempt to recreate accurately the personality of Freud, Jolyon Oxley was no foil for the larger-than-life Nijinsky of James Griffiths.

For all my criticism, however, the play was a great success and I think that—without being too cliched—it was a very inspiring exercise. Its greatest virtues are the very powerful dramatic qualities of the theme. The mime, the marionettes, the intermingling of past with present all assumed a truly integral part of the drama, rather than gimmicky asides. The main weakness was an ambiguity of ideas which was never quite resolved.

Although fighting an uphill battle in the Gym, the set was good as were the costumes. Above all, the direction was extremely imaginative and skillful. Scenes took place rapidly. In fact, the changeovers sometimes seemed too fast compared with the occasionally rather slow acting, which at times could have been crisper and better paced. The girls especially were comparatively weak. There were good performances from Nick White who had just the right amount of devilishness as Mesmer; a subdued Jeff Tobias who produced about his best performances to date as Diaghilev, only faltering in his difficult crisis scene with Nijinsky. Robert Robertson and George Blackledge fulfilled themselves. The main lead was played by James Griffiths with considerable dexterity. He seemed to enjoy every moment. He was very mature and excellent in a wide variety of roles once he had got over his rather naive characterisation of Nijinsky as a schoolboy. His was undoubtedly the best performance of the evening, in a part in which he had to *act*, rather than exaggerate his natural flamboyance.

MIKE WHITE.

The cast assembled on the Gym stage.

Bart's Drama in Southampton

January 1st 1971

The play reviewed above, "The Mirror and the Star," was accepted for the National Union of Students drama festival this year. The festival was sponsored by the Sunday Times, whose adjudicators chose about ten out of about seventy productions, in other words we did rather well just to get to the festival. Essentially the emphasis was on novelty—either new plays, or original adaptions of old plays or other material, were accepted—if we had done a conventional production of Skakespeare for instance, we would not have been accepted. As it turned out there were very few new plays per se at the festival, and we benefited quite a lot from this. "The Mirror and the Star" was written/concocted by Paul Swain during the late summer from a wide variety of sources, but mainly from Freud's and Nijinsky's own writings. The result was a play, which used most of the conventional techniques of the theatre—unlike almost anything else at the festival—but which presented within this framework many more new, exciting, and original ideas than could most of our fellow students in Southampton. Paul himself received a great deal of acclaim for this, and we must all be very proud to be associated with someone who is probably going to find himself inundated with work for the BBC! And by the way it seems within reason to hope that the play itself has a future. Keep your eyes peeled!

As far as I could gather from the people we met in Southampton, and from the five other productions that I saw there, the standard of drama seen varied from pretentious amateur (for which we coined a new phrase: 'intellectual pus') to the extremely good and almost professional. I admit that I was expecting most of the festival to fall into the second category, but it didn't and was as a result slightly disappointing. But the good things that we saw there were very exciting, and made me feel glad that Barts Drama was not the only competent student drama group in Britain.

JAMES GRIFFITHS.

Public Reviews of "The Mirror and the Star"

From "Noises Off" the Festival newspaper:

"James Griffiths as Nijinsky produced a performance that was occasionally brilliant and always worthy of attention. . . .

Jolyon Oxley as Freud was totally believable, I would not have thought it possible.

The Play: An altogether facsinating concoction, somewhat long and analytical for a lay audience but never dull. . . .

I feel that with some cutting and judicious reshuffling of scenes to create a more clearly defined dramatic thread the play will move from the interesting and entertaining to the brilliant and unforgettable."

TONY DENT producer of Southampton's winner in 1966 Festival.

From the Sunday Times 3 January 1971:

"The most original piece of the week was, paradoxically, the most conventionally theatrical: Paul Swain's THE MIRROR AND THE STAR (St. Bartholomew Hospital Drama Society). Mr. Swain knows his Freud and his R. D. Laing, his Mozart and his Stravinsky, his Victorian melodrama, and God help us, his Strindberg, and from all this, with stylish additions of his own, he distilled a hilarious, esoteric, and volatile play. His central situation shows Freud psychoanalysing Nijinsky, and the question he's asking is whether the witch doctors of the mind are any use for the soul. I don't know that Mr Swain gets near an answer; but I was spellbound by the way he sought it."

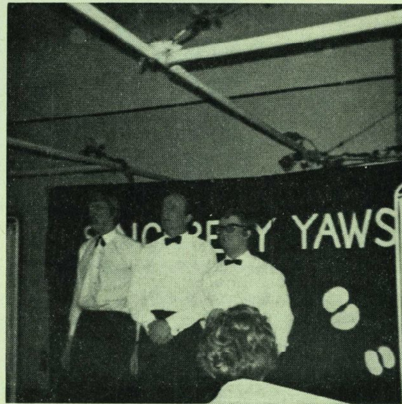
JOHN PETER.

Even as we go to Press, we have just heard that Paul Swain has been awarded a £150 prize for the best play of the Festival. Our congratulations to him, especially, and to the rest of the company also, on this splendid achievement.

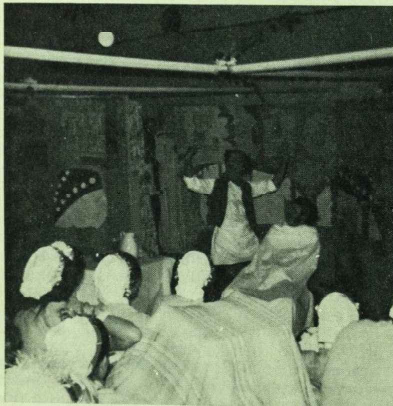
WARD SHOWS 1970

Wander around Barts on Chistmas Eve and you will find six or seven groups of medical students in the final panic-stricken stages of rehearsing their contribution to the Christmas happiness of several hundred patients, their visitors, and many of the old and poor of the city area of London. You will learn from these people, without asking, that Christmas at Barts is a merry one, and if you can't spend it at home you can have just as good a time in hospital. The wards look like Kew Gardens, the nurses all trained at the Folies Bergeres, the doctors at Bertram Mills circus, and the students with Spike Milligan and Frankie Howerd; and talking of students, isn't it rather a tribute to them that each group produces not less than twenty-five minutes of mostly original material, the greater part of it being witty and humorous, and quite a lot of it being frankly very funny indeed. An amazing observation, when you consider that none of us studies anything but medicine, and only a handful of the many students involved would list acting as one of their hobbies. Yet the shows are slick, very few jokes are lost, only a few of the lines are inaudible and most of the material is enjoyed by staff and patients alike.

This year, two of the shows deserve the 'Best Show Award.' The paediatrics produced a performance of 'Puss in Boots' specially for the kids, which was unfortunately not seen in the Pot Pourri. This production was remarkably well rehearsed and remarkably well written; it was a coherent story, easy to follow, yet never predictable, with plenty of music and songs, and the characterisation of the parts was convincing. Special credit to Chris Higgins as Puss, and all the cast for an excellent and most appropriate children's pantomime. A show like this, specially for the children, must become a regular feature.



"THREE JOLLY CONSUMPTIVES" —FINALISTS



"BARBER" SKETCH—HOUSE SHOW

The House show contained rather more conventional material, but had two sketches that were particularly good. Chris Bridget's 'Barber' was quite excellent; not only was the sketch a foolproof success from its conception, but its delivery also contained exactly the right amount of supporting material, and was performed with precision. The song which followed it about 'you know who', carried exactly the right amount of sting and humour to spice its message. It was also noticeable that the House show had very few pauses between sketches, a quality which was noticeably missing in some of the other shows.

The dressers show was mostly performed by students new to Barts. Perhaps as a result of this their show contained more references to bedpans than to nurses, which made it mildly unconventional but there were several good songs and imitations of Arthur Neagus and Dr. Cameron which were very well done. Unfortunately the mainstay and producer of the show was unable to repeat these successes for the Pot Pourri. As a result the dressers joined the clerks and put on a combined show in the Cripplegate. I enjoyed the clerk 'ward round', and thought that 'Steve's Song' with the moustachioed nurse was particularly good.

One of the shows began by revealing the cast all wearing towels around their waists and very little more. While they stood self consciously grooving to the introductory music, a stooge in the audience began inciting the others to object to this revolting and disgusting sight, and led into the opening song. This was the best opening to any show yet and was well executed by George Blackledge. The rest of the show was an obscure piece of Roman history involving the Amazon rugby team, and a very serious young man called Abstemious. The Bathus scene was very successful, and many of the more difficult scenes, including a bedroom scene and a rugby match, were well organised and came off without a hitch. Credit to George for writing it and for his muscles.

Before talking about the DQC show, I must say that I admire their courage, but I'm very glad not to qualify for the club. They are the backbone of Barts, the last of the pioneers in this age of feckless, hardworking, exam-passing, qualification-chasing automata. For these are the men who revise 'chest' for all of anatomy, liver for the sake of their phisiology and will only revise 'detoxication' to satisfy the examiners in Biochemistry. Naturally however a good wine takes longer to matriculate, and this particular 'special cuvee' rejoices under the name of the Delayed Qualifications Club. They produced three of the best sketches of the year, with Dragon Story, Duncan in his usual role, Oliver Else making the advertisement sketch, and the miming to doctored songs. The imitation of Tom Jones was superb and well studied. The prize however goes to Pete Burnett for 'Puff the Dragon,' 'Rolf Harris,' and for other invaluable contributions.

And lastly the finalists. Mark Pepper's humour was most in evidence here with revolting scenes like 'Three Jolly Comsumptives,' Halitosis,' and 'Balls,' (which was stolen from Mr. Peter Cook). Steve Leech was very good in some scenes but especially as 'Wonder Body,' and Andy Mason sang for us again richly and effortlessly, though not with quite such success as last year.

In conclusion I would say that although I have praised the efforts of many people, much of the material could have yielded more humour, and the ideas were often under-exploited, and not rehearsed with quite enough feeling for pace. In any performance like this the material must be analysed and worked over, feedlines and punchlines must be distinguished and rehearsed accordingly, and any weak material must be spotted early and either rewritten, or concealed by slickness, an amusing gesture (eg, Harry Secombe's famous apology swallow), or any other device that may occur to the producer. Although we cannot all aspire to the standards of Monty Python, we can at least give our audiences efficient and fast moving performances, thus showing off our best material in the best possible light. We can all do this, and we do produce good material that is worth waiting for. There was enough this year both actually and potentially to justify the continuing success of the Ward Shows, and I am confident that they will next year continue to be the central event of Christmas.

JAMES GRIFFITHS.

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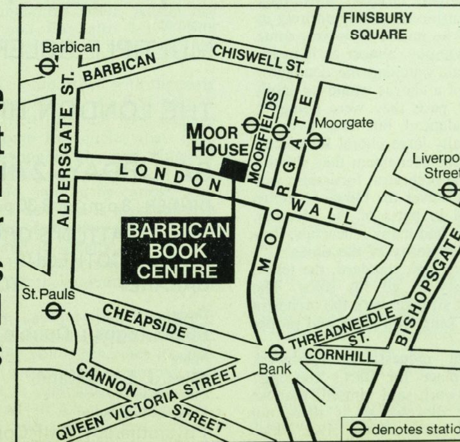

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BARTS MUSIC

THE MESSIAH

The Messiah is certainly a very popular work, some would say over-exposed, and whilst a performance can be almost assured of popular success, and a large audience, the music is by no means easy to perform well, and the two and a half hours length of this piece means that it is difficult to sustain an overall high standard of performance. Also Handel himself made it difficult by cramming the first half with the easily appreciated arias and choruses and putting his more intellectual and difficult work into the second and third parts, when both musicians and audience are flagging.

Considerable praise, therefore, must go to the Music Society and its conductor, Robert Anderson, for their excellent performance of the Messiah in Southwark Cathedral on 17th December. The Cathedral was very crowded, and some were turned away. Accoustically the Cathedral is not perfect for large Choral works, for the choir tended to be swallowed up, and entrances and endings were very indistinct at times. But, with every performance, Bart's choir improves, and they showed they were capable of choral singing of a very high standard in choruses like, "And the Glory of the Lord", and "Surely He hath Borne Our Griefs", when they sung with a very pleasing translucent quality entirely in keeping with the emotion of he music. However, some of the entrances were very scrappy, almost as if members of the choir were not all watching the conductor and often the first few bars of a chorus would be spoilt by people deciding at what pace they were going to sing. The parts were well balanced, but there were no reserves of power for the really large choral set pieces, which did not thus generate the excitement they should. The same was also true of the orchestra; fortissimo was reached often and easily, but never the bursts of molto fortissimo that are expected in parts of the Messiah. For an orchestra that had not had many rehearsals, they held together very well, the majority of the time.

The soloists were of a very high standard, the tenor, especially, singing effortlessly in all his solos. The soprano had perhaps a slight struggle with the orchestra at times, but all the soloists sang with good and proper emotion.

One final, and personal request; is Southwark Cathedral really the best place for Bart's concerts? The representative of Southwark said himself, that we had absconded to another diocese, so is there not perhaps some suitable hall north of the river which would welcome an excellent and forward-looking choir?

With this concert, Bart's has a Music Society capable of putting on assured and expert performances, one can only wait in anticipation for the Summer Concert.

GEORGE BLACKLEDGE.

Bart's Music Society wishes to express its sincere regret that a number of people were prevented from entering the "Messiah" Concert at 7.30 p.m. by order of the Southwark Cathedral Authorities, in accordance with a G.L.C. regulation. We were unaware of this restriction and will ensure that the misunderstanding does not recur.

IAN HANN, *Chairman.*

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BOOK REVIEWS

"The Survival of the Fittest", Pamela Hansford Johnson. Penguin Books, 50p (10/-)

"The Survival of the Fittest" centres around the two main characters from similar backgrounds, who grow up to be very different. When the book opens Jo Upjohn and Kit Maltings are both poor, young and unknown, and both live in South London. Both spend their leisure hours in pubs—especially Bloomsbury pubs—with their literary, artistic, and eternally hopeful friends. The atmosphere of the Bloomsbury set is carefully and effectively invoked, of a close circle of friends relatively unknown, but certain of future success.

As Kit begins to achieve success, Jo begins to fall behind. Where Kit is adored by Alison Petrie, Jo adores Alison in vain, and in addition to this version of the eternal triangle he is further hampered by the demands of his widowed mother and his spinster sister. Even a brief sexual encounter with Alison can provide nothing but shame and embarrassment for Jo, while Kit marries Polly, writes a best seller and settles down to a relatively happy life.

Despite the fact that Kit has achieved fame, and mixes with lions of his literary world his life is not entirely happy, because he is already showing signs of alcoholism. Jo remains a born loser, marked with a quality of fated heroism, unsatisfied in literature or sexually, and shackled by the demands of his crippled mother and perenially disappointed sister. Alison has married an Army officer and Fay also leaves him through his inability to make a positive break with his stifling family in Clapham.

The final part of the book is concerned with the early 1960's, where all the protagonists of the first part of the book are settled in married life, and with teenage children. The wheel has come full circle; they have abandoned their brave left-wing ideals, and plumped for a comfortable middle-class existence. Kit leans more heavily than ever on Jo, smitten by cancer, with the discovery that his sister's husband is a compulsive exhibitionist. Even the deaths of the two men are typical: Kit dies dramatically, and Jo quietly, and without fuss—never quite realising how important he was to their group, as a lynch-pin for their gyrations through the years.

Pamela Hansford Johnson has not tried to paint a detailed picture of life in the three decades seen in the book, but rather to show how youth generates its own excitement and fury, which is inevitably tempered and mellowed by age. The circle is completed and the balance is maintained throughout—if Kit is Don Quixote, then Jo is his Sancho Panza, and although less fiery, in many ways a more important character.

A very readable book, perhaps of more interest to women, as I feel that Pamela Hansford Johnson shows a better and more sympathetic understanding of her female characters than of some of the men. It is both stylish and witty, and a good book with which to while away a winter evening.

JAMES POPE

Penguin Modern Stories, No. 6.

The sixth volume in this series is, like most of the others, a bit of a mixture—both in style and quality. To my mind, the most successful stories in this collection are those by Elizabeth Taylor (no, another one), especially the longer one entitled "The Excursion to the Source". It explores the relationship between two women, companions by convenience, and attempts a great deal more besides; and to achieve a convincing tragedy in twenty pages is not to be sniffed at.

Tragedy too, mixed with high comedy in Robert Nye's extraordinary tale called "The Same Old Story". He writes in a refreshing nonstop way rather like a half drunk Irishman might tell a joke in a Dublin bar, without pausing for breath. Certainly this is the cleverest of all stories, an attractive blend of horror and surrealism. I could not help comparing it with Maggie Ross's "The Special Pair", and finding the latter dull as a result. Her best story is "Death by Drowning"— if, that is, you have a macabre sense of humour.

The other stories are by Dan Jacobson, and they left me stone cold.

J. S. TOBIAS.

Lecture Notes on General Surgery.

By HAROLD ELLIS & ROY YORKE CALNE.

Third Edition Blackwell Scientific Publication. £2.25

The wide field of surgery covered by this excellently produced book is very impressive. The notes are clearly written and the subjects well covered.

Such a book is of more use to postgraduates brushing up, or looking up in a hurry, than to undergraduates; but could well refresh the memory before examinations.

The whole production and lay out is good and makes for easy reference.

E. G. TUCKWELL.

Bart's Sport

RUGBY CLUB

1st XV v London University

This game was played at Motspur Park on a typical November pitch, greasy at first and then decidedly muddy by the end. Nick Packer had recovered from his back injury sustained at Falmouth and Doctor Britton from his surprise at passing finals, so the team was almost at full strength. In previous seasons this game has taken place on a Wednesday when the University can raise a side marginally better than that on a Saturday, but mid-week Bart's lose players both to Counties and United Hospitals so this year the game was fixed up for the weekend. Last season London inflicted our heaviest defeat of the year, so we were determined to do better this year.

All in all it was one of those games which justifies all the training, all the cold wet Saturday afternoons spent tramping around muddy fields chasing a stupid yet elusive leather object. It was a very toughly contested game between two evenly matched sides which included plenty of open play and cunning moves, with the minimum of "aggro." In the first half London opened the scoring with an unconverted try, the result of some rather half-hearted Bart's tackling. Just before half time, however, Mason went over in the corner for the equalising try, and this was superbly converted by Rhys-Evans to put us into the lead 5—3.

The second half produced some fine needle rugby, both sides desperately trying to score. Although the Bart's forwards obtained plenty of possession the backs somehow lacked any really determined running or penetration, and were frequently stopped just short of the line. Midway through the second half Sullivan, our cuddly 16-stone prop, left the field with a nasty cut on his forehead, but despite this the forwards still held their own. Towards the end Rhys-Evans scored as the result of an excellent break by Martin, but failed with the conversion. From then on London really put the pressure on, and there were a few missed heartbeats at an attempted drop goal which shaved the posts, but fortunately the defence, particularly in the back row, held out and the score remained 8—3 in our favour.

1st XV v Treorchy

Played at Chislehurst on a beautiful afternoon with nearly perfect conditions, everything was set up for a really good game. The Welshmen had travelled up all the way from the Rhondda Valley that morning, having left Treorchy at 6.30 a.m. Incidentally it is often a struggle to prise Bart's players out of bed by 12.30 on a Saturday morning, so congratulations to the Treorchy Secretary for having his team at Chislehurst by 1.30 p.m. even with a stop for lunch. Someone said they had come straight off the night shift—but this was later denied. Little can be said about the game, which disappointingly turned out to be a very dour and dismal affair. The referee penalised every tiny, minor infringement, as perhaps he had to with fifteen very critical Welshmen (to say nothing of 15 critical Bartsmen) so the game never really got going, and all Bart's could do was to score a mouldy penalty—kicked by Rhys-Evans. Treorchy had earlier scored a try, and when two further tries were (justly) disallowed, it was a group of very disgruntled Welshmen who left the field when the final whistle blew. Final score 3—3.

1st XV v Old Askeans

This game resulted in another win for Bart's, this time away at the Askeans ground. Gordon Brain replaced John Wellingham, who was not available, at scrum half, and Paul Cooper came into the second row to replace Dr. Britton, who had gone skiing. After an initial try from each side a stalemate descended upon the game until midway through the second half when a Bart's player charged down a kick and scored a lucky unconverted try. Thereupon the game erupted into life, and there was a flurry of scoring. Despite the fact that three scoring passes were dropped within inches of the Askeans' line Bart's still won 14—6, after another encouraging performance.

JOHN LAIDLOW.

CROSS COUNTRY REPORT

With the addition of several new members, together with some old faces, the Club has started the present season keenly. In U.L. League races, Bart's have easily maintained last season's placing in the league table and did, in fact, improve on it in the last such race before Christmas.

On Wednesday November 18th (a rather wet afternoon), the Club scored an overwhelming victory in winning the St. Mary's Hospital Porritt Cup. J. Brooks was placed second and the remainder of our scoring men were all amongst the first 15 runners.

In the U.L. Championships at P.H.F. on December 12th, we were narrowly edged into second place in the Roehampton Cup by R.V.C.—maybe the Vets. will be less lucky when we next meet.

Many fixtures lie ahead in the New Year. These include one down in Devon against the Britannia R.N.C. at Dartmouth. Our aims in the remainder of the season will include endeavouring to defend our title in the Inter-Hospital Championships at Chingford on March 6th.

Enjoyable training, faithfully attended on Monday evenings, has certainly played a major part in knitting the team together in the earlier part of the season-despite several bitter and blustery sessions.

A. H.

SOCCER CLUB REPORT

So far this season Barts soccer team has played eight league games, and has gained nine points, putting us fifth in the United Hospitals League Table. These matches include some very peculiar results e.g. losing 13-1 to St. George's Hospital in the League Cup, but beating the same side the very next week by 1-0! But such is football. However, we have played all the sides above us in the League, and can now look forward to the lower sides with some anticipation.

Bart's v. Westminster Hospital (A)
Drew 3-3
Monday, 2nd December

We played Westminster on a muddy day, with the rain falling in abundance. As is usual with Barts, we gave away an early 'soft goal' and took time to recover. Then after 19 minutes of play, the Westminster winger got round the Barts full-back, Peter Jones, and was making a beeline for goal with Jones in hot pursuit. At this moment Tony Wall decided to attempt one of his most spectacular sliding tackles, taking away the winger's legs, the ball, and those of his own full-back. Unfortunately, the winger fell rather heavily on to Jones and broke his clavicle. Our best wishes go to Peter Jones for a speedy recovery. This incident upset the Barts team to a certain extent, and we lost another goal, but thanks to a fine individual goal by Pete Dunlop, we faced the wind in the second half only 2-1 down. The team then found its true form and tackled and ran furiously. Murphy was admonished by the referee for his enthusiasm, but continued to act as the workhouse of the team in midfield, laying on an equaliser for Knight—score 2-2. Westminster pulled back into the lead, but the ten men again pushed their efforts to the limit, and Murphy unloosed the equalising goal just before the final whistle. This match was the best team effort we have had this season, and there is no reason why we should not always play like this.

Tuesday, 9th December
Bart's v. Charing Cross (H)
Match abandoned.

This match was played at Chislehurst with the fog and mist swirling around the goalposts, and it was very difficult to see more than twenty yards ahead. Barts scored two goals, both superb headers from corners by Knight, and gave away six goals—as much due to the weather as to the other side. The referee finally abandoned the game with twenty minutes to go, as he could only see four players at any one time.

Saturday, 12th December
Bart's v. Guy's (H)
Won 4-2

This game against Guy's is always looked upon as our Derby game of the season, and it turned out to be the best so far. Thanks to Richard Franklin forgetting his kit, we played with ten men in the first half. Guy's scored first, but Dunlop, running everywhere up front, soon levelled the score. Guy's drew ahead again, but thanks to a fine header by James House from a corner, we again equalised, and never looked back. The return of Skanderowicz in midfield made a great difference, and he floated across a centre for Murphy's header to leave the goalkeeper groping for the sky. Pete Franklin at left back kept Guy's out with fine tackling, and aided by Wall and Abbott sealing up the Bart's half, all it was needed for Skanderowicz to score the last goal to give Bart's a satisfying 4-2 win.

We look forward to seeing Ian Benson back on the field after Christmas, having recovered from his back injury.

Anthony R. J. Wall

SECOND XI FOOTBALL REPORT

v Guy's—Away—Friendly

Having conceded 21 goals and scored only 3 in our opening three games of the season we had hopes of our first victory in this match. It was not to be however, since circumstances obliged us to play a weakened side, fortunately somewhat strengthened by the inclusion of three regular members of the 1st XV, Nick Fairhurst, Paul Cooper and Robin Lambert. We offer our thanks to them and the advice that they are obviously wasting their talents with the oval ball since they all played so well, notably Robin Lambert whose last minute thunderbolt proved the best goal of the match.

v Westminster—Away—Cup

This was the first competitive game of the season for us. Unfortunately, as had happened so frequently in the past, we treated our opponents to a gift goal in the opening minutes of the game and not learning from that moment of defensive slackness we were soon 2—0 down. In the second half we "clicked" and played easily our best football of the season, but we could not find the net until ten minutes from time when Janusz Kolendo broke through alone and scored. In spite of heavy Bart's pressure Westminster held on and just before time broke away to make the final score 3—1.

v St. Thomas's Hospital—Away—League

Tommies were our hosts for our second league game and in a torrential rainstorm we achieved our first victory of the season. We were always the better team and for once made the most of our advantages. Early on in the first half Isenberg boosted our morale with a well taken goal after a goalmouth scramble. In spite of our superiority we still lacked the ability actually to score and it was not until the second half when Carr stroked the ball home between keeper and post from close range. This goal stirred Tommies to some action and they played above themselves and applied heavy pressure for the last ten minutes during which time they reduced the final deficit to 2—1. Our winning margin might have been greater but sadly Knight celebrated his call up to our ranks by aiming a dubiously awarded penalty at the corner post.

v Charing Cross—Home—League

A very disappointing performance by the whole team led to a 5—0 defeat by a competent but by no means brilliant Charing Cross squad. Our attack never once looked like scoring, while the defence returned to the slackness exhibited in our earlier matches with such disastrous consequences. We can only hope for better luck in the New Year.

P. MORRISON.

mps

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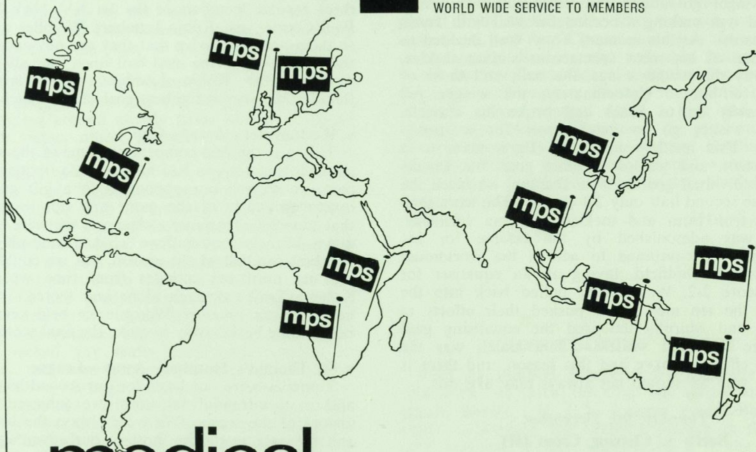

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* Reprints received and herewith gratefully acknowledged. Please address this material to the Librarian.

Junior Registrars in Surgery

APPLICATIONS ARE INVITED for five **appointments** of JUNIOR REGISTRAR IN SURGERY, as under:—

3 posts: six months General Surgery/six months Special Department.**

1 post: six months Emergency & Accident/six months General Surgery.

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Applicants should state for which post they wish to apply and give a second choice. The posts are tenable from 1 June, 1971, and the Salary Scales are that of a Senior House Officer in the National Health Service.

Applications, with the names of two referees, should reach the undersigned by Friday, 12 March, 1971. (Application forms are available from the Medical Staff Office.)

Further information may be obtained from the Professor of Surgery or from Miss M. E. Turner in the Medical Staff Office.

J. W. GOODDY,
Clerk to the Governors.

**Urology
Orthopaedics
Thoracic Surgery

SAINT BARTHOLOMEW'S HOSPITAL JOURNAL

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Editorial

The part that so-called "medical politics" plays in any hospital administration—but particularly in that of a teaching hospital—probably goes unrecognised by the majority of students of medicine unless they are directly concerned with the Students' Union. In general this is an administrative problem, and here, as the hospital is almost completely divorced from the medical college, it hardly concerns the students. In a recent editorial in this Journal, however, attention was drawn to the fact that few people have the courage, and even the good sense, to speak out against common opinion when they believe that common opinion is wrong.

A few months ago the subject of teaching machines was broached in connection with clinical studies, particularly as there had been some measure of discontent amongst both the student body and the staff on the quality of, and the attendance at, lectures. It was felt that in view of this, these machines would be a definite asset to the course, and with little further publicity being given to the scheme, most people are unaware that little action has been taken, with the possibility of waning enthusiasm in "high places". The subject of teaching machines is featured in this Journal to draw attention to this particular problem, but this is really a far wider issue.

The prime object of a teaching hospital is surely to teach. This does not mean that patient care is secondary, but good clinical instructors are few and far between. The selection of a surgical consultant or registrar, for example, must surely be based on his ability to impart his knowledge rather than his speed with the knife. No matter how brilliant a man may be in his own field, if he cannot pass on his secrets, he is of relatively little use in a teaching hospital: similarly if he cannot adapt to new ideas. Basic facts in medicine become more scientific and technological every day. That the practice of medicine is an art to be learned from example and the patients at the bedside is an established fact, but there must be technological methods to instil technological facts. The rapid growth in numbers of students makes this inevitable.

Various rumours are circling as to the possible use of the old canteen in the hospital; to the student it provides a valuable opportunity for increased knowledge and awareness of medical problems. To members of the staff it means variously married quarters for housemen, a postgraduate library, and a storeroom for pathological specimens, to mention but a few examples.

We have in Barts the somewhat anomalous situation of a reputedly wealthy hospital and an impoverished medical school. For better or for worse the college is attached to the hospital, in name at least. To lag behind the other teaching hospitals in this matter is shameful. Could not the hospital find its way to contributing more to the education of its students than solely the presence of its medical staff? Students feel themselves to be far more a part of the hospital than of the medical college per se, even in preclinical years. Cannot the hospital recognise that without proper educational facilities in machine and person, the standard of medicine and the name of Bart's will rapidly decrease, and that it owes a responsibility, if not to its associated students, then to humanity as a whole?

Letters

STUDENT'S UNION LETTER

Abernethian Room,
St. Bartholomew's Hospital,
28th January, 1971

Dear Sirs,

The Council Meeting on 19th January covered a great deal of ground and I suggest that the published Minutes are read.

The House Liaison Committee met on 19th January also and George Blackledge and myself were invited to attend since the future of the Ward Shows was being discussed. The feeling of this meeting was that the Shows are a valuable asset and greatly add to the Christmas spirit at Barts—so long as they are properly controlled (as they were this year). By this, it is meant that beer should not be taken into the Wards, that the number of people watching a Show must be controlled, that priority of watching must be given to patients, in that their view must not be blocked by other viewers and, most important of all, that one of each pair of wards be made into a sick ward so that critically ill patients or patients who choose not to watch may be moved away from festivities. A report of this meeting will go both to the Hospital Council and the Board of Governors, with whom the final decision rests.

On 26th January the Student/Staff Committee met for the first time; the Minutes of these meetings will be available and published. The subject of Paediatrics showed the value of such a Committee in that we were able to sort out what appear to have been four different concepts as to what was the exact ruling on 'Paediatrics abroad'. This Committee will not deal solely with academic problems, but will also act as a liaison group on general matters.

The Union now has a new sub committee (yet another!) under John Wellingham, whose job it is to précis Minutes and put out Union statements and information on "information sheets"—the first of these should have appeared by the time this letter is published.

The U.L.U. Festival fortnight begins on 8th March, and many London Colleges are organising functions—the profits of which go to O.S.C.A. (a U.L.U. based organization performing similar work to that of Task Force). Bart's is holding a Festival Night on 18th March in the College Hall Bar.

PAUL MILLARD,
Chairman, Students' Union.

Announcements

GIFT TO LIBRARY

Dr. Malcolm Donaldson has presented to the Library a copy of his privately produce **Memoirs of a surgeon and oarsman,** 1970, which he wrote "to while away a few hours in the worst of all purgatories—Complete Retirement."

The book consists of autobiographical fragments relating to his childhood; school; Cambridge University; Bart's; the two World Wars; radiotherapy; retirement; and his work on cancer education. Dr. Donaldson has travelled widely, and in 1966 he went to Tokyo via Siberia with his wife to attend the International Cancer Conference. A full itinerary is included.

Although mainly intended for the eyes of his family and close friends, this book will prove interesting to any Bart's man, particularly those who have met that dynamic personality, "Dottie" Donaldson.

J.L.T.

Engagements

HARPER—GOODMAN—The engagement is announced between Mr. Geoffrey K. Harper and Miss Yvonne L. Goodman.

WALL—PLATTEN—The engagement is announced between Mr. Anthony R. J. Wall and Miss Margaret Platten.

HOOKER—WHITE—The engagement is announced between Dr. David Hooker and Miss June White.

WINTER—TALBOT—The engagement is announced between Dr. Richard Winter and Miss Jane Talbot.

GABB—MORGAN—The engagement is announced between Mr. Richard Gabb and Miss Susan Morgan.

KERRIGAN—COBB—The engagement is announced between Dr. Gervase Kerrigan and Miss Angela Cobb.

BOARDMAN MAKINSON—ADCOCK—The engagement is announced between Mr. John Boardman Makinson and Miss Janet Scott Adcock.

Marriage

VANDENBURG—GLENTON—The marriage took place on February 14 between Mr. Malcolm John Vandenburg and Miss Diane Glenton.

HANNING—VINER—The marriage took place on February 20 between Mr. Christopher Hanning and Miss Margaret Viner.

Deaths

WINNICOTT—On January 25, Mr. Donald Woods Winnicott, M.A., F.R.C.P. Qualified 1920.

GREEN—On January 22, Dr. Ralph Green, M.R.C.S., L.R.C.P. Qualified 1925.

WIGGLESWORTH—On November 16, Dr. G. F. Wigglesworth, M.B., B.S. Qualified 1943.

DONALDSON—On December 13, Dr. Eric Donaldson. Qualified 1914.

Births

STEPHENS—On January 16, to Major and Mrs. K. Stephens, a daughter.

SILVERTON—On January 11, to Annemarie (née Chapman) and Dr. John Saunders Silverton, a daughter.

Change of Address

The new address of Dr. J. Q. Matthias is 17 Eton Villas, N.W.3.

The new address of Dr. A. G. Dawrant is 270 Meadowlark Professional Building, 8702, Meadowlark Road, Edmonton, Alberta, Canada.

Appointments

Mr. J. A. Bonn, M.R.C.P., D.P.M., has been appointed Senior Lecturer in Psychiatry and Consultant Psychiatrist at the Hackney Hospital.

Mr. T. Chard, M.B., B.S., M.R.C.O.G., M.D., has been appointed Senior Lecturer in Reproductive Physiology and Honorary Consultant in Clinical Measurement.

Mr. L. R. I. Baker, M.A., M.D., M.R.C.P., has been appointed Consultant Physician with an interest in Nephrology.

New Year's Honours List

C.M.G.: Ronald Lawrie Huckstep.

O.B.E. (Civil): George Smith Innes.

Life Peerage: Sir Miles Thomas, Governor of the Medical College.

Memorial Service for Dr. Geoffrey Bourne

The Service of Thanksgiving for the late Dr. Geoffrey Bourne, Consulting Physician to the Hospital, was held on Wednesday, February 3rd, in the Church of St. Bartholomew-the-Less. The address was given by Sir James Paterson Ross, Bt. K.C.V.O., the text of which is produced below:

It is right that we should meet together in this Holy Place, the Church of the Hospital which he loved and served so well, to remember with gratitude the life and work of Geoffrey Bourne. And we hope that to those who were nearest and dearest to him it may be some added comfort to be surrounded for a while by friends who knew Geoffrey well, admired him for his achievements and loved him for himself.

I am privileged to try to put into words some of the many and varied thoughts which are now in our minds—they are bound to be varied because some of us knew Geoffrey as a companion from student days, some as a colleague, and others as a teacher, but all as a valued and beloved friend. However, my chief care must be not to disturb the precious memories cherished by each one of you, and I must ask to be forgiven if I omit to refer to matters which you regard as important. This is almost inevitable because of the very full life which Geoffrey lived.

No doubt many of you will recall what he wrote about this—"I often said that I would have liked to live five simultaneous lives; one devoted to teaching; one to hospital practice; one to private work; one to research; and finally, of course, one devoted to the pleasures and enthralling interests of civilized human life." And he enjoyed being a Consultant because it enabled him to do just that!

He loved teaching because he could influence students at an early stage in their career and inculcate the basic principles of the practice of medicine—first, reliable methods of eliciting facts, by history-taking and physical examination; secondly, the consideration of these facts so as to establish the nature, and if possible the cause of the malady; and thirdly, with this knowledge, to decide upon the rational treatment. These methods were described in full in his first two books, written for undergraduate students. And he was so convinced of their soundness that he believed a similar process could be applied to the solution of social, political and international problems, as he expounded so brilliantly in his book "Return to Reason" which was published during the second world war. He pointed out the importance of testing the validity of every "fact" before it is accepted as the truth; the judicial weighing-up of the value of all the ascertained facts; and finally the formation, on the facts, of a reasoned judgement or opinion. He argued that in this way Reason could overcome the bad effects of uncontrolled Emotion, and there is no doubt we would all be better off if everyone responsible for administration and government could take a leaf out of this remarkable book.

The Department of Cardiology is a lasting memorial to his hospital practice, and it is well-known how it started very moderately as Cardiography and grew gradually till it achieved its full stature as a special department. Geoffrey's own interest in heart disease undoubtedly sprang from personal experience of a lesion which interrupted for a time his clinical studies, prevented his playing games, and interfered with service in the Forces in the first war. However, he adapted himself so well to changed circumstances that ultimately his own experience was turned to the benefit of innumerable patients who were encouraged by the advice he was able to give them about adopting a similar attitude to their disability. We know about this from his own writings on this subject, and also because he made a point of giving patients time and opportunity to talk to him about what was on their minds.

And what did "the pleasures and enthralling interests of civilised human life" mean to him? It meant literature, both reading and writing; music, for he enjoyed Glyndebourne, and listening to the great musicians and singers, and also his own violin; pictures, painting, and architecture, and visits to galleries and museums as well as to places of historical interest in London and abroad; the simple pleasures of the countryside, and fishing; and always laughter and the love of friends. And his enjoyment of all these interests was doubled by being shared with Pat.

He had a genius for friendship, and his wonderful memory, combined with humour, made his auto-

biography consist very largely of amusing anecdotes about people he had met, and with whom he had worked. His good humour was valuable in many ways, and I remember when several of us were working at an outlying hospital in the Emergency Medical Service during the Second World War, and were inclined to resent some of the petty rules and restrictions and even to rebel against them, when Geoffrey came into the mess he made us see the ludicrous side of the whole affair, and it all ended in a fit of laughter instead of a fit of bad temper.

I will end by referring to some examples of the special delight he took in arranging meetings of friends. In 1926 he spent some months working in the United States, and was so impressed with the value of Anglo-American friendships that he was responsible for founding in 1932 the Horse Shoe Club, the object of which is to foster friendship between American and English men and women interested in medicine, the encouragement of academic exchanges, and the provision of hospitality for overseas visitors.

And we should not forget the good work he did for Old Bart's men in organising for some years the Past v. Present cricket match, and more recently undertaking the Secretaryship of the 10th Decennial Club. A remarkable feature of these meetings was that though some of the members of the Club were obviously ageing, Geoffrey never seemed to change. Indeed, some words I came across recently of Henri Fréderic Amiel about the Secret of Youth could be applied to him:

"The whole secret of remaining young in spite of years, and even of grey hairs, is to cherish enthusiasm in oneself, by poetry, by contemplation, by charity—that is, in fewer words, by the maintenance of harmony in the soul. When everything is in its right place within us, we ourselves are in equilibrium wth the whole work of God. Deep and grave enthusiasm for the eternal beauty and the eternal order, reason touched with emotion and a serene tenderness of heart—these surely are the foundations of wisdom".

We shall miss him sadly, but we shall remember him for what he taught us by his example about the importance of the pursuit of Truth, the importance of being guided by Reason, and the supreme value of Kindliness to all with whom we come in contact, kindliness which was in Geoffrey a blend of humility with love for his fellows. It is well that we are *here* to return thanks for his life and work, for we believe that his great qualities were spiritual gifts for which we should thank God.

St. Bartholomew's Hospital

House Appointments: 1st January, 1971 to 31st March 1971

CONSULTANT STAFF	HOUSE OFFICERS	WARDS Male	WARDS Female
Sir Ronald Bodley Scott	G. R. H. Baker		
Dr. W. E. Gibb	I. R. Battye	Harvey	Luke
Dr. G. W. Hayward	R. K. Knight		
Dr. H. Wykeham Balme	K. G. Taylor	Smithfield	Mary
Dr. K. O. Black	J. F. Smyth		
Dr. A. M. Dawson	J. Mackinnon	Rahere	Colston
Dr. N. C. Oswald	C. K. Bridgett		
Dr. G. Hamilton Fairley	S. B. J. Sutcliffe	Dalziel	Annie Zunz
Professor E. F. Scowen	R. P. Hayward		
Dr. A. G. Spencer	N. Thatcher	Stanmore	Garrod
Mr. E. G. Tuckwell	P. J. Maddison		
Mr. M. A. Birnstingl	J. F. Shaw	Rees Mogg	Paget
Mr. D. F. Ellison Nash	G. N. L. Hyde		
Mr. J. D. Griffiths	J. A. Rennie	Waring	Abernethy
Mr. J. O. Robinson	J. A. D. Vanhegan		
Mr. H. B. Ross	R. C. Froggatt	Bowlby	Heath-Harrison
Mr. Ian P. Todd	V. S. Blanchette		
	M. S. Elliot	Fleet Street	Harmsworth
Professor G. W. Taylor	Miss B. Bailin		
Mr. I. McColl	N. H. Brooks	Percivall Pott	Lawrence
Dr. K. O. Black	R. T. Jolly	Casualty House Physician	
Mr. J. O. Robinson	W. E. J. Leverton	Casualty House Surgeon	
Department of child health			
Dr. P. J. N. Cox	A. M. Burke	Lucas	
	Miss G. V. Davies	Kenton	
Ear, nose and throat department			
Mr. J. W. Cope	P. Bowen-Roberts		Henry Butlin
Mr. R. F. McNab Jones	N. B. Houghton		
Mr. A. P. Fuller			
Mr. L. N. Dowie			
Eye department			
Mr. J. H. Dobree			
Mr. M. A. Bedford	Miss S. A. Lack		Radcliffe
	R. Markham		
Department of Obstetrics & Gynaecology			
Mr. D. B. Fraser	E. Vandyk		
Mr. Gordon L. Bourne	M. J. Rymer	(O)	Martha
Mr. David Williams	I. D. Fraser	(O)	Elizabeth
Mr. C. N. Hudson	R. S. Baumber	(G)	Sandhurst
		(G)	Pitcairn
		(G)	Harley
Dental department			
Mr. T. T. Schofield	M. B. Taylor	Fleet Street	Harmsworth
Mr. F. R. Coffin			
Mr. B. D. Markwell			
Mr. D. Winstock			
Orthopaedic department			
Mr. J. N. Aston	I. W. L. Bintcliffe	James Gibbs	Hogarth
Mr. C. W. S. F. Manning	S. A. Copeland		Henry
Mr. A. W. F. Lettin	H. G. Dunckley		
Department of Thoracic Surgery			
Mr. O. S. Tubbs	C. P. L. Wood		
Mr. I. M. Hill	C. I. V. Franklin		Vicary
Department of Neurological Surgery			
Mr. J. E. A. O'Connell	G. Gordon		
Mr. R. Campbel Connolly	B. D. Cutler		W. G. Grace
Skin department & special treatment centre			
Dr. P. F. Borrie	P. J. McKenna	Smithfield	Mary
Dr. D. D. Munro			
Dr. C. S. Nicol		Rahere	Colston
Department of Neurology & Psychological Medicine			
Dr. J. W. Aldren Turner	P. V. L. Curry	Stanmore	Garrod
		Harvey	Luke
			Radcliffe
Professor W. L. Linford Rees		Dalziel	Annie Zunz
Dr. C. M. B. Pare			
Department of Urology			
Mr. J. E. A. Wickham	J. S. Davies	Bowlby	Heath Harrison
Mr. C. A. C. Charlton		Waring	Abernethy

The Elective Period

A curriculum giving details of courses available to students for their elective periods has been prepared, and every 2nd and 3rd year clinical students will receive one. The report is prefaced by the following letter from the Dean:

The elective period is six weeks in duration and is taken in the last year of the three-year clinical course. The elective period is an integral part of the student's training and should not be looked upon as free time. It should be used either to increase knowledge in depth of a particular field or to correct deficiencies.

Not all students will wish to arrange an elective period in one of the subjects offered in the curriculum. Nevertheless, all arrangements should be notified to the Sub-Dean, Mr. I. M. Hill, or his secretary, Miss Foreman. Those who wish to take advantage of any of the electives offered should let the Office know in plenty of time. This is particularly important for the elective topics at other Medical Schools.

A summary of elective periods available is given. For a number of reasons some Departments were unable to supply all the necessary details of proposed electives but Heads of Departments concerned will be able to supply further details to interested students. By the next edition it is hoped that these details will be available. This curriculum does not cover the overseas clinical appointments arranged in Paediatrics and other subjects as these are taken in the Second Year.

The elective periods are arranged on the basis of those available at Bart's and those available at other centres. The topics are presented alphabetically; there is no significance in the order otherwise.

J. S. Malpas,
Dean of the Medical College.

AUDIO-VISUAL TEACHING AT BARTS

by Primrose Watkins (member of Students Union and teaching committee)

There has been mounting student interest in the proposal for an audio-visual teaching laboratory designed for the clinical student. It has been proposed that the clinical students' refectory, which was abandoned in April 1970, should be converted for this purpose. The Medical Illustration Department of this hospital have devised an audio-visual desk and method of programme production at reasonable cost, and could pioneer such a project. The Students' Union see no valid reason why such a project has not yet materialised, and would like to know why the Department of Medical Illustration have not yet implemented this.

A description of two proposed visual aids for the laboratory is included below, by kind permission of Mr. Cull and Mr. Tredinnick of the Medical Illustration Department of Barts from their report of January, 1970 on "Individual Self-instruction using Tape-slide Methods":—

Tape-slide Programmes

The basic concept of the recorded lecture accompanied by slides is not new. The Royal College of General Practitioners Sound Recording Service under the direction of Drs. John and Valerie Graves pioneered this method, and work in this field has been reported in the Universities of Glasgow and Newcastle-upon-Tyne.

At St. Bartholomew's Hospital, the Department of Medical Illustration has, over the past three years, been concerned with the development of apparatus and tape-slide presentations of a more "programmed" nature, specially prepared to meet a specific need. These programmes differ considerably in character from a normal lecture performance, particularly as regards the planning of the verbal aspect, the illustration content and the way in which the latter are integrated into the programme. In addition, these presentations can be programmed to include support material such as microscopes, museum specimens, short loop films, printed matter, etc. Simple question and answer sequences for self-testing can be included as slides, or printed multiple choice questionnaires can be distributed with the programme. Other printed information for the student to retain can be included, for example, complex data on laboratory estimations or drug dosage, etc.

Programmes can either take the form of factual presentations on the general aspects of a disease entity, or, a specific case presentation, possibly including patient interviews. This latter could be developed as a diagnosis test with the student being supplied with all the necessary information to enable him to form an opinion. It could also be envisaged that collections of illustrations showing the various clinical appearances of a condition may be used without the support of audio or printed material.

Apparatus

It is proposed to equip the teaching laboratory with two basic types of apparatus.

1. **The "Barts" A-V Desk (see fig. 1.)**

This is essentially a study desk into which is incorporated a standard rotary 35mm. slide projector with drum type magazine holding up to 80 slides. The image from the projector is reflected off a membrane mirror onto the back of a translucent plastic screen providing a picture area approximately 12in. x 12in. Also incorporated is a small casette tape recorder which is linked via a built-in electronic slide changer to the projector. Voice is recorded on one track of the tape, the other track being utilised for the slide synchronising pulses. Sound is received either from the loud-speaker or more usually through ear-phones for individual working. The student controls include "start", "stop", "rewind", "tone" and "volume" on the tape-recorder, there is also provision for manual operation of the projector in programmes which are not pulsed for automatic slide changes.

The basic type of programme would be a tape-recording with slides, pulsed for automatic changing; however, it is envisaged that several other forms may be employed.

1. Tape recording—Voice and other sounds only.
2. Tape recording with manually operated slides.
3. Slides with printed script.
4. Slides only with catalogue description.

The desk as shown was designed in the Department of Medical Illustration and can be constructed for a total cost of £150 inclusive of sound and projection equipment. The initial production of one programme costs approx. £20: thereafter each copy costs approximately £5. The cost of one slide (replacement) is approximately 2½p: a type may be used an infinite number of times.

The individual items used in the construction are listed in the drawing, but it should be pointed out that the desk has been to accept alternative equipment. For example, reel-to-reel tape recorders can be utilised with separate slide change unit, and the design could probably be modified to incorporate 2 screens and a loop cassette motion picture projection for showing short sequences of film as an additional feature.

2. **The Plessey Communicator. (See fig. 2.)**

This commercially produced apparatus employs a tape recording with film strip as opposed to slides and both the recording and film are contained in a single cassette. The machine which is a table model and similar in shape and size to a small television receiver uses a mirror reflected image on to a ground glass screen providing a picture size of 8in. x 6in. The sound is received either via a loud speaker or, more usually, ear-phones for individual working. The audio content of the programme is broken down into a series of "paragraphs" each accompanied by one illustration. At the end of each "paragraph" of speech the machine stops, but the picture remains on the screen. The programme will then proceed only when the student operates a foot switch which changes the picture and re-starts the tape recording. By turning a switch to "backspace" the student can replay one or more of the preceding paragraphs as often as desired. At the end of the programme the same switch is turned to rewind and on operation of the foot switch the tape and film strip is returned to the start position. It is also possible with more recent designs to run the programme continuously.

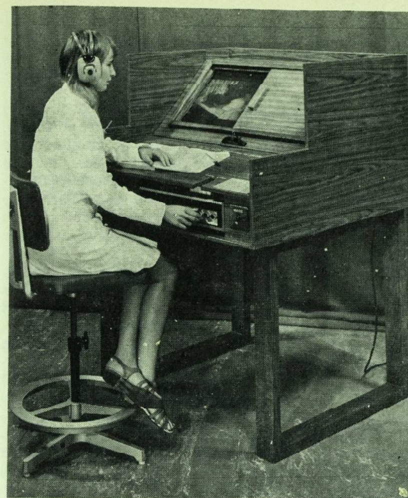

Fig. 1.

As with the "Bart's A-V Desk", simple question and answer sequences can be introduced and the apparatus can be used in conjunction with other support material, but programmes are limited to the automated type. Additionally, by removing the top of the machine and tilting it, the picture can be displayed on a large screen, thus, in conjunction with a loud speaker the system can be used for small group teaching.

Comparison of the two methods

"Bart's A-V Desk"—The advantages are that it incorporates standard and relatively simple apparatus. Its concept is flexible both as regards the type of apparatus employed and in the type of programme which can be produced. There is some saving in initial cost compared with the "Supervisor", but one of its main advantages lies in the fact that the choice of projection and recording equipment is under the control of the purchaser and therefore one is less at the mercy of manufacturers design and price changes. The cost of programme production is low in comparison with the "Supervisor". Modification of audio and visual content is simple and cheap and therefore it is particularly suitable for programmes where changes in content are likely to occur with any frequency. The technical side of programme production is less complicated. Its **disadvantages** are that replay of particular portions of a programme is not automatic or synchronous with the slides: however if the programme content, particularly the visual support, is carefully planned the necessity for partial repeats need not occur very often.

Plessey "Communicator" The **main advantage** is that of automatic synchronous repeat of portions of the programme. It is also compact and easily portable. Its **disadvantages** are the higher initial cost of purchase and more expensive and complex programme production. The electronics are complex and therefore more liable to breakdown. Alteration in one picture requires the complete remake of the whole film strip and tape thus the cost of modification is high. It would be unsuitable for programmes which are likely to need modification often, but particularly useful in the teaching of techniques involving some manual dexterity and practice, or for subjects of a more static nature (e.g. anatomy).

The organisation of the Teaching Laboratory

It has been proposed that the unit be organised on a library basis. The laboratory should be open for 12 hours per day (9 a.m.—9 p.m.) with a technician/librarian supervising from 9 a.m. to 5 p.m. Monday to Friday. The remaining periods (in the evenings and at weekends) to be supervised by a medical student. Where large numbers of students are required to study, within a specified time limit, a series of programmes (e.g. An introductory course in Pathology), a group of machines maybe allocated on a semi-permanent basis for this purpose. Apart from this all programmes should be available at any time.

Tape-Slide Programmes—Content

The average programme should last for a maximum of 20-25 minutes on continuous run, however it should be realised that the student may take up to double this time to study it. It has been found that in some cases the content of a 50 minute formal lecture can be covered adequately in a 20-25 minute programme, this is be-

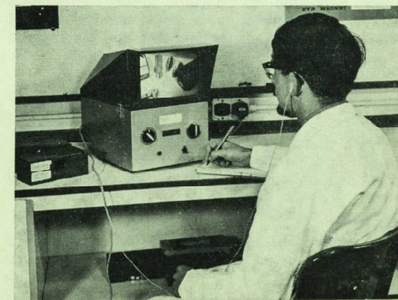

Fig. 2.

cause more information is presented in visual form; and much of the time involved in blackboard work, allowing students time for note taking, and repeating information, can be saved.

Normally a 20 minute programme (approximately 2,500 words) may contain between 30 and 40 illustrations consisting of Titles, Artwork, Photographs, Charts etc. Some of these may be pictorial, demonstrating facts which cannot be explained verbally (e.g. clinical pictures, anatomical drawings, pathological specimens, photomicrographs, diagrams etc.) some will contain statistical information in graph or tabular form, others may be statements in words used to emphasise, tabulate or summarise the spoken content. It is important to bear in mind the sort of information on which the student might wish to take notes, and this should if possible be included in slide form. It is also very important that the content is tailored to the right "level" for the student and that he never feels that he is being "spoken down to". There is a strong temptation to do this in order that the programme should reach a wider and perhaps less sophisticated audience.

Although the tape-slide programme bears a similarity to a recorded lecture, it differs in certain essentials. The usual way of preparing a formal lecture consists of writing a script and then adding the illustrations separately. In the tape slide programme the illustrative content plays a role equivalent in importance to the spoken words and ideally these two aspects should be planned simultaneously. A logical sequence in the presentation is important and breaking the script down into a series of "paragraphs is particularly helpful. The aim should be to have slide changes at fairly frequent intervals thus assisting the maintenance of interest. It is also vital that the slide on the screen should be pertinent to the spoken words at any particular time—a change of subject should be accompanied by a change of picture.

Programmes have been produced at St. Bartholomew's Hospital by the Dept. of Gynaecology and Obstetrics (they have 2 "supervisors" and approx. 20 programmes); the Dept. of Medicine at St. Leonard's (3 Barts AV desks and approx. 10 programmes); the Surgical Unit are in the process of producing 6 programmes, and 2 are being made by students for the Dept. of Pathology, similarly for Paediatrics. The Dept. of Gynaecology are making programmes in conjunction with UCH Medical School. The Surgical Unit have arranged a one-for-one exchange scheme with Guy's Hospital. This cooperation is an economical way of augmenting the stock of programmes, and much could be gained by a combined effort of the London teaching hospitals in this way. There are also Barts AV desks at UCH, the Royal Marsden, and one on order for Hackney: it seems likely that Guy's will consider installing one.

The General Practitioners' library (mentioned above) has been drawn on for material (i.e. at St. Leonard's), though naturally only some of the programmes are directly suitable for the clinical student. There must be many potential sources which could be tapped as material for the library. For instance, the set of Pathology tapes and slides used by the clinical students of the London Hospital on their portable AV machines would be a possibility.

An essential adjunct to the teaching laboratory would be a team with facilities to produce programmes and keep them up to date; this has been incorporated as part of the teaching laboratory plan. (It is noteworthy that not all the London teaching hospitals have medical illustration depts with these facilities).

It is not envisaged that the "room" will be confined to one AV service; rather that programmes made by Barts and other hospitals (acceptable only if suitable for the clinical students of Barts) should form a substantial part of its potential. It is hoped that other machines and programmes, probably commercial, will find a place there too: for example, a film of an interview might be considered more useful in sociological medicine than slides and a tape.

I have demonstrated the Barts AV desk to 40 of the first year clinical students. I hope to arrange with the Medical Illustration Dept. to have the new (cassette tape) model, ordered for Hackney, on show here prior to its instalment there. Those who have watched the peptic ulcer recording are unanimously enthusiastic to see the machine in operation, together with even a small library of tapes and slides. Suggestions made by the students included multiple choice quiz tests, the possibility of having several earphones at each desk for group study, and the combination of slides with explanatory tape and microscopes with slides for comparison in Pathology. The second year clinicals have seen the Bart's Gynaecology programmes and the third year the Bart's desk in action at St. Leonard's. Each of these years has discovered this form of instruction worthwhile.

The clinical students woul d like the old refectory as an audio-visual teaching room, and hope that a request for the necessary money will be placed before the college grant committee as soon as possible.

Students View on Teaching Aids

BY

R. J. J. Field

Introduction

Most preclinical study and the basic facts of clinical training are pure book work. Which medical student has not burnt the midnight oil with a wet towel round his head in the assimilation of basic Anatomy or Pathology? For some years now, both abroad and in the UK, the idea of self-instruction with the assistance of Audio-visual (AV) aids has been investigated and proved effective. Mr. Cull and Mr. Tredennick of the Department of Medical Illustration at this hospital investigated the problems in relation to medical education and produced a well-reasoned report as long ago as January 1970.

This method cannot take the place of bedside teaching

which is all-important in clinical studies, but it can take a large part of the tedium from lectures, for students and staff alike.

Types of Machine

Details of the types of AV aids available at the moment are covered by a separate article in this issue. A probable newcomer to this field in this country is the Electronic Video Recording (EVR) which is, in effect, a simple home videotape replay machine which feeds monocolour into an existing television set.

A number of other London hospitals are interested in AV aids, including closed circuit TV. It seems that both King's College and the Royal Free Hospitals have systems in operation. From the former, the students seem unimpressed with the programme content of the clinical tapes. Preclinical supplementary lectures on tape have recently been introduced for Physiology but there are no comments on the standard of these.

The Royal Free use tape-recorders with 100, twenty minute Pathology programmes on casettes each with 10-20 photographs viewed through mini-viewers, and these are a great success. The hospital makes its own programmes. The same department uses closed circuit TV on which it records post-mortems of technical interest and replays them at other times. (Incidentally this c-c TV is said to be linked to the London University internal circuit.)

Advantages of the Desk

To produce a good tape-film programme is rather expensive, and the information has to be continuously updated. Commercial equipment changes with surprising rapidity with technological advances, so the servicing of a film-projection-cum-sound machine more than a year old can present difficulties.

When our Dept. of Medical Illustration considered the problems they proposed as a basis the Bart's AV Desk. By using this relatively large desk, with sides, the student will not be so liable to disturbance, and he may replay the sequence or stop it in order to make notes.

Problems

So much for the principles. How about the practical problems? It is all very well to design a desk; to teach hundreds of intellectually starving students some of the facts in basic clinical work will require 30 to 40 desks with an attached programme library. For maintenance and administrative purposes these are best arranged in one room with an area apportioned for a limited audience of, say, ten people for group study.

Current thinking would have a proportion of the desks tied to a basic study series (e.g. basic Pathology Revision course) while the rest would be used for programmes of individual choice.

Here another problem presents itself. Why should there not be a larger 'self-teaching library' with sufficient space both for clinical and pre-clinical students? Proposals apparently exist for a new complex of teaching buildings north of Little Britain which would include such a room, but this would take years to get under way. If this is finalised, then surely a temporary home ought meanwhile to be found to run on a smaller scale. The students are pressing for the old Clinical Students Dining Room which, contrary to rumours, is not beneath the Pathology block whose roof apparently, is soon to collapse.

Money is always a problem. The source at Barts for this idea is a general educational fund which is ever impoverished. Hence, apparently, we have to obtain a grant from the University Grants Committee. In order to get this, there must be a site available.

Programmes

The flexibility of approach afforded by the Barts desk is very attractive, although, as always, the lesson is only as good as the lecturer. Once properly produced, however, the programme is not temperamental, is clear, only repeats itself where necessary, and goes at the pace of the individual student. If the student does not understand the subject, it will immediately repeat all or part of the lecture verbatim—what lecturer could, or would want to do that?

The programmes can incorporate charts, graphs, drawings, tables, and photographs, all displayed at the relevant moment and for such time as to produce maximum effect. Questionnaires can be introduced to help the student to keep up to date.

Four desks are installed in St. Leonards Hospital for the students, and the Gynaecology Department has a tape film aid in a small room for projection to a limited audience. One desk is used by the Medical Illustration Department itself, while a further machine is awaiting delivery for Hackney. At the present time there are no programmes available from the Pathology Department.

Conclusion

It appears that A-V aids are to be used at Bart's in the future, whether as part of the syllabus or as a supplement being undecided. The tape-slide system has the edge over the tape-film because of simplicity of equipment and reduced cost of programme production and maintenance generally.

The EVR idea is not available now and for my money will cost more to buy than the tape slide alternative. The definition of television pictures is not as high as a projected transparency and, surprisingly, many students have no private TV set. The Barts A-V desk is a sound concept although it would be nice to be able to hire or borrow the basic equipment (à la Royal Free Hospital) as well. Thirty per cent of first year clinical students have already seen the desk and all are very enthusiastic about it and asking when it will be installed. Were it not for the enthusiasm and determination of a few members of the staff, nothing tangible would have been achieved even now. This medical school pastime of tossing a project from committee to committee be they formed of consultants or students or both, is self-perpetuating. Could we not have an industrial-type system with one man given deadlines for certain phases to be completed? It works well in industry notwithstanding the reports in the press.

Here is a very good idea. Let's get on with it. The original report came out over a year ago.

SINUS OF VALSALVA ANEURYSM

BY
GARETH DAVIES AND JOHN COLTART

At the origin of the ascending aorta, opposite each of the cusps of the aortic valve, there are three small dilations called the sinuses of Valsalva.

Aneurysms of the sinuses of Valsalva owe their interest to the complications which they may produce on rupture. Characteristically, the clinical picture is acute with an attractive physiologic-pathologic correlaton and definitive surgical cure.

Case Presentation

A 41 year old man was admitted to Smithfield Ward on 17.10.69, complaining of acute onset of dyspnoea with mild exertion, paroxysmal nocturnal dyspnoea and orthopnoea of short duration. There was no past history of rheumatic fever and on discharge from the Army twenty years previously he was perfectly fit.

On physical examination, the positive findings were only in the cardiovascular system. The pulse was 50 beats/minute, regular, large volume, collapsing in nature. The Jugular Venous Pressure was raised 2 cms. with irregularly occurring cannon waves; the blood pressure was 150/50.

On examination of the heart, the apex beat was in the 5th intercostal space in the mid-clavicular line and on palpation there was a marked left ventricular cardiac impulse. At the left sternal edge there was a systolic and diastolic thrill and on auscultation in this area, there was a grade 2 systolic ejection murmur and a grade 3 long decrescendo diastolic murmur. No dependent odoema was present and the lung fields were clear.

Investigations

Haematological, bacteriological, chemical pathological and serological tests were within normal limits.

Chest x-ray revealed a large heart (TD 17 cms.) with a prominent left ventricular configuration, the pulmonary vascular pattern being normal. Electrocardiography showed complete heart block with a junctional pacemaker; QRS complexes and T waves were within normal limits. Vectorcardiography showed severe left and right ventricular hypertrophy. Cardiac catheterisation showed normal right heart pressures. Aortography revealed an aneurysm of the non-coronary sinus of Valsalva 1.5 cms. in diameter (Fig. 1) projecting downwards into the interventricular septum, and grade 3 aortic valvular regurgitation; no shunt was demonstrated. The regurgitant jet of contrast medium was directed mainly to the left raising the possibility of an aortic valvular cusp perforation. In the dilated left ventricle, on its left superior aspect, a small diverticulum was seen which contracted in systole; the significance of this was uncertain.

Thus a diagnosis of a sinus of Valsalva aneurysm was substantiated by aortography. The complete heart block could have been caused by the aneurysm encroaching upon the interventricular septum and pressing upon the atrioventricular node or alternatively it might have been congenital in origin. However, in the absence of a previous cardiac evaluation it is not possible to discriminate between these two aetiologies.

The patient made a good symptomatic improvement on digoxin and diuretics and was discharged on 1.11.69 prior to cardiac surgery. He was warned that he should limit his activities due to the possibility that the aneurysm might rupture,

Unfortunately the patient's symptoms suddenly deteriorated and he was admitted on 24.11.69 when his dyspnoea was very marked and he was extremely distressed. From the history, classical rupture of a sinus of Valsalva aneurysm was a priority diagnosis. His pulse was 60 beats/minute, regular, collapsing. Blood pressure was 130/30. Jugular Venous Pressure was raised 3 cms. There were loud systolic and diastolic murmurs, rapid respiration 35/minute, bilateral basal crepitations and expiratory rhonchi. Clinically, there was no evidence for a rupture of the aneurysm and the resulting left ventricular failure was urgently treated. The patient rested in hospital whilst awaiting surgery.

The operation was performed on 4.12.69 by Mr. O. S. Tubbs. Cardio-pulmonary by-pass was instituted and the ascending aorta opened. The aortic root was of moderate size; there was an aneurysmal dilatation between the base and non-coronary cusp and sinus of Valsalva. (Fig. 2.) An aneurysmal dilatation was also at the base of left coronary cusp with two small perforations. The non-coronary cusp was prolapsing into the left ventricle, producing aortic incompetence. Granulations were present at the base of the right coronary cusp and also the left coronary cusp adjacent to its aneurysm.

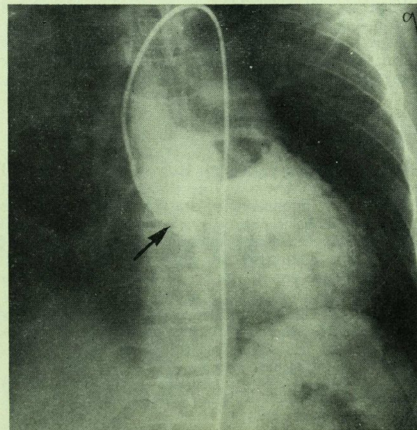

Fig. 1. Aortogram, showing an aneurysm of the non-coronary sinus of Valsalva (arrowed)

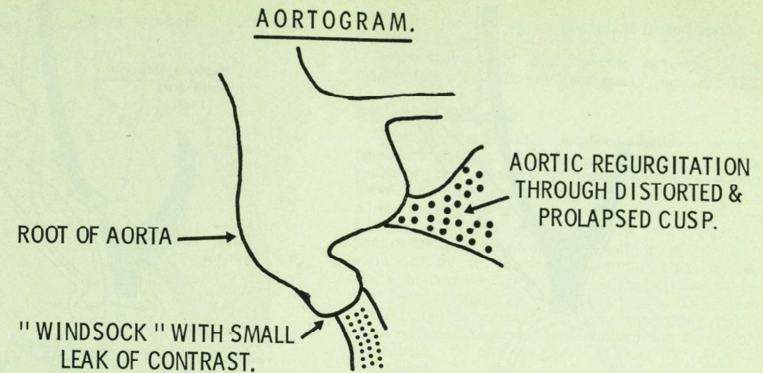

Fig. 1a

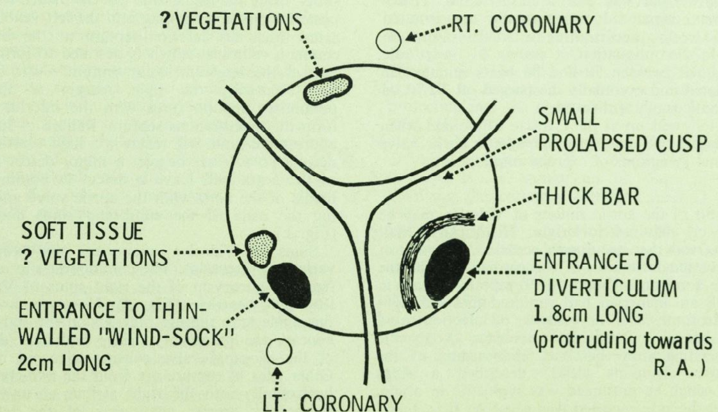

Fig. 2. Surgeons drawing of aortic valve seen from above, showing entrance to two aneurysms.

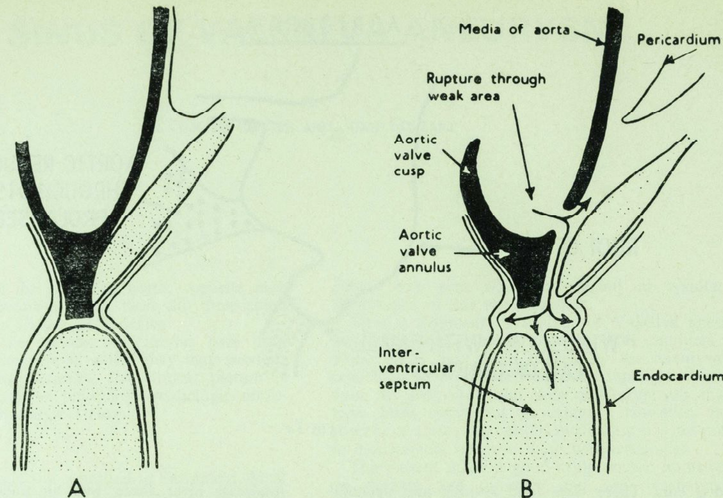

Fig. 3. The probable cause of aneurysms of the sinus of Valsalva.
A. Diagramatic representation of the normal continuity which exists between the media of aorta and aortic valve annulus (in black)

B. Diagram shows break in continuity between media and annulus which is a congenital defect permitting formation of the aneurysm.

The aortic valve was excised and replaced by a Starr-Edwards prosthesis. Mersaline matress sutures were passed through the neck of the aneurysm in the non-coronary sinus emerging and returning from the right atrium; the granulations were curetted.

Post-operatively, the patient was electrically paced because of his heart block and was making good progress when, on 8.12.69 for no apparent reason he had a cardiac arrest but was quickly resuscitated. Thereafter, he was comatosed and mentally disorientated for several weeks, necessitating a tracheostomy on 20.12.69. On discontinuation of pacing his heart rate was maintained between 70 and 80 beats/minute. He was ambulated and eventually discharged on 7.2.70 on long-term anticoagulant therapy.

He was followed up at the Cardiac Clinic and when last seen had a well-functioning prosthetic aortic valve with minimal symptoms of exercise intolerance.

Discussion

Aneurysms of the aortic sinuses of Valsalva may be congenital or acquired in origin. Historically, Mall (1912), observed that aneurysms occurred at points of weakness in the formation of the cardiac wall at the base of the aorta and Abbott (1919) reported a case in which such an aneurysm had ruptured into the right ventricle. In some cases, no evidence of infection could be found but a few did show evidence of mycotic origin extending from bacterial endocarditis of the aortic valve. Tomkins (1941) described a sinus aneurysm which he presumed was syphylitic in origin, serology in the case reported was negative. It is, therefore, possible that the aetiology of the aneurysm in this patient could have been congenital with a superimposed bacterial endocarditis or acquired from mycotic involvement of the aortic valve and adjacent sinuses.

Embryologically there is an explanation for the congenital sinus of Valsalva aneurysm. The aortic and pulmonary arteries are formed when the aortico-pulmonary septum divides the truncus arterious. The septum grows inferiorly in a spiral fashion at about the 4th week of intra-uterine life (5 mm. stage); the aorta shifts from the right side of the heart to occupy a posterior position opening into the left ventricle. At the same time, the inferior septum at the base of the common ventricle, which is destined to form the upper part of the interventricular septum, shifts to the right and eventually the right margin of the aortico-pulmonary septum fuses with the inferior septum to form the membranous septum. Failure of fusion of the appropriate septa will result in a high ventricular septal defect. To a lesser degree, a minor defect in the shift of the aorta will leave a defect in continuity of the media of the aorta with the aortic valve annulus forming the ostia of the congenital sinus aneurysm sac. (Fig. 3.)

Sinus of Valsalva aneurysms may rupture in a variety of directions. The commonest site of rupture is from an aneurysm of the right sinus of Valsalva into the right ventricle (Fig. 4). However, aneurysms of this sinus may rupture high up on the septal wall just beneath the pulmonary orifice and near the insertion of the tricuspid valve causing tricuspid insufficiency. Other sites of rupture are from the non-coronary sinus horizontally into the right atrium or upwards in the pulmonary artery; aneurysms of the left sinus of Valsalva usually rupture into the left ventricle.

It is important to note that the intracardiac mode of

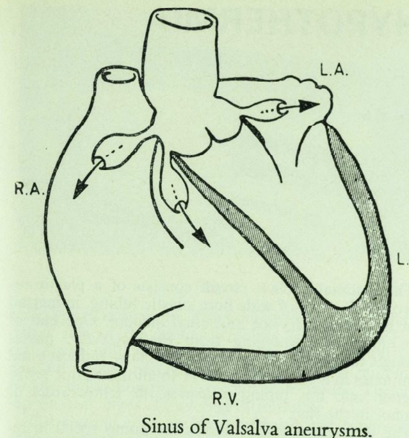

Fig. 4. Various sites of rupture of sinus aneurysms.

rupture of these aneurysms avoids fatal exsanguination as is common with rupture of aneurysms at other sites. Rupture of an aneurysm from a high pressure vessel into the lower pressure of the right atrium or ventricle produces a left to right arterio-venous fistula.

Clinical Manifestations

Sinus of Valvalva aneurysms present certain clinical peculiarities. Intense precordial pain seems to be a relatively inconstant feature. Mycardial ischaemia usually results when the aneuryism involves the coronary orifice (Schuster, 1937), unless there is associated coronary artery disease.

Hepatic enlargement may occur rapidly after the aneurysm ruptures, and if the tricuspid valve is involved hepatic pulsation is easily palpable. Pulmonary congestion and oedema are the outstanding terminal complications. Cardiac enlargement after the aneurysm has ruptured may be so rapid as to precipitate cardiac failure. A loud continuous murmur and thrill throughout systole and diastole is the most characteristic of all the physical findings. Indeed, a patient experiencing an acute rupture of a sinus of Valsalva aneurysm in bed at night mistakenly thought her resulting cardiac murmur was due to an unexplained cat's purr (Hayward, G.W. personal communication).

Special Investigations

E.C.G. Snyder and Hunter (1934) believed that heart block was due to the extension of the aneurysm through the ventricular septum and encroaching on the atrio-ventricular node and main branches of the Bundle of His. Micks (1940) reported a case in which he demonstrated that the heart block was progressive. However, it should be noted that it is the exception rather than the rule to find conduction defects in this condition.

Cardiac catheterisation may show an increase in oxygen saturation in the blood on the right side of the heart, the step-up in saturation corresponding to the site of rupture.

Angiocardiography confirms the anatomy of the malformation and the resultant site of rupture.

Differential Diagnosis

Clinically, the condition requires differentiation from persistent patency of a ductus arteriosus, aortic insufficiency and primary pulmonary hypertension combined with pulmonary insufficiency, aneurysm of the aorta, aneurysmal dilatation of the coronary artery, coronary occlusion and pericarditis and possibly a hemi-truncus arteriosus. The condition may also be simulated by an anomalous communication between the right coronary artery and the right ventricle and also by a coronary arterio-venous fistula. The relative clinical and investigatory criteria supporting any of these various diagnoses is a concern for the cardiac specalist.

Treatment

Medical treatment is supportive with digoxin and diuretic therapy tailored to the degree of cardiac decompensation produced by the lesion. Successful surgical closure of the aneurysm may be life-saving. The prognosis in an untreated case is poor, death usually occurring within months due to cardiac failure. Abbott, 1919, however, reported one patient who lived nine years after rupture.

Acknowledgements

We would like to thank Mr. O. S. Tubbs and Dr. G. W. Hayward for permission to report this case. Mr. O. S. Tubbs provided the graphical illustration of the operative findings. We are grateful to the Medical Illustration Department for their kind assistance.

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Addendum: Since going to press it has been learnt that the patient in this report has suddenly died. A necropsy was not performed.

REGIONAL RENAL HYPOTHERMIA

By
V. K. Mathur, M.B., B.S.
and
J. E. A. Wickham, B.Sc., M.S., F.R.C.S.

In the last ten years, the desire to produce complete renal circulatory arrest without depression of renal function has been stimulated by the requirements of the Urologist, the vascular surgeon and those concerned with homotransplantation.

The operations of partial nephrectomy and nephrolithotomy are often best performed in the dry field afforded by temporary occlusion of the renal pedicle. This introduces an additional hazard for the kidney, whose function is already depressed by disease and may precipitate irreversible renal failure.

It has been shown (Wickham, Dec. 1967) that with adequate cooling (renal parenchymal temperature reduced to 20°C), permissible renal ischaemia time may be increased to 3 hours.

COOLING APPARATUS

The cooling apparatus that was devised with the help of the Medical Electronics Department at St. Bartholomew's Hospital is shown in Fig. 1. It consists of an external coolant circuit, a telethermometer and a renal heat exchanger.

The external coolant circuit consists of a plastic reservoir with a coil of wide bore silastic tubing, immersed in a mixture of dry ice and ethyl alcohol. One end of the tubing, on emerging from the reservoir, passes through the pump (Watson Marlow flow inducer) and terminates in a plastic adaptor. A small thermistor probe inserted into this tubing measures the temperature of alcohol in the line.

The telethermometer controls the pump speed in relation to line temperature, a falling temperature slowing the pump and vice versa.

The renal heat exchanger shown in Fig. 2 consists of two discs fashioned from continuous lengths of rubber tubing. Sponge rubber covers to the outside of the coils provide insulation for the surrounding tissues.

NEPHROLITHOTOMY UNDER HYPOTHERMIA

The reservoir is primed with ice alcohol mixture while the kidney is exposed and mobilised through the bed of the 12th rib. The ureter is clamped and the pelvic portion of the stone removed through a posterior pyelotomy. The renal artery is occluded with a small bulldog arterial clamp. The cooling coils are applied at either side of the kidney. Cooling is commenced and continued until a deep core temperature of 20°C is reached. Renal parenchymal temperature is monitored by two indwelling thermistor pulse electrodes. The cooling process takes on average 8 minutes.

The cooling coils are then removed and nephrolithotomy commenced. Starting at one pole the parenchyma is incised radially, the calculus displayed and extracted with a blunt dissector. Other stones are similarly extracted.

A localising grid is then placed over the kidney and contact radiography performed. Any unidentified stone fragment is cut down upon and removed. The calyces and pelvis are flushed out with cooled normal saline. When all radiographically- and directly-vivible calculus has been removed, the nephrotomies are closed by simple suture of the capsule. Fig. 3 shows the radial nephrotomies and the capsular suture. There is no necessity to suture the parenchyma. The wound is clased with the insertion of a portex nephrostomy tube. Ureteric patency is checked with a nephrostomy tubogram one week post-op., then the tube is removed

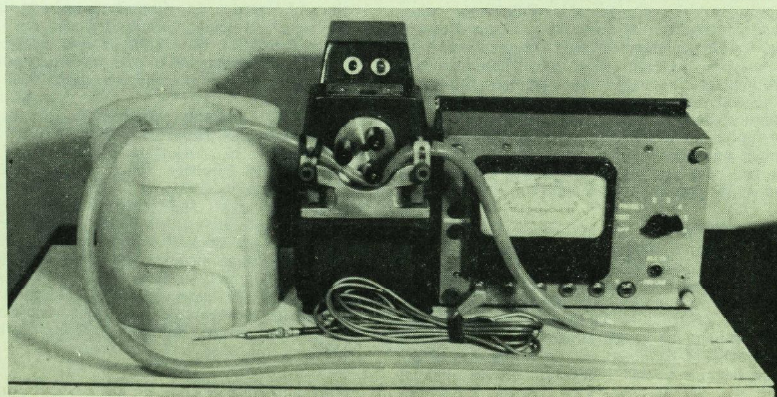


Fig. 1.

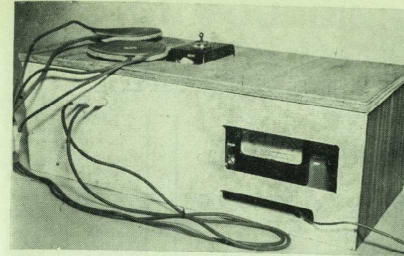


Fig. 2.

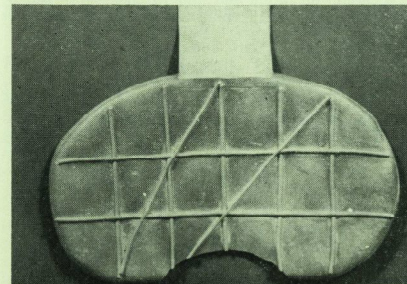


Fig. 3.

CLINICAL STUDY

In an effort to evaluate this type of surgery, a survey of the results of nephrolithotomy under regional hypothermia has been carried out, and they have been compared with the results of conventional nephrolithotomy and conservative treatment. All patients in this series had calculus disease of staghorn or multiple type. The patients were grouped as follows:

Group I—
25 patients who received conservative management.

Group II—
24 patients who received conventional nephrolithotomy.

Group III—
23 patients who received nephrolithotomy under regional hypothermia.

One patient in Group II and two patients in Group III underwent bilateral nephrolithotomy. In Group III all cases were assessed pre- and post-operatively by IVP, serum creatinine, creatinine clearance and I^{131} renograms, in order to determine the effect of the whole procedure on subsequent renal function.

POST OPERATIVE RECURRENCE.

	TOTAL NO. OF CASES	IPSILATERAL URINARY TRACT FREE FROM CALCULI	RESIDUAL CALCULI
IMMEDIATE RESULTS IN GROUP II	25	10 (40%)	15
IMMEDIATE RESULTS IN GROUP III	25	25 (100%)	NIL

Fig. 4.

RESULTS

Efficacy in achieving calculus removal:— Fig. 4. In all cases of Group III radiologically complete evacuation of all calculi from the collecting system was achieved. In Group II only ten out of twenty-five (that is 40 per cent.) were cleared.

Average follow-up period in Group II is twenty months, and in Group III nineteen months. In Group II one patient who had been cleared relapsed by twenty-three months. In Group III no recurrence has so far been noted. Regional renal hypothermia was first used three years ago.

Urinary Infection:— Fig. 5. In Group III careful bacteriological examination of the urine was made before and after the operation and all patients were placed upon appropriate antibiotic therapy three days prior to surgery. In Group III 19 out of 25 had pre-op. infection. At 3 months post-op. three out of twenty-three were infected. In the other two data was not available. These three had infection pre-operatively and have calculi on the unoperated side. No cases were infected by the procedure.

In Group II pre-operative infection was present in fifteen cases. At 3 months ten out of seventeen were infected. In the other eight cases data was not available. Of these ten, calculi were present on the other side in three, residual calculi present in five, residual calculi and calculi on th other side in one, and one was cleared. Three cases were infected by the procedure.

Renal Function:— The mean clamping time of the renal artery is 58 minutes, a period of time that would have caused permanent renal damage in the absence of hypothermia (Fig. 6). The pre- and post-op. serum creatinine levels indicate that there has been no loss of renal function consequent upon renal circulatory arrest. Fig. 7. The pre- and post-op. creatinine clearances have confirmed the trend of the serum creatinine values.

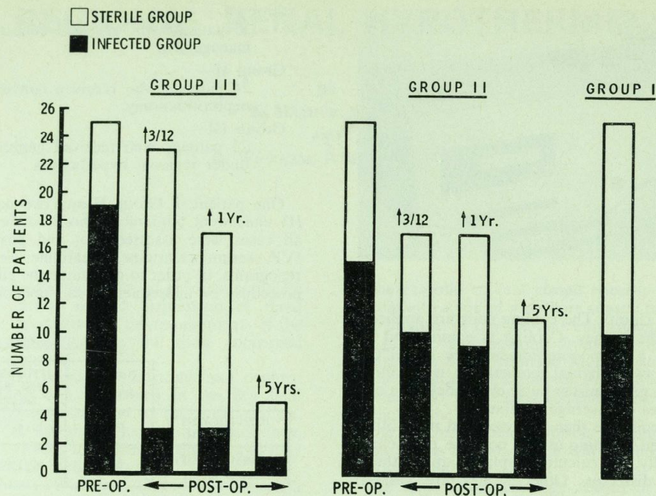


Fig. 5.

Without statistical evaluation, it would appear that renal function, as judged by the blood urea, is more or less unchanged following nephrolithotomy under regional hypothermia, whereas those patients undergoing conventional nephrolithotomy appeared to show a slight loss of renal function following surgery. This is not altogether surprising in view of the trauma that has been associated with conventional nephrolithotomy. Our follow-up of patients treated conservatively confirms the findings of other workers, that there is slight deterioration in the renal function of these patients over the years.

Blood loss: — In Group III cases, blood loss has been minimal throughout. Only 4 units of blood were used in the 25 cases of nephrolithotomy.

Discussion: — From this study it seems possible to conclude that regional renal hypothermia is simply and easily produced and has permitted the performance of complete nephrolithotomy in all of these 25 cases. In no cases had a permanent depression of renal function occurred despite arterial clamping. Arterial clamping times of up to 92 minutes have been recorded, and in several cases there has been dramatic improvement in renal performance post-operatively, due to removal of obstructing calculi. In most cases, the urine was rendered sterile within a short period of the operation. This technique has resulted in a minimum of blood loss both at operation and subsequently.

In conclusion, it is obvious that regional renal hypothermia is not an end in itself, but a means of bying time—time for the surgeon accurately to plan and carry out a careful operation and time to take regard for the finer anatomical details of the organ on which he is working.

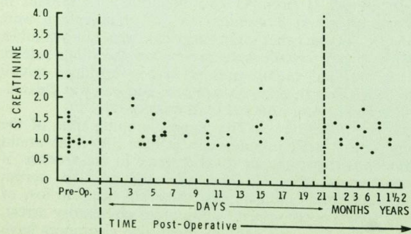


Fig. 6.

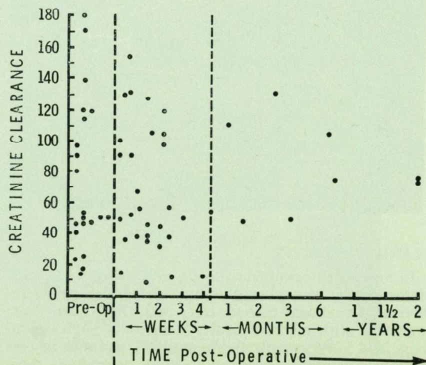


Fig. 7.

ON FOUNDING THE FILM SOCIETY

BY

Adrian Padfield, F.F.A., R.C.S.

It all started very early one morning in someone's room in College Hall (in the days before the S.U. ran the bar). A number of us were putting the world to rights over coffee when someone (it might have been me) said "we ought to have a Film Society", everyone agreed, pointing out that we had an excellent site, the Physiology Lecture theatre with dual projection box, there should be a large response from the nursing side and that there was no culture in the place anyway. In fact everyone was so much in agreement that we quickly started arguing about something else (a society for investigating City antiquities, I think)

I turned the matter over in my mind for a few days and discussed the idea with others, most of whom thought it was good but weren't prepared to join in the organising. It was suggested that I go and see "Mac" (D. M. McDonald) then reader in physiology (now a prof. in U.S.A.). He thought it was a great idea and agreed to be President suggesting that I organise an "ad hoc" committee and rustle up some vice presidents. These included the Prof. of Physiology to get the use of the Lecture theatre and the Prof. of Pharmacology to borrow his projector so that we could have an almost continuous show when changing reels.

I was already an Associate of the British Film Institute and obtained a list of films for hire from them. I also wrote to J. Arthur Rank and several other companies for their glossy film catalogues.

It became obvious then that a decent feature film was going to cost about £5 and a short about £1 and I approached the S.U. committee for a loan which was *not* forthcoming. However I went ahead and ordered "The 39 Steps" the pre-war Hitchcock (?) version with Robert Donat. The committee then started painting posters and sticking them up around the Hospital and Med. College. We had decided that to stay within the law we had to have a membership fee plus an entrance fee for each performance. This was 2/6 and 1/- respectively—if anyone didn't want to become a member it cost 2/- to go in.

Ten days before the first show on Monday (at 8.30 p.m. so the nurses could come) a seeming catastrophe occured. I had a curt letter from J. Arthur Rank saying that "The 39 Steps" was not available and they would send "The Lady Vanishes" (or something) instead. This was probably because at the time a new version of "The 39 Steps" was being previewed and they didn't want the competition!

Frantic efforts were made to change the posters and inform everyone of the new title but by the time Monday evening came I was biting my nails thinking about the money I owed J. Arthur and whether there would be another show.

As it turned out over 100 people attended, a lot joining as members and the costs were covered.

My nails started to reach their proper length again when we showed "Rear Window" and the Lecture theatre was full; literally standing room only, with the stairs occupied, and this despite the fact that the film was in black and white so that the clue of the flowers changing colour was completely lost!

This was one of the minor problems associated with the growing pains of the society. I was keen to show some of the old classics and generally raise the tone and this led to a couple of amusing occurences. We had arranged a showing of "The General" one of Buster Keaton's best films. This was silent of course and silent films run at 16 frames per second whereas sound films run at 24 frames per second. We duly showed it at 16 frames per second. I thought the titles stayed up rather a long time and some of the scenes were a bit slow moving but it *is* a very funny film. 2¼ hours later instead of 1½ hours we realised that the film had been "stertched" to 24 frames per second by the distributors, the British Film Institute. Incidentally this late show had a paradoxical side effect—the nurses there did not have late passes, they had to give their names and reasons for being late and I believe "the Film Show went on late" became a very convenient excuse in the future!

On another occasion I decided to have a programme of shorts including the superb Rembrandt film by Bert Haanstra (which culminates in the chronological superimposition/fade of the self portraits). Also in the programme was a film on one of the Brueghels which turned out to be in black and white and had a French commentary! After that I hurriedly ordered a popular feature so as not to frighten the audience away.

Financial security was assured by now, we even bought the Physiology Lecture Theatre a new and better projection screen, and a request came from the S.U. that we hand over the control of finances. This got a very rude answer but we realised that apart from making a film ourselves, for which one enthusiastic committee member wrote a script, we couldn't keep the money ourselves. We compromised by having a free show for members every time we accumulated enough money to afford it and I was able to persuade the committee that we could afford to lose money on the more esoteric screen gems that *I* wanted to see. We showed "Battleship Potemkin" for which I wrote a laudatory piece in the *Journal* but afterwards I couldn't answer the criticism that it was old fashioned and out dated—after all the Odessa Steps incident never actually occurred, even though it is, to quote my piece,—"one of the most influential five minutes of cinema ever filmed."

Another film shown; "Night & Fog" by Alain Resnais actually stimulated people to think a little,—at least they came and told me I should never have shown it! It *is rather a* horrifying film about Belsen and Dachau and Auschwitz . . .

All in all it was great fun and very enjoyable; some things never came off; we tried early evening showings, we had "sort of" newsreels of the Hospitals Cup and the Head of the River and we printed small cards showing the future programmes—this last in an effort to overcome a problem which seems to be very common and probably holds out hope for us versus the advertising media—nobody reads advertisements . . . I could guarantee that 15 people would ask me on Mondays what we were showing that evening despite highly coloured posters around the hospital and Medical college.

Eventually I had to give up the Hon. Secretaryship, because of an examination or something, although I stayed on the committee for a while trying to book films I hadn't seen. I think they made me a Vice President after I qualified. When is the next show? I might get in free . . .

(The society held its first meeting on 19th January, 1959, and has flourished ever since—Ed.).

PARASCENDING - A personal appraisal

by T. D. Bunker

Lasham, April 1969. The dawn is breaking: The sky dark grey: Wind cold. Ten young men in flying suits and white crash helmets finish loading the topless Landrover and jump on. Adjusting his sunglasses (doubtless wondering why it is so dark) the instructor crashes into first gear. The Landrover roars across the grass airfield. Birds squawk, frightened from their nests. Ten crash helmets hang on for dear life.

The Landrover is stationary, heading into wind, driver at the ready. The white towline snakes through the wet grass towards the instructor. The instructor is standing in the harness; a shower of parachute lines falling from his shoulders to the massive parachute lying, as if dead, on the ground. Two assistants are kneeling, holding it down. The tow line is clipped, via the yoke, to the instructor's harness. All is ready.

"Ready in the harness?" . . . "Ready"

"Ready on the canopy?" . . . "Ready"

"Take up slack!" The Landrover inches forward, the towline becomes taut.

"Up canopy!" The two assistants rise. The wind catches the parachute. It billows out, a giant red, black and yellow mushroom, pulling the instructor backwards as surely as the Landrover pulls him forwards.

"All out!" The Landrover roars forwards, straining against the parachute canopy, in four wheel drive. The instructor and the two assistants start running forwards.

"Release canopy . . . release NOW!" The assistants let go and the vast canopy rises majestically into the cold morning air taking the instructor with it.

One thousand feet in front the Landrover speeds up. Defying bumps, ditches and runways it dashes towards the end of the airfield.

Now almost vertically above them, the instructor releases the towline, grabs the steering toggles and turns violently to the left, then the right, then the left, then deliberately stalls, restalls and turns again. Nearing the ground he turns into the wind to reduce forward speed, lands, rolls and is back up on his feet to run round the back of the parachute (bringing the apex into wind) successfully deflating it.

The Landrover burbles up alongside. The instructor is seated inside. The parachute is rolled up. The Landrover returns. The instructor steps down, unbuckles the harness and the next victim harnesses up.

Dusk is falling. The parachute is descending for the last time. Of the ten, most have landed on the runways (dangerous). One has landed in a tree (suicidal!). One was thrown from the Landrover at forty miles an hour (wearing a crash helmet). One burnt the rubber fly buttons from his flying suit, being towed across a runway on his stomach by a parachute which refused to deflate (no, it was not a demonstration for "Men's liberation"!). One was left on the towline, one thousand feet up, whilst the Landrover was mended. One even towed the Landrover backwards, back wheels off the ground! All have learnt to land a parachute, to steer it and to spot land. All have experienced what must surely be the cheapest way of flying. Flopping onto the Landrover they trundle off to a warm bowl of soup and reminiscences around the local pub's fire.

T. D. BUNKER

BARTSTIME - 1, Richard Horton

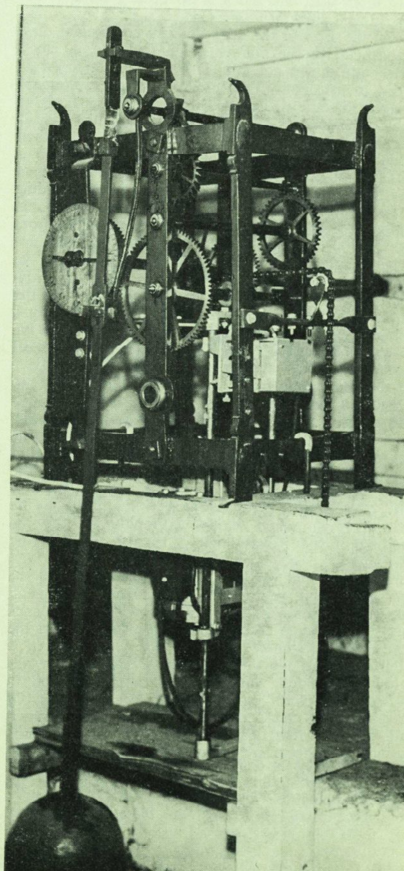
By A. J. B. Missen F.R.C.S.

Today, when most people have their own watches, and clocks are to be found in nearly every room, a reasonably accurate time check is available to all at a moments notice and we take the measurement of time very much for granted. This situation has only been made possible by the development of mass production techniques over the past 150 years. Before that watches and clocks were expensive and their use restricted to the well-to-do. Yet time is one of the fundamental dimensions underlying all scientific observations and its measurement has occupied astronomers and mathematicians from the dawn of civilisation. Only our progress from the earliest sundials to the atomic clock (accurate to the equivalent of one second in 3000 years) has permitted first the precise charting and navigation of the surface of this planet and then the technological developments which culminated in the American and Russian moon landings.

The sundial was known in ancient Egypt and in Mesopotamia and was used extensively by the Greeks and Romans. When Rahere founded Barts in 1123 the sundial was the most widely used instrument for measuring time, though water clocks and candles which would burn for a specific period were also known. The sundial retained its importance until well into the seventeenth century since the early mechanical clocks were far from accurate and had to be checked daily against the sundial, weather permitting!

In the early Mediaeval period the dominance of the church in mens lives led to the division of the day into "canonical hours" which corresponded to the offices of the Church (Mattins, Prime, Nones, Vespers, etc.) these being marked for the benefit of the laity by the ringing of bells. By about 1400, the division of the day into a double set of twelve equal hours was generally accepted throughout Europe and many of the earliest mechanical clocks, which first appeared in England in the 14th Century, had 24-hour dials. It is recorded that a clock-tower was set up opposite Westminster Hall and the clock installed in 1370—"which striketh every hour on a great Bell, to be heard into the Hall in Sitting Time in the Courts". Such clocks were rare and set up only in the most important public places, often in Church and Cathedral towers which were strong enough to take the weight of the massive work and bells. Being set up high they were visible to many and the striking of the bell could be heard far and wide, both by night and day. Two of the three oldest surviving mechanical clocks in the world are in England (Joy, 1967) they are the cathedral clocks of Salisbury (c. 1386) and Wells (c. 1392).

At Barts during the Mediaeval period the passing hours were probably marked by the ringing of the Priory bell, at first according to the "canonical hours" and later hourly with the aid of sundial and hour-glass. It is also possible that an "alarum" was used to aid the bellman: this was a crude form of dialess clock or Mediaeval equivalent of a kitchen pinger! As the old hospital buildings have all been pulled down there is sadly no sundial of the period in existence at Barts today.



Turret time-piece by Richard Horton in the Henry VIII gate at Barts. The dial on the left is a tell-tale used when setting the hands. The hole in the centre upright indicates the position of the pivot of the original winding barrel.

By the end of the 15th century the continental clock-makers had made great improvements in design. Smaller weight driven clocks suitable for use in private houses had been introduced, they were however still rather heavy and the weights made it difficult to move them about. It was usual to set up the clock in the main room of the house and rely on the striking mechanism for telling the time elsewhere. The development in the 16th Century of the coil spring as an alternative to weights for driving clocks led to a further reduction in size and at last clocks could be moved from room to room as required. This was necessary as clocks were still so expensive that only the most wealthy could afford more than one and it is doubtful if Barts owned a mechanical clock at this period.

From the 14th to the 16th Century continental makers, particularly the Germans, led the field in clock-making and it was not until Henry VIII developed an interest in astronomy that French craftsmen were encouraged to settle in England. English clockmakers up to this time had all been blacksmiths but the French makers were locksmiths adept at springwork and their influence was soon felt among the London makers. Later the religious persecutions in the Spanish Netherlands brought other immigrants to our shores including the Fromanteel family who established themselves in London and ranked amongst the foremost makers from 1630 to 1700. Not only did John Fromanteel introduce the pendulum into England in 1658, following its development by the great Dutch scientist Christian Huygens, but two other members of the family provide the earliest recorded contact between Barts and London's clockmakers. Two cartouches on the north wall of the Great Hall record gifts of £100 each from Mordecai Fromanteel in 1698 and Hannah Fromanteel in 1701.

If the continental makers gave the initial impetus to English clockmaking its final flowering was due to a more diverse set of circumstances including the reaction against Puritan austerity which accompanied the Restoration of the Monarchy in 1660, the vast amount of rebuilding and refurnishing which followed the Great Fire in 1666 and, most important of all, the new spirit of scientific inquiry which followed upon the work of Newton and which was epitomised by the founding of the Royal Society. English clockmaking now entered its golden age and led the world for 150 years. During that period English makers invented the long one-second pendulum, the anchor escapement, temperature compensated pendulums and ballance wheels, the marine chronometer, rack striking and the English lever watch.

Bart's is fortunate in owning four clocks from this period. The oldest was presented to the hospital in 1941 and will form the subject of a later article. Of the other three clocks the earliest is that in the Great Gate. The fact that this clock has no striking mechanism and faces outwards into Smithfield suggests that by this time the hospital may have had one or more other clocks for internal use, since this one is clearly of more value to the passers-by than the hospital.

The contract for the making of this clock was let on 7th September 1702 to Richard Horton, clockmaker, to make a "dyall in the front of the New Gate in West-smithfield and a small dyall in the Coffee Room over the same", for the sum of £18. The gate was finished in 1703 and presumbly the larger "dyall" was installed to the satisfaction of the governors in that year for the accounts show that Horton was paid £18 on 29th September 1703. If the room over the gate was still a Coffee Room the small dyall might still be there—as it is history does not record its fate.

Richard Horton is probably the same maker listed in Baillie (1966) as Richard Houghton of London who was apprenticed in 1653 and made free of the Clock-makers Company in 1690. The clock itself is of robust "four-poster" construction in iron and is fitted with the anchor type of escapement invented by Robert Hooke, F.R.S. and first used *c.* 1670 by William Clement of London. The clock has the long one second pendulum (39.1 inches) which is commonly found in long-case or "grandfather" clocks. Although I have been unable to find the signature of Richard Horton on the accessible parts of the movement there is no doubt that this is the original clock and the only mechanical modification appears to be the recent provision of automatic winding gear by Messrs. Thwaites and Reed of Clerkenwell. This necessitated the removal of the barrel to which was attached the rope and 60 lb. stone weight which provided the power for the movement. The weight ran in a specially constructed stone chimney which had small windows through which the weight could be observed. The clock required winding once a week.

It seems that the clock originally had a round dial, for it is shown thus in an engraving made in 1755 for Lamberts History of London. An inscription on the small tell-tale dial, which is used in setting the hands, records that new dial work was added by Robert Wood of Southwark in 1800, (Robert Wood is recorded in Baillie as working in the Borough between 1799 and 1811). This fine example of an English turret clock has now been in use for over 250 years and given a modicum of routine maintenance should still be going 250 years hence.

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I am most grateful to Miss N. Kerling for verification of details from the hospital archives and to the Department of Medical Illustration for permission to use the photograph of Horton's clock.

ARTS REVIEW

The Vienna Secession: "Art Nouveau" to 1970. (Royal Academy till early March).

As with almost everything else, the First World War also saw the decline in the energetic burst of the Vienna Secessionists which had continued unabated since their foundation in 1897. This group of artists who had broken away from the conservatism of their contemporaries—their motto was "To each century its art, to each art its freedom"—encompassed not only painting, but sculpture, architecture, graphics, furniture, and fabrics in a whole series of enthusiastic exhibitions through the early years of the century. Linking up with other European centres of art, the French Impressionists in painting, the British in the applied arts, they surrounded themselves with new ideas and techniques. The influences these other artists brought to bear often smothered their own creative originality, but when they managed to produce something entirely of their own it was usually extravagant, flamboyant and successful.

The "Wiener" Secession still exists today, but it is a pale shadow of its former self and the large number of exhibits by its more modern artists were mainly tedious and uninspiring. It was such a pity that the better known and more important artists associated with the Secession should have been so sparsely represented. This was particularly true of Kokoschka. Though strictly unrelated to the group in its early infancy, he was nevertheless an important painter from the Vienna period, and there were few examples of his work on display. There were more works of Gustav Klimt, but many of those were the least satisfying, although the "Stoclet Frieze" was a superb example of his artistry, (illustrating, incidentally, an oriental influence quite common among many of the Secessionists' more successful works). The reclining woman by Schiele was, I thought, one of the best paintings there, but it was a pity that several other of his works on show were poor imitations of other artists, notably Toulouse Lautrec. The large collection of posters—many were designs for the front cover of the Secessionists' magazine "Ver Sacrum"—was probably the most interesting section in the whole exhibition. There were fine examples by Moser and Klimt—brilliant in colour, sharp in original design. The "Art Nouveau" furniture and fabrics from the workshops of Josef Hoffman, though probably not to everyone's taste, were also interesting to see.

It must be remembered that this exhibition represents only a part of the Secessionist movement. The architectural impact of the group is lacking as is that of its musicians—Berg, Schoenberg and Webern. In its own way, however, the exhibition does manage to capture the flavour of the era—occasionally. It is a pity that one has to wade through so many irrelevant distractions as well

Shock of Recognition.

The current special exhibition at the Tate Gallery is a comparison of the English School of Romanticism and the Seventeenth Century Dutch School. There must be thousands of examples from these particular periods, yet this small exhibition consisting only of about 100 works is all one needs to comprehend the nature of the romantic period and the remarkable influence the earlier Dutch painters had on it. There is a splendid catalogue on hire for one shilling, although it is worth buying, for its contains much useful information, which one would probably never otherwise be able to obtain. In addition, there is a fine analysis in the introduction on the role of the artist as Society's only true conservationist. The collection of paintings seems carefully selected for an easy and worthwhile comparison as well as for the merit of the individual paintings themselves. Artists include Constable, Turner, Gainsborough and Cozens on the English side, and Ruisdnel, Cuyp, Van de Velde and Hobbema on the Dutch. An extremely worthwhile exhibition.

M. C. WHITE.

BOOK REVIEW

Immunology for Undergraduates, D. H. Weir, Livingstone Medical Text (Price 15s.).

Conceived from a series of lectures at Edinburgh University, this excellent little book is well orientated towards Medical Students. The basic concepts of the mechanisms and structures involved within the subject are covered concisely but thoroughly, whilst its essay form remains easy to read.

Thus the first 50 pages cover both specific and non-specific immune mechanisms, (including a description of antibodies at a molecular level), explains antigens in depth and discusses the involvement of the body tissues and cells in the process of acquired immunity. While admitting the lack of specific knowledge about the role of the thymus and lymphoid tissues it gives a good up to date summary with experimental evidence for the present conclusions.

The other 50 pages are then devoted to such topics as transplantation, immunohaematology, hypersensitivity and a short discussion on malignant disease. It is perhaps unfortunate that rather more space could not have been given to this last topic as it is of increasing interest to the profession.

For 15 shillings the student has bought an interesting and informative Sundays entertainment, and a good investment for his first year pathology exam.

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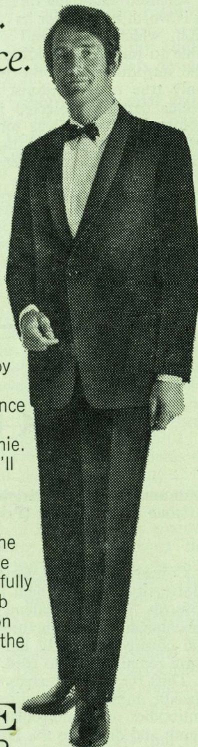

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DIARY OF EVENTS FOR MARCH

March 1st
Harvey Society Meeting, Pharmacology Lecture Theatre, Charterhouse Square at 5.45 p.m. "Genetics and Intelligence" by Mr. James Shields, Senior Lecturer, Institute of Psychiatry, Maudsley Hospital.

March 2nd
Lunch-time Talk, Clinical Lecture Theatre at 1.15 p.m. "Work of the Police Dogs" by P.C. Buckle from Snow Hill Police Station, accompanied by his dog. Bartsfilm. Physiology Lecture Theatre, Charterhouse Square at 9.15 p.m.

March 3rd, 4th and 5th
Smoker. Charterhouse Square at 8.30 p.m. Refreshments. Stag night on the 5th.

March 4th
Music Society Concert. Great Hall, at 7.30 p.m. Admission 30p. in aid of Bart's-the-Less Restoration.

March 7th to 21st
University of London Union Festival. Further details in this issue and on programmes distributed around the College.

March 9th
Bartsfilm. Physiology Lecture Theatre, Charterhouse Square at 9.15 p.m.

March 12th
Boat Club Ball. Charterhouse Square at 9.30 p.m. Tickets £3.25 from Noel Snell, College Hall, Charterhouse Square, E.C.1.

March 16th
Bartsfilm. Physiology Lecture Theatre, Charterhouse square at 9.15 p.m.

March 18th
London Medical Group Symposium. Charterhouse Square at 5.45 p.m. "Some Aspects of Student Problems". Chairman, William P. Kramer, M.D. (Sienna). Consultant Psychiatrist, Centre for the Analytical Study of Student Problems. H. J. H. Home, M. A., Member of the Psycho-Analytical Society.
Bart's Contribution to the U.L.U. Festival. "Bart's v. The World" See fuller accompanying details in this issue.

March 20th
Squash Club and Athletics Club Hop, Charterhouse Square.

March 22nd
Cheese and Wine Party, organised by the Students Union and the Student Nurses' Association. Billiards Room in the Hospital at 8 p.m.

March 23rd
Bartsfilm. Physiology Lecture Theatre, Charterhouse Square at 9.15.

March 24th
Pre-Clinical Spring Term ends.

March 26th
Wine Committee Dinner. Would ex Wine Committee members contact the secretary, David Wilkinson at College Hall, Charterhouse Square, E.C.1.

March 27th
Physiotherapy Charity Ball. The London Hilton in aid of Multiple Sclerosis. Tickets £6.30 from Miss J. E. McKane, Pysiotherapy Department.

March 30th
Bartsfilm. Physiology Lecture Theatre, Charterhouse Square at 9.15.

April 3rd
Rifle Club Hop, Charterhouse Square.

Future dates for your diary:—

May 8th
Guinness Stroll. Fuller details later.

May 27th
Bart's Music Society. Verdi "Requiem" at Southwark Cathedral.

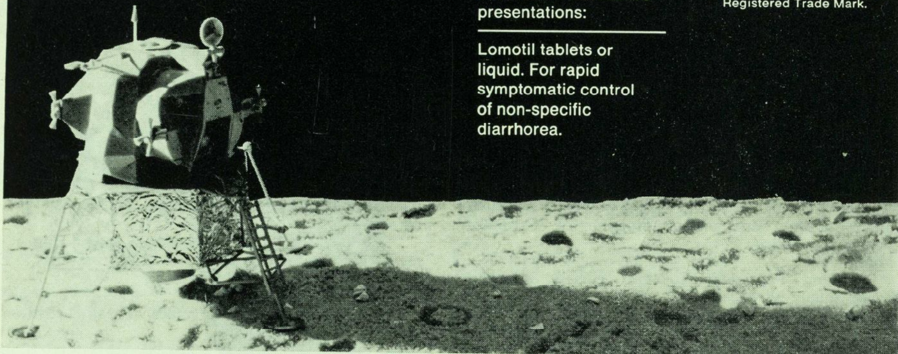
June 11th
Barbecue Ball.

BART'S SPORT

RUGBY CLUB REPORT

1st XV v Streatham and Croydon

This was our heaviest defeat of the season, and possibly the hardest as well. Streatham have had some notable wins this season, being one of only three sides in the country to beat London Irish, and the week after our game they travelled up to Lancashire to beat Waterloo. In the Bart's side Jefferson was not available due to a different game up in Hartlepool, so Simon Smith came into the centre in his place. In the first half the two sides seemed very evenly matched with everything (except the score) just about level. Streatham scored two tries, one rather luckily when Martin was tripped up on his way to touching a ball down over our goal line, but their other try was a cunning inside move from the centre. They also scored a penalty and converted one try, and Rhys Evans put over a penalty for Barts in reply. Early in the second half Martin unfortunately became concussed after a kick on the head, and after wandering around in a daze for a few brave minutes eventually left the field—only to reappear later on when Rhys Evans had the same trouble and had to leave as well. Ollie Else had a very uncomfortable game when he was moved out into the three-quarters to make up the numbers, a great pity because he had played very well up till then, and the Streatham



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backs were very powerful runners. With only thirteen fully fit players the game degenerated and Streatham scored a further 13 points so that the final score was 24-5.

HOSPITALS CUP 1971

As one of the National dailies said in their report of the game, this Bart's side was a shadow of the team which won the cup two seasons and retained it last year. This is putting things too strongly, but it certainly wasn't one of the Great Games to go down in the annuals of Rugby, and our performance will have to be much better against Guy's in the next round.

Our opponents in this game were the Royal Free, only because the Middlesex Hospital, who had beaten them in the first round were disqualified for fielding an ineligible player. The fact is that this particular chap kicked all 18 of the Middlesex points, so the Royal Free were quite justified in complaining.

This game was played at the Westminster ground at Cobham, on a very wet pitch with large areas of standing water. In the first half, playing uphill, Bart's scored 20 points through tries by Laidlow (2), Smith, Mason and Brookstein, the Cambridge blue. One of these was converted by Cassidy, who altogether missed 6 conversions and two penalties and who was not happy in the wet conditions. Fairhurst and Carroll were pillars of strength in the scrum while Else and Fenton showed that Bart's have still got a pretty good back row even after the departure of McIntyre.

In the second half the pitch became very chewed up, with unpleasant sticky mud bringing the game almost to a standstill. All credit to the Royal Free, however, who played above themselves to hold a much more experienced pack with great spirit despite being 20-3 points down at the beginning of the second half. All the possession Barts obtained seemed to be wasted, either by Mason running straight into six forwards or by the backs not being quite sure of their moves. Towards the end Heslip charged down a kick to score, and the balding Fenton (is he really only 23) scored the final try to make the score 26-3.

1st XV v Cambridge

This game was played in Cambridge on a muddy pitch on a very cold wet January afternoon. The team had been changed around a little from the week before by the return of Simon Smith to the wing and Barry (Kick-along) Cassidy to fly half, with Mick Martin going to centre. Ian Weller and Pete Rhys Evans were very unfortunate to lose their places after all their hard work and enthusiasm, but both are easily capable of getting back into the side in the near future. Up front Brian Rees came in at hooker, so it was quite a changed team that faced Cambridge.

Cambridge scored uncomfortably quickly, the result of a high kick ahead being misfielded by half the Barts side, and then a wing forward bursting through the other half. This try was converted, and following indifferent Bart's play several set scrums near our goal line gave the Cambridge fly half opportunity to drop two very neat goals. There was no further scoring in the first half, but "kick-along" hit an upright post with one penalty attempt and just missed with another.

In the second half, playing with the wind and rain, Barts played better but still with no real conviction or cohesion. Eventually after much pressure Cassidy landed two penalty goals from reasonable distances—making up for his earlier failures, and Laidlow scored a try. The only threequarter who really played well was Jefferson, whose parents were watching the game. After a few recent exploits someone cynically suggested that the Rugby Club pay for their expenses to attend every game, but with luck this won't be necessary! Despite putting everything into the last few minutes Barts were unable to score again and the final score remained a narrow defeat by 9-11.

1st XV v Oxford University Greyhounds

A Great Victory. Despite the fact that it's much easier to beat the Greyhounds after the Varsity match than before it, this was a very good performance by the Barts team. Both Brookstein and Heslip, our Cambridge blues were playing, and there is no doubt that they strengthened the side a great deal.

The Greyhounds pack was light and mobile but lacked Club rugby experience. Nearly all the players on the Greyhounds side were considerably harassed by Else and Fenton, who are both playing really well this season, and Sullivan's prop spent a major part of the set scrums with his nose brushing against the turf. It was also demoralising for them to reach our "25" give away a penalty as they did quite regularly and then retreat 30 or 40 yards as a result of Cassidy's huge kicks down the touchline.

At half time the score was 15-3, with scores from Laidlow, Fairhurst and Else, and two penalties from Cassidy. The only Greyhounds score was a penalty. With Else's try considerable interpassing left Mason with the ball, who ran up the field only to be tripped by a 'hound. Desperately trying to regain his balance he didn't quite manage to, and passed to Else who scored. The referee said afterwards he would have given a penalty try anyway—but at least this boosts Else's number of tries this season. In the second half a further five tries were scored, two of which were converted by Cassidy. One happy feature of the game was the number of moves that actually worked. Mason made a try for Jefferson "bobbing and weaving" after a phD, and some of the others were directly responsible for tries and near misses as well.

Once again, a great victory, and one that bodes well for the coming Cup matches. Final score 34-3.

Results so far:—

Played 20, Won 13, Lost 6, Drawn 1. Points for 240, Points against176.

HOCKEY CLUB REPORT

Bart's v Tulse Hill Wanderers
Drew 1-1

This was a poor match, marred by some indifferent umpiring. Bart's scored first with a good goal by Edmondson. Smallwood and Young combined very well on the right and at times made the Wanderers' defence look very suspect. In the second half, although only leading by a single goal, Bart's looked as though they had the game in the bag. However, the Wanderers equalised midway through the half to produce the final score.

ST. BARTHOLOMEW'S HOSPITAL

JUNIOR REGISTRAR IN MEDICINE

APPLICATIONS ARE INVITED for the post of JUNIOR REGISTRAR IN MEDICINE TO DR. BLACK and Dr. Dawson. The post is tenable for one year from 1st June, 1971, and the salary scale will be that of a Senior House Officer in the National Health Service.

Applications, with the names of two referees, should reach the undersigned by Monday, 22nd March, 1971. (Application forms are available from the Medical Staff Office.)

J. W. GOODDY,
Clerk to the Governors.

met/mae 1.2.71

Hospitals Cup 1971

Bart's v U.C.H.
U.H. Cup Won 2-1

Bart's started the match in fine style and soon had a shaky U.C.H. defence under pressure. With half-backs and inside-forwards linking well together it seemed only a matter of time before Bart's would open the scoring. However, it was U.C.H. who scored first with a fine goal following a cross from the right. This goal resulted from one of their few sorties out of defence.

In the second half and a goal down, Bart's play showed signs of frustration as the all-important goal eluded them. Then with 8 minutes to go, Yates put things in perspective and the ball in the U.C.H. net, with a superbly struck shot. The winning goal followed soon after, as a result of a scramble in the U.C.H. goalmouth.

Bart's v St. Thomas's Hospital
U.H. Cup Lost 3-0

Bart's took the field against a Tommies side that contained five Oxford "Blues" and an England international in the person of Paul Siebert. Bart's were 2-0 down in the first five minutes, following two short corners by Siebert. Despite this early setback, Bart's did not lose heart and at times played attractive hockey. With Wright playing well, Tommies dominated the centre of the field, although the much vaunted combination of Hunt and Siebert had a quiet afternoon. Midway through the second half Tommies took their tally of goals to three, following some slack Bart's defence on the right. With the final score at 3-0, Bart's were eliminated from the U.H. Cup. It was a fine game and not as one-sided as the score may suggest.

Bart's Team:—D. Price, C. Reid, I. Fraser, C. Yates, G. Coleman, J. Tweedie, J. Smallwood, A. Young, D. Edmondson, R. Ashton, D. Robinson.

JIM TWEEDIE.

BOAT CLUB REPORT

United Hospitals Regatta

This is, for us, the main event of the winter season, and we had our most successful day for seven years, reaching four finals and winning three.

The Junior eight had trained very hard for their event, and cruised easily through three rounds to reach the final, where they beat the Guys 1st eight by ½ a length, thus reversing last year's result.

Crew; Close, Hunt, Edwards, Lambley, Dehn, Down, Gray, Patrick, Boursnell.

A very enthusiastic Junior four excelled themselves by reaching the final of their event, where they lost to a Guys crew who were in fact ineligible but were allowed to compete on a technicality.

Our other two victories were in the sculling events, where Leander oarsman Vic Pardhy, respectively plus and minus the aid of Barry Grimaldi, won the double and single sculls easily.

Other results were; Senior IV "A" beat UCH r.o., lost to Mary's by 1½L. Senior IV "B" lost against Thomas's, easily. Senior pair "A" lost to Thomas's, 4L; Senior pair "B" lost to Guys by 1L. Junior four "B" lost to Thomas's by 2L.

U.L. Winter Eights

This is seldom a successful regatta for us, since the different events and status rules mean re-arranging all our crews after the UH regatta, and therefore competing with little practice. This year was no exception, though all our crews acquitted themselves reasonably well. We had high hopes of retaining the Novices cup which we won last year, but these were scotched by the non-attendance of the stroke who remained in his bed until halfway through the regatta.

Results; Open eight "A" beat U.C. 1 by ½L, lost to I.C. 1 by ½L. Open eight "B" lost to I.C. by 4L. Novice eight "A" lost to Guys 1 by 1½l. Novice eight "B" beat Vets "B" by 2L, lost to I.C. by 3L.

Easter Term

We are boating 2 fours and 2 eights, and will be competing in the U.L., Kingston (March 6th) and Tideway (March 20th) Head of the river races. Supporters are always welcome.

Boat Club Ball

This will be held on the 12th of March (Friday) at College Hall. Tickets are available from N. Snell, R. Fowler, and T. Dehn, at £3·25 (£3 5s. 0d.)

WATER POLO CLUB

Last term the first team ended up fourth in the 1st. Division of the U.H. League, a considerable improvement on the sixth position of last year. It was a good achievement, since teams like Guys and Mary's each contain University players, and Guys (who won the league) have an international, Roddy Jones.

Once again, however, we were hindered by lack of support, and often had to play the same five for a whole game without substitutes; it was unfortunate that some of our players were doing courses outside London. One notable addition to the team was Terry Ludgrove, whose swimming is a tremendous asset, and his water polo improves with every game.

The second team began really well in the third division, winning their first three games; but then they began to suffer from exams etc., and were only able to finish 3rd. in this division.

In the U.L. Knockout we were knocked out in the first round by Mary's, who reached the semi-finals. The margin was only one goal difference, but even so was a disappointing result as we were runners-up in the competition last year.

This term we have one team in the second division of the U.L. League, played at U.L.U. We made a good start (especially as Paddy Weir and Pete Durey couldn't play), losing only 4-7 to Imperial College II, the strongest team in our division. We won the second match against Thomas's I 3-2; we would have won by a lot more, but only three of the first seven were able to play.

With training (and support from all the team) the team-work and match-play will improve, and we should do well this term in the League. Training is at U.L.U. every Friday at 6.30 p.m.—anyone is welcome.

CHRIS FENN.

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*Reprints received and herewith gratefully acknowledged. Please address this material to the Librarian.

BATTLE

(Revisited 16.1.71)

by Teifion Davies

In their meeting was a beginning.
Or an end: like an egg or a fallen mushroom.
And in their touching the first crack or lip
of peeling. A volume of hate between them
in the flowing valley. Cold: a steady grey above;
a running, not sweat, below. Crushed grass,
swollen with sun, bristled and spat under leather.
Moist in waiting. A rise and sway of wind
blooded their faces: fear paled them.
The scrape and suck of air asthmatic: the gasp
but gathering tears steaming in sun.
Facing face they stood—many and few.
Two drawn close to fight.
§ A silent whisper far from eye twitched many lips:
"Why are we here?"
"We are here to fight. To hate and tear
and penetrate flesh: others and our own.
To trample grass and blood.
We must lose and fall but give life
by our bleeding. In this is our end.
Blood must clot to flow again.
It is but a transient death—
a brief cloud dissolved in sun."
§ "Blood me then, my enemy.
Cut the silken skin of my heart.
In my surrender feel the violence of waves
or of a leaf beneath the sun. Come,
break my body with your thrust.
My shield shall be your first glory:
my last protection."
§ The sun ran west across their tears
to its microcosmic death. White blood
and red mingling sank in fertile earth:
spoiled and seared. A tower fell.
The evening merged them with its shadow
in the silence of the rising moon.

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ST. BARTHOLOMEW'S HOSPITAL

PRE-REGISTRATION HOUSE APPOINTMENTS, JULY 1971

APPLICATIONS ARE INVITED FOR the appointments set out below:

1 post:	House Physician to Sir Ronald Bodley Scott
1 post:	House Physician to Dr. Hayward
1 post:	House Physician to Dr. Black
1 post:	House Physician to Dr. Oswald
1 post:	House Physician to Professor Scowen
1 post:	House Surgeon to Mr. Tuckwell
1 post:	House Surgeon to Mr. Nash
1 post:	House Surgeon to Mr. Robinson
1 post:	House Surgeon to Mr. Todd
1 post:	House Surgeon to Professor Taylor
1 post:	House Surgeon Casualty
1 post:	Junior House Physician to Department of Child Health
1 post:	House Surgeon to E.N.T. Department
3 posts:	House Surgeon to the Department of Orthopaedics
2 posts:	Rotating locums

Regional Board Hospitals

CRAWLEY	House Surgeon	(one post)
CRAWLEY (SMALLFIELDS)	House Surgeon	(one post)
CONNAUGHT	House Physician	(one post)
HAROLD WOOD	House Surgeon	(one post)
HEMEL HEMPSTEAD (ST. PAUL'S WING) ...	House Physician	(one post)
NORTH MIDDLESEX	House Surgeon	(one post)
	House Physician	(one post)
PRINCE OF WALES'S	House Surgeon	(one post)
	House Physician	(one post)
ROCHFORD	House Physician	(three posts)
SOUTHEND GENERAL	House Physician	(one post)
	House Surgeon	(one post)
ROYAL BERKSHIRE	House Surgeon	(two posts)
ST. LEONARDS	House Physician	(two posts)
PLYMOUTH GENERAL (DEVONPORT) ...	House Physician	(two posts)
	House Surgeon	(one post)
ROYAL CORNWALL	House Physician	(one post)
WHIPPS CROSS	House Physician	(one post)
	House Surgeon	(one post)

Applicants should state for which post they wish to apply and give a second choice. The posts are tenable for six months from 1st July 1971 and applications (forms are available from the Sub-Dean's Office where further information may be obtained) should reach the Sub-Dean's Office by *Monday, 19th April,* 1971.

SAINT BARTHOLOMEW'S HOSPITAL JOURNAL

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Editorial

Nowadays the aphorism "no news is good news" would appear to be particularly applicable to the medical profession. It seems that one cannot open a newspaper without seeing yet another doctor bite the dust through some heinous social crime. If a doctor is involved in any legal tangle or newspaper story, it is always the fact that he is a doctor that comes out in the headline, regardless of the details of the rest of the story. The public, of course, have a right to know the "facts", and it is the duty of the national press to bring these facts to their attention. After all, everyone pays their contribution to the National Health Service, and as it is a nationalised industry, everyone should know what happens to its practitioners. Pillars of society, of which the doctor is a good example, have always been fair game for unscrupulous reporters, and other professional groups are not immune: perhaps the Profumo case is the one which springs most readily to mind. All the same, the impression remains that undue prominence is given to the misdemeanours of the medical world. Perhaps the answer lies in the fact that for many people, the role of the doctor in society epitomises everything they would like for their eldest sons: a solid, respectable job that automatically makes one a worthy member of the community, irrespective of political, religious and racial prejudices, and without entering the degrading rat-race of the business world. Do people like to feel that respected members of society are not so respectable after all? There must be many with their illusions sadly shattered. Or is it perhaps that, being medical ourselves, the whole business is more noticeable to us?

Medical sensationalism is good "journalese", something that will always sell a newspaper. Recently, though, stress seems to have been laid on the competence of the profession, in particular of its junior members, with a couple of "serious professional misconducts" thrown in for good measure. The state of the casualty departments in this country has long been a bone of contention among doctors, and the problems of making casualty appointments attractive is a very real one. Many casualty departments in this country are closed due to lack of medical as well as nursing staff, and many more are functioning badly or at half strength, being open only in the peak hours. Consultant coverage is at best poor, but mostly virtually non-existent. Racial problems come into this question as, with the exception of the teaching and larger county hospitals, the underpaid and overworked casualty officer is likely to be an immigrant doctor, who is the only person prepared to take the job in order to gain an entry into British medicine and perfect his English.

Many hospital management committees are under the control of "lay" persons who must be made to realise that the whole framework of the emergency service is collapsing. Let us not invite the attitude of America where suing the doctor is almost a national past-time, and the insurance premium for a junior doctor is 2,000 dollars each year. Forewarned is forearmed, and an awareness of a situation which must strike us all as unsatisfactory should act as an incentive to improvement.

Letters

Abernethian Room,
St. Bartholomew's Hospital.

Dear Editor,

The Editorial of the September Journal in 1968 entitled "Dirty Bart's" drew our attention to the face-lift that Smithfield and many buildings in London were receiving, while Bart's remained dirty and black.

Since that date the Fountain and the Henry VIII Gate have been cleaned, and the new Pathology Block finished; all showing up the remainder, black as ever. The Great Hall and the Gibbs' Wings are most in need of the scrubbing brush. Rumour has it that the Gibbs' Wings are not to be demolished as the redevelopment scheme proposes. Indeed the East Wing is at present being updated internally for the Obstetric Unit. If interiors may be new, why may there not be clean exteriors?

Two further Editorials of August 1969 and April 1970 have mentioned these and other problems but apparently with no avail. The Archway into the Square is daily damaged by lorries and soon will be difficult to resurface without altering the present stone-work and without great expense. There is an entrance for commercial vehicles in Little Britain. Why is this not used by all lorries? Surely a notice "No commercial vehicles" or "Cars and Ambulances only" would mar the Archway less than the present trend towards destruction?

Please may we have action and assurances from the Hospital Authorities soon.

Yours faithfully,

IAN H. BAKER.

STUDENTS' UNION LETTER

10th March, 1971

Abernethian Room,
St. Bartholomew's Hospital.

Dear Sirs,

At the Staff/Student Committee on 23rd February the use of Students in Experiments was considered. It was generally agreed that (i) if a student wishes to be the subject of an experiment he should be able to do so, but that it is the responsibility of the College to ensure that the Student is fully aware of the nature of the experiment and of any possible dangers; (ii) the College should keep a record of every experiment in which a student is the subject, and (iii) even routine Class experiments (such as Douglas Bag expts.) carry remote hazards and that perhaps a committee should be set up to vet such Class experiments. The Dean has asked Professor Linford Rees if he would agree to chair a working party to study the problem (if asked to do so by the College) including:—

1. The obtaining and selection of students for a particular experiment.
2. The legal position of the College.
3. Payments.

The London Medical Students' Presidents' Council met at Bart's on 18th February and were pleased to welcome Sir Rowan Boland and Mr. M. Draper from the General Medical Council. Sir Rowan and Mr. Draper answered questions on a great variety of subjects, including Retention fees and Registration fees. There seemed to be some doubt as to the exact reason for the increase in Registration fees. The Council were informed that due to rising legal and administrative costs combined with doctors refusing to pay their Retention fees, the Registration fee had, of necessity, been increased. The point (which might be considered "ethical") that it is the younger, poorer, newly qualified doctors (who must register in order to practise medicine) who are balancing the books, does not seem to carry any weight with the G.M.C. Later in the discussion it was asked how many doctors were not paying Retention fees and we were informed that only 10 per cent of doctors were not paying. Having put pen to paper to work out the amount of money the G.M.C. were obtaining through increased Retention fees, minus the estimated increase in legal and administrative costs and the loss from the "10 per cent" of doctors not paying Retention fees, we found that a very large sum of money was left unaccounted for. Having been assured previously that the G.M.C. were not embarking on any new ventures we were puzzled at the discrepancy—but were told that we, as students, just did not understand . . .! However, areas of "not understanding" apart, the meeting was both useful and informative in many ways.

The Great Hall Concert, the Smoker and the Tennis Club Dinner were all highly successful, but they had one major fault—they all took place on the same night, 4th March. Clearly the Union must somehow organize the booking of dates for social events more carefully. To this end the Union Council is to appoint a Social Secretary at the Council Meeting on 16th March.

Other Students' Union news is included in this *Journal*.

The Minutes of the S.U. Council meeting on 16th March are now published.

PAUL MILLARD,
Chairman of the Students' Union.

Announcements

Births

CARTER—On February 14, to Judith (née Lintott) and Dr. Timothy Carter, a daughter.

CLARKE—On February 6, to Angela (née Gates) and Dr. Peter Clarke, a daughter.

TATHAM—On February 19, to Prudence (née Nahum) and Dr. Peter Tatham, a son.

Engagements

MAW—PAYNE—The engagement is announced between Dr. A. R. Maw and Miss A. C. Payne.

COPELAND—ALMEYDA—The engagement is announced between Dr. Stephen A. Copeland and Dr. Jenifer A. Almeyda.

CASSIDY—SECCOMBE—The engagement is announced between Mr. Barry Cassidy and Miss Frances M. Seccombe.

GOLDSMITH—GAYER—The engagement is announced between Mr. Michael Goldsmith and Miss Amanda Gayer.

Deaths

DIX—On January 31, Dr. Charles Dix, M.R.C.S., L.R.C.P. Qualified 1902.

GREEN—On January 22, Mr. R. Green, M.R.C.S., L.R.C.P. Qualified 1925.

Change of Address

The new address of Dr. A. N. Crowther is 77, Church Street, Tewkesbury, Glos.

The new address of Dr. W. Chalmersdale is St. Olaf, Kirkside, Strathmiglo, Fife, Scotland.

Appointment

Professor H. Lehmann of the Department of Biochemistry, Cambridge University has been appointed Horder Travelling Fellow.

Retirement

George Hutton, better known as "Jock", retired from the Hospital on March 3rd after 42 years service. "Jock" came to the Hospital from the Scots Guards in 1928. In those days one came on a trial period of six months before being appointed. To be appointed meant a fairly stiff interview with the Governors and Heads of Department. "Jock" started in the Pathology Department and during the years has worked in many departments including Records, Gateman and the "Massage Department". However, for the past twenty years he has been the Orderly in Theatre G where his efforts have been much appreciated. On February 28th a party was given for "Jock" and this was attended by many of his friends including Sir James Paterson Ross. During a short speech of thanks for the gifts he received "Jock" said how much he had enjoyed his years at Bart's and of the many interesting people he had met. He had enjoyed watching the progress of Surgery. May we at Bart's wish "Jock" and his family a very happy retirement and thank him for his devotion over the years.

WARD CLOSURES

Various wards are to be closed during the following months in order to rebuild or modernise existing accommodation for patients. Most people realise that Rahere and Colston (ground floor medical) wards were fitted with carpets last year as an experiment, and the *Journal* would like to publish any views on this. We have received this communication from Mr. Antony Brett, the Hospital Steward, and publish it for your convenience:—

1. The agreed programme for the closing and re-opening of wards and theatres during 1971 is attached. There would still appear to be some doubts about the carpeting of the wards so, rather than delay any further the issue of this programme, two separate dates for the re-opening of each ward is given.

2. Whilst Smithfield Ward is closed, the following wards will lend beds to Dr. Hayward's Firm and to the Skin Department.

Stanmore 5 Medical (to include Cardiology) + 2 Skins.
Rahere 6 Medical (to include Cardiology).

3. Whilst Percivall Pott and Lawrence wards are closed, emergency cases admitted on the surgical units duty day (Tuesday) and duty week-ends, will be admitted to the following wards.

Tuesday, June 1st—Bowlby.
Saturday, June 5th—Waring.
Sunday, June 6th—Bowlby.
Tuesday, June 8th—Rees Mogg.
Tuesday, June 15th—Fleet Street and Harmsworth.
Tuesday, June 22nd—Rees Mogg and Paget.
Tuesday, June 29th—Waring and Abernethy.
Tuesday, July 6th—Fleet Street and Harmsworth.
Saturday, July 10th—Bowlby and Heath Harrison.
Sunday, July 11th—Rees Mogg and Paget.
Tuesday, July 13th—Waring and Abernethy.
Tuesday, July 20th—Fleet Street and Harmsworth.
Tuesday, July 27th—Bowlby and Heath Harrison.
Tuesday, August 3rd—Paget.
Tuesday, August 10th—Abernethy.

4. Whilst Mary Ward is closed, the following wards will lend beds to Dr. Hayward's Firm and the Skin Department.

Garrod 5 Medical (to include Cardiology) + 2 Skins.
Colston 6 Medical (to include Cardiology).

5. Whilst Pitcairn and Sandhurst Wards are closed, the re-opened Martha (South) will admit gynaecological patients. Harley will also have reverted to a gynaecology ward permanently. This, however, still leaves the gynaecology department with only 50% of their normal bed complement; the General Female Surgical Wards will therefore be expected to take gynaecology duty cases on their duty days.

Ward or Theatre	Patients—Out	Workmen—In	Workmen—Out	Patients—In (If no renewal of flooring)	Patients—In (If carpets to be laid)
Smithfield	31st March	5th April	29th May	3rd June	7th June
Angio-Cardio-graphic Theatre		29th March	? (approximately 5 months)		
Percivall Pott	26th May	1st June	24th July	29th July	2nd August
Lawrence	9th June	14th June	7th August	12th August	16th August
Theatre G	——	14th June	24th July	——	——
Mary Pitcairn	4th August	9th August	18th September	23rd September	27th September
Sandhurst		13th September	? ? ?		

HOUSE POSTS

By I. M. Hill, M.S., F.R.C.S.
(*Sub-Dean of the Medical College*)

After qualifying by a recognised degree or diploma and registering provisionally with the General Medical Council a doctor must serve satisfactorily for twelve months in approved pre-registration resident house appointments before he is entitled to have his name included in the full medical register. At present this entitles him to practice all forms of medicine and surgery and to sign certain certificates and prescribe drugs, including scheduled poisons and those restricted by the Dangerous Drugs Act.

The pre-registration house appointments served must be six months "general" surgery and six months "general" medicine. Obstetrics and gynaecology may count as either medicine or surgery providing the remaining six months is spent in a truly general appointment. Locum tenency appointments are not generally acceptable as satisfactory certifiable pre-registration experience. On completion of the pre-registration appointment the clinical consultant under whose care the houseman has worked certifies that the houseman has served to his satisfaction and a responsible member of the hospital administration issues a certificate to this effect and sends it to the University concerned with the student's undergraduate training. In the case of London University students at Bart's this certificate is sent to the Sub-Dean's office. Oxford and Cambridge students have their certificates sent to their own University Medical School. When certificates covering twelve months are received by the University office a designated responsible officer signs a certificate of experience which the doctor takes to the General Medical Council to complete his full Registration.

At Bart's there are two pre-registration house posts of six months duration on each of the general medical and surgical firms. In order that there shall always be an experienced house officer on each firm, appointments are staggered, one being appointed every three months, to start work on 1st January, 1st April, 1st July and 1st October each year. Appointments to these house posts are made by the Board of Governors of St. Bartholomew's Hospital on the nomination of the Committee of Physicians and Surgeons. This committee is an autonomous one and consists of all members of the consultant staff of the hospital (including members of the College staff with honorary consultant contracts with St. Bartholomew's Hospital) who have clinical charge of beds. In addition this committee nominates approved pre-registration appointments at certain regional hospitals and these posts are advertised at the same time as the Bart's house posts. It is a condition that such advertised posts are truly available and not bespoken and that the management committee concerned will accept the candidate nominated, the consultant concerned delegating his choice to the Committee of Physicians and Surgeons at Bart's, though his expressed preference would be considered by the Committee.

In addition there are some approved posts where the local management committee does not wish to delegate its authority, but where a recommended Bart's candidate is generally accepted. These posts are not advertised on the Bart's list.

There are also at Bart's post-registration house appointments. These are largely in the special departments and are advertised and allocated separately. Some of these posts are recognised for pre-registration purposes but are not usually filled with pre-registration candidates as they are not ideally suited for this purpose, being too specialised or carrying too high a load of responsibility for the newly qualified. Apart from these special exceptions a pre-registration house post is never allocated to a man or woman whose experience is sufficient for their name to appear on the Full Register.

Principles of Allocation

Applicants apply for a first choice post, but state alternatives that would be acceptable should their primary application fail. Posts are rarely allocated outside the expressed choices of the candidate.

Posts are allocated on students' records, both academic and extracurricular and estimated compatibility with the members of the firm concerned.

The committee considers the posts in the order they appear on the advertisement; but on the first time round the chief may only choose a candidate who has placed the appointment as his first choice. If posts are not filled in the first round of the table, candidates who have marked the post as an alternative may be chosen.

In making its recommendations the committee work on the policy that Bart's house posts should be as widely distributed as possible and that they are probably of greater value to the candidate after a six month appointment has been served at another hospital. Only in very exceptional circumstances will two pre-registration posts at Bart's be given to one individual. Where a good candidate has failed to obtain any pre-registration post at Bart's he would be more favourably considered for a post-registration appointment than one of similar merit who had been fortunate enough to hold a pre-registration post at the parent hospital.

Preference will always be given to candidates holding a University degree rather than the Conjoint Board Diploma alone.

Dates of Appointment Committees

The date of the meeting of the Committee of Physicians and Surgeons is governed by the publication of university pass lists. The meeting is held, by tradition, at mid-day on a Wednesday so that as many members as possible may attend; but the third, and in January, June and October the fourth Wednesdays in the month are not available. Candidates are never appointed on an "if qualified" basis. The closing date for applications cannot be placed earlier than a week after the publication of the university pass list. A week must then be allowed for compilation, duplication and circulation of the lists, and a week for the consultant staff to discuss the applicants before the appointment meeting is held. This meeting cannot, therefore, be held earlier than three weeks after the publication of the pass list.

In practice this means that January and April pre-registration posts are allocated about the first week in December, July posts in the first week in May and October posts late in July after the Cambridge results. Post-registration appointments are allocated further in advance to allow unsuccessful candidates as much time as possible to find other appointments—the meeting for the July posts is held early in May and the January posts in October.

All pre-registration and post-registration posts are advertised within the hospital and in the *Journal*; but post-registration appointments that may be difficult to fill in specialist departments are also advertised in the medical press.

Candidates for the Bart's posts should always communicate with the chiefs with whom they wish to work. This is not regarded as canvassing and is a simple courtesy measure which ensures that the chief and houseman recognise one another and it gives an opportunity to indicate that an applicant might be unacceptable.

The lists of applicants are not published, but are available for inspection in the Sub-Dean's office so that candidates may know the competition for an individual appointment. Armed with this information the candidate should be able to make a rational first choice and express alternatives, perhaps including "any other appointment" which will give the maximum chance of securing a post within the allocation of the committee. Experience shows that not all posts allocated are accepted and new vacancies may arise in the few days after the allocations are made and it is worth while keeping in contact with the Sub-Dean's office at this period.

Remember, in January there will be many more students recently qualified than posts available and disappointments are inevitable; in July and to some extent in October the reverse situation may occur and applicants available are likely to have a much greater choice.

STUDENTS UNION REPORT

BY JOHN WELLINGHAM (*Assistant Secretary*)

This is the first quarterly report of the Union to appear in the *Journal* as suggested in a letter to the February *Journal* from Bruce Noble and John Wellingham.

The apathy of the student body at the end of last year must have been at its worst for many years. No year representatives were elected due to lack of a quorum at the E.G.M. Thus the chairman has co-opted year representatives and these reps and the elected executive have now settled down to get the Union into a going concern, truly representative of an interested student body.

Although the outlook for the academic year 1970-1971 was bleak, by the end of last year several useful things had been achieved as outlined in the chairman's letter to the January *Journal*, viz.

(1) Random allocation to firms.

(2) Reconvening of the Curriculum Committee.

(3) The Chairman of the S.U. Teaching sub-committee has been invited to be a member of the Curriculum Committee.

(4) Agreement on the formation of a staff/student committee.

The last two of these have given the Union a much closer contact with the administration of both the hospital and the college.

We have thus entered 1971 with a Union in a position to tackle actively some student problems as well as being able to inform the student body of the changing situation within Medical Education.

LOCUMS

(a) **Pay**

There is at present considerable inequality of pay within the Hospitals for students undertaking locums. For example at present students are paid these amounts in the following hospitals:—

Barts £8.00 per week; Charing Cross £20.00; King's College Hospital £20.00; Royal Free £12.50; St. Thomas's £35.00; Wesminster £12.50.

With the exception of about three, peripheral hospitals do not pay their student locums.

A recent survey showed the value of student locums in peripheral hospitals and these are the results from fourteen.

Midlands	*Are Locums done?*	*Could hospitals do without the labour?*	*Are payments made?*
Birmingham	Yes	?	No
Bristol	Yes	No	No
Leeds	Yes	No	No
Liverpool	Yes	No	No
Manchester	Yes	No	No
Newcastle	Yes	No	No
Q.U. Belfast	No	—	—
Sheffield	Yes	No	No
Welsh National	Yes	No	No
Scotland			
Aberdeen	Yes	No	No
Dundee	Yes	No	No
Edinburgh	Yes	No	No
Glasgow	Yes	No	No
St. Andrew's		Preclinical Only	

The Department of Health, in response to these figures, offered us via the B.M.S.A. £11 per week plus free lodging. However after payment of National Insurance stamps and Superannuation, which are compulsory, the pay works out at only a little over £6 per week. This figure has given B.M.S.A. a starting position for bargaining. They are arranging a meeting with the B.M.S.A. to discuss the proposals and are likely to accept the free lodging but will try and get an increase on the £11.

(b) **Legal Cover**

Although students doing locums can shift responsibility for any "mistakes" to their supervisors, should they ever get sued, there still remains the problem that if the student undertakes emergency action without supervision he is not legally covered. To help exclude this possibility hospitals have been advised not to use unregistered doctors for casualty locums.

It is thought that if a student was sued in such a situation he could pass the responsibility on to the hospital for not having him properly supervised at all times. Since there has been no test case, one cannot have complete confidence in this kind of assurance. It is thus hoped that after the locum position is officially recognized by the Department of Health and becomes a paid position, this serious loophole in legal cover may be closed.

GRANTS

New levels of grants for all students are at present being assessed for implementation on September 1st, 1971.

The National Union of Students (N.U.S.) and also the British Medical Student's Association (BMSA) are actively campaigning at present to make these increases as large as is feasible.

At the Union meeting of 19/1/71 George Lodge, BMSA Vice-President, informed us that they were discussing the question of students grants, and asked the Union to help inform students in Bart's of the situation.

The present London grant as in "A Report of the Advisory Panel on Student Maintenance Grans 1968" is broken down into the following values:—

Allowances for Extra Weeks
Above 30 Weeks
£7.38
—
See Below §
—
£1.45
——
£8.83
§ Vacation allowance of £1.75 is then removed from this figure
Total £7.08

	Full Grant
Board and Lodging	£240
Books and Equipment	£40
Vacation	£39
Travel	£12
Pocket Money	£43
Clothing and Laundry	£42
	£416
Rounded up to	£420

In addition to supporting the BMSA's official "Five Points" as in Scope, we are particularly concerned with the following points, which are related specifically to the value of £7.08 for our extra week's grant. For clinical students this amounts to 16 weeks.

The Brown's Committee of July 1967 estimated that the average cost for board and lodging in London was:—

In Hall £9.375 (In the larger halls of Brunswick Square etc.)

In Lodgings £7.595.

Three years later we are still on grants of £7 for our extra 16 weeks. In order that our grant should be more realistic we would like to see:—

1. A books and equipment allowance for these weeks, since 4 months in clinical can mean a complete course unit and perhaps even two. We do need new books for each course.
2. Since clinical students have no long holidays to earn money, we would like to see the vacation allowance returned to the extra weeks allowance, and in any case certainly not subtracted from it.
3. We are satisfied with the present arrangement of being able to claim travel expenses over £12 per cent a year.
4. Clothing and Laundry allowance should be extended to the extra week's grant since the same standard of dress applies to this period.

In order that we can obtain these allowances we are strongly supporting BMSA's request for a grant of £12.33 for these extra weeks. This figure is calculated to allow for the fall in purchasing power of the grant since its last increase in 1968.

The Union is pressing for these increases by:—

1. The London Medical Schools' Presidents' Council. (LMSPC). LMSPC is:

(a) sending a letter to The Times (which we hope

will be in print by the time this edition of the journal is distributed). This will be followed soon afterwards by duplicates to the popular dailies. This is hoped to stimulate some correspondence on the subject;

(b) sending a document to the Department of Education and Science (DES) to back up the approaches of the BMSA;

(c) arranging a date for lobbying MPs personally at Westminster. Each Hospital is intending to produce 10 well briefed students to speak to their MPs.

2. organizing a letter to MPs from individual students.
3. accepting an offer of a pre-clinical student to inform every MP, by letter, of the grant situation.

The BMSA is hoping to talk with the DES within the next week about these claims.

CLINICAL TEACHING

The Council meeting of 19/1/71 passed the matters of Paediatrics abroad, obstetrics and gynae teaching to the teaching sub-committee to investigate and to bring up at the student-staff committee meeting. Primrose Watkins undertook to look into the question of the donation of £10,000 for Bart's Teaching machines which has not yet materialized.

Obstetrics and Gynaecology

Students feel that this course is too long and diffuse, and suggestions were made for an integrated course of Gynae Out-patients and Gynae In-patients. When this was presented to the Student-Staff Committee on 26/1/71 it was pointed out that there is a University rule of four months clinical teaching for Gynae M.B., B.S. One problem is the lack of work in the department and the type of Gynae out-patients and in-patient cases coming into Hospital. However, the course was felt to be relatively good compared with other London Hospitals. The meeting was informed that plans were in hand to enlarge the working area in the clinic to facilitate the use of more practical medicine in future and smaller student groups. The students felt that the free half day that Gynae out-patients students had every day was a waste of time.

It was pointed out that the Hospital had neither the monetary means nor staff to teach during these half days. However, if the course is concentrated to six weeks as suggested, and audio-visual aids are made available to students, the free wasted time would not be so obvious.

Curriculum Committee

The Dean has put forward a new Curriculum which is being discussed at present. A change to the two month module has been accepted but changes in the 2nd and 3rd years are still being discussed; likely changes are:

(i) The inclusion of Anaesthetics as part of General Surgery.
(ii) The inclusion of Orthopaedics in the 2nd year.
(iii) A more comprehensive Elective period and Revision period prior to finals, including extra study in Surgery and Medicine.

Paediatrics

In the address to the first year clinical students in October, the students were led to believe that the paediatrics course was the one big chance to go abroad. They were thus surprised and aggravated to find that this had suddenly been changed and only 12 students were to be able to go abroad in any 3 month period. Several people approached the Union about this and it was brought up at the Council meeting of the 24/11/70. Primrose Watkins then made a census of student opinion and went duly armed to the Student-Staff Committee meeting of 26/1/71*. It turned out that several misunderstandings had occurred. The students at the meeting were informed that for a viable paediatrics course to exist at Bart's the minimum number of students required was 12 per quarter. In future permission to go abroad is to be obtained through the sub-dean's office.

The paediatric department has made a determined effort to improve the course over the last few years, a fact which is being appreciated by the students on the course at the moment. Students should realise that the chance of going abroad is not limited to paediatrics, there are opportunities for obstetrics, gynaecology and some psychiatry abroad. Perhaps the higher standard of the present paediatrics course might cause students in future to think about looking for places abroad in the other subject courses.

The curriculum committee is meeting regularly, and extensively revising the present curriculum. Any new curriculum arrived at will be passed on to the students by information sheets and will be covered fully in the respective *Journal* reports.

*Her census was of 140 first year clinical students. Out of a 64% response only 5% showed a desire to stay at Bart's for Paediatrics.

ST. BARTHOLOMEW'S AND EPIDEMICS IN THE CITY OF LONDON

BY NELLIE J. KERLING (*Hospital Archivist*)

For as long as people have lived in a community the world has known epidemics. This hospital was founded in 1123, nearly 850 years ago, but we know nothing about work during epidemics before 1665. Even then we have no information about actual treatment of patients. One of the most dreaded epidemics in those days was that of the plague. This disease came from northern India where the bacillus Pasteurelle Pestis was endemic, living on fleas which infest animals, preferably those with a fur skin like the rat. Rats sometimes migrate because of lack of food, floods and other disturbances: thus spreading the flea with its bacillus. Rats also travel among cargo in ships, and medieval merchants and, above all the crusaders, brought them to England from the Middle East. In England they soon spread the dangerous plague bacillus by contaminating food, water, kitchen utensils and cloths. Humans were thus infected and developed the so-called bubonic plague. It was known to be very infectious and each case the physicians knew of had to be reported to the authorities. The house in which the victim lived had to be locked up for 40 days and the unfortunate inhabitants had to remain inside, receiving food through a window or on the doorstep. There was a vague idea that an outbreak of the plague had some connection with cleanliness, and in the 14th century London made each householder responsible for keeping the streets clean. As a result large dumps of rubbish appeared at some collecting points, making a paradise for rats.

There were four epidemics in the 17th century, in 1603, 1625, 1636 and 1665. Only for the last one do we have information concerning the reaction of the hospital staff. The first cases were reported to the City authorities in June 1665, the beginning of a very hot summer. The number of deaths rose steadily until the middle of September when rain fell, giving some cooler weather. When the rain ceased, the plague returned and did not finally disappear until the beginning of November when the temperature dropped considerably. In the London area nearly 68,000 people died during that summer and autumn. Burials were no longer allowed to take place in the church yards but fields outside the City walls were prepared instead.

St. Bartholomew's hospital never took in plague victims. They were sent to so-called pesthouses though more often these unfortunate victims died at home. In 1665, however, with an unchecked infection appearing all round the building, it was impossible to keep it out of the hospital. A number of Governors came almost daily to watch the situation. They must have been very brave men for on 2 September they reported to the Naval Commissioners for the wounded of the army and navy that the hospital was "visited." This was in fact a warning to the Commissioners not to send any wounded men to the hospital. It was obvious that Bart's could not accept any new patients.

Immediately the Governors called on their medical staff to help. Matron with 15 sisters and some nurses stayed on and so did the apothecary Francis Bernard but the physicians Dr. Micklethwaite and Dr. Tearne went to the country to join their families. They obviously considered their task as father and husband

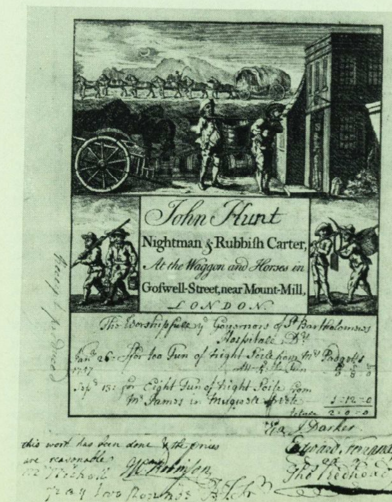
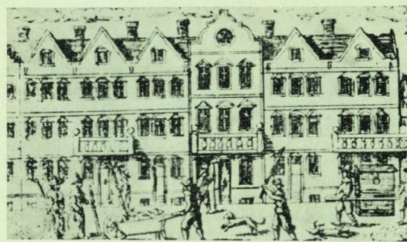

John Hunt
Nightman & Rubbish Carter,
At the Waggon and Horses in
Gofwell-Street, near Mount-Mill,
LONDON.

Fig. 1. Bill of night-soil man 1757.

more important than their professional duties. In September the Governors called on the two surgeons of the hospital, Henry Boone and Thomas Woodhall. Mr. Woodhall did not come personally but sent a Mr. Thomas Turpin. Both he and Mr. Boone were asked whether they would work in the hospital or whether they preferred to pay another surgeon to do the work. Mr. Turpin said that the business was "too hot" for him and Mr. Boone answered that he would not desert his post but that he "desired to be excused to do the service." After these disappointing answers the Governors had no option but to appoint a Mr. Gray for the period of the epidemic. Mr. Gray had no connections with the hospital but he was already working in the City. Fortunately for our patients, he had no objection to visiting them as long as the epidemic might last.



Figs. 2-5 taken from a Dutch pamphlet describing the plague in London.

It was an extremely anxious and busy time for the remaining staff and for the Governors. One can see from the records that every one was doing what was necessary whether it was his or her duty or not. When it was all over the Governors rewarded Matron, the apothecary, the clerk, the steward and the renter. Matron was mentioned specially as having done the cooking and some of the actual nursing herself. We do not know how many patients died or how many suffering from the plague were in the hospital. We only know that the physicians and surgeons deserted them and that nothing much was done except by a temporary surgeon, the apothecary and matron with her sisters.

The Great Fire of London in 1666 cleansed the streets, destroying narrow alleys and houses built far too closely to each other. After that year the plague never returned on such a large scale.

A new danger came to England in the 19th century, the cholera. This infectious disease came from Asia spreading to Asia Minor, Russia and in 1832 to England. Once established it caused waves of epidemics, like the plague in earlier centuries, in 1832, 1849, 1854 and 1866. In London the fight against cholera is largely associated with the name of Edwin Chadwick, a barrister, who devoted himself to the cause of sanitary reform. He pointed out drains and sewers too near the surface of the road with badly bricked up holes, cess-pools in basements and over-crowded houses without any proper sanitation. Thanks to him and others the City authorities passed a new City of London Sewers Act in 1848, greatly extending the powers of the Corporation for sanitary improvement of the City. Though Chadwick also pointed out the importance of having a clean supply of drinking water, he did not succeed in abolishing the private water companies more interested in making a profit than in supplying wholesome water to the City. The Metropolitan Water Board was not formed until 1903. Notwithstanding the improvement in the sewer system, the cholera easily spread in the City because of infected water.

In the early 19th century the sanitary conditions in the hospitals were also far from satisfactory. The buildings designed by James Gibbs in the 18th century may have been modern as far as the wards were concerned with ample space for each patient but they were almost without any sanitary arrangements. On each floor there were "rooms of ease" or "necessaries" as they were elegantly called by the Governors. These were connected by brick pipes to a cess-pool at the back of each of the three wings used for patients, that is behind the East, West and South wing. A small wooden door was put at the end of each brick pipe where it entered the cess-pool. This door could be raised by a metal handle to enable the contents of the pipe to be discharged, or it could be pushed down closing the entrance to the cess-pool. Whenever the pool was full, it was emptied by the night-soil man and rubbish carter and his helpers who closed the wooden doors before beginning the work. When finished they opened them again and they carried the contents of the cess-pool to country farms thus spreading bacteria and all kinds of infection.

It is not surprising that the neighbours sometimes complained: as, for instance, in 1785 when they said that the cess-pool near Little Britain was too full of soil and therefore offensive to the inhabitants and even to passers-by. By 1800 more complaints reached the Governors and in addition the physicians informed them that the atmosphere in the wards was unpleasant. This was remedied by installing a forcing pump with a cistern of water which would force the matter down into the cess-pools.

In 1827 the Governors realised at last that the sanitary arrangements were completely inadequate and out of date and they ordered the hospital surveyor, Philip Hardwick, to prepare a report for improvements. In June 1829 this was laid before the Board. In this report it was stated quite clearly that the cess-pools were extremely offensive and that if an epidemic occurred they "might be productive of great mischief to the hospital and the neighbourhood." Mr. Hardwick proposed to connect the pipes with the common sewer already in existence outside the hospital and to erect a water cistern for at least 3,000 gallons in the centre of the roof of each wing, obtaining the water by boring at the back of the South wing, now demolished and

replaced by the George V Block, as the water supply of the hospital, provided by the New River Company, was insufficient. In future this water should be used only for the laundry, medical building and in the houses of the staff. From these cisterns on the roof the water had to be pumped by a small steam-engine of two-horse power to the water closets on each floor. A cistern for 100 gallons would be sufficient for two such closets. A valve apparatus should be put in which opened by the weight of the patients sitting down and closed on rising-up. An air-trap must be fixed at the bottom of each funnel pipe to prevent any matter rising from the drain. In addition the surveyor proposed to screen off a small area near the water closets in which patients might wash themselves with water laid on from the cistern. The roof cisterns should also supply a bath. A steamboiler could heat the water on the ground floor from where it would rise to fill the baths which should be made of copper protected by paint. In order to prevent the system from freezing up, the roof-cisterns had to be emptied at night into the cisterns of the water closets which must be under cover and well sheltered against frost. The surveyor calculated that these improvements would cost about £4,300. His plans were accepted by the Governors.

These alterations may well have been almost finished when the first outbreak of cholera reached the City in 1832. The City of London Board of Health asked the hospital whether cholera patients would be accepted and if so, how many. The Governors refused to admit any into the hospital buildings because they did not want to endanger other patients but they proposed to nurse them in a house specially arranged for sufferers of cholera. Their first choice was a house in Christopher Street off Finsbury Square but the neighbours made such a strong protest that a house in Smithfield was prepared instead for the Governors still refused to accept any cholera patients "for a difference of opinion still exists whether this disease be or be not communicable to others." The patients in this Smithfield house were registered separately and we know therefore that between 12 March and 9 November 1832 57 cases were admitted, 21 of whom died.

Another epidemic occurred in 1849 but this time the patients were admitted inside the hospital, in Bentley and Lucas wards in what was then a new building finished in 1842. (Now Kenton and Lucas wards). Between 17 June and 6 October 1849, 478 patients were treated who came mainly from overcrowded streets. During this period 199 died. In their report to the Governors the physicians proudly stated that St. Bartholomew's Hospital was the first hospital in London to admit cholera patients. Their treatment proved to be more expensive than that of other patients for extra bedding and washing was needed and brandy and wine had to be prescribed. Some of the patients were extremely poor and had to be given clothing on discharge. Only one member of the staff died but though the two ward sisters, the apothecary and some clinic clerks developed the same symptoms as the patients, they were soon cured after a short leave. The Governors were given a detailed description of the treatment. "A delicious hot bath was arranged which was glided so gently and so noiselessly to its side that the lightest sleep of the sick in the adjoining beds is unbroken by its movement." This relieved the painful cramps and back in bed the patient was kept warm by "frictions" used by the nurses. He was given cold water to drink to quench his thirst and also pieces of "American ice." We are not informed whether any medicine was prescribed but the physicians must have given prescriptions for the apothecary was kept extremely busy, needing an assistant for the period of the cholera epidemic. The Governors appreciated the extra work which had been done. The apothecary received a gratuity of 50 guineas and the two ward sisters received 15 guineas each.

A third epidemic occurred in 1854 and patients were admitted from 23 July onwards. Again the Bentley and Lucas wards were reserved for sufferers of cholera only. The last case arrived on 23 October. In total 322 cases were admitted, 105 of whom died or about one-third, but of these 105 patients 93 were brought into the hospital already dying. As in 1849 the wards were thoroughly cleaned afterwards and this time none of

the staff contracted cholera. We are also better informed about the actual treatment. The patient's were given calomel in doses of 5 grains at frequent intervals and sometimes smaller doses were used, given every 10 or 15 minutes. Whenever necessary one grain of opium was added to the 5 grains of calomel. The physicians also tried calomel with salines, emetris and occasionally castor oil with capsicum. Ice-cold drinks with liquid nutriment was given and a moderate amount of alcoholic stimulants. Yet in their report the physicians had to acknowledge that their remedies had little influence on the course of the disease and that only in the early stages calomel with opium had been beneficial.

In 1866 the hospital again accepted cholera patients but we do not know how many. Between 17 July and 1 November 1866 31 of them died. After that year cholera patients appear only sporadically in the hospital's registers.

During the epidemic of the plague in 1665 the medical staff ran away leaving the patients to a substitute surgeon and the apothecary with matron and the ward sisters. In the 19th century the hospital was much better equipped to deal with emergencies. The sanitary conditions had been greatly improved and the wash place next to the closets was a great step forward. Not knowing much about cholera the Governors cannot be blamed for refusing to accept cholera patients in the wards. When they did come into the hospital in 1849 the staff was affected to some extent but in 1854 even this danger was avoided. They may not have had our systems of warnings sent out before hand, yet considering the comparative ignorance of the physicians and the absence of any disinfectives, they managed remarkably well.

BARTSTIME - 2, Richard Rooker

By A. J. B. Missen, F.R.C.S.

The earliest mechanical clocks made in this country were clearly derived from continental designs and were made in relatively small numbers. The first typically English clock to be evolved was the lantern clock which started to appear in the reign of Elizabeth I. Simple in design and robust in construction, these clocks gave good service and remained popular for a long period, some country makers continuing to produce them until the mid-18th Century. More recently the makers of Birmingham brassware have flooded the market with a host of replicas which differ mainly in that they are spring driven. The lantern clock was first designed to hang on the wall and is usually provided with a staple at the back and two steel spikes to stop it moving. Many examples also have bun feet on the case so that the clock could stand on a bracket if desired.

These clocks were driven by a weight and rope or chain, requiring winding daily. The escapement was by means of a foliot (a swinging weighted beam) or a crude form of balance wheel. There was usually only one hand which told the time to the nearest quarter hour. Following the introduction of the short pendulum by John Fromanteel in 1658 the accuracy of these clocks was greatly improved without material change in their appearance. However, the subsequent development of the anchor escapement and long "Royal", or one second pendulum offered a further improvement in timekeeping and many lantern clocks exist today which were converted at an early date to the "new" system. From the lantern clock was developed the hooded wall clock. This may best be described as a weight driven version of the bracket or mantel clocks which were coming into fashion in the last quarter of the 17th Century. Being weight driven and often equipped with the long pendulum these clocks could only stand on a bracket or hang directly on the wall. However, the "hood", or case, was now made of wood instead of brass as in lantern clocks.

The development of the 8-day movement which required heavier weights than the 30-hour timepiece made it difficult to hang these clocks on the wall and led to the introduction of the dustproof wooden "long case" which housed both the weights and the pendulum and supported the movement. Thus originated what is probably the archetypal English clock which remained in production in various forms for 250 years and in the popular song of H. C. Work (1878) acquired the name of "grandfather" clock.

Bart's owns a good example of a long case clock dating from the first half of the 18th Century. The movement is by Richard Rooker of London. Baillie records that he was apprenticed in 1685 and was free of the Clockmakers Company in 1694. His workshop was in West Smithfield. Research in the Hospital archives reveals that Rooker was a tenant of the Hospital living in a house near the South Gate in King Street. He signed a contract on 6th November, 1717 for 21 years at a rental of £12 10s. 0d. p.a. and made his last payment in September, 1741.

In 1735 the minutes of the Board of Governors record on 3rd July "Ordered that the renter do pay to Mr. Rooker, the clock maker, ten guineas for the new clock set up in the Compting house and 10s. for winding up the dyall on the Hospital gate for the half year". The "Compting house" is now the Clerks Office and the new clock set up by Richard Rooker in 1735 remains there to this day.

Fig. 1 shows the fine burr-walnut veneered case 8ft. 6in. tall with the rather heavy dome and gilt wood finials above the dial which are typical of the period. The dial (Fig. 2) is signed in the arch Richard Rooker, London. There is a subsidiary seconds dial and a calendar aperture inside the chapter ring above the figure VI through which the date, inscribed on a separate calendar ring, may be seen. The movement itself follows the pattern already well established by 1730. The escapement is of the anchor type with a one-second pendulum. The two weights drive striking and going trains placed side-by-side and the striking mechanism

is of the "rack" type invented in 1676 by the Revd. Edward Barlow. The plates are thinner than those of bracket clocks of the period and are separated by five pillars which is compatible with the overall quality of the clock. The movement appears to have suffered less than usual from "improvers" and "bodgers" perhaps because it is a "one owner from new model". In today's changing world there is something very reassuring in the thought that this clock has given faithful service in the same room for over 200 years.

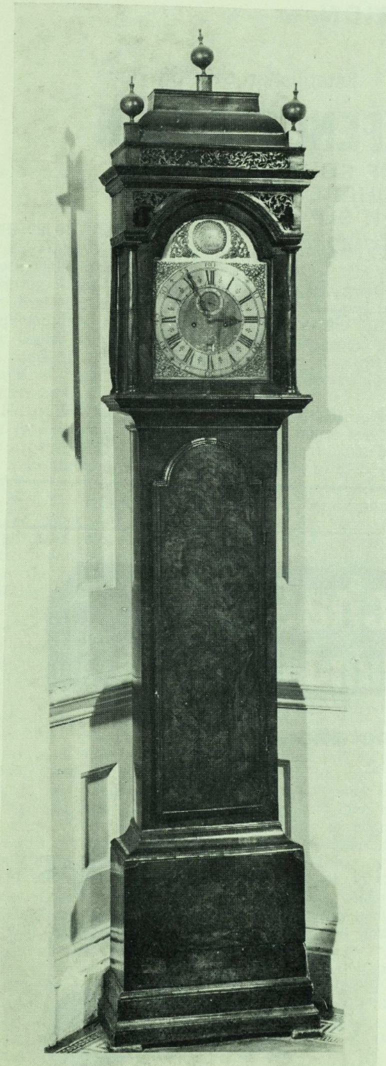


Fig. 1. Long case clock by Richard Rooker of London bought by the hospital in 1735.

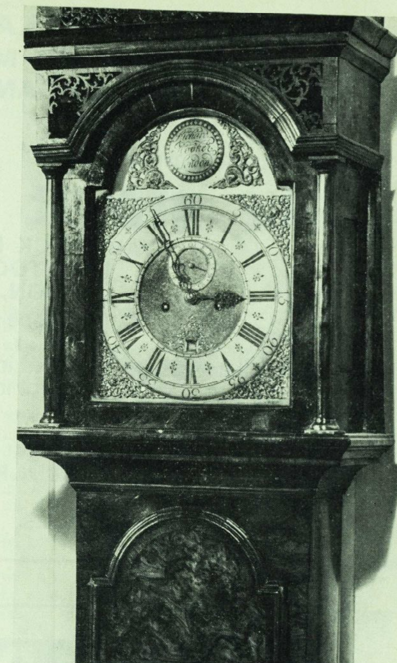


Fig. 2. Dial of clock by Richard Rooker showing signature in the arch.

Acknowledgements

I am most grateful to Miss N. Kerling for verification of details from the Hospital archives and to the Department of Medical Illustration for permission to use the photographs of Richard Rooker's clock.

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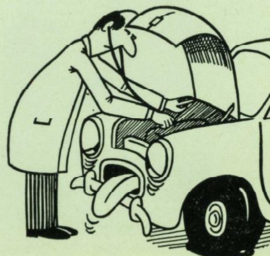

THE CUT RATE

JOHN PAYNE *gives a blow-by-blow description of his vasectomy*

THE SURGEON was a small, neat man with hair brushed like Denis Compton's used to be in the Brylcreem ads, except that it was white. At our first meeting, when he had explained what the operation involved, he had struck me as being pleasant and unpretentious. He had a Rover 2000 parked outside the clinic, which is pretty modest as surgeons' cars go, and at 16 guineas per vasectomy, each taking about as long as a haircut, he could clearly afford something fancier if he wanted.

He smiled me into the room and casually invited me to drop my trousers down to my ankles and get up on the table. He was in his shirtsleeves and had on a see-through plastic pinny. He looked as if he was going to do some weeding, and I began to wonder if perhaps the informality wasn't being a bit overdone.

The room had been hired for the day from the local child-welfare clinic. It was painted eau-de-nil with a dark brown dado, and the only furnishings were the makeshift operating table and a bundle of stacking chairs. Someone had tried to add a homely touch by sticking a handful of paper chrysanths in a vase on the windowsill, and there was an unframed picture of a Disney-type rabbit leering down at you from the wall beside the table. I wondered if everyone who came there saw the irony of it.

Thoughtfully a cloth had been spread over the table to take the chill off. I unzipped my fly and reluctantly uncovered myself and lay down, staring at my bunched-up trousers with my shoes poking up out of them like old tombstones. I had an urge to arrange my hands coyly like Botticelli's Venus but managed to rake up some sangfroid and fold them on my chest. They were shaking a little, but of course that was only because I'd had to hurry to keep my appointment; and that was why I was breathless, too.

The surgeon was scrubbing up at the sink in the corner. Somehow still having my tie on was making me feel even more naked than if I'd been completely stripped, and the longing to pull my shirtfront down was pretty well irresistible.

But is wasn't till the nurse who was to assist the surgeon came into the room that just how foolishly obscene I must look lying there like that really hit me. It was as if I'd been caught out in the lavatory. I'd had to shave my vitals for the operation, and the absurdity of this bald patch at the end of my hairy legs—well, I think it was then that I started to sweat.

The plastic pinnies they had on seemed to make it worse somehow. If they'd been got up in the whole theatre bit, decently veiled by face-masks, shrouded in Mother Hubbards, and clumping about in those great white wellies—at least they would have been sort of like robots then and perhaps I could have seen it through with my dignity intact.

Belatedly the surgeon came over and draped me with a green table cloth sort of thing. As he shook it out I saw there was a slit in the middle, and it didn't take much working out what this was for. Lying flat out as I was I couldn't see what he was up to down there, but I felt him draw me through the slit and arrange me on top of the cloth.

God, I thought, now I must look like sweetbreads on green salad.

But at least he was being gentle about it, and that was a relief because last time he'd handled me, when he demonstrated where he would make the two tiny cuts he said were more or less all a vasectomy involves—well, let's put it this way, he'd seemed to believe in grasping the nettle firmly.

It was after that encounter, two months earlier, that I started to get nervous about what I was letting myself in for. It's too throw-away to say I'd put my name down simply because I was bored with hearing my wife moan about the weight the Pill had larded on her; but certainly there hadn't been any soul-searching about it. I had no hang-ups confusing fertility with virility, which make some men fight shy, and the irrevocability of the operation didn't bother me at all. We have three children, and who needs more with the ecology and the economy in the state they're in?

This was about the time Richard Crossman announced that he was putting vasectomies on the National Health, so I went along to my GP and asked him to fix me up. But it turned out to be another bit of Crossman's sleight-of-mouth, and in practice getting a vasectomy on the State is about as easy as getting Scrooge to underwrite the Concorde development costs.

I could go into hospital for a night and have it under a general anaesthetic for 25 guineas; or, suggested my doctor, how about the cut-rate job the Simon Population Trust do with a local?

And that was what I was having—the alfresco version, complete with rabbit.

And there was the syringeful of local anaesthetic being squinted at by the surgeon prior to making me numb. So the story went, to his knife. He saw me looking at him, and my tension must have been showing, for he smiled reassuringly.

"You'll just feel a small prick, that's all," he said.

That was wildly understating what I'd felt up to then, but I let it pass.

The needle stuck me, and in spite of my toes being curled up tight inside my shoes my right leg jerked as if I'd been plugged into the light-socket. But the anaesthetic took effect immediately and after that he could have been using a blunt breadsaw on me for all I knew. All I felt was ridiculous.

The object of a vasectomy is to short-circuit the supply route of the sperm, which travels down to the testicles via two thin tubes called the *vas deferens*. Each *vas*, right and left, is cut through and sealed, and the only difference it's supposed to make to your sex-life is that for ever after you're only firing blanks. The *ejaculate* is just the same as before but there are no sperms lurking in it.

The surgeon gave me one of his relax-and-enjoy-it smiles. "Not hurting you at all, am I?" he asked.

"No, not a bit," I had to admit. (Then why was I sweating so much?) "The only thing bothering me is what it's going to be like once the anaesthetic's worn off."

"Oh," he said airily, "most people tell me it's no worse than being hit there by a cricket ball."

I didn't like to say that that had always been the worst possible thing I could imagine happening to me.

The nurse kept passing him instruments and things, and it was obvious there was more to it than simply the odd cuts he'd made out. The way his nearside elbow was jerking reminded me of when I used to watch granny do her crochet. I looked up at the grinning rabbit and was sorry myxomatosis seems to have run its course.

Then it was over, all done in 20 minutes flat, with the cuts sewn up by a couple of catgut stitches that would self-destruct after seven days; and there were my trousers yanked up back where they belong, and I was shaking hands with the surgeon (though still not able to bring myself to look at the nurse) and thanking him—actually thanking him, masochist that I am.

As we parted company he pressed a small cardboard box into my hand. I thought at first it must be some kind of medal, or the sort of token dentists used to hand out—you know, storybooks about the Ivory Castle and Dragon Decay—if you were a brave boy and didn't cry.

But it turned out to be two small glass phials for me to send specimens to the laboratory for sperm counts, the first after eight weeks and the second a week later. Apparently there's quite a large stock of sperm held in readiness in the testicles and you have to be sure you've used up this lot before you can be guaranteed sterile once and for all. It's a pity they can't find a way of giving you the all clear without making you feel like you're in "Portnoy's Complaint," but there it is.

And how was it after the anaesthetic wore off? Not nearly so bad as I'd feared, as a matter of fact. The closest analogy I can think of is the ache one used to get when a girl kept saying "No" no matter what one tried. What we called lovers' nuts when I was a lad.

And except for anyone who has to ride a bicycle for a living it's like what they say about having a baby: a pain soon forgotten. The embarrassment, though—well, that's something else again, and maybe it's worth running to the extra for the fully orchestrated hospital job. At least you go through that with the dignity of oblivion.

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CURRENT APPROACHES TO FERTILITY CONTROL IN THE MALE

BY PETER M. COLLINS, M.Sc., Ph.D.
Department of Zoology and Comparative Anatomy

Recent estimates show that at its present rate of growth the world population will double in less than 35 years. The fact that 50% of the world's population is confined to only 5% of the global surface means that certain areas are already experiencing the consequences of this unchecked growth in an acute form (Dorn, 1964). Unless the birth-rate in many under-developed countries is reduced dramatically there is no possibility of their ever achieving a successful industrial economy. In more developed countries also deficiencies in social systems are increasing under the strain of excess numbers. There is thus an urgent need for reliable contraceptive procedures, applicable to a variety of economic, religious, and cultural situations. Modern techniques with a recognised physiological basis have proved more effective and generally acceptable than "conventional" contraceptives. Thus in the female, suppression of ovulation, by the oral administration of compounds chemically similar to endogenous ovarian hormones, has set a new standard of effectiveness for contraceptive procedures.

Recent advances in our understanding of the way in which the male reproductive system is regulated have led to a point where a similar approach may be considered for the male. The present brief account is concerned with the development of methods for the physiological control of male fertility and the basis for their action.

1. Some Aspects of Normal Testis Function

The primary function of the mammalian testis is the daily production of the many millions of germ cells (spermatozoa) necessary to ensure fertility. Formation of these cells takes place in the seminiferous tubules where each spermatozoa is formed as the end-product of a complex series of cell divisions and developmental processes (spermatogenesis). Over recent years work in this laboratory has produced evidence that spermatogenesis is controlled locally by a hormone produced by the only non-germinal element of the seminiferous tubules—the Sertoli cell, (Lacy et al, 1968; Collins and Lacy, 1970). As a collateral function the testis also produce male sex hormone (androgen), responsible for the outward signs of male sexuality and the maintenance of the accessory organs of reproduction. The glandular tissue which secretes this hormone lies between the seminiferous tubules and is termed the interstitial tissue.

The duality of testis function is emphasised by the fact that each of the two testis components is conrolled by a separate gonadotrophin hormone produced by the pituitary. Thus the maturation and maintenance of the interstitium is dependant on the so-called luteinising hormone (L.H.) while the follicle-stimulating hormone (F.S.H.) promotes and maintains spermatogenesis. Recent experimental evidence indicates that F.S.H. exerts its effect by stimulating the production of hormones by the Sertoli cell (Lacy, 1963). In turn the levels of secretion of pituitary gonadotrophins are controlled by the tubules and interstitial tissue. It is well established that the reciprocal relationship which exists between levels of circulating testosterone and L.H. results from the inhibitory action of the sex hormone on the pituitary. Similarly there is some evidence that the tubules also produce a hormone with an inhibitory action on the pituitary. If the production of this hormone could be attributed to the Sertoli cell, the duality of testis function would be complete (see Collins, 1969)

2 Control of Testis Function as a Contraceptive Measure

From the fore-going account it is apparent that fertility control in man may be achieved by preventing the formation of normal sperm either by the direct action of an injurious agent on the seminiferous tubules (or epididymis) or indirectly by interrupting the normal supply of gonadotrophic hormones to the tubules. Unfortunately most agents which modify testicular function affect both components and hence produce a loss of fertility which is associated with a reduction in libido and potentia.

AGENTS WHICH ACT DIRECTLY ON THE TESTIS

Spermatogenesis is extremely vulnerable to a number of physical stresses such as heat or irradiation. While it has never been seriously suggested that such agents be used to control fertility their application to experimental animals has provided a great deal of useful information on the way testis normally functions (Lacy, 1963; Collins and Lacy, 1968). Of more practical value are those substances which act specifically to impair metabolic processes related to spermatogenesis. Of the numerous pharmaceutical compounds possessing this action only a few have proved sufficiently free of side-effects to justify a clinical trial. Amongst these a series of bis (dichloroacetyl) diamines proved effective in inhibiting spermatogenesis when administered orally, and this effect was reversible. These compounds had the additional merit of not modifying the endocrine functions of the testis or pituitary. Unexpectedly it was found, during the course of clinical trial, that the use of these compounds was attended by an exaggerated re-action to the effects of alcohol! (Nelson, 1964). Mean while research into compounds for use as antispermatogenic agent is continuing and it is likely that many will become available for clinical study.

AGENTS WHICH ACT INDIRECTLY ON THE TESTIS

The sex hormones found both in the male (androgens) and the female (oestrogens and progestagens) belong to a closely interrelated chemical family known as steroids. When administered in appropriate doses to the human male substances of this type suppress the secretion of gonadotrophic hormones by the pituitary gland to produce *qualitatively* similar effect on the testis. Oral administration of such compounds causes a total disruption of spermatogenesis and in a number of weeks (usually 6-12) an azoospermic ejaculate is attained. When the treatment is discontinued there is a gradual return to the pretreatment condition over a period of two months to over a year. In some cases sperm production continues to rise to above pretreatment levels and may remain elevated for many months. Use is made of this so-called "rebound phenomenon" in the treatment of oligospermia (Heller *et al*, 1968). Marked *quantitative* differences exist in the ability of different steroids to suppress the pituitary. The potency of the various compounds tested in this respect seems to be directly related to their oestrogenecity. In short the more effective a particular compound is in inhibiting spermatogenesis the greater will be the accompanying feminizing effects.

Since steroid hormones are the natural regulators of testis function attention has been given to the possibility of employing compounds of this type to control fertility in man. Research associated with the female pill has provided a battery of natural and synthetic progestational compounds suitable for clinical use. Similarly many potent forms of orally administrable androgen are available. Each type of compound is exceptionally effective in inhibiting sperm production. Unfortunately their *individual* administration depresses total gonadotrophin levels and hence interstitial cell function. Consequently sterility induced by oestrogens and progestagens is invariably accompanied by impotence and a lack of libido. Orally administered androgens on the other hand directly compensate for the loss in natural production of male sex hormone, but are only effective as anti-spermatogenic agents in quantities far in excess of those needed for normal sexual development! However our own experience with the use of this type of compound has shown that their use in judicial *combinations* can overcome the disadvantages noted when they are used singly. Thus small doses of an oestrogen

and/or a progestagen may be used to suppress the pituitary and hence sperm production, while the addition of androgens in *physiological* doses would serve to maintain the masculine status. There is every reason to suppose that in this way a male contraceptive pill based on a combination of clinically tested compounds could be devised.

3. Applications of the Male Pill

The effect of a contraceptive pill of the above type would be to prevent sperm production by precluding certain specific developmental processes. Under these conditions there would be a continual degeneration of large numbers of germ cells as successive generations reach the limit of their development. The immediate consequence of this loss in germinal material would be a shrinkage in the testicular apparatus to prepuberal size. In addition biochemical evidence available from studies of the effect of various stresses indicate that germ cell degeneration on this scale is accompanied by an abnormal pattern of hormone production by the testis (Lacy, 1963; Samuels *et al* 1967; Collins *et al* 1968). Thus alterations in the hormonal milieu arising both from modifications in endogenous hormone production, and from the administration of biologically active compounds might follow the use of the pill. The possible long-term effects of these changes needs to be considered in judging the merits of the method. Finally there would be a long time interval between the commencement of contraception and the attainment of a sterile ejaculate. An even longer period of time would be necessary for the recovery of fertility when contraception is discontinued. These factors would make the male pill less flexible in its application than its female counterpart.

In spite of these possible shortcomings the male pill could prove useful as part of a sophisticated, long-term family planning programme. Thus the alternate use by the husband and wife of their respective pills might avoid some of the objections to protracted usage of hormonal preparations.

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A SURVEY ON SYNOVECTOMIES OF THE WRIST

BY JOHN W. FRANK

Rheumatoid arthritis is an inflammatory condition of some chronicity affecting primarily the small joints. The exact cause of the disease is unknown: auto-immunity has been postulated, but recently the theory of micro-organisms, such as Mycoplasma, as the causative agents has been re-advanced.

The medical treatment of rheumatoid arthritis consists mainly of rest of the affected joint where practicable, splinting, physiotherapy to prevent stiffness and deformity, and drugs to either reduce pain, or inflammation, or both. Aspirin, which combines both these properties, is the drug of choice, despite its side-effects. Other drugs such as phenylbutazone, indomethacin, gold and intro-capsular hydrocortisone are also used.

Surgical treatment, by synovectomy and removal of all excess rheumatoid tissue, was until recently only performed as a last resort, when there was no active inflammation. However, synovectomy is now undertaken earlier in the course of the disease.

The purpose of this survey was to find out, by questioning he patients, if synovectomy had been useful to them. It was not a controlled trial, merely an objective evaluation of patients who had been seen by Dr. Balme and operated on by Mr. Lettin. The survey only concentrated on those patients having had synovectomies of the wrist and fingers—"finger" includes those having had flexor or extensor tendon synovectomies.

The notes of all patients operated on between 1967 and 1969 were obtained from the Statistics Department and a questionnaire drawn up. Twenty-five people were contacted and asked to attend; of these, 21 (84%) did so.

Of the 21, 7 (33%) were men, whose ages ranged from 40-60 years, the average being 49 years. The rest were women, with an age range of 29-66, the average being 53.7 years. Eleven of the patients (52%) had had wrist synovectomies, the rest "finger" synovectomies.

The pre-operative conditions needed for the questionnaire were taken from the Houseman's admission notes. The only comment that I have on this is that in only 8 (38%) cases were pre-operative wrist movements and grips recorded as meaningful figures. This made objective assessment very difficult. In these 8 cases, 4 had decreased post-operative grips, and in 4 they were increased or unchanged.

The following results could be drawn from the questionnaire and assessment at interview:

	Total		Wrist	"Finger"
1) Immediate post-operative pain				
Severe	4	19%	2	2
None or slight	17	81%	7	10
2) Pain at assessment				
None	15	71%	7	8
Slight	6	29%	2	4
Severe	0			
3) Tenderness, on a scale 0-3, at assessment				
0 = no pain	18	85%	10	2
1 = pain on deep pressure	3	15%	1	8
2 = pain on light pressure	0			
3 = pain just on touching	0			
4) Grips, at assessment				
R—range 15-240, average	110			
L—range 15-240, average	107			
cf normal of 280 for both hands				
5) Mcvement at assessment				
Inc. or equal	8	38%	3	5
Decreased	5	24%	5	0
Not recorded pre-op	8	38%	3	5
Post-op range—palmarflexion 0-90, av. 25; dorsiflexion 5-60, av. 35				
6) Pre-op disability—less than 1 year				
Better post-op	9	43%	5	4
Worse post-op	1	5%	1	0
greater than 1 year				
Better post-op	7	34%	5	2
Worse post-op	1	5%	0	1
Not specified	3	14%	0	3
7) Subjective post-op disability re fine movt.				
Less than pre-op	16	76%	7	9
Greater than pre-op	5	24%	3	2
8) Patients' impression on assessment				
Better	19	91%	10	9
Worse	2	9%	1	1
9) Work				
Easier	16	76%	8	8
More difficult	4	19%	3	1
No change	1	5%	0	1
10) Improvement noted				
Immediate	8	38%	5	3
Few weeks	3	14%	1	2
Months	10	48%	5	5
None	0			
11) Operation again?				
Yes	13	62%	7	6
No	4	19%	2	2
Don't know	4	19%	2	2
12) Latex fixation test				
Positive	16	76%	8	2
Negative	5	24%	3	2

As far as the post-operative course is concerned, there is no greater improvement in those patients with −ve Latex than those with + ve.

The general impression, from these results and also from the patients themselves, is that the operation is worth-while, and leads to an improvement by reducing pain considerably. Most patients put up with decreased grip strength or a slight decrease in movement, especially when there is no pain, which means that they can use the joint more than they could previously, making work or housework easier, a finding in 76% of cases. There also appears to be no difference in result if the operation is done earlier rather than later.

Of course, there were only a small number of patients involved in this survey, yet the general feeling is that the operation is successful in relieving pain, and is therefore beneficial.

I would like to thank Dr. H. Wykeham Balme and Mr. A. W. F. Lettin for allowing me to use their patients in this survey; and Dr. P. A. Bacon for help in drawing up the questionaire, and encouragement throughout.

John Frank is a final year student at St. Bartholomew's Hospital

Bart's Folk and Blues Club

Folk music is becoming more popular every day; all over the country new clubs are being formed by people who have listened and found real enjoyment from this type of music—and now we at Bart's are doing the same.

The club was started about 18 months ago by a group of nurses and medical students. The response was excellent and I think the evening was enjoyed by both singers and audience.

At that stage we were holding the meetings on outside premises—the idea being mainly to see how we would be received.

Several meetings later (to all of which the response was really good), it was decided to make the club a little more official and we were very pleased to hear that we could use the Abernethian rooms. Since then we have had two meetings there and find the situation ideal.

Folk music cannot be categorized, not even into traditional and contemporary—so much we have found out on club evenings; the talent which has come forward is of a high standard and versatile, and this is what encourages the audience to join in as a whole.

We are still happy to receive new members, also new singers so why don't you come along and sing with us!

E.J.G.

Nursing in Depth

March 1971 sees the publication of the first four titles in this important new series of nursing handbooks. The authors are all well known in British nursing, and the intention is to provide in each volume a detailed survey of facts and practice in a specific aspect of the nurse's work. Pocket-size and at an incredibly low price, they will be ideal for the student nurse as study guides, revision aids or as the basis of refresher courses for women returning to the profession after a break.

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Book Review

"KNOTS" by R. D. Laing. (Tavistock, £1.50).

A new book by R. D. Laing is always assured of a large readership, but is it the right sort? Since "The Divided Self" appeared in 1960, his work has been widely read in the bedsits of Cambridge and Keele by a bevy of eager Art students who, though well-meaning, usually lack the background to understand what he is all about. No one would expect the average untutored mind to cope with the intricacies of Melanie Klein or Harry Stack Sullivan, so why Laing? Sadly, he has become fashionable, and as everyone knows, the essence of fashion is transience. As a result, many young people revere Laing and reject more conventional psychiatric writing for the wrong reasons; and although Laing needs all the friends he can get, it would be nice if his camp were pruned of band-waggoners.

For those who don't like his work anyway, "Knots" is a heaven-sent gift. The book is set out as a series of statements couched in poetic vers libre form; there is little more than a sequence of introspections. No reasoned discussion, no analysis, no evidence, and (horrors!) no smug conclusions. Thirty shillings for ninety pages; and all of it, according to some critics, fit for "pseud's corner".

But what many detractors fail to realise is that you don't have to be wordy to make your point. And further, that Laing's choice of form allows for the greatest clarity in the exposition of ideas that are often very complex. For example, the first page reads:

> They are playing a game. They are playing at not playing a game. If I show them I see they are I shall break the rules and they will punish me. I must play their game, of not seeing I see the game.

Now, would it have been clearer, if Laing had expressed his thoughts in a less skeleton-like fashion? I doubt it, for by giving us the bones only, he allows us to follow him and stay the course; moreover, the example quoted above is the most straightforward in the book. Things are getting sticky by about page twelve. As we can see, Laing's concern with role-playing is as pronounced as ever. However, he has taken the psychotic's subconscious juggling of self and not-self two stages further; neither are the subjects of these statements psychotic, nor are their devious mental twists purely subconscious. It is this universality that makes "Knots" so informative and entertaining. One identifies the whole way through, and for those who enjoyed the perceptiveness of his earlier book "Families of Schizophrenics" I can guarantee that the insights contained in "Knots" are every bit as startling. Most of it, admittedly, is tough going—and one does well to remember that two negatives make a positive, for the book bristles with impossible situations which make "Catch-22" seem like child's play:

> Jack thinks
> he does not know
> what he thinks
> Jill thinks
> he does not know
> But Jill thinks Jack does know it.
> So Jill does not know
> she does not know
> that Jack does not know
> that Jill thinks
> that Jack does know
> and Jack does not know he does not know
> that Jill does not know she does not know
> that Jack does not know
> that Jill thinks Jack knows
> what Jack thinks he does not know.

J. S. Tobias.

Bart's Drama

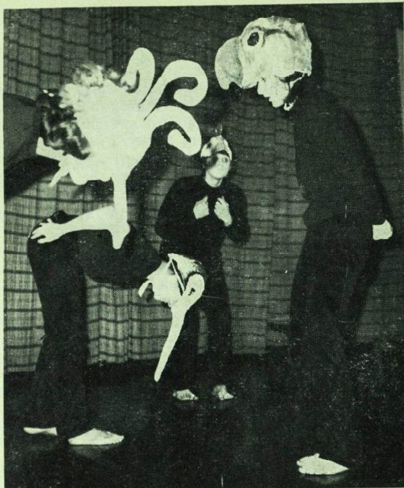
'THE BIRDGARDEN'

By Paul Swain

Paul Swain's new play was performed by the Drama Society at this year's University of London one-act play festival. It turned out to be an ideal medium for an amateur company—as was implied by the festival adjudicator—being colourful, formal, and very lively. For the second year running the Society received two awards at the festival—one for the best production and one for the acting—presented to the chorus en masse.

The acting without exception was unashamedly vigorous and enjoyable, but Robert Robertson in particular, playing the central rôle, is to be congratulated for his extremely entertaining and flowing performance. The make-up was really excellent, as were the highly effective and unobtrusive music and sound effects. In fact the production as a whole—masks, costumes, and of course carp-assisted the play beautifully.

The play itself was an allegorical fantasy, set in a mediaeval garden inhabited chiefly by some lovely pedantic and humane birds. A magician enters this walled-in paradise bent on testing his creative powers, and builds up a beautiful young girl. In a marvellous passage we hear how he has acquired his sympathetic powers, starting off by being happily immoral and only appreciating human melancholy after he has seduced a newly-wed, whose husband in desperation tries to kill him. But the magician's innocent creation



Scene from "The Birdgarden".

has to age, and is reduced to a lifeless puppet when the real master of the garden, Death—a banal, petty character (in the production dressed in a dinner jacket)—enters and sets his merlin onto the magician. As the magician dies he realises that he is unable to feel any pain, and understands that he himself is only an illusion created by some other magician . . . and so on, presumably, ad infinitum.

The play, then, was highly creative, and in parts nothing short of brilliant. But I felt that in general its poetical style, and some of its humour (much of which I found embarrassingly apologetic) tended to blur rather than enhance the message. A deeper dissatisfaction is due not so much perhaps to a criticism of what the play was, as to a feeling of what it might have been. Its message, if it is intended to be applied to life, is surely one of profound despair. This being so, it seems to me that the play did not sufficiently follow through and communicate its theme—which anyway is perhaps not fully approachable from the particular range of aesthetic values presented.

To end with a eulogy: Jolyon Oxley's direction was masterly. His abilities in working with a big cast were given full rein by the play—which I suspect was written expressly for him. He was thoroughly at home ordering large numbers of birds around the stage, or directing a rose in bloom—and his five-man carp, leaping gracefully, was an absolutely breathtaking sight. The play's formalism was given all the energy it needed to thrive on; and its oblique, mysterious feeling was carried through superbly, by, for example the bird-chorus's postures and movements, or sudden violent, fluid actions by various characters.

As a whole the play was very impressive and very enjoyable—my thanks and congratulations to everybody concerned.

PETER BACON

Hotel Paradiso

BY GEORGES FEYDEAU

A Review—Prose and Cons.

Prose thoughts.

Farce seems a decadent and nebulous art form. Its virtuosity lies simply in the playwright's ability to concentrate comic plotting, in the speed with which he can manoeuvre from one extraordinary comic posture to another. Feydeau is the master of this evanescent medium—it is the very swiftness of his changes of situation and confrontation which differentiates his plays as farces from the comedies of Molière and Congrève, for example. The purity of this form involves of course, a loss. The loss is this. The moral, or rather sexual, basis of his brilliant plotting is stolidly bourgeois. Feydeau's cosmos is farcically simple. Heaven is bedding your neighbour's wife in a little hotel, Hell is being found out. By skilled plotting, Boniface the hero so nearly manages to bed his Marcelle, and is so nearly found out, and by farce alone avoids his salvation or his damnation though we are not always sure which is which.

That paragraph seemed a bit posh for a review about a funny play. So.

Interruption.

In attempting to make this review presentable, even entertaining, one of the authors hit on the idea of writing a review in rhyming couplets—something witty, Byronic and elegant. He had realised at least that it was not easy to write elevatedly about farce without seeming pompous. So he dashed off a few flimsy lines, free in form, in a clinic, and then handed them in the library to another of the authors who snorted, counted syllables and wrote more lines but in a wild stanzaic form. Finally the concoction was passed to the third author who at least gave it feet, if not wings and it grew to completion. For reasons that can only be described as those of quality it was decided that the poem should not be published in full and a review, part prose, part poetry, was chosen.

Extracts from it can of course only hint at the heights that may have been achieved by the completed work. For example

George Blackledge's volcanic Boniface
Made us wonder at the talent that he has
To throw away his lines. The incident
With a hot water bottle was without a precedent
In creating a furore of audiential mirth.

George Blackledge. Boniface. He has the ideal build of the farcical actor, small, energetic and infectiously delighted with himself. Moves fast, neatly and inventively, actually exploiting difficulties with doors. He can strut—could play a hen well. Occasionally and lightly hinted at a sadness in the character that in farce passes for depth. Poor Boniface, so pathetically energetic and inventive in his attempt at infidelity.

Jila Pezeshgi Marcelle. Adept in the technology of farce. Her arms angle extravagantly, her face mugs away expressively as disaster approaches. Very wide awake for a comic actress, she can make maximum comic capital from the classic farcical situation—the faint was fine. She vies though and part of the entertainment was her duel for the audience's attention with George Blackledge. But the result was even and the form of farce admits of a measure of indulgence in acting.

The poem was by no means silent about her, but suffered from a pathetic rhyme for Pezeshgi—confess she—so we abstract the adjective "ravishing", the noun "faces", the phrase "resplendent in comedy".

Janet Dinwiddie. Madam Boniface. Her first middle-aged part. Both vocally and physically more powerful than we had realised. Can girls really turn into middle-aged dragons? Her voice certainly had that authoritarian dominance that men can only dream of disobeying and men were bounced from her rubber enveloped body just as a punch bag would defeat Chaplin. She achieved the authentic farcical frisson terrorising her husband with a hatpin

We relished
The horrific latex embellished
Madam Boniface of Janet Dinwiddie
The director had imposed on her or did he
That stentorian assertiveness that every woman can
Find within herself to dominate her man.

Andrew Boon. Cot. Powerful vocally, he is the reliable foil feeding the lines that Boniface can turn to more volatile comic advantage. Quick enough when his turn comes to exploit with vocal inflection simple exchanges such as that with his wife's lover through a bedroom wall. C. Aatishoo. B. God bless you. C. I thank you.

The poem pays service to his zeal, the word "undaunted" is used. It continues using a particularly adventurous rhyme

With an accent that wandered
From York to Bishop Stortford
He puffed, panted and epitomised a man whose life was drains.

Some of the bit parts were curiously well acted: the cool "I say" of Steven Stansfeld epitomising the fears of every pale boy who has attempted to smuggle an opera singer into a seedy hotel. Nigel Sudworth's Tabu was confident and energetic.

The poem is not silent.

Miss Robertson's demeanour
Might almost have been a trifle seamier
To overwhelm us with the lechery that motivates the play
Now to utter
A word of praise for Martin and the stutter
Handled very skilfully by Peter Bacon.
Those three little girls, they could shriek.

The direction. James Griffiths. His tuition of his actors was excellent, some being relatively inexperienced. They were well spoken and never underacted their lines. His control of many of the comic set pieces was excellent where directorial attention had been plainly lavished. Occasionally it suffered just a little from underdirection, the movement, the comic invention and the style slipping and a few laughs were lost, but then farce makes desperate demands on direction.

In correction
Some delicate criticism of the direction
Might not be out of place. James Griffiths
Is an actor and with actors never stiff he's
Fine controlling delivery with precision.

The technical staff, especially Mike Maguire and Keith Jones have our respect for an absolute terrifying fit up. To open a show as complicated as that with only three and a half hours available to set it up actually in the theatre sends shivers down our technical spines. Jackie Heath did well to find the large numbers of props needed and the costumes (Wiz Mansi) were helpful.

Hotel Paradiso got its audience and its laughs. It entertained a lot of people and it felt very confident as a farce.

First used in English in 1530, the word farce really does come from the French verb "farcir" to stuff. And we quote. "Those Nauseous Harlequins in Farce may pass." Even Dryden could murder a rhyme, too.

JOLYON OXLEY
OLIVIA HUDIS
PAUL SWAIN

Nurses Report

The present Student Nurses' Association Committee is as follows:—

SIAN ROBERTS (*Chairman*).
KATIE SMITH (*Vice-chairman*).
SUE P. SMITH (*Secretary*).
CHRIS MELLOR (*Treasurer*).
SUE JONES.
JILL RUSSELL.
CAROLINE WITT.
TERRY CLARKE.

The Cheese and Wine party organised by the S.N.A. and the Students' Union was referred to by Paul Millard in the February issue of the Journal and was the beginning what we hope will be a long lasting affiliation between the two student bodies. It was enthusiastically supported by both nurses and medical students and we have decided to hold other social events along the same lines; in fact by the time this issue is published we will have held another such party on March 22nd.

For nurses reading the Journal it may be of interest to you that the S.N.A. are now holding monthly meetings which you are invited to attend. The programme is very varied and includes a talk with Mr. Drinkwater, the Hospital psychologist on whatever you would like to discuss—so come armed with plenty of ideas; a film on continental holidays for young people—you travel in a land-rover over whichever country you choose to pick out; a cookery and a make-up demonstration.

Have you any suggestions as to further topics for these meetings? If so I would be very grateful to receive them. We hope that you will support us in these ventures and take an active part in your unit.

SUE P. SMITH,
Secretary of the S.N.A.

BART'S SPORT

INTER-HOSPITAL RUGBY CUP SEMI-FINAL

In the semi-finals of the Hospital Cup Bart's met Guy's whom they had beaten in the final last year. A large contingent of spectators from Bart's was present hoping for further success but this unfortunately was not to be the case.

As with most cup matches the game started at a hard and fast pace with Rees in his usual boisterous manner on the field getting a final warning from the referee after only eleven minutes. After the first ten minutes when play was mainly in Bart's half, the game moved from one end to the other in quick succession with neither side gaining much advantage over the other. This changed however after thirty minutes when Bart's produced the best try of the afternoon. From a line on Guy's 25 yard line Cassidy, passing to Jefferson, ran outside, Guy's backs thus moving across to cover the extra man; however Laidlow coming infield from the wing collected Jefferson's inside pass and streaked through the ensuing wide gap and with only the full back to beat, scored under the posts; Martin converted. With renewed vigour Bart's pack spent the remaining minutes of the first half pressing hard on the Guy's line forcing them to concede 5 yard scrums and to kick hastily out of trouble.

Both packs settled down and play became less scrappy after the interval; Bart's now playing against fourteen fit men, Guy's scrum half having injured a leg late in the first half, might have increased their tally. But Guy's winger Novak was their undoing having a hand in all three tries that followed; moving to the centre he made good ground for Cambell to squeeze in by the corner flag, was obstructed from running for a loose ball over Bart's line from which a penalty try ensued and scored the third try again by the corner flag.

This was an enjoyable game to watch and Guy's were the better side in the second half thwarting Bart's by good covering in defence; in retrospect the score was a fair one, but looking ahead Bart's have every prospect of doing well next year with many good young players in the club.

Final score:— Bart's 5, Guy's 13.

Team: N. Packer, S. Smith, D. Jefferson, M. Martin, J. Laidlow, B. Cassidy, M. Heslip, N. Fairhurst (capt), B. I. Rees, R. Brookstein, N. Allan, J. Carrol, O. Else, A. Mason, T. Fenton.

ROGER LAMBERT

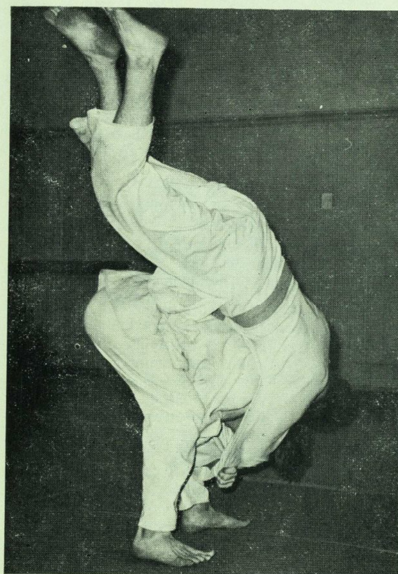
Heslip receives the ball from the scrum prior to starting a move for the backs.

JUDO CLUB

This season so far has not been a successful one for the Judo team—in fact we have only won a single match. However, out team started relatively inexperienced, and with the practice we have had recently and improved fitness, we hope for better things in the rest of the year.

Congratulations to Mark Podkolinski and Bob Miller, who succeeded in grading to 4th, orange, and 5th, yellow, Kyu respectively.

The absence of George Duncley and Adrian Ruddle, due to qualification, was a loss to the team. We wish them as much success in medicine as in judo.



Grand Slam—a match-winning Seoi-Nagi throw.

Judo seems to be an exclusively male sport at Bart's, and it seems a pity that nurses, physiotherapists and women students should miss an opportunity not available at many other colleges. Should there be a demand we provide softer practice mats than those in present use, which we find are a deterrent to beginners of either sex.

Practice nights for the Club are Tuesdays and Thursdays at 5.30 p.m., so contact any of the following if you are interested:—

Hugh Jones—College Hall
Mark Podkolinski—Hospital
John Davies—Hospital

J.R.D.

SAILING CLUB

Match v London Ladies

This match was sailed on the Harp on 17th February with overcast skies, rain, ice on the decks, and a lot of wine.

The Barts team were: Tom Moore, Chris Waite, Dave Patuck, Charles Russell-Smith.

A poor start by Chris Waite in the first race was amply redeemed later on, when he not only managed to overhaul both of the opposition's boats, but also made one of them retire in the process, giving us first and second places. This put us in a strong position for the second race, since we only had to complete the course to win. This we managed to do, finishing second and third after a very close race, in which the same member of the opposition was again forced to retire due to a collision.

This was a good win for us, since the Ladies are renowned as a strong team. Also this was the first time this year that we have managed to sail with the full first team, so this promises well for the Castaways cup in March.

TOM MOORE

CROSS-COUNTRY CLUB REPORT

Having survived the Christmas festivities remarkably well, the team began the erm's fixtures with a match against Britannia Royal College, Dartmouth.

Carloads of clubmembers drove down to Somerset on Friday, 15th January where we were most generously and hospitably accommodated at the home of Hugh Glennie's parents. The following morning saw the BART'S BRIGADE driving on to Dartmouth for the afternoon's encounter with the Senior Service.

Fortunately, all their runners had enjoyed far too good a holiday. We beat the College very soundly—their first defeat this season. It must be added, however, that the two mainstays of the RNC side had been press-ganged off to sea only a matter of days before our arrival.

R. A. Moody (right) moves up the field.

All club members enjoyed the "mini-tour" which is clearly the sort of occasion one hopes will recur in the not too distant future.

In the U.L. League, Division I, Bart's continue to keep the flag-flying (a battered running vest on the parapet of Lambeth Bridge).

RESULTS: 1—U.L. Championships P.H.F. 12-XII-70. 1 LSE 64; 2 QMC L 74;
3 RVC 91; 4 I.C. 112; 5 U.C. 144; 6 BART'S 196; 7 QMC II 247; 8 RHC 292.

In this race, John Brooks came 5th overall with a time of 27.59.

2—U.L. League Race, Division I
Petersham 20-1-71

Bart's: 8th overall—an improvement of two places on our previous League Race at Borough Road on 25-XI-70.

Again a fine run by John Brooks and good supporting performances by Richard "Captain" Moody (see picture) and Bob Miller.

Other results from January-February races:

1—Bart's—Sussex Univ. Brighton 27-1-71—the hospital team was heavily defeated in this fixture by a superb Sussex side—in fact, something of a walk (? run) over:

Sussex University 27
Bart's 64

However, the field was led home by John "The Fox" Brooks (something one has come to expect all through this season as a matter of course) who finished 24 seconds ahead of the next man (Sussex). Unfortunately, there were 6 more Sussex hounds behind John's pursuer. The rest of the Bart's men prefered to bring up the rearguard rather in the style of old-timers at the back of a hunt.

2—On Wednesday 2-II-71, the hospital redeemed its name by sweeping to success in the Middlesex Hospital Relay at Regent's Park. Dave Wainstead ran superbly and laid the sound foundations of the victory.

3—A select quartet, R. Moody, D. Wainstead, M. Erith and H. Glennie (see picture) went to Cambridge on 17th Feb. to participate in the Selwyn College Road Relay. A lap time of 12'47" returned by Mike Erith gave the Club a flying start. Dave Wainstead again ran on top form and ended with the second fastest lap (2 1/2 m.) for the team.

Overall Bart' finished 15th in a field of 25. Not as bad as it appears since the Selwyn is very much a road-race specialists' affair.

4—Saturday 20-II-71 I.C. Hyde Park Relay. Another fast road in which we finished 57th in a field of 80. A result which is two places worse than that of last year—but, of course, some allowance has to be made for Decimalisation, etc...

Our performance in the race as a team in no way reflects the outstanding first leg run by John Brooks. He flowed round the Serpentine course (3 miles) in 14'34" and set a standard which, had it been maintained by the rest of us, would have given us 19th position. Sorry, John!

Fixtures yet to come this season:
(excluding United Hospitals races)

1—Bart's—London Hospital 3-III-71
2—Inter-Hospitals Championships 6-III-71
3—U.L. League Division I race 10-III-71
4—The Club Dinner (a homematch) 19-III-71

A CORRESPONDENT.

DIARY OF EVENTS FOR APRIL

April 3
Rifle Club Hop. Charterhouse Square.

April 6
Bartsfilm. Physiology Lecture Theatre, Charterhouse Square.

April 13
Bartsfilm. Physiology Lecture Theatre, Charterhouse Square.

April 15
London Medical Group Lecture. 'Sexual Abnormalities'. W. Lindesay Neustatter, M.D., F.R.C.P., formerly Senior Physician to the Department of Psychological Medicine, Royal Northern Hospital. 5.45 p.m.

April 17
Golf Club Hop. Charterhouse Square.

April 28
Pre-clinical Term begins.

May 1
Rugger Club Hop. Charterhouse Square.

Future events for your Diary:—

May 8
Guinness Stroll.

May 27
Bart's Music Society. Verdi "Requiem" at Southwark Cathedral.

June 11
Barbecue Ball.

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Editorial

In this issue of the Journal, we feature an article on the National Health Service, commenting primarily on the rigidity of the system and the frustration of interested doctors who are unable to make any impression on a system which is run almost entirely by "lay" people. We, both qualified and unqualified, need to take a long, cold look at the NHS and consider where exactly we are heading in relation to the period of flux which this country is going through. It is extraordinary that a man can practice as a registered doctor in this country, without having any medical degree whatsoever. The height of impudence is then reached when one of these "bogus" doctors announced that he was returning to this country, not only to claim his tax rebate and free treatment from the NHS, but also once more to set himself up as a practising hospital doctor, as he found this deception so simple.

Recently a meeting of the BMA was held to discuss the question of the NHS and the Common Market. A paper printed in the BMJ (1970, 3, 216-218) makes interesting reading on this point. What provision will be made for the practice of medicine if Britain joins the Common Market? The general behaviour of doctors and patients is very different on the Continent: there are restrictions on movement and definite requirements laid down in some countries for the time spent, not specifically knowledge gained, in training for a specialist post. Will the NHS in its present format, and indeed medical training as it is now, be adequate to meet the contingencies of a "united Europe"? Will there be free passage of doctors between countries, and if so, what safeguards will be instituted to ensure that these doctors are competent, both linguistically and medically, to deal with the disorders, mental and physical, of a native population?

No comment has yet been made by the Department of Health and Social Security on these matters—in fact, as the Common Market is primarily an economic agreement (European Economic Community) it appears that very little thought has been given to the problem. The somewhat ludicrous state of affairs is that the Standing Committee of Doctors of the EEC has not yet been recognised as the official advisory body to the European Commission; and yet with the present state of international preoccupation with health, surely somebody is doing something—somewhere?

Spring is the time when everything is supposed to be bright, new and shiny—where the world is one's oyster and the time is ripe to embark on new enterprises and refurbish the old ones. Recently, the Budget was announced, to be met with general enthusiasm, but there was little, if anything, in it which applied to the medical profession per se, or to its present and future problems. The proposed increases in prescription charges have provoked mixed reactions and seem a strange way of filling the government coffers.

"Now is the merry month of May"—but is it?