they only required 40 runs with 4 wickets in hand. Two wickets fell in consecutive overs, and from then on the remaining batsmen obviously attempted to play out time. It was then a question of whether Bart's could capture the final two wickets with less than ten minutes to "stumps".

The ninth wicket fell, leaving Bart's to remove the last batsmen with five minutes to go. With the pavilion clock at 2 minutes to 8 o'clock, the final batsman was caught off the bowling of Martin, to win Bart's a place in the final for the fourth time in the last five years—this time against St. Thomas's.

Bart's

P. Cooper, l.b.w., b. McCleod	13
P. Furness, ct. Goodwin, b. McCleod	50
F. Rowland, ct. McCleod, b. Vaughan	87
C. Reid, l.b.w., b. Vaughan	40
R. Firmin, ct. McCleod, b. Vaughan	2
A. Davies, run out	10
J. Capper, st. Williams, b. Goodwin	6
M. Martin, not out	3
Extras	10
TOTAL for 7 wickets declared ...	221

I. Hann, J. Sowden, D. Edmondson, did not bat.

Bowling

Vaughan, 17-4-56-3. Goodwin, 25.3-6-51-1.
McCleod, 22-7-57-2. Colburn, 13-0-47-0.

St. Mary's

Evans, ct. Furness, b. Martin	60
Rance, run out	34
McCleod, ct. Reid, b. Rowland	32
Goodwin, b. Rowland	23
Williams, run out	13
Bulow, ct. and b. Hann	2
Schneerson, l.b.w., b. Hann	13
Mosten, b. Rowland	1
Glynn, b. Edmondson	1
Vaughan, ct. Reid, b. Martin	0
Colburn, not out	0
Extras	14
TOTAL	193

Bowling

Edmondson, 11-2-37-1. Rowland, 13-2-55-3.
Martin, 16.2-1-54-2. Hann, 15-4-33-2.

Sun., 4th July, v. Bart's Past, away. Lost by 6 wickets.

Bart's Present batted first on an easy paced wicket against a useful attack. A. Whitworth used the humid atmosphere to good effect and soon the Present side were struggling at 50 for 4. Eventually, the side was all out for an undistinguished 127. In reply, after the rapid dismissal of Purcell, the Past, with time on their side, accumulated the runs for the loss of 4 wickets.

As usual, this was a most enjoyable game.

COLIN REID.

NURSES' SWIMMING

Once again Bart's nurses have been in the fore of Inter-Hospital Swimming. The first competitive events were the heats of the Summer Gala and these were held at the Middlesex Hospital on June 15th. This involved all the London hospitals and the fastest five for each event qualified for the final. Bart's did well in every event so at the final held here on June 29th, we were well represented, and figured in the first three of each event. The result is that we have gained the most points in the Summer Gala. The Autumn Gala will be held at the Iron Monger Row Baths, E.C.1, on September 29th and the overall winners of both galas will be presented with the Nursing Mirror Swimming Shield, which incidently has been at Bart's for the past three years and must stand a good chance of staying here for a fourth.

DAPHNE POLSON,
Swimming Captain.

Results in Summer Gala Final
Individual Medley: 1st, Janet Lodge.
Freestyle: 2nd, Daphne Polson.
Breaststroke: 3rd, Caroline Wilcock.
Diving: 3rd, Janet Houlton.
Backstroke: 2nd, Daphne Polson.
Freestyle Relay: 1st, Caroline Wilcock, Janet Lodge, Janet Houlton, Daphne Polson.
Style Contest: 2nd, Daphne Polson.
Medley Relay: 1st, Janet Lodge, Janet Houlton, Daphne Polson, Caroline Wilcock.

Sponsored Swimming

A chance for all swimmers who do not wish to swim competitively will be on September 25th when a sponsored swim will be held at the Bart's pool in aid of the St. Bartholomew the Less Restoration Fund. Details of this swim will be posted nearer the time but it is hoped that many people will support the event.

Swim for Fun

An amusing evening of swimming and general chaos is promised on Tuesday, August 24th, at 7 p.m. at the Gloucester House Pool. All are invited from the most junior nurse to the most senior sister and from consultants to students. Events between all the aforesaid will include pyjama, egg and spoon and mixed pairs races (tied together!), diving for plates, etc., and many other attractions, refreshments and prizes. Fuller details of this occasion will be posted around the hospital.

SAINT BARTHOLOMEW'S HOSPITAL JOURNAL

Founded 1893. Vol. LXXV No.9

Editorial

Filtering back down the grape-vine come criticisms of the *Journal*: it's dull, too parochial; it contains too little non-clinical material, too much clinical material; there is insufficient discussion on life outside Bart's (for present students), and insufficient information on life inside Bart's (for past students); it displays to small advantage the talents of the few, and to even less the dearth of talent among the many. The list is endless. It is, however, a continuing source of amazement to us, that in this emancipated, free-speaking world, no one (with one notable exception, and even that was not signed) is prepared to put his comments in writing.

The *Journal* was first published on October 14th, 1893. Briefly, its aims as stated in the first editorial, were to put on permanent record such clinical and other work as is done in the hospital, enabling the student and practitioner to keep in touch with the Science and Art of Medicine in Hospital and School; to promote and extend the feeling of *esprit de corps* among students, past and present, to give non-active members some idea of the means by which the name of this great Royal Hospital is being maintained, and so, by example, to rouse them to activity; to record clinical and other lectures; to give publicity to anything original and so to act as a means by which those who write may learn to perfect themselves in that art, to bind as much as possible the past with the present.

Times have changed, and with them the format of the *Journal* and to a certain extent its contents. The Abernethian Society, then the primary society of the Hospital, is of a bygone age. The Amalgamated Clubs, with whose benefit the *Journal* was to a large degree concerned, are still around under the auspices of the Students' Union. The *Journal* is as yet an independent publication, and is striving to remain so. Yet, in the quest to continue to ensure that the *Journal* has a universal appeal, it is remarkable that so few people are prepared to swell its pages with the glowing articles full of fascination for all and sundry, of which they so deplore the lack. Perhaps they are just shy . . .

The time has come when we must consider whether perhaps the Journal has fulfilled its purpose. With an unbroken record of monthly publication since its inception, shall we now go the way of the other London hospital journals and produce an issue four times each year? The apathy endemic in this hospital is obviously not confined solely to the students; considering the countless hundreds who have marched with their stethoscopes from under King Henry's benevolent gaze, an external circulation of around 1,100 copies is something scandalous. The subscription to this *Journal* for students and practitioners alike is far less that of other medicals schools, and its quality is acknowledgedly superior.

Is it worth the struggle to maintain?

LETTERS

PRESCRIPTIONS

The Pharmaceutical Department,
St. Bartholomew's Hospital,
London, E.C.1.

July 28th, 1971.

Dear Editor,

I usually enjoy reading the editorial of the Journal, but that published in the issue of July 1971 shows a clarity of thought and logic of presentation which I am bound to say is somewhat inferior to those of previous editions. What is a prescribing pharmacist? Pharmacists in General Practice, I know, advise their customers on the selection of everyday remedies for everyday ailments. A function for which I have been informed General Practitioner Physicians are continually grateful. This, of course, provided the pharmacist is aware of his therapeutic limitations of which I am sure the vast majority are. However, within the context of your editorial I know of no such creature as the prescribing pharmacist.

Further, when a doctor prescribes a medicine does he really know what he is prescribing? Is he aware of the potential differences in therapeutic efficacy between differently formulated presentations of the same drug? Can he judge if these are likely to be significant? Does he conduct a clinical assessment of every product he uses when he changes the brand name by which he prescribes it?

I am unaware of any circumstances in which anyone has suggested that a pharmacist should have the power to change or substitute a *drug* prescribed by a doctor. The majority of hospitals allow the pharmacist to decide on the form in which the drug is to be presented, i.e., to decide on the *medicine*, the doctor having decided on the drug. Let us be clear that when a doctor writes a prescription he may think he is prescribing a drug but is in fact prescribing a medicine, i.e., a formulated presentation of that drug. Evidence is fast accruing that the method of formulation of the drug can have hitherto unsuspected effects in the efficacy of the drug. However, I would submit that the assessment of these effects will require the close collaboration of the clinician and the pharmacist.

Like the editor, I am suspicious of medicinal forms originating from the continent, but I have yet to see substantiated evidence that the variation in active constituents is as great as 10-110%.

And what of the responsibility of the pharmacist? I too abhor cost related charge systems and agree entirely that it would be invidious to place the pharmacist in the position of advisor to the patient on the selection of which drug from those prescribed by the doctor he could best afford.

Every pharmacist I know is equally opposed to cost related charges and none that I know of have the slightest desire to usurp the authority of the prescriber in any way. I would sincerely hope that we could progress to the better care of our patients by friendly collaboration between the professions of medicine and pharmacy and let us eschew any thought of the competition hinted at in your editorial of July.

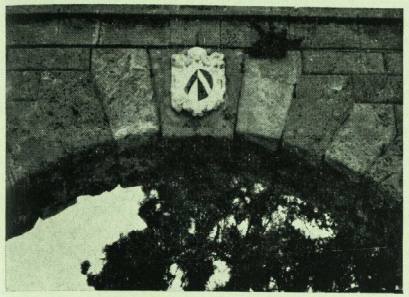
Yours sincerely,
W. R. L. BROWN.

Pharmacist to the Hospital.

I should like to thank Dr. Brown for his interesting and informative letter. I regret my misuse of the term "prescribing pharmacist" which has obviously led to a great deal of confusion. The meaning intended was the concept of the chemist fulfilling prescriptions, in which circumstances one might consider the adjective "prescribing" best omitted. No one, least of all myself, would wish to infer or introduce a state of competition between the pharmacist and the doctor; indeed, all qualified doctors have reason to be grateful to pharmacists for elucidating them on many of the finer points of prescribing drugs, and for sorting out many of their problems

The point of the July editorial was to underline the dangers and difficulties for the doctor **and** *the pharmacist (to whom the patient will often take his query) if the new cost-related scheme comes into operation. One hopes that this aim was not obscured.—Editor.*

HOSPITAL COAT OF ARMS



6, Hale House,
34, De Vere Gardens,
London, W8 5AQ.
July 15th, 1971.

Dear Sir,

While on holiday in Cyprus my wife and I visited the Old City of Famagusta. During its turbulent history the island has been conquered and occupied by more than a dozen nations and during the XVI century Venice was the dominant power. The Venetian Palace lies today in ruins but over the gateway which remains, we were surprised to see a familiar crest. The guide-book stated that this was the Arms of Giovanni Renier, Captain of Cyprus in the year 1552. Our hospital archivist may perhaps know of some connection between Venice and John Wakeryng, otherwise Blackberd, of Wakeryng in Essex where, I believe, the hospital owns property to this day. He was elected the Master of St. Bartholomew's Hospital on Tuesday, March 2nd, 1423, *per viam spiritus sancti*, a rare if not unique event "where all present at once acclaim the same person". Thus Dr. Norman Moore records the fact in his history of the hospital and between pp. 14 and 15 of volume 2 of that monumental work one may see a plate of the famous deed of agreement between the Master and the Prioress of St. Helen's concerning a drain and waterfall in Mugwell Street in the parish of St. Olave. The seal attached to this deed, which was made with Wakeryng's signet ring, illustrates for the first time the shield—party per pale argent and sable a chevron counterchanged—which passed into the common use of the hospital during the 40 years of his mastership. Somewhat later it is found in the Cartulary of Brother John Cok and most impressively in the stained glass window which commemorates King Henry VIII granting the Charter, in the Great Hall.

Purists today incline to the view that the chevron was Wakeryng's personal crest and they prefer those rather dull lions as the genuine hospital Arms. Since I have never come across the more familiar chevron elsewhere I think my "discovery" may be of interest to your readers. Perhaps Giovanni was really a Bart's man before he went to Cyprus? I fear he met with a sticky end.

Yours faithfully,

MICHAEL HARMER.

Dr. N. Kerling, the Hospital Archivist, kindly supplied us with the following information in answer to Mr. Harmer's letter:

The crest shown in Mr. Harmer's photograph does not seem to be the same as the one of Bart's. The Hospital coat of arms shows the black and white bars half way in the crest, not coming down from the top as in the Cyprus one.

This type of crest is a fairly primitive one. Crests were originally used to distinguish a leader, such as a knight, to his followers in battle. This simple design was used by different families who changed the colours or the position of the bars as they liked. Crests were not protected in the Middle Ages. The reverse of the Hospital crest is on the tomb of Sir William Lillebourne in Winchester Cathedral and also on a rail of arms of the same family in Wiltshire where they became knights of the shire in about 1300.

Whether John Wakering used this crest because it was already used by his family or whether he started to use it when he became Master of this Hospital in the 15th century, is impossible to say. If he started to use it, he may have designed a simple crest or he may have seen this crest and have considered that he had a right to it though perhaps in a very remote way. The Lillebourne family held a manor in Wiltshire from John de Neville who was Lord of Great Wakering in Essex. Was there a link here? I am afraid we will never know.

The Lillebourne family was of Normandy origin. Normandy knights settled in Sicily in the 11th and 12th centuries. Did they inter-marry with Venetian families and did they change the Lillebourne crest for their own use or did some Venetian traders come across it in Normandy or England? I should not be surprised if there had been other families both in England and on the Continent who used this crest in some form.

The answer to Mr. Harmer is that one does not know the answer. The crest which he saw, is a simple design dating back to the 11th or 12th centuries. As crests were not protected any family could use them, changing them as they liked to distinguish them from other families. Though I do not know for certain, I would say that there was no connection between John Wakering and the Venetians.

By the way, the deed mentioned by Mr. Harmer as being copied with a photograph in N. Moore's History of the Hospital, was "lost" long ago. Did Moore take it or someone else as a souvenir? We have now only the photograph.

CAMBRIDGE GRADUATES CLUB OF ST. BARTHOLOMEW'S HOSPITAL

Dear Editor,

The 81st Annual Dinner of the Cambridge Graduates' Club of St. Bartholomew's Hospital will be held in the Great Hall of the Hospital at 7.30 p.m. on Friday, November 19th, 1971.

This will be a unique occasion as it will be the first time in the history of the Club that lady members and guests have been invited to dine.

Dr. Alfred White Franklin, Consulting Physician in Child Health, will be in the chair, Mr. Donald B. Fraser, Physician-Accoucheur, has kindly consented to propose the health of the Club and the Mistress of Girton will respond to the toast of "the Guests".

In order to bring the record of lady members fully up to date, it would be appreciated if lady graduates who have been associated with the work of the Hospital, in any capacity, would write to Dr. Ruth Hutchinson, 8 King Street, Wimborne Minster, Dorset BH21 1DY, whether they are proposing to dine this year or not. They are also asked to state their married and maiden names, present address, College, honours and degrees, year of medical qualification or other degree, and their present appointment.

Any male graduate who has not received an individual notice of the dinner by October 1st, 1971, is asked to write to Dr. T. B. Boulton, Department of Anaesthesia, St. Bartholomew's Hospital, London, E.C.1.

Yours sincerely,

R. A. SHOOTER,
T. B. BOULTON,
RUTH HUTCHINSON,
Secretaries.

NURSES' CANTEEN

The Abernethian Room,
St. Bartholomew's Hospital.

Dear Editor,

I, one of the journal's intrepid and fearless undercover agents, noticed with concern last week that a mysterious, ungainly, but none the less intriguing structure had suddenly made its appearance in the Nurses' canteen. Presumably it was erected by a stealthily efficient team of artisans from the Work's Department at dead of night who crept away into the shadows whence they came, their horrible deed being done.

This amazing creation, if that word can adequately describe it, consists, dear readers, if I may briefly outline it for those who have yet to encounter it, of two lengths of stout rope some 25 yards in length held at each end by a pole firmly fixed in a concrete base, and so subtly arranged that at any one moment it very effectively prevents one from going wherever one happens to be to wherever one happens to be meant to be going without making a lengthy detour—unless one chooses to grovel beneath the horrible thing or risk life and limb by vaulting it.

Naturally rumours were soon in the air as to the nature of the "Thing": was it a new "Henry Moore" commissioned by the Ministry and generously donated to Bart's?—a hasty 'phone call to Sir Henry soon discounted this. Were the final heats of the International Horse of The Year Show to be held at Bart's? Would we see Anneli Drummond-Hay gallop the length of the basement passage, leap this mighty hazard and make a perfect four-point landing in a pile of 400 assorted sandwiches?—apparently not, a spokesman for the Empire Pool, Wembley, informed us. Was it some sort of aerial to enable one to get the test score and/or last week's weather on the dial-a-meal machine? A firm "NO" was the canteen supervisor's answer.

Then what was it? Some motive had to be found, and suddenly the answer came one afternoon whilst circumnavigating the obstacle with the able help of one of the skilled W. Indian guides the catering dept. were kind enough to swiftly provide. It is a device for boosting sales in the canteen; for now one arrives at the tea room so dehydrated that two cups of tea are required whereas before one sufficed, and no doubt the more faint-hearted also require extra cakes and sandwiches to replace energy lost on the long and tiring journey. This theory, though no doubt quite true, was apparently not the original cause for the barricade, and it was in fact only very recently that your learned correspondent accidently stumbled across the real facts. It had been erected by the security officer—single-handed or with accomplices we do not yet know—to prevent people walking off with unpaid for cups of tea and the like. Ingenious indeed, it apparently identifies them in an instant and ties them up whilst phoning Ext. 257 at the same time. Effective no doubt, but very inconvenient to those who pay.

Rumours that it is to be replaced by Typhoo[131] labelled tea and some scanning device should not be heeded at present. (Although the SO has been seen lately in the isotope dept. with a large teapot concealed in his left trouser leg.)

Yours, etc.,

Agent E.L.D.
Wilton House,
33, High Street,
Hungerford. Berks.
Tel. No. 2861.

July 14th, 1971

THE LATE SIR ALEC MARTIN

Dear Madam,

Sir Alec Martin was also the kind and generous donor of the portrait of John Abernethy by C. W. Pegler that hangs in College Hall.

Yours faithfully,

A. L. MORETON.

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

STUDENTS' UNION LETTER

Dear Editor,

Since my last letter to the Journal we have had two very successful social events, Sports Day and the Barbeque Ball. I would like to thank the organisers of both for the considerable effort put into them. Thanks should also go to Nick Fairhurst who is handing over his post as Financial Secretary of the Union to Tony Wall. Tony was elected at the Council meeting on the 22nd of June.

At this meeting a Union Calendar was proposed. It was felt that if all the clubs could decide when their AGMs and dinners would be, the dates for the balls were fixed, and other dates such as Sports Day and Hops were also fixed early in the year, then a Calendar could be printed and a lot of coinciding dates might be avoided. This would also serve to give Consultants sufficient notice to be able to attend meetings. We propose to fix these dates when the hop dates are fixed.

We have been approached by the Chief Nursing Officer through the Dean to see whether students would like to undertake certain nursing duties, particularly weekend shifts. This seems to be a very reasonable way of assisting our grants (rates being approximately 42 pence/hr.) and also of learning a bit more about the nursing side of Hospital treatment. Anyone interested should contact Miss S. W. Roberts, Senior Nursing Officer, Central Nursing Offices, or contact me.

The next joint Student Nurse/Student Union function being planned is a Bartholomew Fair. It is hoped that we will be able to use Charterhouse Lawn for this purpose. The date is not yet fixed. We are also proposing to enter a float in the next Lord Mayor's Show. I would be grateful if anyone with any good ideas or interested in structural work could contact either me or the wine committee, since it is intended as a joint venture.

Yours sincerely,

JOHN WELLINGHAM,
(*Chairman*)

STUDENTS' UNION REPORT

By GUY ROUTH (*Assistant Secretary*)

This is the second report on the Union's activities to appear in the Journal. Since the last report in April, there have been several changes in the Union and many reportable events. Most of these have been mentioned in the Chairman's letters—but a few points can be enlarged upon.

Union Activity

The Council has agreed that a motion should be passed at the A.G.M. in October amending the constitution so that the office of Chairman of the Union will run from May to May rather than from October to October as at present. This means that the new Chairman will be supported by an experienced executive and council when he takes office, and also he will be well-versed in Union business when the new Council is elected in October. To comply with this decision, Paul Millard resigned from office on May 1st, and John Wellingham was elected Chairman at the next Council meeting. It is hoped that this change will help the smooth running of the Union throughout the year.

A "FIND-A-FLAT" service is now run by Tony Wall, which we hope assists all students. Details of available flats are posted on notice-boards in the hospital and College Hall. This service should be of particular value to Freshers starting in October. Tony Wall was elected Financial Secretary of the Union on June 22nd.

A proposal that the Union should purchase a Minibus has now been rejected by the Council after discussions with Mr. Morris concerning the financial aspect. The return fare to Hackney Hospital would have to be 40p daily for the scheme to be at all feasible. This was felt to be beyond most students' budgets and the Union could not afford to subsidize the service, so a more organised system of lifts in students' cars was suggested, which will be left to students working at Hackney.

Student/Staff Committees

There are now active clinical and pre-clinical Student/Staff committees operating. The pre-clinical committee sent out a comprehensive questionnaire to help decide what improvements would be requested in the pre-clinical courses. It is hoped that when the committee re-convenes in October it will meet a good response on the Staff side as it is widely felt in the student body that these courses need, in some cases, drastic changes, particularly in view of the increasingly bad 2nd MB results.

The clinical committee has been very active with many successes, particularly with respect to teaching machines and first year clinical teaching.

A hospital centre for Audio-Visual aids to teaching will now be set up as soon as possible. These aids should be of great value in general teaching and for revision before examinations. Also, the plan for six two month firms in the first year has been adopted with random allocation and re-allocation of students for each firm. This should give a fuller picture of General Medicine and Surgery and help, especially Oxbridge students, in social mixing within the year. The committee also pressed the departments for a fuller tutorial system. The Pathology department arranged a series of tutorials which many students found valuable but many more did not attend—which led to the sessions being cancelled.

Social Activities

There have been several attempts to extend the social activity of the Union. This year we participated in the ULU Festival and hope to do so in the future if the Festival continues, also we are looking into the possibility of having a float in the Lord Mayor's parade.

This year has seen an increase in the co-operation between the SU and the SNA mainly in joint social events. We intend to increase this inter-action in the future as it seems absurd that two large groups of people of similar age, living and working in such close proximity, should have so few organised activities linking them.

The Union has become more active in the past year largely because of Paul Millard's influence and we hope that interest has increased sufficiently for a few more students than last year to come to the AGM in October and tell us what they want, as, you may never know, we might be able to do something about it.

Announcements

Births

HAYDN WISE—On July 21st to Julia (née Oxenham) and Kenneth Haydn Wise, F.R.C.S., a daughter.

GREEN—On June 17th, 1971, to John and Dr. Sheila Green (née Minns) a daughter (Clara Margaret) sister for Emma and Hannah.

Engagements

HARFORD-CROSS—ELDER—The engagement is announced between Dr. Michael Harford-Cross and Dr. Elizabeth S. Elder.

COLTART-POSNETTE—The engagement is announced between Dr. John Coltart and Dr. Suzanne Posnette.

CHAPMAN-PRESTWICH—The engagement is announced between Mr. Roger W. G. Chapman and Miss Gillian P. Prestwich.

Marriage

PAYNE-YOUNG—The marriage took place on Saturday, July 19th between John H. R. Payne and Miss Jennifer J. Young.

Deaths

GONIN—On July 13th Mr. Mervyn Willett Gonin, D.S.O., T.D., M.R.C.S., L.R.C.P. Qualified 1929.

LOGAN DAHNE—On June 12th Mr. Stanley Frederick Logan Dahne, M.D. (Cantab.), F.R.C.S. Qualified 1927.

MAY—On July 19th Mr. Arthur George May, M.B., B.S. Qualified 1951.

NOORDIN—On May 29th, Dr. R. M. Noordin, M.R.C.S., L.R.C.P. Qualified 1934.

PRICE—Brig. Robert Bernard Price. Qualified 1908.

Awards

The honorary degree of M.Sc. has been conferred on Dr. George Kersley by Bath University for his work on rheumatology.

Announcement

The University of London have conferred the title of Reader in Medical Physics and Electronics on Dr. B. W. Watson.

Notice of Production of a Calendar of Events

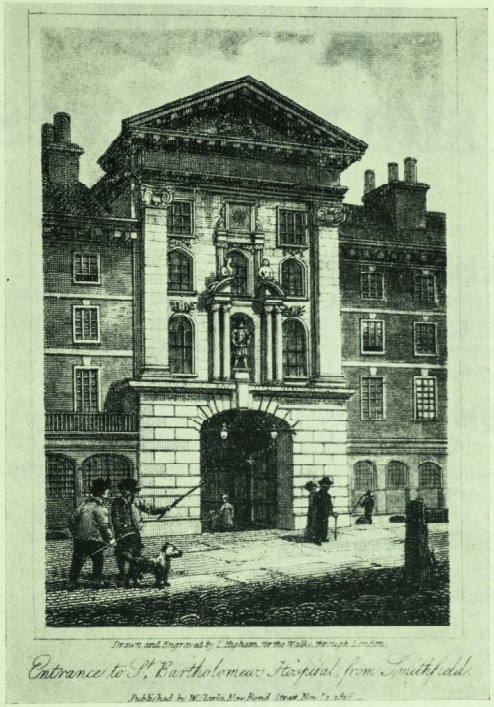
The Student's Union proposes to compile and publish a Calendar of events for the coming academic year. This is intended to include a list of all dates of hops, club AGM's, club dinners, balls, Sports Day and all other events that can be fixed in advance.

It is hoped that the calendar will be printed in the manner of the club fixture cards. It would then be possible to include the times of the various clinics and ward rounds which are available to students. The postgraduate groups which allow and encourage students to attend will also be included, but it will be up to the individual students to check whether or not they are welcome at any particular session.

The current curriculum will be included for the benefit of pre-clinical and first year clinical students on arrival at the hospital.

Club Officials are particularly requested to fix these dates and to let Janet Dinwiddie have them as soon as possible, and by September 15th at the latest.

Journal Christmas Card 1971



The Journal is again producing a new Christmas card this year which will be available throughout the Hospital.

The card will cost approximately 6p. Overprinting of names and addresses can be arranged at a cost of about £2.55 per order. This can only be done if the orders are received before the end of September. Full details will be available next month.

All enquiries and orders should be addressed to the Arts Editor, St. Bartholomew's Hospital Journal, St. Batholomew's Hospital, West Smithfield, London, EC1 and clearly marked "Christmas Card".

All orders must be accompanied by a remittance before they can be dealt with.

"CHANNEL 7"

Department of Medical Illustration, St. Bartholomew's Hospital and Medical College.

Earlier this year the Medical College was linked to "Channel 7", the television service for higher education, run jointly by the Inner London Education Authority, the University of London and the City University. This is a closed circuit system and an extension of the ILEA Schools Service. Broadcasts originate from the ILEA Television Centre at Battersea and some 1,500 establishments ranging from Nursery Schools to Postgraduate Centres are linked to the cable.

The Medical College has established two links with the system, one to Charterhouse Square and one to the Clinical Lecture Theatre in the main Hospital. Only the latter is at present operational and with a large screen monitor recently installed, will be available for viewing by individuals or groups commencing Monday, 11th October, 1971.

At the present time five channels are obtainable on the system:—

Channels 2 and 3: for ILEA Schools, Establishments of Further and Adult Education.
Channel 8: BBC 1 (until 17.30). BBC 2 (from 17.30).
Channel 9: ITA Programmes.
Channel 7: For Institutions of Higher Education.

Channel 7 will serve the needs of most of the Institutions of the University of London, the City University, Colleges of Education, Art Schools and Polytechnics. The service operates during term time from Monday to Friday with programmes transmitted hourly throughout the day commencing at 10.00 hrs. and closing down at 20.00 hrs. Most programmes are repeated twice or three times on different days and at different times. The subject range of the programmes is wide and during the Autumn term (October-December) includes Anthropology, Architecture, Art, Biochemistry, Chemistry, Computers, Communication, Education, Extra Mural Studies, Languages, Law, Management, Mathematics, Medicine, Psychology, Science, and Audio-visual Methods. In the field of Medicine there are four series of programmes:—

The Scientific Basis of Medicine

This is a series of lectures in which distinguished scientists describe recent advances in biomedical research and current developments in their own investigations. Speakers will include Professor Andrew Huxley on muscle contraction, Professor Lynne Reid on respiratory diseases, Professor P. Daniel on brain degeneration and slow viruses, Professor E. S. Perkins on ocular toxoplasmosis, Dr. V. P. Whitaker (Cambridge) on synaptosomes and Dr. Ronald Calne on levodopa in Parkinsonism.

Postgraduate Medicine ("Clinical Medicine")

A series of lecture demonstrations, primarily of interest to Junior Hospital Doctors, of clinical and emergency procedures. Topics to be covered include emergency procedures for diabetic coma, cardiac arrest and status epilepticus, and clinical techniques such as ECGs and simple lung function tests.

Postgraduate Medicine ("Medicine this Week")

A weekly series covering current topics in medicine, of interest to all doctors.

Postgraduate Medicine ("Update")

A series of programmes for continuing medical education, covering recent advances in medical research and their application to medical practice. This term topics will include a series on contraception and cardiology.

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DIETARY TREATMENT OF CHRONIC RENAL FAILURE

By

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The prime functions of the kidney are to eliminate from the body the nitrogenous waste products of protein catalobism and to regulate fluid, electrolyte and acid-base balance. Impairment of these functions in patients with chronic renal failure gives rise to the clinical, haematological and biochemical features of this condition. In this situation, much can be done to control symptoms and complications by adjusting dietary intake so as to minimise the biochemical consequences of reduced renal function. Indeed, dietary treatment is of greater importance than drug therapy to the well-being of many patients with chronic renal failure.

Aims of dietary protein restriction

A major aim of dietary treatment is to reduce the blood and tissue concentrations of toxic metabolites resulting from the breakdown of protein. Not all of these have been identified and the relative importance of those compounds known to be retained is far from clear. Certainly, urea itself is relatively non-toxic and its concentration in the blood is measured simply because of the ease of the chemical estimation and because it is believed that urea retention parallels that of substances of greater clinical importance. These give rise, directly or indirectly, to malaise, anorexia, nausea and vomiting, anaemia, itching, pericarditis, a bleeding tendency, peripheral neuropathy, osteodystrophy and acidaemia.

It has long been recognised that protein restriction may have a beneficial effect upon some of these symptoms and complications, but a major re-examination of dietary treatment followed the work of the Italian school of nephrology (Giordano, 1961; Giovanetti and Maggiore, 1964). Protein-restricted diets based on those described by these workers may prolong life in end-stage renal failure (Ford, Phillips, Toye, Luck and de Wardener, 1969) and certainly prolong symptom-free working life to a worthwhile extent (Berlyne and Hocken, 1968).

Indications for protein restriction

Dietary protein restriction does not affect renal function or alter the natural history of the underlying renal disease. It follows that protein restriction is necessary only when symptoms are troublesome or when there is reason to suspect that even the uncomplaining patient may benefit. The most common symptoms, anorexia, nausea and vomiting, are unusual when the blood urea concentration is 150 mg/100 ml. or less and an alternative explanation should be sought when they occur at this level. Symptoms and complications occur increasingly as the blood urea concentration rises above 200 mg/100 ml. Although anaemia occurs at lower levels of blood urea, Shaw (1968) has shown red cell survival is reduced when the blood urea exceeds 200mg/100 ml. and a more rapid decline in haemoglobin concentration can be expected above this level. Symptoms, particularly those of anaemia, may develop insidiously and go unrecognised until corrected. It is therefore reasonable to institute a trial of protein restriction when the blood urea is 200 mg/100 ml. or more or when symptoms or marked anaemia are a problem. Eating habits are deeply ingrained and troublesome to change. To institute dietary protein restriction in an asymptomatic patient with a blood urea of, say, 70 mg/100 ml. is an interference with civil liberties.

Dietary needs

Protein—The minimum protein requirement in the diet, below which the subject will be in negative nitrogen balance, is not known in normal man, still less in patients with chronic renal failure (Hegsted, 1968). Berlyne and Hocken (1968) claimed that the large majority of patients with chronic uraemia can be maintained in positive nitrogen balance on 0.26 g of protein/kg body weight/day (18 g/day for a 70 kg. man). Several other workers, of whom Ford et al. 1969 are an example, found that 0.4-0.5 g/kg/day (28-35 g/day for a 70 kg. man) were required for the maintenance of nitrogen balance. These

workers also noted an increasing incidence of complications and prolonged rehabilitation-time in patients transferred to regular dialysis treatment the longer they had been maintained on diets containing less than 0.4-0.5 g protein/kg/day.

The question of how much of this protein should be "first class", that is, rich in essential amino acids, is also controversial. It has been known for over 100 years that dietary proteins are not of equivalent nutritive value. Very early attempts to feed dogs upon gelatin showed that this protein would not support life. Kossel and Kutscher in 1900 showed that different proteins contain different quantities of amino acids and this is still believed to be the basis of different nutritive values. It has been claimed that protein requirements will be lower and nitrogen retention less if "first class" protein predominates in the diet. Giovanetti and Maggiore, 1964, Giordano, Exposito, de Pascale and Santo, 196/ and Berlyne and Hocken, 1968, whose diets contained 20 g protein or less per day, all subscribed to this view. Ford et al. 1969, found no effect upon nitrogen balance when the amount of first class protein varied from 40-90% in diets containing the larger protein allowance of 0.4-0.5 g protein/kg/day. Bone (1968) found no significant difference in urea production rates in patients taking 20 g protein diets containing 50% and 95% first class protein respectively.

Calories—It is generally held that normal man requires at least 35 Calories/kg body weight to produce maximum sparing of body protein. Calorie deficiency results in the breakdown of body protein to supply energy and defeats the object of a protein-restricted diet, as well as resulting in a sick, wasted patient. Protein restriction must be accompanied by increased Calorie intake from other sources. Fat is not well tolerated and most of this must come from carbohydrate. The amount of Calorie supplementation necessary is a matter for debate. Robson, Kerr and Ashcroft (1968) detected higher urea production rates than could be accounted for by catabolism of ingested protein in patients on a 70 g high biological value protein diet containing as much as 3000 Calories/day and suggested that uraemia itself exerts a catabolic effect. By contrast, Ford et al. (1969) detected no effect on nitrogen balance when Calorie intake ranged from 23.6 to 59.0 Calories/kg per day in patients on a diet containing 0.4-0.5 g protein/kg body weight per day.

Dietary policy

All these conflicting observations are difficult to reconcile. A sound policy for the dietary management of chronic renal failure may, however, be based upon the following conclusions:—

1. A fundamental change in diet should never be imposed lightly.

2. In the "basic Giovanetti" diet containing 19 g protein/day, at least 75% of the protein should be of high biological value and Calorie supplementation is important.

3. At levels of protein intake of 30-35 g/day and above, the proportion of "second class" protein may safely be increased and Calorie supplementation is less critical.

4. The presence of renal failure of such severity as to demand the long term use of a basic Giovanetti diet should prompt consideration of the patient for transfer to a renal replacement programme.

The diet may be considered as being built upon the basic Giovanetti diet (19 g protein) to which are added "units", each consisting of 7 g protein. Thus, a "Giovanetti plus II" diet contains 33 g protein. The choice of a 7 g protein unit is based upon the fact that an egg or an ounce of meat each provide approximately 7 g protein. This system is convenient for the dieticians and easy to teach to patients.

In the majority of patients presenting with uraemic symptoms it is advisable to begin with the basic Giovanetti diet so that maximum relief of symptoms occurs rapidly. This facilitates acceptance of the diet. The basic diet should contain at least 75% (14 g) first class protein usually provided as egg and milk protein. Second class protein is supplied in the form of vegetables. To obtain an intake of about 3000 Calories per day, low protein bread, sugar, double cream (60g/day), low protein pasta, "Hycal" (425 Calories per bottle) and "Caloreen" are provided. Patients who complain of hunger are receiving inadequate Calories.

Every effort should be made to improve palatability by advising on the best use of low protein foods and high Calorie supplements. The patient must, however, understand that his diet is an important part of his medical treatment. Pleasure in eating is very desirable but of secondary importance to this consideration.

"Units" may be added to the diet as soon as symptomatic improvement and a satisfactory decline in blood urea concentration have occurred. The aim should be to maintain blood urea concentration around 130-150 mg/100 ml., if possible, although absolute rules are difficult to frame. It is essential to treat the patient rather than the blood urea. This range is below the level of blood urea at which protein restriction is usually begun. The extra margin allows for the fact that the decline of blood urea concentration with protein restriction is greater than that of other toxic metabolites.

The first "unit" added should be of first class protein. In a "Giovanetti plus II" diet, the second "unit" may be provided by the substitution of normal, for low protein, bread. This greatly increases palatability since low protein bread tastes like chalk when raw and is only slightly better when toasted. The nature of the third "unit" of protein added to the basic diet may be decided according to the tastes and preferences of the individual patient.

Except in the case of high protein eaters, it is rarely necessary in the United Kingdom to recommend specific 50 or 60 g protein diets. Thus, if the patient is able to tolerate more protein than is provided in a "Giovanetti plus III" diet he can usually be allowed a free diet. In doubtful cases a dietary history should be obtained regarding his self-selecting diet and restrictions only imposed where the protein intake is high.

The exact composition and protein content of the diet should be tailored to the requirements and tastes of the individual patient. Patients with proteinuria, for example, require first class protein to be added to the diet to balance urinary loss. Due allowance must be made for large variations in body weight of different patients.

A useful rough check on the amount of protein being taken is provided by measurement of the mean urinary urea excretion in g/day over two or three days. Multiplied by three, this gives the protein intake which can be tolerated without the occurrence of a rise in blood urea

concentration. Thus the blood urea concentration of a man excreting 10 g urea daily will remain constant on a 30 g protein diet and will fall if protein intake is restricted further. If it does not do so and glomerular filtration rate has meanwhile remained constant, the patient should be suspected of breaking his diet.

Electrolytes, Water and Vitamins

Sodium requirements must be assessed in formulating dietary policy. Patients with chronic renal failure may be unable both to increase urinary sodium excretion to meet a sodium load and to conserve sodium when dietary intake in inadequate. A common problem in such patients is salt and water overload with hypertension, elevation of the jugular venous pressure and oedema. Less often, a predominant salt-losing tendency is present, treatment of which will improve renal function. The basic Giovanetti diet contains approximately 20 mEq sodium if no salt is added in the cooking. Patients with oedema and hypertension should receive a 20 mEq/ sodium diet whilst these signs remain. Salt wasting may be difficult to recognise clinically, and patients without oedema or hypertension should receive a 20 mEq. sodium diet plus gradually increasing supplements of caps. sodium chloride (17 mEq/g) or sodium bicarbonate (12 mEq/g) during initial in-patient assessment until these signs appear. Sodium intake can then be adjusted at a slightly reduced level. The addition of salt in the cooking brings the total sodium content of the diet up to approximately 50 mEq. per day. If additional requirements are large, they may be provided simply by the patient adding salt to his food. Periodic measurement of body weight and clinical examination will indicate if salt intake is inadequate or excessive. Small additional requirements in patients finely poised between salt overload and depletion are best provided more exactly as sodium bicarbonate tablets or sodium chloride capsules. The latter can be opened and the contents sprinkled over the food, if preferred.

Potassium restriction is rarely necessary in patients passing 1 litre or more of urine daily but patients at risk need to be warned of the dangers of sudden hyperkalaemia resulting from major dietary indiscretion involving the ingestion of large quantities of fruits, potato crisps, chocolates and so on. The occasional patient may require a Giovanetti diet modified so as to provide minimum potassium (about 30-40 mEq/day). The unthinking use of artificial salt substitutes, all of which contain potassium, occasionally results in tragedy in such patients.

In advanced renal failure, maximum water excretion is limited, being, very approximately, one-third of glomerular filtration or about 1.5 L/day for a patient with a GFR of 3 ml/min. This calculation ignores insensible loss and metabolic water. Water intoxication will result if intake exceeds maximum water excretion and rapid overhydration is particularly dangerous. If necessary, water requirements can be assessed in hospital during initial institution of the diet. An initial fluid intake of 1400 ml/day can be given, increasing every other day by 200 ml. until the patient's wish for fluid is satisfied or weight gain and increasing hyponatraemia indicate the development of water retention.

B Vitamin supplements, for example tabs. "Orovite" 1 daily, are generally given with the basic Giovanetti diet. Berlyne and Hocken (1968) describe a pellagra-type skin rash occurring in one patient who neglected this precaution. Amino acid supplements are unnecessary. Routine iron supplements (ferrous sulphate 200 mg daily) should be given if the basic Giovanetti diet is to be continued for more than a few weeks.

General Considerations

Successful implementation of dietary treatment demands the cooperation of a physician and trained dietician. Physicians do not usually possess the detailed expertise to undertake the work of the dietician. The physician's role is to define the dietary objectives of a particular patient and to see that they are carried out. It is negligent merely to prescribe a "low protein diet" or even "Giovanetti diet" and to consider that nothing further is required. It is essential (1) that the aims and benefits of dietary treatment are explained to the patient so that maximum cooperation is obtained; (2) that the patient is eating *all* the food provided. Failure to do so will lead to protein malnutrition; (3) to check that the patient and, more important, the relative who cooks for the patient, have seen the dietician as often as is necessary to comprehend the diet. This usually takes at least two sessions with each person. Sample menus should be obtained from whoever is to do the cooking in order to test understanding; (4) to ascertain that individual patients know where to obtain the low-protein and other products which they require and that adequate warning has been given to local shops such as the Co-op or chemists before the patient's discharge from hospital. Some doctors may not know that many such products (low protein bread, flour, "Aproten" products and "Hycal" are examples) can be prescribed on an EC10: (5) that due account has been taken of the individual patient's tastes and circumstances—for example, a diet that is practicable when all the food is prepared at home may be impossible to obtain at work; (6) that assessment of dietary needs does not cease with discharge from hospital. Such assessment is facilitated by the attachment of a dietician to nephrological out-patients, a facility we enjoy at Bart's.

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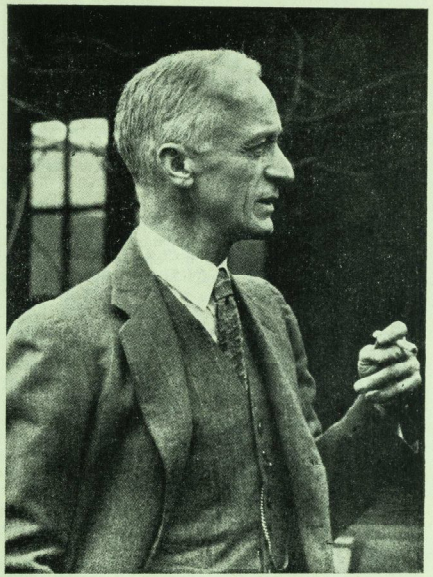
PERPETUAL STUDENT

By ROBIN WHILE

HARVEY WILLIAM CUSHING, M.D.



HARVEY CUSHING *from "Cushing Birthday Volume"*

> "The day is short and the work is great. The reward is also great and the Master praises. It is not incumbent on thee to complete the work, but thou must not therefore cease from it."
>
> (TALMUD)

Harvey William Cushing was born on April 8th, 1869, in Cleveland, Ohio. He lived and worked as if Talmud's words governed his every thought and action. He had the inspiration not only to enter the medical race but to lead it. He is everywhere recognised as the father of Neurosurgery and became one of the greatest bibliophiles of all time. Writing was not one of his natural gifts but he followed the precept of Benjamin Jowett, "He who would write well should each day read from the great books and commit something to paper", and with his writing as with his surgery he was meticulous almost to the stage of compulsion.

At an early age he developed the characteristic that was to remain with him always, that of recording everything. He became one of the most prolific diarists of his time and once said, "The pen is mightier than the sword, but the scissors and paint pot are mightier than either." His ability to draw was an attribute of which he made great use. He found that no written description was ever of equal value to a sketch. Harvey Cushing saw himself primarily as a physician and secondarily as a surgeon when careful surgery was required. He set a standard of performance which the present generation can neither equal nor forget.

Harvey Cushing was the youngest of ten children of Betty and Henry Cushing, M.D., and was brought up in a strictly medical environment, his immediate family having all been doctors for the previous three generations. His school career was described as good but not brilliant, showing an inclination towards mathematics. He took the entrance examination to Yale in 1887, passed and went up to University the same year. His letters home at this time indicate a rather slow emotional and intellectual development. It is amusing to note that he wrote separate letters to each of his parents and assumed that they would not show each other what he had written. He was diligent in his studies and was also an extraordinarily apt athlete, so much so that much to his father's consternation he came to "sit on the fence" by playing for the nine which beat Harvard in the annual baseball game. During his Yale days he acquitted himself creditably but not brilliantly. Probably his greatest personal triumph was his election to "Scroll and Key", the senior society at Yale. This pleased him immensely. He described it to his father as "The greatest honour a man can receive during his college days". He graduated after four years at Yale and after expressing a brief interest in physiological chemistry he went on to the Harvard Medical School. His days as a Medical Student were uneventful, and he made a conscious effort to avoid social contacts so as not to be distracted from his studies. His dissection at this stage was said to have much impressed his teachers and it was probably at this point that he first developed a passion for surgery.

His first appointment was at the Massachusetts General Hospital, when he was elected Surgical Extern in 1895. His letters home declined from this moment, but his clinical histories are still kept in the records room at the hospital, and are nearly always accompanied by a sketch. This is usually much more informa-

tive than a photograph of the same condition. His next appointment was with Professor Halsted at the Johns Hopkins Hospital, Baltimore. After four years in Baltimore he left to spend fifteen months in Europe associating with the leading men in the Neurological field. He then returned to Baltimore where he married and remained on Professor Halsted's staff, until his appointment to the Moseley Chair of Surgery at Harvard.

Cushing had a demanding home and family background which must have given him the incentive to come out on top. This coupled with the hallmark of genius which he once described as "99% perspiration and 1% inspiration" set the pattern for his life. The impression of a young doctor's life which is most likely to be recalled in later years is the anxiety at the time of his inauguration as an anaesthetist. Life and death is balanced so finely in his hands. This was the case with Harvey Cushing. To a friend at that time he wrote, "My first giving of an anaesthetic was when as a third year student, I was called down from the seats and was sent into a little side room with a patient and told to put him to sleep. I knew nothing about the patient whatsoever, merely that a nurse came in and gave the patient a hypodermic injection. I proceeded as best I could under an orderly's directions but it seemed to me an interminable time for the old man who kept gagging to go to sleep. We finally wheeled him in. The operation was then started and at this juncture there was a sudden gush of fluid from the patient's mouth which was inhaled and he died. I supposed that I had killed him. I was later told that he had died of a strangulated hernia, but I have never forgotten about it". It was typical of the man that when he was an intern at the Massachusetts General Hospital he devised a method of recording pulse and respiration during operations. Later when he was in Pavia, Italy, he saw the Riva Rocci pneumatic device for recording human blood pressure which he incorporated into his anaesthetic record charts.

At an early age he saw the value of X-rays and after pioneering with them in Boston he soon introduced them in Baltimore, using them to great effect almost immediately in locating a bullet in the cervical vertebra of a woman who showed the typical features of the Brown Sequard Syndrome.

After four years in Baltimore he was advised to travel abroad. It was generally accepted at that time that his horizons were too narrow. And indeed after fifteen months travelling, he changed much. He studied under Sir Victor Horsley, the Surgeon of University College Hospital, but did not think he could learn much from Horsley's impetuous approach. They later developed an understanding when he became much interested in Horsley's aggressive attitude to vivisection. He then went on to study in Berne under Theodore Kocher. He commented on Kocher's Operations—"The Johns Hopkins Outdone. It is easily seen why Halsted thought so highly of his work. Detailed technique, tedious operating, absolute haemostasis."

He performed some experimental work for Kocher, on the compression or dilatation by stasis of the arteries and veins in the brain, before going on to Liverpool to study with Charles Sherrington. He helped Sherrington to explore the anthropoid brain at an epic moment in his research; indeed, his skill and drawing ability were much used.

His work at Berne centred around the regulation of blood pressure, particularly in relation to the pressures within the skull, it became evident to him that the blood pressure indicated the patient's condition. This was his reason for incorporating its measurement into the anaesthetic records at the Johns Hopkins immediately he returned from Europe.

Sir Victor Horsley performed the first neurosurgical operation in England, but Cushing was definitely the founder of this speciality in the USA. His first interest in the nervous system can be traced back to his removing a dog's brain at Yale in 1890 for Professor Ladd. His notes on the physiology of the nervous system are also seen to be particularly full. His first involvement in Cranial Surgery was with J. W. Elliot. Although their first attempt at removing tumours from the brain resulted in fatalities, he was most impressed by the fact that they were at least able to locate the position of the tumour prior to operation. It might be that this development was the initial spur to drive him into a neurosurgical specialty.

He started with neurological cases by himself writing up the histories rather than leaving it to the junior house staff. His earlier work was in the removal of the Gasserian Ganglion which was a refinement of the Hartley Krause procedure. It was soon realised that all that was needed in the surgical treatment of trigeminal neuralgia was the division of the sensory root.

He wrote a classic paper on the sensory distribution of the Vth cranial nerve for the Johns Hopkins Hospital Bulletin. He related all his findings to embryological development and pointed out, for instance, that the sensory supply to the external auditory canal could have been foretold. He also set up a map of the dermatomes of the whole body by observing the areas of skin affected when a different level of the spinal axis developed herpes zoster. It was Harvey Cushing who through a study of perineal "herpes" elucidated the confusing distribution of the sarcal nerve segments. He also concerned himself with nerve regeneration and published several papers on treating facial paralysis by nerve anastomosis. In the first few years of his involvement in cranial surgery he met with little success except perhaps his ganglion operation and the removal of meningocoels from the spinal cord, nevertheless he made tremendous advances into operating techniques. He developed a cranial tourniquet and devised many burrs and saws for opening the skull.

His overwhelming surgical interest became the pituitary body. This sprang from the time when he had a young girl patient with a visual disturbance who also complained of headaches and was sexually immature. Cushing failed to make a diagnosis and she died. However, Professor Fröhlich in Vienna had a similar patient and noticed that it was a pituitary lesion. He reported on the case. This failure was too much for the pride of Cushing, and after this episode the pituitary became his overriding occupation. Many regard his work on the pituitary gland as the most original and important contribution which he made to medical science.

In the spring of 1909 working with Drs. Samuel Crowe and John Homen he issued a monograph entitled "Experimental Hypophysectomy" which established that the pituitaries of animals, although probably not essential to life, normally exerted an important influence on the metabolic processes of the body. The disturbances which followed partial and complete removal of the gland are described in detail and correlated with the corresponding

symptoms of pituitary disturbance in man. In the summer of the same year he presented a paper to the American Medical Association; here he introduced the terms "hypo" and hyperpituitarism. This was the beginning of the clinical distinction between excess secretion of the anterior lobe (acromegaly) and states of diminished secretion such as occur when the pituitary is completely or partially destroyed.

This paper was the cornerstone in his progression to publication of his famous pituitary monograph in 1912:

> "Experimental observations show that not only is the condition of apituitarism not compatible with a long life, but removal of it leads to symptoms which we regard as characteristic of lessened secretion."

He then submitted another report with Crowe and Homen for Sir E. A. Schafer's Journal at Edinburgh. Here they described the restorative effects of transplanting pituitary tissue into hypophysectomized animals.

It was at this point in his career that he became interested in the Acromegalics. The French neurologist Pierre Marie had first associated this condition with a tumour of the pituitary gland in 1886. But by 1909 there had been only one successful report of operating on the pituitary of an acromegalic patient and this was by Schloffer in 1907. Harvey Cushing's first Acromegalic was referred to him in 1909 and he immediately decided to operate. The operation was not only conspicuously successful as far as relief of symptoms were concerned but the patient also made a prompt post-operative recovery and was able to walk into a surgical clinic six days after the operation. He adopted the procedure which Schloffer had recommended two years previously, namely that of approaching the pituitary through the middle of the forehead via the frontal sinuses to the base of the skull and then opening the sella turcica. He reported his success immediately to the International Medical Congress and it whetted his interest in similar cases. Between the time of this operation and when his pituitary monograph was published in September 1911, he had forty-six cases involving the pituitary referred to him, nine of which were acromegalics. He operated on three and two died from the disease.

He also interested himself in giants. He noticed that the anterior pituitary was also involved here. He pointed out that gigantism was akin to acromegaly but the onset was earlier in life. He thus discovered the presence of a secretion from the anterior pituitary which controlled growth. His sixteen years at Baltimore culminated in the publication of a technical monograph in 1912 entitled "The pituitary body and its disorders". It stands as a milestone in the history of endocrinology. It is based on a study of 50 cases going into incredible detail. He described his nine cases of acromegaly and he concluded that the disease tended to be self limiting.

> "It starts with a phase of active hyperituitarism which in the course of time may subside and with the atrophy of the secreting cells of the anterior pituitary the patient may pass into a state of hypopituitarism. Since however vision may be lost due to the pressure exerted by an enlarged pituitary on the optic nerve, operative relief is generally indicated for the following reasons:
> (1) Preservation of vision.
> (2) Conversion of hyperpituitary state to hypopituitary state."

He also made discoveries of the cell types present in these conditions. He concluded that the growth hormone was produced by eosinophilic cells and that the basophilic cells present, probably produce some other secretion. As far as surgical techniques are concerned he noted that the frontal approach left a disfiguring scar and that the sinuses tended to become infected. He used the method of elevating the upper lip, and approaching the sphenoidal bone by a submucous direction of the nasal mucous membrane known as "Cushings transphenoidal approach".

Following his acclamation as a world figure in neurosurgery, many calls to take up academic posts arrived which he turned down before accepting the Moseley Chair of Surgery at Harvard in 1910. Of his appointment, his former high school teacher, Mr. Newton Anderson, wrote:—

> "I saw it all twenty-seven years ago and had the greatest delight in seeing the materialisation of my vision. You certainly have become all I dreamed and hoped you might be."

In 1916 he published with the assistance of Miss Louise Eisenhardt, a monograph on the acoustic nerve. The publication was an outgrowth of a chapter on endotheliomas of the cerebelopontine angle which he had intended for the monograph of meningiomas. From this moment he published many other papers such as the "Purpose and technical steps of subtemporal decompression". This paper appeared in Ochsner's Surgical diagnosis and treatment. He also made a progress report in the field of neurological surgery every five years. He did a great deal of work on the medulloblastomas and found this work particularly stimulating, operating on children again and again with the object of keeping them alive for a few more months.

In 1913 as Moseley Professor of Surgery he went to the 17th International Medical Congress in London. It is doubtful if the medical profession will ever again witness a gathering of such pomp and circumstance, for the whole "spectacle" was arranged on an amazingly lavish scale. At the age of 44 he had the unusual distinction of giving one of the three principal addresses to the Congress. He spoke on "Re-alignments in greater Medicine". This was one of his most famous speeches. He spoke out against the anti-vivisection movement, and following the example of Flexner in the United States made a plea for reform in medical education. It started a controversy in the British Medical Schools when he asserted that their productivity had gone down since the time of John Hunter, following the fact that animal experimentation had been curtailed. He himself rearranged the clinical teaching at Harvard and made certain that students were brought into contact with clinical material at the earliest possible moment of their career. He inaugurated voluntary Saturday morning Clinics for the 1st year students, and strongly advocated the early acquisition by students of that special relationship with their patients. He once wrote "as coming from a family of general practitioners, the intimate and confidential relationship between doctor and patient is one of the most precious things in medicine and worth preserving".

When war seemed imminent to the United States he immediately organised a Harvard Medical team and was one of the first to go on a fact finding mission to the front. He was fascinated by the wealth of clinical material that he saw, and the countless opportunities of

removing shell fragments from the brain. He desperately tried to stir America into a state of readiness and came across incredible naiveté whilst trying to impress the public with the importance of hospital units being attached to the fighting forces. He once tried to get a full-sized base hospital installed on Boston Common, but he met with no success—little did he appreciate the sanctity of the Boston Green.

During the war itself he kept his case notes just as if he was in his office at Boston. So meticulously recorded were they that in 1942 Brigadier Cairns of the British Army Medical Corps cabled Yale Library to refer to them. They were the only records of wounds involving the brain and the related structures to survive from the Great War. At Boulogne in the winter of 1918 he operated incessantly right through the German offensive on Amiens in March. By May of the same year, however, he was in trouble for keeping a diary, in war time. This was strictly against all regulations. Harvey Cushing, since he was the man he was, could no more have gone through the war without keeping a diary than he could have performed an operation without describing it afterwards. Finally he ran foul of the Censors: the first time for quoting a remark of a British soldier in a letter to his wife which he himself had censored, and the second time for enclosing in a letter home a paper written by one of his unit offering criticism of a British Surgeon. It was extremely fortunate that the Censors did not see his voluminous diary with its detailed entries and sketches of the front. A Court Martial was threatened, but finally the matter was dropped and he was transferred from the British to American Headquarters. Later on in the same year he was promoted to Lt. Colonel and appointed Senior Consultant in Neurosurgery to the American Expeditionary Force in Neufchateau. He operated during the battle of Ypres and still he had time to record bits of comedy, pathos, acts of heroism and sketches of Flanders: he wrote the war-time obituary of Jack McCrae the poet of "In Flanders Fields" fame.

> "Someone has said that children and animals follow him as shadows follow other men."

In August 1918 he had an attack of polyneuritis; from this moment on he fought against ill-health for the rest of his life.

He was awarded the Companion of the Bath in recognition of his services to the British Forces.

In 1925 he won the Cameron Prize Lectures as Pasteur and Lister had done before him. It was a considerable honour. He gave three lectures—(1) The third circulation and its channels. On the cerebro spinal fluid. (2) The pituitary gland as now known. (3) Intra cranial tumours and the surgeon.

The use of high frequency currents in Surgery did not originate with Cushing but their value in neurological surgery was first established by him. He first used the system to assist in the more vascular types of tumour. He was delighted to see how well it worked, and was presented with the first commercially constructed unit by the Liebel Flarsheim Company. He was so encouraged by the success of the new procedure that he recalled all his patients with supposedly inoperable meningiomas especially those of the olfactory groove. He then proceeded to try out the new electrosurgical procedure. He met with phenomenal success. In June of 1927 he gave the Macewen Memorial Lecture. It is a landmark in the history of neurosurgery because it is the first account of the use of electrosurgical methods in the removal of brain tumours. For the lectures he chose to talk about the group of meningiomas in the region of the olfactory groove. When in England in the summer of 1927 for this purpose he could hardly have felt unappreciated, as he was given three honorary degrees and four honorary memberships all in the space of a month. But his delight was soon dimmed when on his return to America he lost his most celebrated patient, "General Wood", on the operating table. On this occasion his ability for self-criticism is well shown, "On my return we were not yet in full swing, nor were my surgical reflexes and judgement at their best. He was a great man. I have never lost a patient at operation that so upset me. It was so near to success. The autopsy showed that there had been some blood forced into the ventricle when I closed and packed the wound. If I had used better judgement he would certainly have been saved."

For many years he considered that pituitary disfunction was entirely due to a glandular abnormality and he ignored the work done by such people as Bailey and Bremer which suggested that this might not be correct. The man who finally convinced him to consider a disfunction of the adjacent nerve structure was John Beattie who spoke at the Harvard Medical Society in 1930, on the excitability of the hypothalamus. Cushing eventually reached the conclusion that a parasympathetic centre as well as a sympathetic region of control had functional localisation within the hypothalamus. This he deduced from observing the effects of injecting posterior pituitary and pilocarpine solutions into the cerebral ventricles of conscious human subjects. This work formed the immediate background to his Lister address to the Royal College of Surgeons. He was presented with the Lister medal "for distinguished contributions to Surgical science" by Lord Moynihan. On the same occasion he read the appreciation and unveiled a plaque to that most distinguished Bart's Surgeon Sir Antony Bowlby. His work for the Lister address focused his attention on the relationship between hypothalamic disturbance and the activity of the gastrointestinal tract. He searched his previous operative notes and came up with clear cut evidence that only the operations which encroached on the nerve centres at the base of the brain were followed by gastric complications. He also found that when pituitary extract or pilocarpine solution was injected into the ventricles of normal humans they exhibited normal visceral functions, but this did not occur in the areas of skin which had been denervated. This proved that the drugs acted centrally and that the centres must lie in the walls of the third ventricle. This was his basic contribution to physiology.

He performed his 2,000th brain tumour operation in 1931. He was then able to point to a steady lowering of the mortality rate over the previous 10 years, except for a brief increase following the introduction of electrosurgical techniques, when he operated on many patients who had previously been considered inoperable. During the latter years he had had nobody to compete with and had to be content to beat his own score. The same year he made his final bow when he read a paper to the International Neurological Congress in Berne. It was in front of his old masters, Sherrington, De Martel and Welch that he chose to end his career in active neurosurgery.

It is significant that Harvey Cushing's most original contribution to clinical medicine was made in his 63rd year when he was about to retire. It was on the subject of Pituitary Basophilism now known as Cushing's disease. He had been observing a special group of patients with a polyglandular syndrome. They had not been subjected to an operation because they did not show any visual defects or signs of increased intracranial pressure. As one of these patients had never come to an autopsy he had been unable to show that a tumour of the pituitary existed but he had suspected it for many years. It was then that he heard of a patient who at autopsy had shown a basophil tumour. The clinical history of the patient reminded him of one of his own patients. He then described all his own cases in detail and managed to obtain a post mortem examination on them wherever they died even to the extent of requesting an exhumation. He thus succeeded in demonstrating that the clinical condition he had described was caused by a basophil tumour of the pituitary. He first described the condition to the New York Neurological Society in January 1932.

Ill health marred his retirement, but he carried on working whenever possible. He was appointed Sterling Professor of Neurology at Yale and in 1934 he founded at New Haven a central registry of all brain tumours, using his own collection as a central focus. His ever faithful co-worker Miss Louise Eisenhardt was appointed director. It was the last year of his life that he succeeded in completing his famous "Meningioma Monograph". He commented at the time,

"I am getting on all too slowly with the Meningioma task and find owing to my hardened cerebral arteries increased difficulty in putting my mind to it".

He stands as the oldest and most dominant of three neuro surgeons, Harvey Cushing (Boston), Frazier (Philadelphia), and Elsberg (New York). There was a fair amount of competition amongst them which drove them to ther maximum capabilities. The difference between them was that Harvey Cushing was not dependent on Neurologists. He insisted on making the diagnosis, treating, ascertaining the pathology and following up the patient all himself.

He would never let a patient die wthout a tremendous struggle to save him, and his follow up clinics had a thoroughness that has not been equalled. He would struggle just as hard after death to get permission for a post mortem to be performed. He had a staggering 90% success in obtaining this permission and would always perform the procedure himself. He used to tell his staff, "If you want a thing done well you must do it yourself". He was a great technician based not only on manual dexterity but more on a knowledge of the re-actions of a human subject to disease and of the tissues with which he was dealing. He was scornful of speed as an index of success, and was much criticised during the 1st World War for operating on too few patients in a day. He often stated that he would rather operate on two or three patients properly than eight or nine with less care. But his capacity for work was remarkable. He seldom ever took a holiday except when ill. "The only time that I was needled into going fishing, the first World War was declared".

The most important surgical contribution that Harvey Cushing made was that he achieved a lower mortality than anyone else. Like all those who had studied under Professor Halsted in Baltimore he spent more time on one case than a general surgeon spent on half a dozen. Probably his greatest surgical moment was at the 13th International Physiological Congress in 1931 when it was held in Boston. It was attended by Professor I. P. Pavlov and Cushing arranged to perform an operation for him and other distinguished visitors. He removed a tumour from the brain of an aphasic boy and then demonstrated to an astonished audience that speech had returned. Cushing stated that "Pavlov was so interested, that he all but put his all too prominent whiskers into the operative field".

He instituted a system of appointing a Surgeon in Chief pro tem each year who would take over his surgical department for two weeks. His students and staff always found this a very stimulating experience. Two such visitors were George E. Gask and Sir D'Arcy Power, both Professors of Surgery at Bart's. He commented after the visit of George Gask "His visit will long be remembered for it made a bright spot in a year's work and was a stimulus to us all". He reciprocated by taking over the Surgical Department at Bart's at a later time and was finally honoured by being made a Perpetual student of the Hospital. It is noted that he credited the Bart's School with relying far more on their fine physical senses in arriving at a diagnosis than his American colleagues. He also instituted at his own expense a scholarship to send his residents to Europe if they wished to go and broaden their experience.

Cushing the perfectionist in tennis and in surgery—he was endowed with the perception of an artist and the patience of a scientist. These are just a few of the ways in which he has been described. He was nonetheless a difficult person with whom to work, and when striving for a "goal" as was nearly always the case, he was intolerant of anything less than perfect assistance from his co-workers. Life as one of his residents must have been extremely arduous. There was never a word of praise and he tended to be so pre-occupied with his own work that he forgot his staff and often kept them waiting. He once even kept an ocean liner waiting for him until he could board. He was popular with his patients but the attitude of some of his staff can be summed up by the view of one of his theatre nurses.

"C" is for Cushing	"C" is Cushing
So cussedly clever	So cleverly cussed
He can be polite	If he ever gets sick
But hardly is ever	He will never be nursed

One of the most characteristic features of his nature was a burning personal pride which throughout his life made it almost impossible for him to request anything from anyone.

"What I disliked was the asking, I wanted offers". He revealed himself as a very impatient person and was on occasions rebuked by his friend Sir William Osler by whom he was greatly influenced, for the rather brusque manner with which he treated his associates. He had the habit of interrupting a speaker and talking about something totally different. He also deliberately split infinitives, "what is more", "and to be sure", are little additives that endear one to his style of writing. He had an incredible capacity for work. During the 1st World War he performed a sixteen-hour operating day, and he still found time to write up his case notes and diary in the small hours of the morning in a cold wet tent. On another occasion when he was writing the Osler biography, which was probably his greatest literary achievement, he came to England and spent eighteen hours a day for six weeks working at it. In June 1926 he had news that his son who was at Yale had been killed in a car accident, with superhuman control he carried on operating without telling anyone in his team. In a typical way he got over his grief by absorbing himself even more in his work.

He was very abstemious in his habits, hardly ever drinking, and he seemed to have an unawareness for the necessity of food much to the dismay of his colleagues. He never ate lunch and would often remain in the Operating Theatre from mid-morning to the early evening. But he allowed himself the pleasure of cigarettes. On a day when he was not operating he could easily smoke two packets. It is worth noting that even at the end of his life when he was warned that they were endangering his health he was still unable to break the habit, indeed his family were always pleased to see him start smoking again, as he was so irritable during the interim period.

He went to Europe a self assured and provincial young American, but he returned a cosmopolitan with a greatly broadened point of view on medical matters and a deep respect for European Culture and tradition. He became one of the critics of "America the Isolationist", and was an advocate of Internationalism especially with respect to the policies of Franklin D. Roosevelt prior to the second World War.

If one measures a man by the company he keeps, then it must be said that he attracted the brighter minds, for he was on terms of intimacy with the most famous intellectuals of his time. They sought him out and all but demanded his presence. Cushing attracted people to his Harvard Clinic from all over the world. They made themselves his pupils, his disciples and his friends. He was so dominant that it was difficult for others to express themselves beside him. His knowledge outside medicine is illustrated by his appreciation of James Ford Rhodes the distinguished American Historian. It illustrated his breadth of interest and his capacity to deal with a subject unrelated to medicine. He refers casually to Thucydides, Tacitus, Herodotus and Gibbon. His daughter married Franklin Roosevelt's son and a warm friendship developed between Cushing and the President. He approached the President about starting a Federal Department of Health, and on many occasions to give advice on medical matters.

Harvey Cushing was the only surgeon to have a society called after him in his life time. And it was at a meeting of the Harvey Cushing Society that he celebrated his seventieth birthday. Tributes and thanks from his colleagues, admirers and above all his patients arrived from all over the world. On this occasion he was made an honorary fellow of the Royal College of Physicians, the only Surgeon ever to receive this recognition. He knew his name would live to posterity and he seemed to live as if he had it in mind. He almost marked the milestones of medical history with a signature.

In typical manner he commented:

"There are those who achieve birthdays and those who have birthdays thrust upon them". He had achieved his own.

SUGGESTED FURTHER READING

(i) Harvey Cushing. A biography. 1946. (Fulton).
(ii) Harvey Cushing's seventieth birthday party. 1939.
(iii) From a Surgeons Journal 1915-18. (Cushing).
(iv) An address on Acromegaly from a surgical standpoint. 1927. (Cushing).
(v) Electrosurgery as an aid to the removal of intracranial tumours. 1928. (Cushing).
(vi) Macewan Memorial Lecture 1927. (Lancet, June 1927).
(vii) Realignments in greater medicine. (Address at International Congress of Medicine).
(viii) Cameron Prize lectures. (Edinburgh 1925).
(ix) Selected Papers on Neurosurgery. (Cushing).
(x) The Pituitary body and its disorders. (Cushing).
(xi) Pituitary body and the hypothalamus. (Cushing).
(xii) The Medical Career. (Cushing).
(xiii) Intracranial physiology and Surgery. (Cushing).
(xiv) Obituary. Sir James Paterson Ross. St. Bartholomew's Hospital Journal. (No. 52 1947-48).
(xv) Harvey Cushing and his books. (Fulton). St. Bartholomew's Hospital Journal. (No. 53 1947-48).

BARTS SPORT

SWIMMING CLUB REPORT

At the beginning of July we entered a four-man team for the Inter-Hospital Swimming Gala held at the Shell-centre swimming pool. Terry Ludgrove, brother of the olympic swimmer Linda Ludgrove, won four out of the five individual prizes (freestyle, butterfly, individual medley medals and the trophy for best all-rounder). So mainly thanks to this, Bart's carried off the cup for the first time ever, with a clear lead of eleven points over our main rivals, St. Mary's.

The AGM was held on July 15th. Elected for the 71/72 season were Chris Fenn as captain, Alan Frane as secretary and Pete Durey as treasurer. Pete Bullock and Terry Ludgrove were nominated for colours.

That evening we held our annual dinner at the Royal Automobile Club, with our President Mr. George Ellis. A swim in the Club's Roman-styled marble pool was followed by a delightful meal. Our thanks go to Mr. Ellis.

The water-polo season re-starts in October. All swimmers are welcome, whether experienced or simply willing to learn.

CHARLES van HEYNINGEN

WATER POLO CLUB—SUMMER REPORT

This term we won the United Hospitals Swimming Gala, the first time Bart's have done so for a long time (at least since the war) if ever! The cup is on show in the Hospital.

The victory was largely due to Terry Ludgrove, who won three individual events. However it was a good team effort, Charles van Heyningen coming second in the breaststroke and Dave Cooke and Chris Fenn gaining points in other individual events. The team also won both relays.

We hope the cup will stay at Bart's for several years, as we will have the same team for three or four more years.

During the Summer Chris Fenn was in the Southern Counties Under 20 team.

In October the club is planning a short tour to the West Country, on which we hope any interested Freshers will come.

The tour will be a warm up to the United Hospitals Winter League, played at Mary's between October and December.

Training and coaching for water polo is at the University of London Union every Friday at 6.30; anyone interested is welcome to come along, even if you have never played before. Swimming training is at Gloucester House on Mondays at 1.00 p.m.

WHO WROTE THIS?

TENNIS CLUB REPORT

(Alan Klidjian. Hon. Sec.)

July saw some important tennis matches for Bart's and the kind weather of the early part of the month was greatly appreciated. We managed to get through to the final of the UH Cup and, one of the highlights of the season, the staff match, was played.

STAFF MATCH

Sunday July 4th

The courts were green, mowed short, the day was bright and fine, with a slight breeze to provide sufficient excuse for bad shots and to cool aching limbs. Battle commenced at 2.30. The staff side, a combination of the subtlety and finesse of consultants and the hardiness of housemen were keen to beat the holders of the UH Cup. This was very nearly achieved. Mr. Dowie and Mr. Lethin were unlucky not to talk their way to victory, it was a cruel twist of fate that kept pushing their shots just wide. Dr. Kelsey Fry and Chris Garrod fared better and remained undefeated at the end of the afternoon. Mark Setchell and Pete Bowen Roberts succeeded in winning two of their three games. Mr. McNab Jones and Nick Houghton endured a long first game and were only just beaten in their other two. Thus after 12 matches the result was.—

Staff 4. Students 6. Drawn 2.

However no ill feeling was borne by the staff in this narrow defeat and all competitors were most excellently entertained following the match.

Students team: J. Wellingham, A. Klidjian, C. Higgins, A. Hambly, H. Simpson, P. Mortimer, D. Stewart, V. Oh.

UH CUP QUARTER FINAL

v. Royal Free. Tuesday July 6th. Chislehurst.

This match was eventually played after many date alterations and then was limited to two rounds due to the late arrival of the opposition. However, this was all that it was necessary to play as Bart's won 6-0.

Mortimer and Smallwood dismissed the Royal Free 1st and 3rd pairs losing only four games. Hambly and Dixon had their usual cliff-hanging performance but in the end achieved two good wins. Wellingham and Higgins did likewise.

The final scores were:—

1st pair:
Peter Mortimer v. 1st Pair 6-0, 6-4. W.
Jim Smallwood v. 3rd Pair 6-0, 6-0. W.

2nd Pair:
Tony Hambly v. 2nd Pair 6-3, 6-3. W.
Adrian Dixon v. 1st Pair 5-7, 6-4, 6-4. W.

3rd Pair:
John Wellingham v. 3rd Pair 6-3, 6-3. W.
Chris Higgins v. 2nd Pair 6-1, 4-6, 6-4. W.
Bart's won 6-0.

UH CUP SEMI-FINAL

v. St. Thomas'. Wednesday July 14th. Cobham.

Thomas' were a much stronger side than Royal Free and it was unfortunate we could not play our strongest team. The team was weakened by the absence of Jim Smallwood and John Wellingham but significantly strengthened by the reappearance of Nick Perry. The game never appeared as close as the 5-4 score suggests since in the last round we were winning 4-2 and had our first pair playing Thomas' third.

Results: Won 5-4.

1st Pair:
Nick Perry v. 2nd 6-1, 6-0. W.
Peter Mortimer v. 1st 4-6, 6-3, 6-3. W.
Peter Mortimer v. 3rd 6-2, 6-3. W.

2nd Pair:
Tony Hambly v. 3rd 5-7, 6-4, 6-3. W.
Adrian Dixon v. 2nd 7-5, 6-3. W.
Adrian Dixon v. 1st 4-6, 2-6. L.

3rd Pair:
Chris Higgins v. 1st 0-6, 0-6. L.
Alan Klidjian v. 3rd 4-6, 4-6. L.
Alan Klidjian v. 2nd 1-6, 4-6. L.

BOOK REVIEWS

The Princess and Other Stories. D. H. Lawrence (Penguin, 30p.).

This collection contains twelve short stories written by Lawrence in the last eight years of his life. For part of this time he was living on a ranch in New Mexico with his wife Frieda; and the deep impression made on him by this barren, timeless land, alive with folklore and mythology, is undoubtedly reflected in these stories. Lawrence appears to have abandoned his style of earthy sensuality where everything is "turgid" or "fecund", and his stories take the form of fables inspired with a certain ethereal spiritualism.

I found "Sun" the most interesting story. This is about a woman who goes away to sunnier climes for her physical and mental health. Here she becomes obsessed with "going naked in the sun" and finds that "something deep inside her unfolded, and she was given to a cosmic influence". She regards the sun as her lover, and is dismayed to find her husband, on his return, as being so totally sunless. This story shows Lawrence's mystical style at its best.

"The Flying Fish" is about a man returning to England after many years in New Mexico, who discovers the elusive quality of life, "The Greater Day"—as opposed to the ordinary "little day"—in the sight of a school of porpoises playing joyfully in the sea. It concerns Lawrence's view that we have lost, or never gained, the state of "swift, laughing togetherness".

It is very hard to criticise Lawrence's writing, it is a style that either deeply fascinates, or leaves one cold. It is a pity that many of these stories are unfinished; Lawrence carefully sets up a situation that fills one with anticipation, and then has no idea how to carry on, which is very disappointing. However this collection includes some very thought-provoking stories, and should certainly be read by anyone already well acquainted with his work.

MARY HICKISH.

Surgeon in Nepal. P. Pitt. (John Murray, £2.50.).

Peter Pitt, who is at present the surgical registrar at Chase Farm Hospital, wrote this book after spending two years at the British Military Hospital in Nepal. Situated in the foothills of the giant Himalayan peaks, this hospital serves all the surrounding population, including the Gurkhas and their families, the Nepalese army and police and the Nepalese people from the flat southern plains or "terai". At a time when the western countries seem obsessed with economic growth and the problems of the so-called "emerging nations" have seemingly been relegated to the position of rather second-rate conversational items or at least clichés, it is a salutary exercise to read about the level of human suffering that is found in these countries. In Nepal, people walk for five days to reach a hospital; Tuberculosis and Rabies, with its peculiarly horrific outcome, are common; villages are decimated during a Smallpox epidemic; osteomyelitis cripples an eleven year old boy and a young girl of thirteen has most of her face removed after being attacked by the "Kanthe Bhalu" or the Black Himalyan Bear. Similiarly, secure in the NHS, it is difficult to grasp the problems of operating in a makeshift theatre, without proper instruments or blood in a climate of extraordinary contrasts. Furthermore, the book contains some fascinating anecdotes about the people, the myriad of superstitions that abound and the incredible treatments prescribed by the mystical Witch Doctors, one of whom allegedly cures a case of rabies.

Criticism of this book will centre on a lack of any definite idea of for whom the book is intended. The explanation of minor procedures or diseases would seem unnecessary for the medical profession while the vivid and accurate clinical descriptions of some of the accidents which befall the Nepalese must prove gruesome to the general public. Occasionally, Peter Pitts writing although clear and forthwright is unable to meet the demands of some of the more dramatic incidents. However, in these days of declining overseas government expenditure, it is refreshing to read about some of the useful, although admittedly limited, work being done abroad. This book is therefore very worthwhile reading, if only for the sympathetic insight it provides.

J. E. SANDERSON.

Applied Human Biology For Nurses, by Wm. C. Fream, Bailliere Tindall & Cassell (£1.80).

This second edition contains 424 pages, including over 200 black and white illustrations. The illustrations used are clearly and simply produced providing exact clarification of the appropriate text for the reader.

The book succeeds in relating normal Human Biology to the changes that occur in disease processes and the resulting clinical picture.

The text is presented in a clear and concise manner with much of the minute detail omitted. This method of presentation allows the author to cover a greater field in the most comprehensive manner.

In view of recent publication date i.e. 1970, the reference to the use of such drugs as Mercurial Diuretics and Quinnidine Sulphate appear somewhat inappropriate. The more academic student nurse will find the information presented lacking in sufficient detail.

However, it should prove a welcome edition as a reference book in any Pupil Nurse Training School, or Student Nurse Introductory Course.

A. P. SMITH.

Modern Medicine for Nurses, by John Gibson, M.D., D.P.M., Blackwell Scientific Publications (£2).

This is a new and welcome text book for both student and trained nurses.

The first chapter gives a simple introduction to the causes of disease. In the next is a concise explanation of micro-organisms with a schedule of immunisation, followed by a clear description of infections with footnotes on word definitions. These footnotes are to be found throughout the text, one fascinating example being that of influenza—discharge or influence i.e. by the stars etc.

The remaining 18 chapters mostly describe diseases in their relevant anatomical systems. Also included are, the Inheritance of Disease—with useful diagrams—and Auto-immune Diseases. Both subjects not always

induced disorders and Poisoning

Throughout this book the text is clearly set out with many illustrations and is very readable. This would be a useful addition to the nurses library and for any nurse to have for her own use.

P. DOBSON.

Do-It-Yourself Revision for Nurses No. 4 By E. J. Hull and B. J. Isaacs (50p.).

This book is the fourth in the Do-it-yourself series. It follows the same format as the previous three books. The nurse is asked to revise a topic and is then asked to answer a question relevant to it. The authors then provide a model answer which can be used by the nurse as a guide line when correcting her own work. The questions are taken from recent Final State Examination Papers.

The authors state their aims clearly in the preface and the reader is encouraged to read the introduction before using the book.

The amount of revision suggested before attempting the written answer to the question is fairly deep and wide ranging. The nurse would need to spend quite a long time on this revision in order to revise the material adequately. Thirty five minutes is then spent in writing the answer following this work.

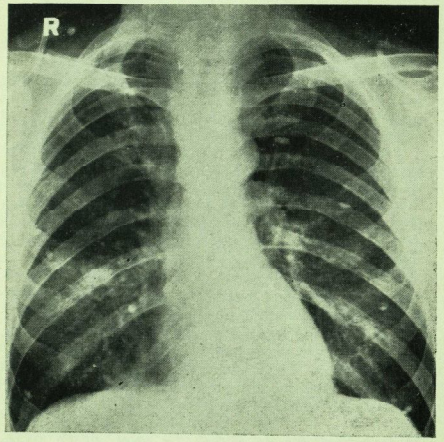
In book number four the authors have included topics relevant to the 1969 General Nursing Council Syllabus and these include questions on the Specialities which become compulsory experience under the new syllabus i.e. Community Care and Geriatric Nursing.

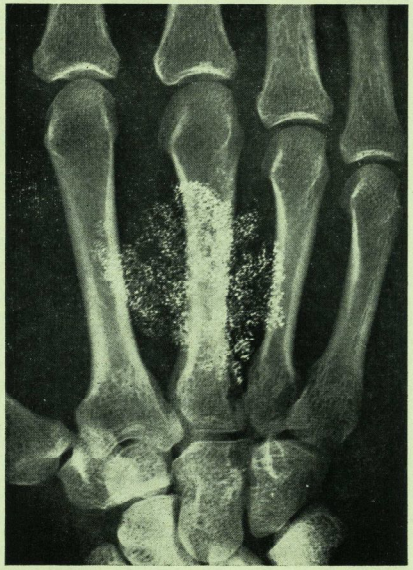
These Do-it-yourself books are extremely useful to the nurse who has the ability and application to work on her own. For these people the series is invaluable and they are to be recommended.

B. D. SARSON.

SPOT THE LESION

By J. Watkins





1. A fifty four year old man presented with a doubtful cerebral attack. He had been otherwise well, and had spent his life in Jersey, apart from 3 years in India during the last war.
   Fig. i was his chest X-ray at the time.
   A. What is the diagnosis?
   B. What is the treatment?
2. Fig ii shows the palm of a 21 year old male nurse, who worked in a mental hospital.
   Can you suggest an explanation for this appearance?

ANSWERS.

1A Tapeworm cysticerci. The skull X-ray appeared normal.

1B There is no specific treatment, and the prognosis must be guarded.

2. In a struggle with a confused patient, a thermometer had snapped, and mercury injected into the nurse's palm.

SAINT BARTHOLOMEW'S HOSPITAL JOURNAL

Founded 1893. Vol. LXXV No. 10

Editorial

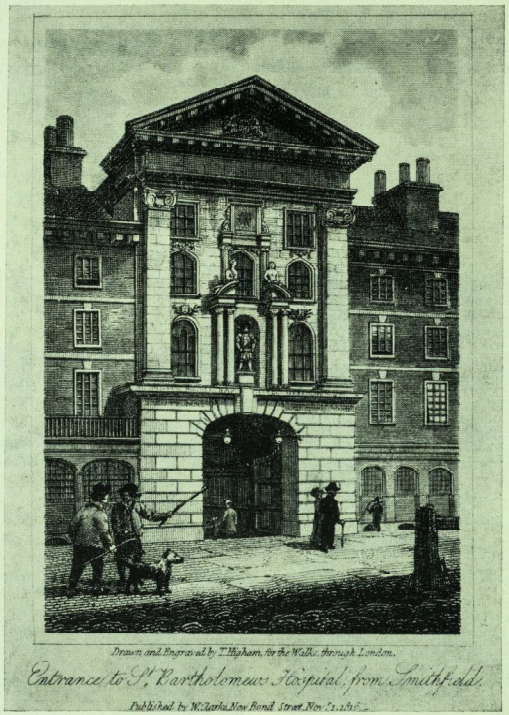
This issue of the *Journal* coincides with the beginning of another academic year with its influx of Freshers and new clinical students. We extend a warm welcome to all of these and hope that they will pass a happy and rewarding time here unmarred by the apathy so often deplored in previous issues of the *Journal*.

Teaching should be a two-way system involving the whole hearted cooperation of both student and teacher. It is part of Man's nature to need some sort of reward as an incentive for any effort he makes. Reward for the student lies in encouragement and stimulating teaching to gratify his undernourished intellect. The teacher needs interested and willing students, and the reward of seeing them become good doctors. Good will and respect between both sides is of paramount importance and can only enhance the system that is all too easily broken down by a vicious circle of indifference.

Clinical students, having survived the harrowing strain of the demanding preclinical course, arrive in the Hospital full of hopeful enthusiasm. At last they have reached the point of actually confronting patients:- something they have been working towards for at least four years. At this point their eagerness is boundless. Alas, all too often it soon falls to a much lower pitch—perhaps because they find that they can "get by" without working particularly hard, or maybe because they become introduced to the frustrations of cancelled ward rounds, etc.

The two-way system can only work if both staff and students pay heed to the maxim inscribed above the entrance to the male students locker-room — "Whatsoever thy hand findeth to do, do it with thy might".

Journal Christmas Card 1971



The Journal is again producing a new Christmas card this year which will be available throughout the Hospital.

The card will be in COLOUR and will cost 6p. Overprinting of names and addresses can be arranged at a cost of £2.55 per order. This can only be done if the orders are received immediately.

All enquiries and orders should be addressed to the Arts Editor, St. Bartholomew's Hospital Journal, St. Batholomew's Hospital, West Smithfield, London, EC1 and clearly marked "Christmas Card".

LETTERS

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

To The Editor of the Journal
Dear Editor,

In past years several occasions have occurred when more than one social event has been organized for the same evening. In order that this might be avoided, and that both consultants and students might be notified well in advance of such dates as Club AGMs, dinners, Balls, Sports Day, etc., a calendar was proposed.

This was announced in your last issue of the Journal and club secretaries have been asked to provide all the useful dates they can. It is intended that further useful Hospital information (e.g. swimming pool opening times, the days and times of various clinics, selected ward round times, postgraduate meeting times), will be included, and the whole will be distributed to all students free.

We have been offered another part time grant boosting job. The Islington Council requires students to attend court with mental offenders and escort them back to their mental Hospital in a taxi, with a driver experienced in this particular job. The pay is 65 pence per hour and further details are available from:

Mr. J. Robinson,
Social Services Department,
Area Office,
11 Tysoe Street,
London, E.C.1.

The Audio Visual Aid Centre should soon be open, and we are already connected in to the University television system. There is a monitor in the Clinical Lecture Theatre, another is to be installed in the audiovisual aid teaching laboratory, and another is intended for Charterhouse. Programmes may be seen on the Union Notice Boards and are well worth a scrutiny. The subjects vary from computer programming to Philosophy.

Our AGM is scheduled for early November and will be held in the Hospital Abernethian Room. Free beer is again being instituted and I hope as many students as possible will be able to attend. Particularly welcome are the freshers who I hope will enjoy their stay here, and make use of some of the many facilities offered.

Yours sincerely,
JOHN WELLINGHAM,
Chairman, Students' Union.

32, Platts Lane,
Hampstead,
N.W.3.
August 9th.

Dear Sirs,

No matter what one's views may be on the question of "Ward Shows," there is no excuse for the appalling inelegance of D. A. Isenberg's letter to the Journal, beginning with a direct personal attack on the Chief Nursing Officer.

May I suggest, perhaps by way of excuse, that he is a pretentious intellectual. After all they're said to be good at observing others and less good at observing themselves!

Yours faithfully,
PATRICIA M. WILSON.

[Patricia Wilson is an ex-Bart's nurse now working as Editorial Assistant to the Journal of Obstetrics and Gynaecology of the British Commonwealth—Ed.]

ST. BARTHOLOMEW'S HOSPITAL

PRE-REGISTRATION HOUSE APPOINTMENTS, JANUARY and APRIL, 1972

APPLICATIONS ARE INVITED FOR the appointments set out below :

JANUARY 1972

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 Dr. Gibb
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 : Junior House Physician to the Department of Child Health
3 posts : House Surgeon to the Department of Orthopaedics
2 posts : Rotating locums
1 post : House Surgeon Casualty
1 post : House Surgeon to the ENT Department

Regional Board Hospitals

CRAWLEY	House Surgeon	(one post)
CONNAUGHT	House Physician	(one post)
HACKNEY	House Physician	(three posts)
HAROLD WOOD	House Surgeon	(one post)
NORTH MIDDLESEX ...	House Physician	(one post)
	House Surgeon	(one post)
PRINCE OF WALES'S ...	House Physician	(one post)
	House Surgeon	(one post)
ROYAL BERKSHIRE ...	House Surgeon	(two posts)
WHIPPS CROSS	House Physician	(two posts)
	House Surgeon	(two posts)
ST. LEONARDS	House Physician	(two posts)
PLYMOUTH GENERAL ...	House Physician	(two posts)
(Devonport Section)	House Surgeon	(one post)
ROYAL CORNWALL ...	House Physician	(one post)
ROCHFORD	House Physician	(three posts)
	House Surgeon	(one post)
SOUTHEND	House Physician	(two posts)
	House Surgeon	(one post)
HEMEL HEMPSTEAD ... (St. Paul's Wing)	House Physician	(one post)
REDHILL	House Surgeon	(one post)

APRIL 1972

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 Dr. Gibb
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

Regional Board Hospitals

CRAWLEY	House Surgeon	(one post)
PRINCE OF WALES'S ...	House Surgeon	(one post)
	House Physician	(one post)
ROYAL BERKSHIRE ...	House Surgeon	(two posts)
HACKNEY ...	House Physician	(two posts)
HEMEL HEMPSTEAD ... (St. Paul's Wing)	House Physician	(one post)
ST. LEONARDS	House Physician	(one post)
REDHILL	House Surgeon	(one post)
ROCHFORD GENERAL ...	House Physician	(one post)
	House Surgeon	(one post)
SOUTHEND GENERAL ...	House Surgeon	(one post)

Applicants should state for which post they wish to apply and give a second choice.
The posts are tenable from 1st January 1972 or 1st April 1972, as listed.
Applications for **both** the January and April posts should reach the Sub-Dean's Office by **Wednesday, 17th November 1971.**
(Application forms are available from the Sub-Dean's Office where further information may be obtained).

I. M. Hill, M.S., F.R.C.S.,
Sub-Dean of the
Medical College.

ST. BARTHOLOMEW'S HOSPITAL

POST-REGISTRATION HOUSE APPOINTMENTS FOR JANUARY 1972

Applications are invited for the appointments set out below and should reach the Sub-Dean's Office by **Monday, 8th November, 1971.** Application forms are available from the Sub-Dean's Office, where further information may be obtained:

H.P. TO THE DEPARTMENT OF CHILD HEALTH
H.S. TO THE E.N.T. DEPARTMENT
H.P. TO THE SKIN AND V.D. DEPARTMENTS
H.S. (2) TO THE OPHTHALMIC DEPARTMENT
H.O. (2) IN OBSTETRICS
H.O. (2) IN GYNAECOLOGY
H.S. (2) TO THE THORACIC DEPARTMENT
H.S. (2) TO THE NEUROSURGICAL DEPARTMENT
H.P. TO THE DEPARTMENT OF NEUROLOGY AND PSYCHOLOGICAL MEDICINE
H.O. TO THE RADIOTHERAPY DEPARTMENT
H.S. TO THE DEPARTMENT OF UROLOGY
H.P. CASUALTY

Posts are tenable from 1st January, 1972.

I. M. Hill, M.S., F.R.C.S.,
Sub-Dean of the
Medical College.

Announcements

Births

HILLS—To Ann-Mary Ewart (née Macdonald) and Peter Faber Hills, a son, Robert, born September 3rd, 1971, a brother for Andrew and Catherine.

EDELSTON—To Nikki (née Allen) and Dr. Tony Edelston, a second son, Christopher David, born on June 19th in Capetown.

Engagements

EDMONDSON—BUTLER—The engagement is announced between Dr. D. B. Edmondson and Miss S. C. Butler.

HARRISON—EDWARDS—The engagement is announced between Mr. Keith Harrison and Miss Susan Edwards.

Marriage

CASSIDY—SECCOMBE—Mr. Barry Cassidy and Miss Frances Seccombe were married on July 31st at Bridgnorth, Shropshire.

Deaths

BHAGAN—On January 3rd, Mr. K. A. Bhagan, M.R.C.S., L.R.C.P. Qualified 1945.

SIMMONDS—On July 28th, Mr. F. A. H. Simmonds, F.R.C.S. Qualified 1924.

TAYLOR—On August 3rd, Mr. J. T. C. Taylor, M.R.C.S., L.R.C.P. Qualified 1931.

BRIGGS—On August 13th, Mr. W. A. Briggs, M.A., M.B., B.Chir. Qualified 1926.

PRICE—On July 5th, Brigadier R. B. Price, D.S.O., M.B. (R.A.M.C. Rtd.). Qualified 1908. (See appreciation).

Royal College of Physicians of London

The Ambriz Natti Bose Prize has been awarded to Sir Francis Avery Jones.

Mr. J. S. P. Lumley has been awarded the first Hamilton Bailey prize of the British Section of the International College of Surgeons. He will visit the University Hospital of Chicago to study audiovisual aids in undergraduate and postgraduate teaching, and the Cleveland Clinic to study aortocoronary venous bypass surgery.

University of London

The degree of M.D. has been conferred on Dr. J. A. Child.

F.F.A.R.C.S. Courses

Dr. Cole would like to bring the Primary and Final F.F.A.R.C.S. Courses to the attention of the Junior Hospital Staff and we should therefore be grateful if you would insert the following details in the next issue of Bart's Journal:

Primary F.F.A.R.C.S.

A 30 week Course in preparation for the Primary F.F.A.R.C.S. examination divided into three terms of 10 weeks each, will be organised in conjunction with The London Hospital on Monday afternoons from 2.00 to 5.30 p.m., commencing on Monday, October 18th, 1971. The fee is £30 and all applications should be made through The London Hospital, Department of Anaesthetics.

Final F.F.A.R.C.S.

A twenty week Course in preparation for the Final F.F.A.R.C.S., examination will be organised in conjunction with The London Hospital on Wednesday afternoons from 2.00 to 5.30 p.m. commencing on Wednesday, September 15th, 1971. The fee is £15 and all applications should be made through The London Hospital, Department of Anaesthetics.

Recent Papers by Bart's Men

To ensure that your papers are recorded here, please send reprints to the Librarian. Although we look through the journals received in the Library, it is not always easy to identify Bart's personnel, and contributions to other periodicals will not be seen unless reprints are received.

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*DU BOULAY, G. H., (and Symon, L.) The anaesthetist's effect upon the cerebral arteries. *Proc. Roy. Soc. Med.*, 64, 1971, pp. 77-80.

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——, *see also* HORNSEY, P. A., and others.

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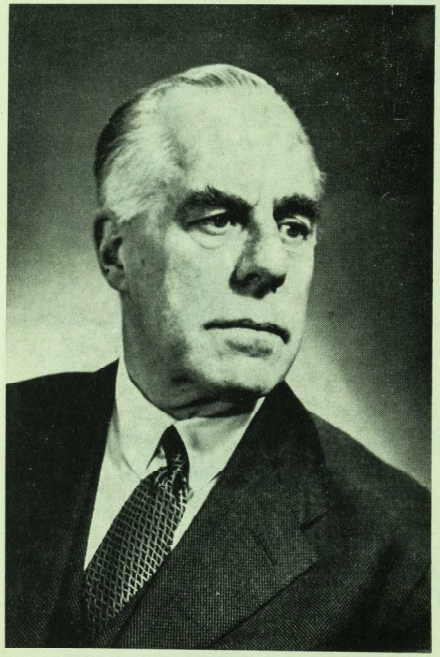
*Reprints received and herewith gratefully acknowledged. Please address this material to the Librarian.

OBITUARY NOTICE



Professor Sir Wilfrid Le Gros Clark, Professor Emeritus of Anatomy in the University of Oxford and Fellow of Hertford College, died suddenly on June 28, 1971, at the age of 76.

He started his career in Medicine at St. Thomas's Hospital and qualified in 1916 when he joined the RAMC and spent two years as a Medical Officer in France. He returned to St. Thomas's as a Demonstrator of Anatomy after demobilization but in 1920 after he had become a Fellow of the Royal College of Surgeons he obtained the post of Principal Medical Officer of Sarawak which was then ruled by the White Rajah Brooke. Here he spent three of the most satisfying years of his life. He was an excellent surgeon and physician and gave of his best for the people. Thus they came to love him and on his shoulders were tattooed the insignia of the Sea Dyaks in recognition of his reputation as a miraculous healer. In his spare time he laid the foundations of his classical research into the mammalian brain. After he had served his period of office he returned to England and took up his first important post as Reader in Anatomy in the University of London and Head of the Department of Anatomy at Bart's. The post was raised to that of a Professorship in 1927. It was here that I first got to know Sir Wilfrid, he was an excellent teacher and a kind and gentle man. He was always ready to answer questions, even naive ones, in a kindly and informative way. It was easy to see why he was so popular with children who soon came to adore him. It was with a real sense of loss when he left Bart's in 1929 to take the chair at his old Alma Mater, St Thomas's. Five years later he moved to Oxford and in 1935 was elected to the Fellowship of the Royal Society for his classical work on the neural connections of the thalamus and in 1961 he was awarded the Royal Medal.

Sir Wilfrid was not only a great experimental neurologist but also an outstanding Physical Anthropologist, indeed, he was the greatest British Anatomist of this century. It is unlikely that he will have a successor for through his influence Anatomy has at last emerged from the doldrums of topographical minutiae into one of the most important growing points in biology. This inevitably means that no one person can be knowledgeable in all its ramifications.

Sir Wilfrid was a member of the Salters' Company, and Master in 1954. He was very proud of his connection with this distinguished Company. In 1955 he was knighted and in 1961 he was elected President of the British Association, a signal honour.

He published a number of important books which will be living memorials. Among these were *Tissues of the Body* which was first published in 1939 and still in print, *The Antecedents of Man* and *Early Forerunners of Man* are classical works. His autobiography *Chant of Pleasant Explorations* is a delight to read.

From the day of his retirement he retained a room in the Department of Anatomy. He became a beloved figure who, without interfering, would give wise advice and encouragement to those who sought it. He will be greatly missed by young and old alike.

AN APPRECIATION OF BRIGADIER R. B. PRICE EDITOR OF THE JOURNAL 1909

When Brigadier Robert Bernard Price, D.S.O., RAMC (retired) died on July 5th 1971, Bart's lost one of her most devoted Old Boys. He was never so happy as when he was reminiscing to his friends and fellow members of the Fountain Club about his days at Bart's, his teachers and his experiences in those good old days, alas many years ago; he was 85.

He never talked about the wars in which he had served although he had earned a D.S.O. "for conspicuous gallantry and devotion to duty" and had been thrice mentioned in dispatches.

Naturally he was a member of the Fountain Club, that particularly Bartish institution composed of men who are clubbable, who have enjoyed their time at Bart's and who like to meet again friends made in those happy irresponsible days, and also to meet new younger men who will assure them that the lamp still burns. He joined the Fountain Club forty-seven years ago in 1924. For most of these years he held the office of Bard. This office is very similar to that of Poet Laureate. He writes when the spirit moves him and when the occasion demands. Two editions of "Pearls of Price" show how frequently his spirit was moved. He summed up his feelings for Bart's and the Fountain Club appropriately in verse:-

"The Fountain's the one club I know
Where men with splendid hearts may go
And of all Hospitals I choose
The stately Saint Bartholomew's
The Imperial City's chief renown
The pride and glory of the Town . . ."

It was altogether appropriate that when the real Poet Laureate, Cecil Day Lewis, honoured the Club by being its guest at a dinner in the Great Hall on the occasion of its fiftieth birthday, he should be Master. He was incidentally one of the three members to be honoured by being Master on two occasions. It is greatly to his credit that he introduced himself, undeterred by the presence of the Laureate, in verse.

So "RBP" has gone, but he would have been quite confident that Bart's would continue to produce the "men of splendid hearts" of which he wrote.

C.K.V.

AMERICAN VIEWPOINT

It was a windy, cloudy morning. The air was heavy, as if in anticipation of the great battle which was to unfold late that Wednesday morning, August 18, 1971.

From the underground station, I hiked the three-quarter mile distance, not feeling or thinking anything, nor knowing what feelings and fears yet lie ahead of me. I approached the area in no special way, but once within, I surveyed the scene closely and meticulously.

I took up a temporary post high upon a surrounding wall. Watching the numbers of combatants swell, I took a reconnaissance photograph. Determining what would be a most stategic position, I set out for it, all the time keeping my eyes open and looking around. Some of the combatants could be heard talking and laughing . . . . laughing with a nervousness which had as yet only begun to pervade the ever-growing throng.

In a deceptively easy fashion, I took up my position. A feeling of tenseness began to grip me. I prepared myself to do battle. Removing my wallet and passport from their pockets, I put them inside my shirt next to my body; I felt it unnecessary to remove my American Traveller's Cheques from my hip pocket, as they were no longer of any value since President Nixon's speech of less than thirty-six hours before. Having done this, I checked and rechecked my armaments. The anxious nervousness of waiting began to overtake me. I re-checked my armaments twice more.

Some were drawn off by what I knew would be only diversionary attacks. Then many, who looked like hardened veterans, quickly drew into the area.

I felt a cold chill down my spine. My trembling hands grew cold and clammy. My eyes twitched. My ears strained, trying to hear the sounds which I knew would harken unto me that fateful morning. It seemed as if every bone and muscle in my body tensed to do battle, yet cried out with fear for the unknown to come.

Nervous, I began to whistle, then sing, patriotic songs to prepare me. Such inspiring tunes as my high school football chant, and then my old college fight song.

Off, in the distance to the southeast, they could be seen to be quickly massing then charging from my left. Just moments before what I knew would be a great battle, I took two close up photographs to tell the story my eyes had seen, should I not survive to let my lips speak it.

I was now prepared, my physical and mental strength at a zenith. O Thor, beware of my lightning strike!! Hercules, beware my strength!!

It was now upon me. Armed only with a small calibre umbrella, I fought violently, viciously. The odds were innumerable! I stayed at the forefront of the throng, but only to be trampled upon by a savage, merciless horseman. I thought surely I had seen my last — O, dear Heaven help me!

I wallowed in the almost lifeless mass of human bodies, wondering if I had made any accomplishment at all. I knew I had been valiant and of pure heart, but that was not sufficient. I began to think. Was it all a senseless occurrence? Why, oh why did I embark upon such a perilous venture? But, with a final surge of strength I clawed and struggled. And then! .... and then! Do my eyes deceive me? No! I saw it! THE CHANGING OF THE GUARD!!

MARK SEGALL.

(Mark Segall is an American student who has been doing an elective period at Bart's).

THE RAHERE ASSOCIATION

By E. L. BURBIDGE, F.I.C.S.

I am just wondering how many people who have noticed the Rahere Badge on television sets in the Wards in King George V Block, or on the walls of the corridors, above the tip-up seats, know much about The Rahere Association, its functions and what it endeavours to do with the cash generously given by so many of the Hospital's well-wishers.

Up to July 5th 1948, the date on which the voluntary hospitals were taken over by the Government, there had been an Appeals Department at St. Bartholomew's Hospital whose duty it was to circulate possible donors to obtain funds for the general running of the hospital. At the time it was felt unlikely that State control would ensure that all the patients requirements would be met and it was anticipated that there would certainly be no facilities available for giving grants to those people in dire need. For this reason the Rahere Association was formed and it was incorporated as a Company the following year.

My predecessor who has recently died was the third Chairman of the Association, Captain Mason Scott (RN) Retd., who on leaving the service of the hospital devoted a great deal of his spare time in an endeavour to build up the funds and meet every possible request made to him. His services to the Rahere, and his personality as an individual were of the highest order and will be remembered with admiration by all who knew him.

The anticipated need for funds to meet special requirements has been found to be very real and since July 1948 numerous demands on an ever increasing scale have been received by the Association. These often make very pathetic reading and vary for requests for help for old sick people who find themselves in financial straits due to their illness to the provision of convalescent holidays. In addition the Association has been able to make grants to ensure that the Hospital has those little extra amenities which make so much difference to the well being of patients and staff, and at Christmas each Ward Sister is given a sum of money to ensure that each patient receives something extra to mark the occasion.

Each week I spend some time with the Medical Social Workers who write a full report of the cases they ask us to help. We regularly assist relatives with their fares, sometimes long distance ones, to enable them to visit their loved ones as often as possible. Financial disaster can face a patient who is suddenly taken ill, and who has several hire purchase or mortgage payments to meet. You can imagine the psychological relief given when the Rahere helps them over this hurdle and thus probably assists the cure. A great many patients are enabled to have a convalescent holiday by the sea, sometimes with their families thanks to the financial assistance given. Recently we arranged such a holiday for a woman, accompanied by her young children, knowing as we did that this would probably be her last one.

Some time ago we had a case where one Sunday morning a man, his wife and young son were travelling through to the seaside on a motorcycle and side-car. They met with a dreadful accident in which the husband and son were killed and the wife had both legs amputated. The Rahere supplied her with an electric typewriter which has made life worth living for her. An old aged pensioner from the City had to come into hospital, and the only thing she had to live for was her cat. Her worries were alleviated when Rahere arranged for the cat to be placed in kennels during her stay at Barts.

On a more general basis, almost every ward in King George V Block has a television set together with ear phones, and every Ward and side room has been wired for reception of television from a roof aerial all supplied and put up by the Rahere Association. Several hundreds of light earphones have been supplied for the radio. Annual grants are made to the Library for the purchase of new books; in fact even the flowers, beautifully arranged by one of the lady receptionists, which brighten up the main reception counter are supplied by Rahere.

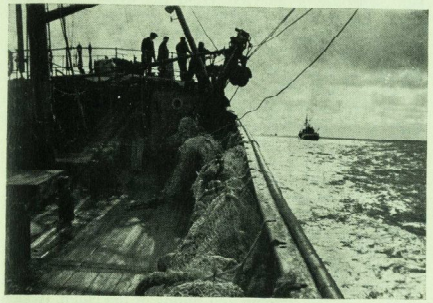
On the staff side, television sets have been placed in the nurses homes, hostels and training school. The nurses hair dressing room was built and paid for some years ago, and last December a further £1,000 was spent on improving a corner of the nurses dining room to make it more comfortable with carpets, armchairs, etc., especially for the benefit of the night staff. Financial aid has been given to deserving cases of the lay staff, when ill, and daily newspapers and periodicals are supplied in the Rest Room. The maids sitting room in the West Wing has a television set, supplied some years ago.

There are of course many other cases, too many to mention where the Association has been able to assist.

Coming now to the other side of the Balance Sheet, from whence do we obtain our funds? A great number of grateful patients and their relatives make annual contributions in amounts from a few new pence to pounds. About fifteen thousand Xmas Stockings are sent out in the autumn for the hospital benefactors to insert a few coins. Several large City institutions, public and private companies kindly assist, but I fear it is generally forgotten by many that Bart's is the only hospital situated in the City of London which is supposed to handle an enormous amount of the world's wealth. Many of those working in the City have the misfortune, as I did, to be taken suddenly ill and be rushed to our Hospital to be nursed back to health. It is surprising how very few show tangible appreciation of their lives being saved by trying to help others not so well off as themselves. Perhaps what I have tried to describe in this article may eventually reach the right ears to enable us to do much more than we are at present.

TRAWLING IN THE NORTH SEA

By Jeremy J. Vevers



It happens to a few of us—we fail second M.B. the first time. It happened to me a year ago. Somehow, within a few days, everything changed. I was surrounded by sparkling sunlight and fresh winds, in the middle of the North Sea, aboard a trawler. She was called the Gallilean, not a big boat: in fact only 120 ft. in length, a middle water trawler looking much older than she really was.

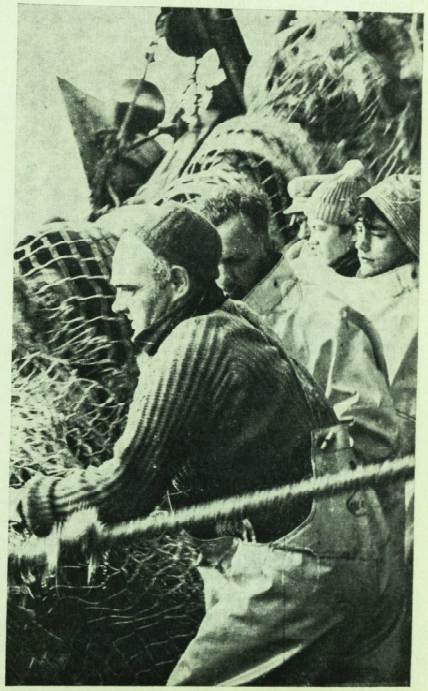
We sailed from Grimsby on a windy morning, straight into a heavy swell, towards a stretch of water between Norway and Denmark known as the Skaggerak. For a day and a half the seas crashed over the bows and smashed against the bridge. At night time, in a tiny bunk amid-ships, the boat seemed smothered in water and noise. At times she seemed to hesitate in mid-air before crashing down again. The back of the boat seemed ready to break at every lurch.

This new experience, coupled with the unaccustomed stench of stale fish and urine (something I never quite got used to) meant that eating and drinking for two or three days was definitely not possible. Mark the cook, a kind but talkative man, gave us a box of biscuits which certainly helped. He was the first person I talked to. In a short time we covered most of his sea experiences, what he thought of the skipper, his sister's housing problems, and how he managed to cook in such adverse conditions. Being trapped by him meant a similar conversation again and again, and most of the crew avoided him, but respected his cooking. His culinary surprises included fruit-tart with no pastry, and "plumduff" with no plums. Speciality: Yorkshire pud.

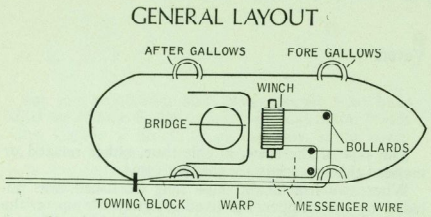
The rest of the crew, at this time, either relaxed or mended the nets ready for the first trawl.

Where we fished, and how long we fished, was decided by the skipper. He lived a lonely life up on the bridge and was prone to melancholy and whisky. Though very well-paid, the decisions he had to make certainly discouraged others from taking his responsibilities. Both the Mate and the Third Hand on the Gallilean had been skippers but they could not stand the responsibility and the loneliness.

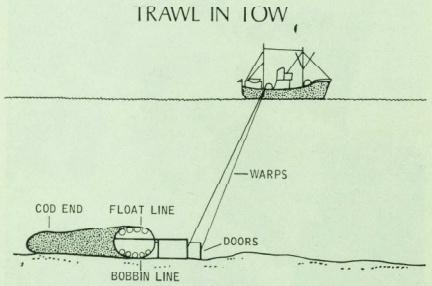
Everything changed when the trawling started. The weather changed and the boat was stabilised by the



trawling. I shall describe briefly the process of trawling, so that you, reader, may not take your cod steaks for granted.



The diagram shows the general layout of a starboard-side-trawler. A huge conical net (about 150 ft. long) is dragged, attached by two steel warps. Keeping the mouth of the net on the sea bed are a line of heavy steel "bobbins". "Cans," or floats, are attached to the upper part and drag it upwards.



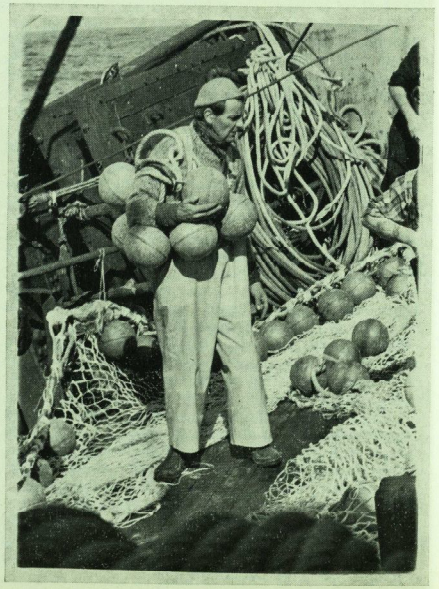
Two wooden doors (weighing ¾ ton each) spread the mouth wide (to a width of 50-80 ft.) The warps are attached to a steel winch, just forward of the bridge, and pass, via stanchions, to the fore and aft gallows. (The gallows are large metal hoops built into the deck on either side.)

Shooting the trawl involves hoisting the doors into position on the gallows. The ship is turned broadside on, so that the working side is windward, and the trawler is blown away from the netting. Most of the netting is pushed over manually, except for the bobbin line, which is hoisted clear by the winch. When the net is running out, a "deckie" must hook both warps with a messenger wire; these are then "blocked up" on the towing block. While he is doing this, any sudden movement of the boat can make the warps spring away, or suddenly come together, and so trap him. This, and the reverse process of "knocking out", can be extremely dangerous. Everyone else in the crew stands well back.

Hauling the nets comes about four hours later. The engine room is warned, and the crew get kitted-up in smocks, rubber gloves and waders. As the engines shut down the winching gear drags the net in. The weight at the end of the warps may be more than eight tons, and they sometimes break with disastrous results. The ship is steered to starboard and the warps knocked out of the towing block. The catch is winched on board and left suspended a few feet from the deck. The Third Hand then pulls the ropes holding the "cod-end" of the net, and fish cascade around him onto the deck.

While this is going on, the trawl's stabilising effect on the ship is lost, and water may be shipped in only a moderate swell. Time and again the nets would float up with virtually nothing, or torn to shreads on a wreck. Then a catch of over one hundred baskets came in and covered the deck with fish. The gutting of that haul went on well into the night.

Gutting a fish looks amazingly simple. Just hold the fish in the left hand with your thumb behind the first gill cleft, and run a sharp knife down the belly as far as the vent. Scoop out the liver (this is kept for cod-liver oil), cut and remove the intestines. Simple, except that the fish may be over four and a half feet in length and still alive. Standing up is a problem. The movement of the boat, the slipping and sliding of the catch, (which may be thigh deep), and the treacherous deck, covered



in blood, faeces, and fish slime, contribute to the difficulties. Gutting takes place every four hours, day and night.

The fish, when gutted, are thrown into the "washing machine". This is a galvanised tin bath, with a shoot that drops the fish to Pete, the Mate, and Jim in the dead-house. They inspect the fish and store them in layers, surrounded by ice.

This may seem very straightforward, for July is usually a fair weather month. When winter comes, passengers are rarely allowed on trawlers. This is hardly surprising as gales may last for days on end, and quantities of ice have to be chipped off the rigging, while the decks may be continually awash with freezing water.

In the White Sea, towards Spitzbergen, all this happens for six months of the year in the dark.

One can only have great respect for them: for the skipper, a lonely person with a lot of responsibility; for the little barrel-chested engineer, who is virtually deaf with the continuous scream of the engines; and for the galley-boy, Terry, who was sick for over a week on his first trip. The mortality rate in trawling is, on average, four times that in coal-mining, and twenty times that in any other industry.

These men are in a different world for most of their lives. A world where gulls scream, where there are no traffic jams, no Sunday papers, very little politics, a lot of racial prejudice and where they have never heard of David Jacobs or Robin Day. To an outsider, common experience is minimal. How difficult it must be for them returning to their wives and children, with only one or two days before the next trip. Out of the crew of twelve, I knew four to be divorced or separated.

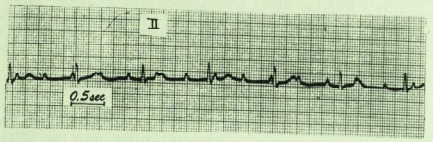
To understand why they do it, one has only to see the crowds of people standing at the quay-side, watching the ships return. Mothers have dragged their children to this event for generations and it is central to their way of life. Young boys go fishing and too easily become bitten by the companionship that such high-risk trades seem to produce.

A sight I shall never forget, driving out of Grimsby on a beautiful Saturday morning, was Eric (the Third Hand) and Mark standing in their suits by a bus-stop — looking really very smart — but completely lost.

SPOT THE LESION

By J. Watkins

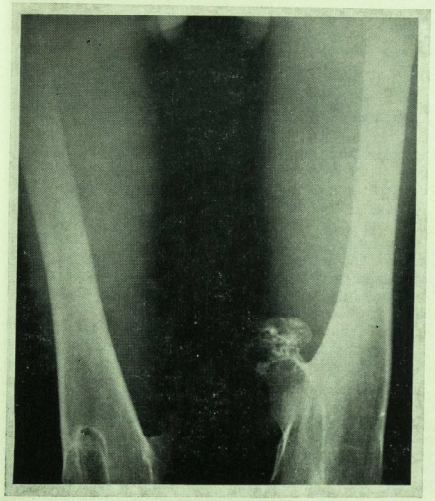
Fig. i



A. Fig. i shows the ECG of a thirty-two year old man, whose presenting symptom was tiredness. His cardiovascular history was negative except for a 24 hour episode of mild praecordial pain two months earlier.

Q. What is the arrhythmia?
What is the most likely cause of the pathology?
What treatment would you advise?

Fig. ii



B. Fig. ii shows the femora of a twenty-one year old man, who gave a strong family history of this condition, and had similar lesions elsewhere.

Q. What is the diagnosis?

Answers

A. The ECG shows complete heart block. (The pulse rate is 50/min.) The history suggests a sub clinical infarct two months earlier, or possibly a myocarditis. Syphilis and Reiters syndrome are rare causes. If the patient's symptoms are debilitating, a pacemaker might finally be needed. If any specific cause can be found this should be treated.

B. The X-ray shows exostoses, which are quite benign. They need only be removed as they cause symptoms.

BOOK REVIEWS

SEVENTH DAY
(Penguin 50p)

Seventh Day is a book about the Six Day war of June 1967. This is the war in which the Israelis proved to the world and the Arabs in particular that their country was a geographical entity and demanded to be treated as such.

This is not a book about tactics, strategies or descriptions of action, but it is more an account of the hesitations, fears, hopes and triumphs of a generation of Sabras (native born Israelis) who suddenly found themselves expressing their ideals in the most violent way: with the bullet!

The Six Day war has always interested me because it was fought by a generation who, though my contemporaries, have views which are in many ways a complete contradiction to my own. Israeli youth is not beset by the distrust of established values of religion and patriotism which are a hallmark of European and American youth. Instead they pursue their goal, to make Israel a nation of the world, with an almost desperate mixture of religious and nationalistic fervour. This book is useful, I think in that it tells us, using the Six Day war as a framework, a great deal about the ideological and emotional make up of Israel and her people.

In the summer of 1967 a group of young "Kibbutzniks" all of whom were under thirty-five, had fought in the war, and were authors and poets of some national standing decided that the oppressive silence following the war had gone on long enough. They borrowed tape-recorders and set off on a tour of the kibbutzes to try and discover the feelings of the young men who had been through what must be the most traumatic experiences of anyone's life. The interviews were always informal and as themes developed they were discussed in depth so that the basis of the war and the moral issues associated with it become quite clear on reading the book. The first edition entitled "Soldiers Talk" was published in October 1967 for internal distribution among the kibbutzes. The book achieved such enormous national interest that further editions were produced and it was finally decided to publish a book for world sale. This book is essentially the same as the original except that the soldiers thoughts have been organised into a logical sequence. There is no loss however of the freshness that only the spoken word can provide.

In "Seventh Day" we find an army composed of men who not only had a complete willingness to fight but felt that the fighting was both unavoidable and just. Incredible when one compares this high morale with the virtual mutiny of the American troops in Vietnam! None of the officers however, talk of heroism but only of training and competence. "Heroism is a matter of technique" — as one young officer puts it — "you cannot ask a soldier to go ahead of you". This demonstrates the kibbutz principle of "Self-Labour" i.e. do not ask someone else to do something if you can do it yourself.

Perhaps the most interesting facet of this book is the comparison that can readily be made between the kibbutz and the army exemplified both in the informality between officers and men and the role of women in the army. It is significant that relatively a far greater number of officers come from the towns and they paid the price in a far higher death toll during the war.

I think that anyone who has any interest in contemporary Israel, should read this book because it provides not only an account of youth's reaction to the horrors of war but also a useful insight into the ideals and beliefs of the first generation of Israelis.

A. PEACOCK.

THE THURBER CARNIVAL
By James Thurber, Penguin, price: 40p, 404 pages

James Thurber was on the staff of the "New Yorker", from 1927 onwards; he died in 1961. In that time he created some of the most amusing and entertaining cartoons and prose ever to grace the pages of that magazine. The characteristic Thurber style gives a wry, half-sad comment on life which is more often than not hilariously funny. The stories and cartoons are economical and to the point, a mixture of fantasy and real life, and, like all good humour, they instil in the reader a compulsion to read on and devour more of them.

The "Thurber Carnival" itself was first published in 1945 and has been through several Penguin editions since 1953. The new edition is the complete original version of 1945 and should prove as popular as ever. The book comprises a large selection of some of the best Thurber articles and cartoons; the famous Thurber dog crops up on several pages, Walter Mitty whose secret fantasy life is always impinging onto reality, and several other Thurber regulars are featured.

The Penguin edition is good value at 40p, with over 400 pages, the last hundred of which consist mainly of cartoons. A worthwhile purchase for anyone to whom the Thurber-type humour appeals.

ALAN KLIDJIAN.

AN INTRODUCTION TO SURGERY: 100 TOPICS
By R. G. ELMSLIE and J. LUDBROOK
Published by: William Heinemann Medical Books Ltd., London. 212 pages. Cost £1.75.

In the introduction to their book Mr. Elmslie and Professor Ludbrook rightly state that up to the present there has not been available a simple introductory surgical textbook to guide the first year clinical student through his initial term of surgery. There is no doubt that, with the present complexity of surgical science and practice, such a textbook is needed.

The present volume written jointly by the Reader in Surgery and the Professor of Surgery at Adelaide University deals with 100 individual surgical topics. Each topic occupies two facing pages, the right hand page diagrammatically illustrating the text on the left hand page.

The book commences with what may be called surgical philosophy. Thus one section is devoted to the concept of "normality" whilst another explains "the diagnostic process". In this latter section the authors indicate how the diagnostic process follows the well recognised path of history, physical examination and special investigations. They then state, however, that it is better to call history the "clinical interview" and consider that special investigations should be labelled as "diagnostic tests". Such a change in terminology would be mere quibbling over words and would introduce terms that are of no greater clarity than the older well known terminology. This section, together with another section on "Time, Disease and the Patient/Doctor relationship" which is incidentally accompanied by an incomprehensible diagram, constitute the only weak points of the book.

The rest of the book consists of concise and lucid explanations of diagnostic procedures such as endoscopy, principles of treatment as diverse as anaesthesia and radiotherapy, and more specific sections covering such standard problems as swellings arising from the pelvis, lesions of the umbilicus, scrotal swellings and the fractured ankle.

An amazing quantity of basic surgical knowledge is dealt with in a practical and clear manner, special emphasis being placed on explaining and defining the new terminology which the student meets in such profusion on commencing clinical work.

This book adequately fulfills its stated purpose of acting as a guide to those commencing the study of surgery. It can be unhesitatingly recommended to students starting their clinical years.

M. H. IRVING.

CANOE CLUB

John Albert: 1969 World Canoe Slalom Championships.
(French Alps).

Canoeing is not really one sport at all, but a variety of different sports under one collective heading. Gliding at high speed across a lake in a sleek wooden racing kayak is very different from battling down the foam flecked rapids of an Alpine torrent, which is in turn different from a leisurely canoe-camping holiday.

The Canoe Club at Bart's offers the opportunity to take part in all these branches of the sport, even if you have never yet set foot in a canoe. Although the club is small, we have close links with the London University club, (being a founder member). We paddle on the Thames every Wednesday afternoon, either at Twickenham—for the flat-water racing types, or at Shepperton weir—for the slalom and white-water enthusiasts. At odd times throughout the year we run trips farther afield. For example, last year we went to the Universities Slalom Championships in Scotland, and to other races and tours in Wales, Yorkshire, the West country.

The club owns a number of racing craft, and has access to half a dozen glass fibre slalom canoes.

Our past captain, Aidie Huskisson, paddled in International competitions within eighteen months of first getting into a canoe, which she did at Bart's. So if you start canoeing now, you may represent Britain before you leave!

If you think the approaching winter is too cold for canoeing, why not come along to ULU baths on Wednesday nights, when we teach new members eskimo-rolling and other skills in a heated pool.

If you want to join, or want more details, contact:
John Albert—1st year clinical.
Steve Watt—1st year clinical.

SAINT BARTHOLOMEW'S HOSPITAL JOURNAL

Founded 1893. Vol. LXXV No. 11

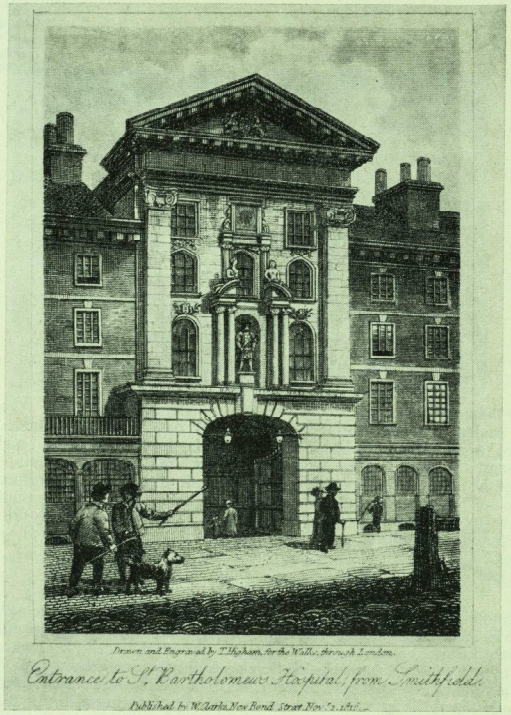
Editorial

The time has come to clarify the role of women in medicine. As a woman medical student, I have been made aware of being an intruder in a male society—this is not to say that I have been treated badly, far from it, Bart's staff and students are amongst the most friendly and charming I know. However, certain prejudices—justified or unjustified—have prevented women from taking a fully respected place in medicine. The most obvious criticism is the wastage involved in training women who leave to get married soon after qualifying. We have also been criticised for lack of stamina, emotional lability, and the various problems associated with female hormones.

It is undoubtedly true that the majority of women do leave medicine for a time in order to raise their families. There are two alternatives to this problem—sterilise all women doctors, or accept that, during this period, they can play a valuable part in the running of the School Health Service, and acting as locums to G.P.s and as clinical assistants in outpatients departments. The N.H.S. desperately needs doctors and should tap this reservoir of labour by providing day nurseries for the younger children, and by creating openings for women doctors willing to work part-time, and later, once they have raised their families, full time. If the N.H.S. needs doctors so badly, why train women at all? This would be grossly unfair to those women who do make a full time career of medicine, and would also mean the demise of those branches of medicine at which women are especially good.

I believe that male antagonism towards women in medicine is really far more basic than the economic aspect—it is an inherent belief that Man should be the predator, and Woman the submissive provider of domestic comfort.

Journal Christmas Card 1971



The Journal is again producing a new Christmas card this year which will be available throughout the Hospital.

The card will be in COLOUR and will cost 6p.

All enquiries and orders should be addressed to the Arts Editor, St. Bartholomew's Hospital Journal, St. Batholomew's Hospital, West Smithfield, London, EC1 and clearly marked "Christmas Card".

LETTERS

The Abernethian Room,
St. Bartholomew's Hospital,
September 22nd.

Dear Editor,

When I first heard that students were no longer going to be required to take bloods I was overjoyed at the prospect of spending an extra hour or two in bed every morning without as guilty a conscience as I may have had previously. However, my initial enthusiasm for my bed waned when I realised that I had lost one of the easiest methods of introduction to patients which was particularly useful in my first few months of the clinical course. Now, having completed my first clinical year, I find that the effort required to summon up the energy to clerk a patient is far greater than if I had initially broken the ice with the patient at the blunt end of the syringe, and because students are now seen at even less frequent intervals on the wards I think that much of the sympathy between students and patients has now been lost. Taking bloods in the morning usually ensured that one was occasionally in early enough to clerk all one's patients adequately before the afternoon round, instead of coming in five minutes before the round, finding two new patients, flicking through the houseman's notes, and then praying throughout the round for the consultant not to let his gaze descend upon your patients.

I do not advocate that students should spend the entire morning taking, or waiting to take, the bloods, as can happen, but I do think that students could be responsible for one or two mornings per week. I have even heard it heretically suggested that students be paid to take bloods, but I think this would be difficult to arrange, although it could be one solution to this problem—perhaps others have different ideas?

Yours sincerely,
A. J. SEARLE

Doctors Residence,
Groote Schuur Hospital,
Capetown, South Africa.

September 26th

Dear Sir,

It is a well known fact that "The long arm of Bart's" stretches to the four corners of the world. Often, therefore, it is commonplace to bump into a fellow graduate from the Royal and Ancient, be it in the Congo, or traversing the Khyber Pass. However, it now appears, that not only is it the well known black and white tie that enables one to spot this peripatetic Bart's man, but also the Vicarage club colours seem to have entered the international tie spotting scene!

At the wedding of a well known "Vicar" in Capetown recently, there were no less than eight Bart's men and their wives present. Of this number, six were members of the Vicarage club, and all were sporting their notorious pink black and white ties, much to the interest of the other guests, who we think are still under the impression they were looking at THE Bart's tie!

Since our time in South Africa, we have met up with several fellow "Vicars". John Hamilton, Consultant ENT Surgeon in Durban, and the tie is being proudly sported in Zambia by Chris Roous. One of the club's more illustrious pioneers, Dr. Alec Ferguson, is the Consultant in Respiratory disease at the Groote Schuur.

It would be interesting to hear if there are a similar number of "Vicars" gathered in any other outposts of the Empire!

Yours sincerely,
JOHN STEVENS

Capetown Vicars:
T. M. Coltart, D. Lloyd, E. Lloyd, G. Mumford, A. D. Edelsten, A. Ferguson, J. E. Stevens.

STUDENT'S UNION LETTER

Abernethian Room,
St. Bartholomew's Hospital,
October 6th, 1971.

The Editor of the Journal,
St. Bartholomew's Hospital,
West Smithfield,
E.C.1.

Dear Editor,

Whilst discussions on student locums are continuing with the Department of Health and Social Services (D.H.S.S.), an interim honorarium of £12 is to be awarded to final year students undertaking locums. B.M.S.A. is intending to negotiate a higher figure than this and perhaps change "final year students" to "senior students". More important, the final honoraria agreed are hoped to be as a set percentage of Housemans pay. The £12 interim award took effect from Monday, September 20th. The D.H.S.S. has also informed Hospitals that students undergoing residencies should receive free lodgings and pay for food under the P.A.Y.E. scheme. This covers such things as midwifery appointments and also took effect on Monday, September 20th.

The contract for the building of the audio-visual aid centre has now been signed by the Dean and the work has started. However completion is not anticipated

before the first half of next year. About 50 programmes have already been prepared and about 20 more are still under preparation. Arrangements to increase the audio-visual library have begun, and we will be able to obtain many programmes by exchange with other schools or buying new ones. To enable the laboratory to open in the evenings and at the weekends, student volunteers will be required to supervise it. If anyone is interested could they please let me know.

We did apply to enter a float in the Lord Mayor's Procession this year, as decided at the last council meeting. However the entrance fee was £70 and floats are valued on average, at several hundred pounds. We felt that whatever the publicity, etc., involved, that this was more than the Union could afford.

The Students' Union Calender has at last been completed for 1971-1972. It was sent to the printers on October 5th, and will be available in both the pre-clinical and clinical cloakrooms, free, as soon as it is returned from the printers.

Yours sincerely,
JOHN WELLINGHAM,
Chairman, Students' Union.

11 Hernes Road,
Oxford.
September 14th, 1971.

The Editor,
St. Bartholomew's Hospital Journal,
London, E.C.1.

HOSPITAL COAT-OF-ARMS

Dear Madam,

I am afraid that Mr. Michael Harmer did not make a discovery in recording a coat-of-arms similar to the *Party per pale argent and sable a chevron counter-changed* arms so well known in the Hospital which he had seen in Famagusta, Cyprus. The Cypriot arms have been known about for many years and certainly at the time of the writing of an Editorial (vol. 51, pp. 19-20) in 1947 discussing why the Hospital uses (so frequently) a wrong coat-of-arms. I searched out the Famagusta arms when serving in the Royal Air Force in Cyprus in 1952 and also made a photograph. You may like to reproduce part of the Editorial to explain things more clearly than in your September number where certain inaccuracies appeared. Belatedly, the help of the late Toby Elmhirst, M.S., F.R.C.S. and Herald, in the preparation of the Editorial is now acknowledged. I suspect that Mr. Harmer knows of the Editorial as an article entitled "The gleam or socialism for others" and signed by "Hogarth" followed it.

Both Mr. Harmer and the Hospital Archivist were incorrect in using the term "crest" in their notes. The Shorter Oxford English Dictionary states "it is a vulgar error to speak of the arms or shields of a college or city as *crests*"! Mr. Harmer refers to the rather dull "lions" in the Priory and Hospital coat of *Gules two Lions passant gardant and in chief as many crowns or,* but this coat is more ancient than the Argent and Sable one and can correctly be used by the Hospital even if it does not have the same attractive simplicity. There are penalties for bogus use of arms going back to the reign of Henry V, and unmentioned by the Hospital Archivist the Argent and Sable arms were granted by Norroy King of Arms to Lawson of Usworthe, County Durham, in 1558. It is reasonable to assume that, unless the Heralds themselves erred, the coat had not been used officially by any family or institution before that date and that the Hospital must have missed an opportunity in not requesting the grant of that coat earlier, if it wanted to use it. As a result of the grant to Lawson, the Argent and Sable coat-of-arms has never truly been the property of the Hospital. It is not just a question of the use of the arms in Wakeryng's seal when Master of the Hospital on June 14th, 1423, and subsequently.

Yours faithfully,
MILO KEYNES

Dear Miss Hickish,

To the average Londoner, Bart's is both a famous Teaching Hospital, and a notable Establishment in its own right, steeped in tradition and an integral part of the City. Or is it? It occurred to me that although Bart's still enjoys 4 lines in the "Places of interest" section of the London A-Z, there are so many *new* and interesting places emerging in the City that perhaps we were deluding ourselves about our notoriety.

So, I decided to find out just what the "Man in the street" *did* know about Bart's. Positioning myself outside St. Paul's, I spoke to some 50 people. Here is a greatly biased selection of some of their comments.

Journal: What do you know about Bart's?
American tourist: About who?
Journal: What do you know about Bart's?
Young man: . . . that place opposite the White Hart . . . .
Journal: Do you know the name of any famous hospitals in the City?
Woman: . . . Well there's Bart's but I don't think I know any famous ones.
Journal: What do you think of Bart's?
Policeman: Oh, great place . . . that's where I got my wife from . . . er. its a good hospital too.
Journal: What do you know about Bart's?
Frenchman: Comment?

Sincerely,
FIFE ROBERTSON II

ANNOUNCEMENTS

Engagement

GLANVILL—GEDDES—The engagement is announced between Mr. Andrew Peter Glanvill and Miss Elspeth Jayne Geddes.

Deaths

HORDER—On August 16th. Dr. P. T. Horder M.B., B.S., D.P.H. Qualified 1960.

BRIGGS—On August 13th. Dr. W. A. Briggs M.B., B.Chir., D.O.M.S. Qualified 1926.

VAZIFDAR—On August 9th. Lieutenant-Colonel S. S. Vazifdar M.R.C.P., M.R.C.S. Qualified 1907.

MAY—On July 19th. Mr. A. G. May M.B., B.S., D.Obst., R.C.O.G., D.L.O. Qualified 1951.

O'SULLIVAN—On June 20th, 1971. Dr. Donald O'Sullivan M.B., Ch.B., age 43, in Rhodesia. Qualified 1957.

BLYTH-BROOKE—On September 24th. Dr. C. O. S. Blyth-Brooke. Previous M.O.H. for Finsbury.

Changes of Address

MR. A. P. FULLER'S new address is 108, Harley Street, London W1N 1AF.

DR. J. D. JEFFRIES' new address is 5, St. Catherine's Close, Colchester.

Cambridge Graduates' Club of St. Bartholomew's Hospital

The 81st Annual Dinner of the Club will be held in the Great Hall on Friday, November 19th, 1971, at 7 for 7.30 p.m. This is the first occasion on which Lady members and guests will be present. The dinner Secretary is Dr. T. B. Boulton, Department of Anaesthesia, St. Bartholomew's Hospital, London, E.C.1.

Association of Anaesthetists of Great Britain and Ireland

J. R. Davies has been awarded the 1971 undergraduate essay prize of the Association for his contribution entitled "Suxamethonium muscle pains".

The work which formed the basis of the essay was undertaken while Mr. Davies was spending his elective period with the Department of Anaesthesia.

Appointment

DR. P. P. RICKHAM, director of studies in paediatric surgery, University of Liverpool, and senior consultant paediatric surgeon, Alder Hey Children's Hospital, Liverpool, has been appointed to the chair of paediatric surgery at the University of Zurich, Switzerland.

ST. BARTHOLOMEW'S HOSPITAL

PRE-REGISTRATION HOUSE APPOINTMENTS, JANUARY and APRIL, 1972

APPLICATIONS ARE INVITED FOR the appointments set out below:

JANUARY 1972

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 Dr. Gibb
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 : Junior House Physician to the Department of Child Health
3 posts : House Surgeon to the Department of Orthopaedics
2 posts : Rotating locums
1 post : House Surgeon Casualty
1 post : House Surgeon to the ENT Department

Regional Board Hospitals

CRAWLEY	House Surgeon	(one post)
CONNAUGHT	House Physician	(one post)
HACKNEY	House Physician	(three posts)
HAROLD WOOD	House Surgeon	(one post)
NORTH MIDDLESEX ...	House Physician	(one post)
	House Surgeon	(one post)
PRINCE OF WALES'S ...	House Physician	(one post)
	House Surgeon	(one post)
ROYAL BERKSHIRE ...	House Surgeon	(two posts)
WHIPPS CROSS	House Physician	(two posts)
	House Surgeon	(two posts)
ST. LEONARDS	House Physician	(two posts)
PLYMOUTH GENERAL ... (Devonport Section)	House Physician	(two posts)
	House Surgeon	(one post)
ROYAL CORNWALL ...	House Physician	(one post)
ROCHFORD	House Physician	(three posts)
	House Surgeon	(one post)
SOUTHEND	House Physician	(two posts)
	House Surgeon	(one post)
HEMEL HEMPSTEAD ... (St. Paul's Wing)	House Physician	(one post)

APRIL 1972

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 Dr. Gibb
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

Regional Board Hospitals

CRAWLEY	House Surgeon	(one post)
PRINCE OF WALES'S ...	House Surgeon	(one post)
	House Physician	(one post)
ROYAL BERKSHIRE ...	House Surgeon	(two posts)
HACKNEY ...	House Physician	(two posts)
HEMEL HEMPSTEAD ... (St. Paul's Wing)	House Physician	(one post)
ST. LEONARDS	House Physician	(one post)
REDHILL	House Surgeon	(one post)
ROCHFORD GENERAL ...	House Physician	(one post)
	House Surgeon	(one post)
SOUTHEND GENERAL ...	House Surgeon	(one post)

Applicants should state for which post they wish to apply and give a second choice.
The posts are tenable from 1st January 1972 or 1st April 1972, as listed.
Applications for **both** the January and April posts should reach the Sub-Dean's Office by **Wednesday, 17th November 1971.**
(Application forms are available from the Sub-Dean's Office where further information may be obtained).

I. M. Hill, M.S., F.R.C.S.,
Sub-Dean of the
Medical College.

ST. BARTHOLOMEW'S HOSPITAL
POST-REGISTRATION HOUSE APPOINTMENTS FOR JANUARY 1972

Applications are invited for the appointments set out below and should reach the Sub-Dean's Office by **Monday, 8th November, 1971.** Application forms are available from the Sub-Dean's Office, where further information may be obtained:

H.P. TO THE DEPARTMENT OF CHILD HEALTH
H.S. TO THE E.N.T. DEPARTMENT
H.P. TO THE SKIN AND V.D. DEPARTMENTS
H.S. (2) TO THE OPHTHALMIC DEPARTMENT
H.O. (2) IN OBSTETRICS
H.O. (2) IN GYNAECOLOGY
H.S. (2) TO THE THORACIC DEPARTMENT
H.S. (2) TO THE NEUROSURGICAL DEPARTMENT
H.P. TO THE DEPARTMENT OF NEUROLOGY AND PSYCHOLOGICAL MEDICINE
H.O. TO THE RADIOTHERAPY DEPARTMENT
H.S. TO THE DEPARTMENT OF UROLOGY
H.P. CASUALTY

Posts are tenable from 1st January, 1972.

I. M. Hill, M.S., F.R.C.S.,
Sub-Dean of the
Medical College.

RECENT PAPERS BY BART'S MEN

To ensure that your papers are recorded here, please send reprints to the Librarian. Although we look through the journals received in the Library, it is not always possible to identify Bart's personnel, and contributions to other periodicals will not be seen unless reprints are received.

*Bacon, P. A. (and Myles, A.B.) Hypoglycaemic coma after partial gastrectomy. *Postgrad. med. J.*, 47, 1971, pp. 134-136.

*——, (with others). Single daily dose corticosteroid treatment. Effect on adrenal function and therapeutic efficacy in various diseases. *Ann. rheum. Dis.*, 30, 1971, pp. 149-153.

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Besser, G. M., with others. Prolonged corticotrophic action of a synthetic substituted $^{1\text{-}18}$ ACTH. *Brit. med. J.*, Sept. 25, 1971, pp. 742-743.

Braimbridge, M. V., (with Chesshyre, M.H.). Dysphagia due to left atrial enlargement after mitral Starr valve replacement. *Brit. Heart J.*, 33, 1971, pp. 799-802.

*Brodribb, A. J. M., (and Ricketts, C. R.). The effect of zinc in the healing of burns. *Brit. J. Accident Surg.*, 3, 1971, pp. 25-29.

*Cholmeley, J. A., (with others). Recurrent Perthes' disease. *Brit. J. Radiol.*, 44, 1971, pp. 675-681.

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Dawson, A. M., *see* Dyer, N. H., and others.

Di Rosa, M., and others. Studies of the mediators of the acute inflammatory response induced in rats in different sites by carrageenan and turpentine. *J. Path.*, 104, 1971, pp. 15-29.

*Dyer, N. H., and others. The value of rectal biopsy in the diagnosis of Crohn's disease. *Scand. J. Gastroent.*, 5, 1971, pp. 491-496.

Fairley, G. Hamilton, *see* Powles, R., and others.

Giraud, J. P., *see* Di Rosa, M., and others.

Hibbard, B. M. and Hibbard, Elizabeth D. Neutrophil hypersegmentation and defective folate metabolism in pregnancy. *J. Obstet. Gynaec. Brit. Cmwlth.*, 78, 1971, pp. 776-780.

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Landon, J., and others. Emergency chemical pathology service in central London. *Lancet*, 2, Aug. 28, 1971, pp. 480-482.

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*Lewis, O. J. Branchiation and the early evolution of the Hominoidea. *Nature*, 230, 1971, pp. 577-579.

*McColl, I., (with others). Ion transport in rabbit ileal mucosa. 1. Na and Cl fluxes and short-circuit current. *Amer. J. Physiol.*, 220, 1971, pp. 1388-1396.

Mack, J. W., *see* Pare, C. M. B., and ——.

Pare, C. M. B., and Mack, J. W. Differentiation of two genetically specific types of depression by the response to antidepressant drugs. *J. med. Genet.*, 8, 1971, pp. 306-309.

Parker, R. A., *see* Watts, R. W. E., and others.

*Partington, M. W., (with others). 5-Hydroxytryptophan (5-HTP) in Down's syndrome. *Devel. Med. Child. Neurol.*, 13, 1971, pp. 362-372.

Pemberton, J., *see* Beard, M. E. J., and others.

Peppiatt, R., *see* Landon, J., and others.

Powles, R., and others. Method of removing abnormal protein rapidly from patients with malignant paraproteinaemias. *Brit. med. J.*, 3, Sept. 18, 1971, pp. 664-667.

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Salsbury, A. J., *see* Clarke, J. A., and others.

Sanders, P., *see* Landon, J., and others.

*Simon, G. Diagnostic radiology in localization of lung cancer. *In*, Deeley, T. J., *Modern Radiotherapy. Carcinoma of the Bronchus*, 1971, pp. 90-104.

*——, (and Pierce, J. W.). Macroradiography in severe congenital heart disease in neonates. *Brit. J. Radiol.*, 44, 1971, p. 729.

——, (with others). Bacteriological and radiographic features of lung infection by opportunist mycobacteria: a review. *Tubercle*, 52, 1971, pp. 232-241.

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Snedden, W., *see* Watts, R. W. E., and others.

Stansfeld, A. G., *see* Dyer, N. H., and others.

Thompson, J. B., *see* Besser, G. M., with others.

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*Watts, R. W. E., and others. A quantitative study of skeletal-muscle purines and pyrazolo [3, 4-*d*] pyrimidines in gout patients treated with allopurinol. *Clin. Sci.*, 41, 1971, pp. 153-158.

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

B.M.S.A. SYMPOSIUM

A Synopsis compiled by JACQUELINE HEATH

The Guest Speakers at the Symposium.

The Annual General Meeting of the British Medical Students' Association was held in Leeds in April, 1971. The principles of NHS were discussed, and a national symposium on the future of the NHS was proposed, with invitations extended to include GPs, hospital doctors, nurses and members of the paramedical professions.

The opening speaker at the Symposium, Sir George Godber, K.C.B., F.R.C.P., Chief Medical Officer at the Dept. of Health and Social Security, spoke of the future development of the Health Service and of the grave financial difficulties besetting the NHS.

Dr. Ivor Jones, M.B.B.S., M.R.C.G.P., next addressed the Symposium on "The Problem of Financing the Health Services". Dr. Jones was the Chairman of the advisory panel which produced the BMA report "Health Services Financing" in 1970. He spoke of the present and future financial difficulties of the NHS. He explained his recommendations, as outlined in his BMA report, of a two-tier system of health insurance with a compulsory exemptible basic rate and a voluntary additional scheme which could offer more benefits at higher premiums. Quoting from his 1970 report, "The only sacrifice that would have to be made would be the concept of equality within the NHS."!

Following Dr. Jones, Mr. Miles Hardie, M.A., F.H.A., Director of the King's Fund Hospital Centre, spoke on "We get the Health Service We Deserve".

Mr. Hardie felt that no government had adequately defined its overall strategy for health and social services. He recommended more discussion and information on the options, priorities and objectives of the NHS. He suggested that the medical profession should give due consideration to ways in which wastage of money could be cut.

Mrs. Theresa Stewart, a member of Birmingham City Council and a previous member of the Birmingham Regional Hospital Board, gave a talk on "Democracy in the NHS". She explained that members of the Regional Hospital Boards are selected from a list of desirable people and installed in office by consent of the Minister of Health. Such proceedings are in private and the general public is denied any knowledge relating to the hospitals for whose upkeep they pay.

The afternoon began with a very interesting illustrated discourse by Dr. Kenneth Easton, M.B.B.S., M.R.C.G.P., O.St.J., on "Medical Care in the Rural Community".

Dr. Malcolm Brown, Ph.D., Senior Lecturer in Social Administration at the University of Birmingham, spoke next on "The Use of the Social Worker in the Medical Setting" Dr. Brown has served as the United Nations General Social Welfare Advisor. Unfortunately, most of his speech was spent criticising the medical profession for not encouraging the use of social workers, and he hardly attempted to mention their functions or how he would like to see their knowledge used.

On Sunday morning, Mr. William Laing, B.Sc. (Econ.), Deputy Director of Health Economics, addressed us on "Wilder Aspects of Health Service Finance". Mr. Laing emphasised that the need of the NHS is not merely for more money, but for reorganisation, increased efficiency, better management, and less waste.

The final guest speaker was Dr. Francis Piggott, M.B.B.S., F.F.A.R.C.S., President of JHDA, and currently on the GMC. He spoke on the "Doctors' Point of View".

An account of the debates and discussion groups follows, together with the resolutions passed. Also discussed were: rehabilitation, group practice and community health teams, care of the elderly, the pharmaceutical industry, and professional standards and consumer protection.

1. PRIVATE PRACTICE—a Conflict of Interests?

The delegates agreed that the present relationship between private practice and the NHS is unacceptable. It was accepted that to abolish private practice completely was unrealistic at present. Many people felt that the belief held by the public that better treatment (as opposed to better service) was obtained privately is a myth perpetuated by consultants for their own gain.

The main suggestions were:—

(i) Employment of Consultants.

More full-time NHS consultants must be employed, and there must be improved merit awards for such consultants. Part-time consultants should be seen as part-time, and should not receive more than five- or six-elevenths of their NHS salary, in order to make a clear distinction. These part-time consultants should not head firms nor be involved in the administration of the hospital.

(ii) Separation of Facilities.

This aims to present the full cost of NHS facilities to private patients. It was felt that there must be greater separation of private and NHS services, so that private beds should be in either a separate block or wing of the hospital. There must be accurate and realistic cost assessment of private treatment, including capital costs.

(iii) Use of Junior Hospital Staff.

Junior doctors, especially housemen, employed full-time by the NHS should not be expected to attend private patients, and their contracts should be so drawn up as to prevent this.

(iv) Tax Concessions.

The delegates deplored a suggestion that tax concessions should be given to people for taking out private medical insurance.

2. FINANCING THE HEALTH SERVICES.

A. A Summary of the Introduction by Graham Winyard (Middlesex Hospital).

The NHS does not receive enough money. Evidence for this confronts patients and health workers every day, and in some fields deprivation reaches appalling depths. Why does it not function adequately? How may the necessary funds be channelled into health care?

The subject of health financing is often confused, probably because it forms an interface between politics, economics and medicine, each with its own jargon and prejudices. The central point in this whole matter is to decide how much of health care is a matter for market forces, and how much falls into a special category to which economic laws do not apply. Economically speaking, death is rather a powerful constraint to free choice. On the other hand, it would be equally difficult, because of Britain's mixed economy, to deny individual patients the freedom to purchase separate rooms or silk sheets, if that is what they choose to do with their money. The contrast is that between "need" and "demand".

Society, perhaps led by the medical profession, decides that certain categories of people need certain facilities and treatments made available to them, irrespective of their financial status. How far the areas governed by need will extend will depend on medical, political, ethical and financial arguments. Outside this, the forces of supply and demand are allowed free play.

Many different financial arrangements are possible to provide these needed services. The only precondition is that the method of fund-raising should provide no barrier to anyone obtaining the medical care to match his medical need. Money could come from general or specific taxation; contributions could be flat-rate or income-related; administration could be public or by private firms. Any combination is theoretically possible: the choice depends on which system can, in practice, yield enough money to run the "need" services.

The NHS was set up with the laudable medical, ethical and political goals of placing virtually all medical care in the "need" category. The basic financial arrangement chosen was payment through general taxes: this seemed reasonable enough making the then current assumptions that costs would remain static for twenty years, perhaps gradually falling as the state of the nation's health rose. "A miscalculation of sublime dimensions," in the words of Enoch Powell.

Today, the high aspirations of the NHS are being slowly eroded by the inadequacy of its fund-raising. The proportion of our Gross National Product (GNP) which we devote to health is rising more slowly than that of virtually any other developed country. We do not appear to be willing to support through higher taxes the services we think "ought" to exist. What is the answer?

Firstly, is our definition of the "need" sector too wide? In principle we seem to say not: financially we think it is. Either way we must be financially realistic, or if we will not provide the money, we must stop pretending we can provide a comprehensive health service.

Assuming we retain the present level of theoretical care, the next choice is whether to adapt our present fund-raising system to provide enough money, or to change to some completely different system. To adapt would be simpler, and could combine a reallocation of existing revenues in favour of health, together with a raising of tax levels to yield more revenue. General pooled financing is said to be more flexible, and can be directly controlled by the elected representatives of the people. Defence is often suggested as a good target for cuts, but any savings here would have to be shared among several deserving causes education, housing and social security as well as health. The major limitation to the present system, however, is that there is enormous resistance throughout the electorate to any tax increases. The link between tax taken and services provided seems to have completely disappeared in people's minds. Perhaps this might be remedied by education and propaganda.

Alternatively, the link might be restored by instituting a universal insurance scheme, or an ear-marked tax (such as the TV licence). Health is a thing that most people value, and might be prepared to pay more for if this extra money went directly and specifically to improve the health services, not into an amorphous central pool. Such alternative systems can best be studied by looking at other countries. Most European states use insurance rather than central financing, and it does seem that their systems are more capable of responding to increased medical demands than our own. Perhaps a complete change is the only answer.

B. Extracts from the Report commissioned in 1967 by the BMA, and carried out by an advisory panel under the chairmanship of Dr. Ivor Jones.

(i) Analysis of the current financing of the NHS reveals that taxation provides 85½% of the total annual expenditure, national insurance contributions account for 9½%, and direct charges 5%. These proportions have not varied significantly during the last twenty years. Though the total cost of the health and welfare services has risen from £830 million in 1959-1960 to £1,770 million in 1968-1969, and it has been rising faster than GNP in recent years, this is only because savings have been made in the defence budget to enable other public expenditure to rise faster than GNP.

(ii) Financial projections produced as an appendix to the report indicate that the public expenditure on medical care cannot increase at the same rate as it has done in the past, inadequate as that was, except in the event of:—

(a) The achievement of an economic growth rate of 4% per annum, or more,

or (b) An increase in tax rates,

or (c) A transferance of expenditure from other public services,

or (d) Deficit financing by the government.

(iii) The following facts become relevant:—

(a) The present rate of economic growth is of the order of 2½% p.a., and the government is not planning to achieve a rate higher than 3-3½% p.a. in the immediate future.

(b) Treasury estimates of future expenditure on the health and welfare services envisage a rise of only 3.7% p.a. over the next five years.

(c) Annual rises in the prices of goods and services which influence overall NHS costs have tended to be higher than 4% even during the periods of maximum government restraint, and may be expected to be well above this level in the immediate future.

(d) Recent relaxation in the Government's policy of severe restraint of increases in personal incomes, and in particular the probability of substantial rises in the incomes of the lower paid workers in the NHS, including nurses, is likely to result in an increase in the costs of staffing at all levels substantially in excess of 4% p.a. This is of great significance in the light of the facts that:—

1. Staffing accounts for about 70% of the total costs of running an NHS hospital.
2. The hospital service is the principal spender within the NHS.

(iv) Additional revenue for the NHS is therefore urgently required merely to maintain the existing inadequate standards which it provides. Implementation of the Government's current plans for financing the service can only result in a deterioration of those standards. The achievement of rising standards, comparable to those in the general standard of living in recent years, must therefore require additional finance.

(v) It is recognised that, though the level of taxation on personal incomes in Britain is high, other nations which have adopted different tax systems have succeeded in raising a greater proportion of the national income by taxation than Britain has done hitherto. There may therefore be scope for an additional tax revenue for the nation's health services in this direction. Any substantial rise in indirect taxation creates new social problems, however, and in the light of the fact that a rise of 10p in the £ on the standard rate of income tax would produce a sum of money only marginally in excess of £500 million p.a., it becomes clear that sources other than general taxation must be found if our health services are to become adequate financially.

(vi) The report explores the possibility of drawing additional money into medical care from current private expenditure on other goods and services.

The volume of such expenditure is great in comparison with the money spent on the NHS, and in 1968 amounted to some £25,000 million. The transfer of only a small percentage of this annual expenditure to the health services would achieve all that is necessary, and the report reveals that this could be done without making unacceptable inroads on other items of expenditure, and certainly without gross change in the pattern of national life.

(vii) The report acknowledges that some desirable degree of equalisation of standards of medical care throughout the country has been achieved by the NHS. There is a much better distribution of consultant services in our hospitals than there was twenty-five years ago. Nevertheless, any claim that the NHS has achieved its aim to provide equality of medical care is an illusion. In fact, absolute equality could never be achieved under any system of health, education, or other essential service. The motives for suggesting otherwise are political, and ignore human factors.

(viii) Assessment of the performance of the NHS reveals facts which are of even greater significance as indicators of desirable reform. Deficiencies are shown to arise partly because of the centralised, non-competitive structure of supply within the service, and also because there is no direct link between payment and the cost or quality of the service received.

(ix) One of the most popular suggestions for financing the NHS has been an ear-marked tax: this would be difficult to organise automatically to health needs or to the actual costs of providing care. Experience shows that such taxes are susceptible to arbitrary government interference, and very soon cease to fulfil even their limited theoretical potential. Furthermore, if levied at a flat rate, an ear-marked tax becomes more oppressive (than income tax) on the poorer sections of the community. For the same reasons, a substantial rise in the health service compliment of the National Insurance Stamp, which is essentially an ear-marked tax, could not provide any satisfactory long-term solution; a similar argument applies to graduated earnings related contributions paid into a separate fund, and considerably increased employers' contributions. An increase in direct charges at the point of consumption (like prescription charges, but including a boarding charge for hospital inpatients, and a consultation charge for out patients) might prove a useful adjunct in raising revenue. The administrative costs of such a scheme, including the necessary exemptions, might well preclude the use of such a scheme, unless the charges are very high. Furthermore, they are likely to create an intolerable barrier to treatment, if they are paid for from the patient's pocket at the time of treatment. Direct charges alone obviously cannot solve the problem. It has also been suggested that private expenditure on health services might be encouraged by granting tax concessions for voluntary health insurance.

(x) It is recommended that inpatient costs (other than those of geriatric patients, the chronic sick and psychiatric patients), outpatient costs, general medical services, dental and ophthalmic services should be financed by insurance.

(xi) Each person should be given the opportunity to contract out of what might be called the "compulsory health insurance" into an insurance scheme which offers higher benefits.

C. Conclusions reached by the Discussion Group on Methods of Financing the Health Services

It was agreed that health services fell broadly into these groups:—

(i) Services which could not conceivably be financed by the actual users, e.g. geriatrics, mental subnormality, long-stay patients, research, blood transfusion, etc. This would form approximately 50% of the financial outlay, and would have to be financed by taxation.

(ii) Services which should be available to everyone without financial barriers to treatment, e.g. inpatient, outpatient and GP care. This could be financed by the users.

(iii) Services suitable for the free market, i.e. service received proportional to financial outlay.

It was agreed that all specifically medical treatment should fall into categories (i) and (ii), but no agreement was reached as to what category (iii) should cover. One view was that extra payments should be able to buy only luxuries, e.g. private rooms, whilst others considered that such things as choice of consultant and short waiting times should be included. There was a widespread feeling that a strong market sector could result in disproportionate diversion of resources to the richer sections of society, and that this might prove a self-reinforcing process, with correspondingly more money to the private sector as the standards diverged.

These possibilities were considered on the methods of financing sector (ii):—

(a) Taxation.
(b) Compulsory insurance.
(c) Direct charges.

As far as direct charges were concerned, it was felt that these were of little use as a means of raising revenue per se, as any amount large enough to yield a worthwhile sum would act as an unacceptable deterrent.

The advantages and disadvantages of taxation and compulsory insurance were discussed. General taxation can be more flexible and varied in its impact and thus socially fairer. While Britain is by no means the most highly taxed country, there are obvious political limits to raising large amounts in this fashion, and there will always be other services competing for money.

If large amounts of extra money are necessary (Dr. Ivor Jones estimated that the NHS required an *extra* £1,000 million p.a., but Mr. Miles Hardie and Mr. William Laing put this figure at nearer £200 million only), compulsory insurance, either flat-rate or income-related, is necessary. It was realised, however, that such a system would form a political springboard for opting out into more luxurious private schemes, on a large scale.

Perhaps most important in any great overall increase in resources is the allocation of present resources. Participation in objective setting by the recipients of services, together with expert control in the attainment of those objectives was thought essential. Using such mechanisms, it could be that the extra money required will be of an order that can be coped with by taxation, thus preserving the present financial system of the NHS.

D. Further Discussion on Finance

(i) IMPROVING THE EXISTING NHS.

A committee of senior doctors interested in the future of the NHS should be commissioned by the BMA to investigate the possibilities of early discharge from hospital, and the effect of the increased work load this would mean for the GP and District Nurse.

If the inpatient stay could be reduced, the total cost of each patient's treatment would be dramatically decreased, the turnover of beds would be much faster, and the waiting-lists for common operations could become non-existent.

(ii) WASTAGE.

Clinical lecturers in both the medical and nursing schools should emphasize throughout the course the heavy cost of hospital treatment, and the price of drugs and other facilities, e.g. expensive drugs are often prescribed when cheap ones are equally effective.

(iii) PRIVATE PRACTICE

Together with movement towards a private practice system goes a movement of manpower: increased time spent by the doctor with each patient, more nurses per private head than per national caput. Yet sages from the BMA insist that the medical care of private patients and NHS patients will be equal!

Health care is a right rather than a privilege to be enjoyed by those who can pay for it. Whatever system is eventually chosen, it seems clear that it must be income-related and that, whatever the contribution, all individuals must receive equal medical attention. To do otherwise would be to sacrifice the whole ideology of the NHS.

3. PARTY POLITICS AND THEIR EFFECTS ON HEALTH AND SOCIAL SERVICES

A. Summary of a detailed review by students at University College Hospital Medical School, London

(i) THE POLICIES AND THE PROMISES.

The manifestos of both the Labour and the Conservative parties include:—

(a) Statements about the need to concentrate resources on the mentally ill and the handicapped, the chronic sick and the elderly.

(b) Acceptance of the Seebohm report and the need to end the tripartite structure of the Health Services.

(c) Claims that resources going into Health Services are inadequate.

The Labour Manifesto pledges to expand training of medical staff and to change the administrative structure. The Conservative Manifesto suggests that extra resources can come from "private provision" and mention voluntary social work, community services (home care), and increased numbers of health centres and group practices. The pre-election Brief on Health issued to Labour Party speakers mentions the benefits expected from a reorganisation of Health Services along the lines of the second Green Paper and "the battle to ward off proposals for health insurance suggested by the Tories". The pre-election Brief on Health issued to Conservative Party states: "We shall maintain the rights of individuals to make their own provisions for health".

The Conservatives recommend an expansion of voluntary private health insurance to provide new health finance, thus giving people the responsibility of providing for themselves.

Both parties accept the need for a Health Ombudsman.

(ii) PARTY PLANS FOR PENSION SCHEMES AND DEALING WITH FAMILY POVERTY.

Labour's National Superannuation Bill would have introduced earnings-related contributions and envisaged a partnership of state and private occupational pension schemes. Their manifesto states that they will review the present system of family allowances.

The Conservatives emphasise "the expansion and improvement of occupational schemes", and say that they will "ensure that adequate family allowances go to those families that need them".

(iii) PERFORMANCE IN POWER.

(a) *Health Service Expenditure.* Labour's claim to have increased the amount of national resources devoted to health is supported by Department of Health and Social Security figures:—

Up to 1964 average increase in expenditure = £42m. p.a.

1964-1970 average increase in expenditure = £106m. p.a.

(b) *Hospital Building.* Labour claims of accelerated hospital building are also justified in terms of capital expenditure on hospitals:—

Pre 1964 average increase in expenditure £22m. p.a.

After 1964 £56m. p.a.

(c) *Doctors.* The Todd report recommended reversal of the Conservative decision to restrict the number of Medical School places; and the Labour Government undertook to expand this number from 2,700 to 3,700 by 1975. The present Conservative Government has accepted this target and will establish a new Medical School at Leicester.

(d) *Health Centres.* December 1964—30 Health Centres open. March 1970—159 open and 124 under construction.

(e) *The Mentally Handicapped.* £3m. was allocated by the Labour Government solely for improvement of hospital services for the mentally handicapped. The Conservative has made £40m. available for this over the years 1971-75.

(f) *Charges.* Although Labour pledged abolition of prescription charges they re-introduced them in June 1968 at a rate of 2/6d. per item and also included an exemption system. On April 1st, 1971, the Conservatives increased this charge to 4/- per item. Both parties also increased the price of school meals. The Conservatives will also increase ophthalmic and dental charges; and school milk (stopped by Labour in secondary schools) will soon cease to be available to children over the age of seven.

(iv) THE PHILOSOPHIES.

The fundamental differences are most simply summed up the titles in the Manifestos:—

Conservatives—"Care for those in need".

Labour—"Caring for people".

B. Conclusions reached by Discussion Group on Party Politics and their effects on Health and Social Services.

The main area of resentment was the attack by both Conservatives and Labour on the principle of health care free at the point of service, the principle that we consider should be the guiding light of the Health Service. It was felt that the source of finance should be from progressive general taxation; but the lack of detailed public discussion and information on priorities governing the distribution of current resources were also disturbing. If these decisions are taken in isolation from the community at large, they cannot possibly respond to the real needs of the community.

The use of the social services as an area in which convenient cuts can be made in times of economic crisis is deplorable.

C. Prescription Charges and the Low-Wage Earner

(From an article by Rose Black of the Royal Free Hospital, London.)

The rationale behind the raising of the prescription charge at the Budget last Autumn was that it would only affect those able to pay, since exemption categories were to be extended. The Budget granted exemption to a much larger group of the lower income (i.e. less than £12.95 per week), as well as existing groups such as children and OAPs. Coates and Silbury in Nottingham and the students of the Royal Free Hospital, London (in a poorer area of Islington), have conducted surveys which suggest the very people most in need failed to claim benefits.

(i) THE PUBLIC.

Only 4 out of 48 people questioned knew that those on low incomes were eligible for exemption. Most people knew that old people and children were exempt but did not know about other categories, e.g. pregnant women.

(ii) POST OFFICES.

Eleven Post Offices were visited and nine of them did not display adequate information nor provide the free stamped envelope supplied. Seven of the eleven were discouraging and indifferent when asked for advice.

(iii) CHEMISTS AND OUTPATIENTS PHARMACIES.

Only one out of nine chemists visited had helpful welfare information on display and this chemist remarked: "It's very complicated for the general public. I don't understand it fully myself; there are so many different forms, so how can they be expected to understand it?" Another said: "People don't know how to go about getting exemption—many are still paying".

Not one of the clerks who dealt with prescription charge exemption in the hospital outpatients' pharmacies knew that people on low incomes could apply for exemption certificates. At the same time all the clerks felt that the new charges were causing hardship and said in many cases patients were asking for only one item on a prescription to be dispensed, and in some cases none at all.

(iv) GENERAL PRACTICE.

None of the seven general practitioners serving the working-class areas approached knew that patients on low incomes could claim exemption for this reason alone. The GPs said that they were trying to prescribe just one item, even when they regarded two as necessary, in order to reduce the cost to the patient. Often the patient asked for this.

4. MEDICAL EDUCATION—A TRAINING FOR WHAT?

This was a well-attended debate, but many of the conclusions reached were aired grievances rather than constructive ideas, and a complete list of the resolutions reached may be obtained on application to the Editor of the Journal. Subjects discussed at length included: present methods of selecting medical students, research into the objectives, structure and methods of medical education, the flexibility of the course, vocational guidance, responsibility for patients during the clinical course, vocational guidance, responsibility for patients during training for general practice, and awareness of the patient in the community and the social and political role of the doctor.

5. CAREERS FOR MARRIED WOMEN DOCTORS

A. Introduction to the problem—(Anon. contributor)

Two large-scale surveys in Great Britain provided the bulk of the material for this paper, with 9,075 (72% of total circulated) (1) and 8,075 respondents (2) respectively.

(a) THE NUMBER OF WOMEN IN MEDICINE.

In 1962 the Ministry of Health estimated the number of women doctors in Britain to be 14,000. In 1968 25% of medical students graduating were women.

(b) EFFECT OF MARITAL STATUS.

(i) At present the loss to medicine is among the married women doctors, particularly those with a child less than five years old—only one in six working full-time and one-third wholly unemployed.

(ii) The age of the women and number of children are less important.

(c) DESIRE FOR EMPLOYMENT AMONG MARRIED WOMEN DOCTORS.

In 1962, 1,000 unemployed women doctors wished to do some work and a further 1,000 in part-time appointments wished for more work. The main factors preventing a return to work were a lack of suitable employment and domestic problems.

(d) INTERIM MEASURES

Recent action to employ women in Oxford (3) and the South-West Metropolitan regions (4) show some interesting developments:—

(i) Both regions carried out a more intensive effort to recruit underemployed women doctors.

(ii) Both showed the ability of regions to organise hospital appointments on a part-time basis of training.

(iii) Both showed that some married women were able to help with emergency, evening and weekend cover on an ad hoc basis.

B. Report and Recommendations of Discussion Group on Careers for Married Women Doctors

Married women doctors appear to have problems related to their profession which can be divided into two categories:—

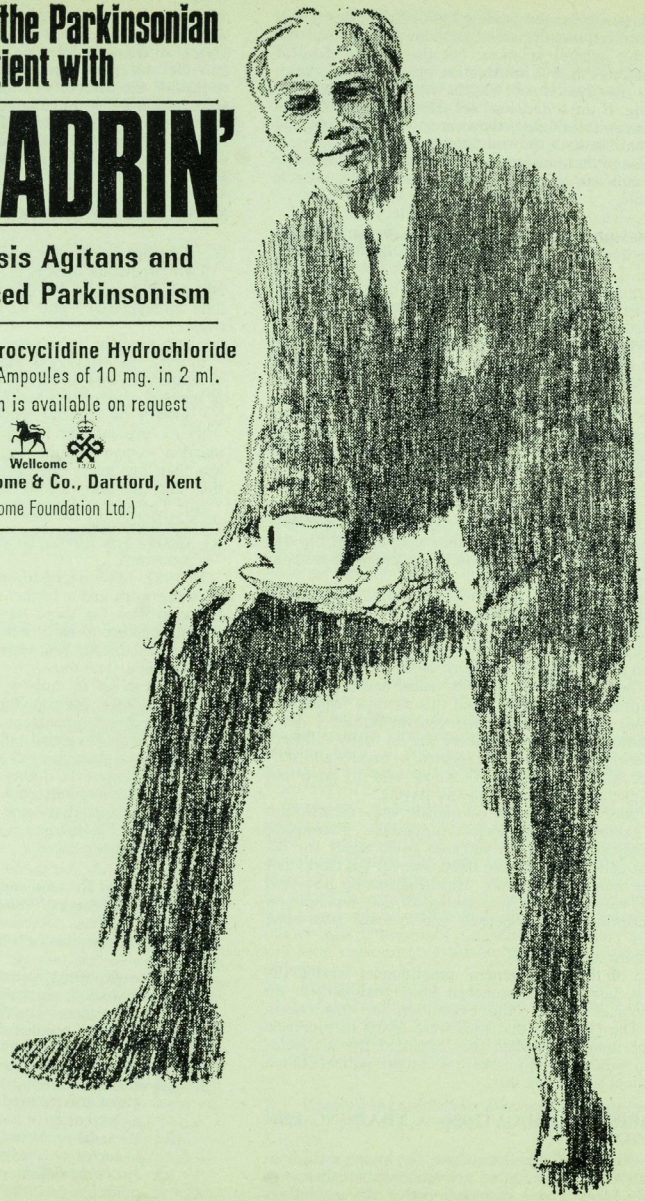
(i) Those problems common to all married professional women, particularly those with a child less than five years—i.e. the need for domestic help. Also special problems of school children during school holidays and illness.

(ii) Special problems of married women doctors:

(a) Insufficient opportunities are at present provided for married women who wish to work as well as have a domestic life.

(b) Personal problems, i.e. with husbands, whether a doctor or a layman.

(c) Accommodation problem related to the last point.



(d) Problem of retraining women once they have left the profession (i.e. raising a family) and wish to return to practice.
(e) Some Royal Colleges do not allow part-time work in preparation for higher qualifications.

Recommendations:

(i) Long term measures to avoid loss of women from the profession rather than to reclaim them from unemployment.
(ii) The encouragement of Regional Hospital Boards to organise hospital appointments on a part-time basis of training, e.g. where two or three married women could share a post rather than one person full-time, as has been done in Oxford and South West Met. RHBs. The pay for this type of post should come from central resources, thereby ensuring difficulties do not arise when women move from one region to another.
(iii) The need for provision of domestic help and/or nursery school facilities, possibly with an allowance for this.
(iv) An increase in the number of Consultant posts so that more married women will have more opportunity of reaching a senior post (as opposed to the Clinical Assistant grade emphasized by the government).
(v) The need for retraining schemes for married women who leave the profession.
(vi) Establishment of a register on a local basis for married women to enable them to easily find similar people to share a post in a hospital or general practice.
(vii) Royal Colleges should revise regulations to allow part-time work in preparation for higher qualifications.
(viii) Deans of undergraduate medical schools should emphasize the importance of full registration and a career structure for women.

NOTE: Married women are already taxed separately.

(1) Laurie, J. E., Newhouse, M. L., Elliott, P.M. (1966) Working Capacity of Women Doctors. Brit. Med. J. 1409-412.
(2) Elliott, P. M., Jeffreys, M. (1966) Women in Medicine, Office of Health Economics.
(3) Rue, E. R. (1967), Employment of Married Women Doctors in Hospitals in the Oxford Region—Lancet I 1267.
(4) Essex—Lopresto, M. (1970), Recruitment of Women Doctors for Hospital Service, Lancet July 204-206.

6. FAMILY PLANNING SERVICES

A. "Introduction to Family Planning Services" (Summary)

By PETER IBBS—GLASGOW

In 1967 Mr. Edwin Brooks' Private Members Bill (National Health Services—Family Planning—Act) was passed through Parliament and made possible for the first time the "advice and prescription for those who wisely desire to achieve the aim of planned parenthood even though no specific danger to health is involved". The Act at last recognised that the government and local health authorities had to play a significant role in preventing gross inflation of the population, along with its associated burdens, and that every child should be a wanted child.

Many authorities have been reluctant to see that family planning is in essence a form of preventative medicine, and in the long run would reduce the load on many of the social services. The National Family Planning Agency Scheme, set up by the FPA, has gone a long way to persuading local authorities to set up FP services.

Most people who attend the clinics at the present time would seek contraceptives anyway, but people of social groups V and VI are not seeking advice on family planning, and have larger families. These facts present a strong case for sex education and family planning education in secondary schools. Perhaps women in hospital for delivery and abortions should be approached.

It has been suggested that lay-staff should set up local information centres providing advice and selling non-prescribable contraceptives. Dr. Malcolm Potts of the IPPF would like to see a situation where "cigarettes are on prescription and contraceptives are in machines along the pavement".

It is bizzare that in a country where one can get free abortions and sterilization that a State still chooses to charge for contraceptive services.

B. Recommendations of the discussion group on Family Planning

(i) The Family Planning Act of 1967 has not been implemented—the Government should make it mandatory upon local health authorities to set up family planning services.
(ii) The service should be free to all who want it. The Government should provide a realistic amount of money for this.
(iii) The Government should maintain a Department of Population so it may be fully informed on the population explosion.

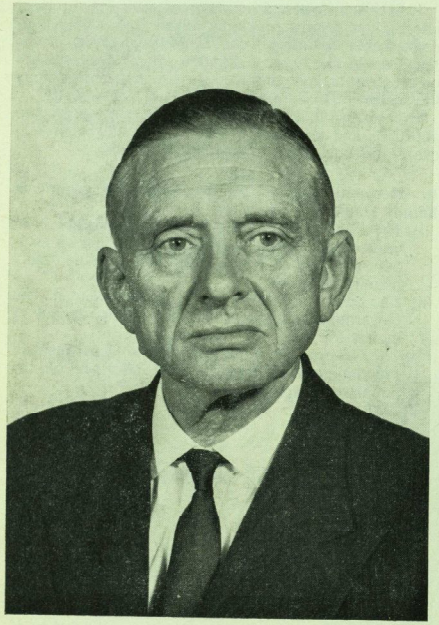
CONCLUSION OF THE SYMPOSIUM

Following each debate a paper was produced, with the recommendations that had been agreed upon during the discussion. At the conclusion of the symposium each paper was read out and the delegates voted for or against the adoption of the recommendations as the policy of the BMSA. These resolutions were to be printed and released to the press, the relevant government departments, medical educationalists and other people concerned.

It is encouraging that such a symposium, organised on a national scale, should have been held, to discuss the prospects of our health service and how it was possible to improve it in its many aspects. The people who attended the conference must surely be the ones who really care about the future of the health service. Let us hope that these are the future doctors of the BMA and GMC and deans of medical schools, who will direct the trends of medicine in this country in the years to come. Perhaps the most useful thing to come out of this symposium is the airing of views and exchange of ideas, with the formation of a national policy for the kind of health service we want to enjoy in Britain.

AN APPRECIATION ON JOHN WIGLEY COPE

by R. F. McNAB JONES, F.R.C.S



John Wigley Cope retired from the Staff on July 31st, 1971 after a distinguished career in this hospital and Medical College and in his chosen specialty of Otolaryngology. His sound judgement and experienced counsel, given in typically brief and witty phrases, will be sadly missed by all his colleagues.

A successful school career was completed by his gaining entry to Trinity, Cambridge to read medicine. He was champion of gymnasium and played in the 1st XV at school and he has maintained a keen interest in rugger throughout his life. His gymnastic abilities later found expression in mountaineering when he became a member of the Alpine Society. At Cambridge he chose Bart's for his clinical training and has remained a most loyal and outstanding member of our community ever since.

His clinical training began in 1929 and his medical career has therefore spanned the most exciting years in medical science. Hospital medicine in the pre-war decade was still largely concerned in combating the acute bacterial infections and exanthemata and widespread effects of tuberculosis and syphilis.

He graduated M.B., B.Chir. (Cambs) in 1932 and was appointed houseman to the Anaesthetic Department and then, in the face of keen competition, he became house surgeon to the Professorial Unit. The Unit at that time was a talented team consisting of Professor Gask with Dunhill (later Sir Thomas) as Assistant Director and having Ross (later Sir James Paterson) and John Hosford as chief assistants. Being house surgeon to this unit must have provided an exciting and exacting introduction to surgery and perhaps it was this that decided him on a surgical career. The next step was a Demonstratorship in Anatomy, still the soundest training for surgery, and he worked in the Rooms for two years.

The year 1937 was busy and eventful. During this twelve months he married, gained his Diploma of F.R.C.S. and took his first steps in a career of Otolaryngology by being appointed Registrar to the E.N.T. Department of Great Ormond Street. Later the same year he became Registrar at the Throat Hospital, Golden Square, and Assistant to Mr. Ormerod in the Throat Clinic at the Brompton Hospital. The work of this clinic largely consisted of treating tuberculosis laryngitis; a dreaded complication of advanced pthisis. Today's students may read about this disease in the text books but are unlikely ever to see a case.

In June 1939 he was appointed Chief Assistant in the Throat Department at Bart's. Describing the Department's work in thost days he recalls that emergency operations for acute mastoiditis were performed nightly during bad outbreaks of measles and scarlet fever while the ward nearly always contained one child who had required a tracheotomy to relieve laryngeal diphtheria. The house surgeon performed two or three weekly lists of guillotine tonsils and adenoids in the small operating theatre in the E.N.T. Out-Patient Department (now used for microscopic examination of the ear). Up to a dozen children were operated upon during each list and sent home the same day after a short period for recovery!

The honorarium of a chief assistant in 1939 was £50 per annum and even in those days this was meagre fare on which to support a wife and child. Private practice was the main source of income but came slowly at first to most surgeons and John Cope's career was rudely interrupted at its very start by the outbreak of war. He served as an E.N.T. Specialist in the R.A.F.V.R. for six years. Most of his service career was spent as an E.N.T. Specialist in Rauceby Hospital, notable for the

Mr Cope's Last Ward Round

fact that a golf course was situated immediately outside the hospital gates.

He returned to Bart's as a supernumerary chief assistant in the E.N.T. Department in 1946 and now had a wide experience in the specialty. The next year he obtained consultant appointments at The Royal Waterloo Hospital for Children (later amalgamated with St. Thomas's) and the Royal National Throat Hospital now consisting of the combined hospitals at Golden Square and Gray's Inn Road. In 1949 he achieved the ambition of all Bart's trained surgeons and was appointed to the Consultant Staff as Assistant Surgeon to the E.N.T. Department becoming Senior Surgeon in 1966.

A keen interest in teaching and student activity led to his serving as Sub-Dean of the Medical College between 1952 to 1956 and being elected Dean in 1962. Rightly regarding this post as a taxing and important one he decided to retire from private practice and from the consultant staff at the Royal National Throat Hospital in order to be able to devote most of his energies to the multifarious activities and demands of the Deanship. He worked unceasingly during the six years he held the post to improve the medical teaching and to further the interests of all the students. He rarely missed any student functions and became a well loved and familiar figure to succeeding generations of students. The photograph of his last ward round gives a good idea of his popularity.

As a student John Cope was a keen member of the Rugby Club playing in the back row of the "A" side which won the Inter-hospitals "A" Competition in 1931. In the same year the 1st XV won the Hospitals Challenge Cup. One can imagine John Cope's delight when thirty-eight years later the feat was repeated for the first time especially as he watched that historic 1969 triumph over Guy's as Dean and President of the Rugby Club.

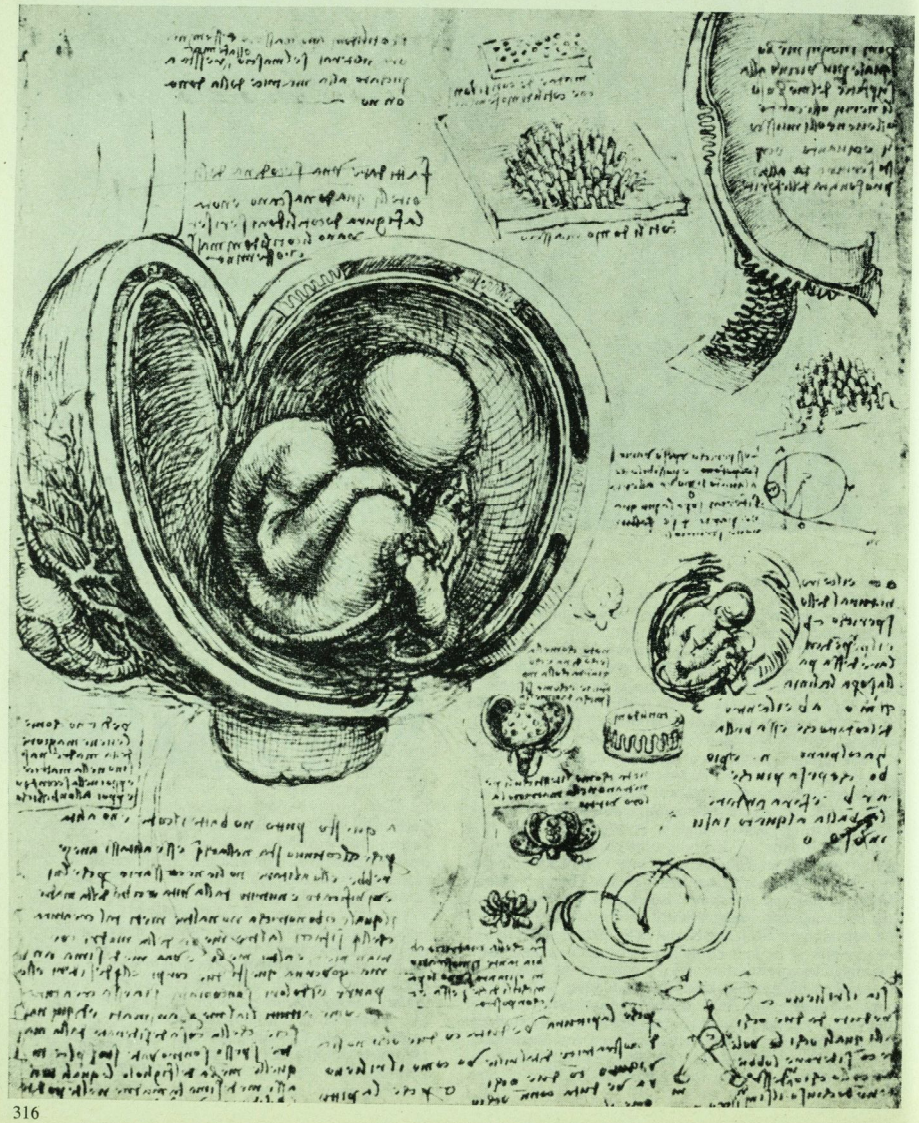
He has been an active member of the Royal Society of Medicine being elected Secretary of the Section of Otology for 1952-54 and becoming President of the Section in 1970 71 - a fitting climax to his professional career. His year of office has been marked by some excellent meetings culminating in his presiding over a plenary session at the Third British Academic Conference in Edinburgh.

This brief summary of a distinguished career has given only a hint of John Cope's human understanding and generous spirit. In all the variety of roles he has played he is perhaps at his best when acting host. No one who has enjoyed his hospitality will ever forget it and like all great hosts he appears to derive as much enjoyment from his parties as do his grateful guests.

We all wish him an active and happy retirement in his lovely country home at Seale where entertaining his grandchildren, gardening, exercising his dogs, fishing and shooting should ensure few quiet moments.

MEDICINE IN ART

YVONNE HIBBOTT, A.L.A. Medical College Library



Left

Leonardo da Vinci (1452-1519)

1. CHILD IN THE UTERUS

(Royal Library, Windsor Castle)

The annotations to the drawings are in mirror-writing. Leonardo writes—"In the case of this child the heart does not beat and it does not breathe, because it lies continually in water. And if it were to breathe it would be drowned, and breathing is not necessary to it, because it receives life and is nourished from the life and food of the mother. . . . And a single soul governs these two bodies and the desires and fears and pains are common to this creature. . . . And from this proceeds that a thing desired by the mother is often found engraved upon those parts of the child which the mother keeps in herself at the time of such desire."

Top right

2. French, 15th Century

CAESARIAN OPERATION

(Bibliothèque de l'Arsenal, Paris)

The detail of a miniature is from a 15th century manuscript *Histoire Romaine,* and shows the birth of Julius Caesar.

Bottom right

3. Jost Amman (1539-1591)

CHILDBIRTH

A woodcut from Jacob Rueff's *De Conceptu et Generatoine Hominis,* Frankfurt, 1580—a famous and widely-used handbook for midwives.
An astrologer is seen in the background casting a horoscope of the newborn child.

ACKNOWLEDGMENTS

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BART'S DRAMA

Edinburgh Festival. 1971.

The whole question of taking a show to Edinburgh was raised at the last Smoker, when someone suggested to James Griffiths that an easy way to make money, and fame, was to go to the festival. At the first possible opportunity, then, James drove up to Edinburgh to try to find a theatre, which, since there are on average seventy companies performing there during the three weeks of the festival, is no easy matter. Luck, however, was on our side, for James was put in touch with the Roman Catholic Chaplain of the University who offered us a theatre free, provided that we shared it with Strathclyde University, who would want to use it in the afternoon only, but were perfectly willing to set up all the lights for us, sell tickets, advertise, and anything else. This seemed too good to be true, for all we had to do was to arrive, perform, and pay for our share of electricity and hiring lights.

The plays were easy enough. "The Bird Garden" was an obvious choice, since it had won the U.L.U. One Act Play Festival, earlier in the year, and Ubu, we felt, we would be able to rehearse in time, since we still had very capable Pa and Ma Ubus, James, and Kate Walker, respectively.

So, at the beginning of August we started rehearsing, leaving three weeks to bring up to scratch three one act plays. It was quite hard work. In fact, it was even seen to be quite hard work by certain members of the community, who apparently thought that a play at Bart's was put on simply by sitting thinking for about five weeks, then going onto a stage, just like the ward shows. They were thus surprised to see us sweating it out for four hours every night, pretending to be birds, doing strenuous dance routines, which we since hear the Rugger Club have adopted as part of their programme, and running through assorted battles, trials, etc.

On Friday, August 19th, five cars set off for Edinburgh, loaded with people, costumes and props. Five cars actually arrived that evening just outside Edinburgh, at the cottage we had rented for three weeks, and under the watchful eye of house-mother Dinwiddie, we arranged our tents, caravans, and sleeping bags around the cottage in a way that neither offended the eye, nor propiety, to any great extent, although it is true that there was a large yellow patch left on the lawn where the tent had been, when we left.

9 a.m. Saturday, we started rehearsing in the Little Theatre, George Square, and carried on for the whole of Saturday, and Sunday as well. We were told that the theatre would hold an audience of fifty, but we didn't quite see how it was going to happen, unless we acted outside. In fact we actually managed to fit in 61, one evening. Strathclyde, the group we were sharing with, were remarkably helpful, in every way, and it is in no small part due to their cooperation that we were able to put on the Bird Garden on Monday 23rd, to a small, but appreciative audience of twelve.

From then on, with more sleep, and organisation, things were much easier. The plays became routine, and the highlights of the day were the evening meal, cooked by a different person each night, and such daring exploits as handing leaflets out, which is against the law in Edinburgh. However, we managed to distribute 4,000, and during the second week played to full houses every night, although we had been shadowed by detectives who kept warning certain persistent advertisers of our number that they would be thrown in the deepest dungeon of Edinburgh Castle, if they continued.

All too soon the three weeks was up, and we returned, this time in four cars, to London, having taken enough money to cover our expenses, just!

It is quite impossible to thank and praise everybody adequately for the amount of work, and time that was spent, but James Griffiths started the whole thing, and gave a wonderfully unpredictable, and enjoyable performance of Ubu almost every night, and Kate Walker knew just when to upstage him as Ma Ubu, and show how good a part it is. Rob Robertson and Olivia Hudis kept the Bird Garden flowing every single night in fine fashion and the rest of the cast battled with birds, carps, roses, armies, courts, windmills, bears, and people with vigour and style.

Sue Lee and the girls did a fine job on the costumes, most of which held the full three weeks, and Nick Whyte and Rob Robertson arranged the props. Lighting and music were impeccably controlled in the hands of Patch Venables and Mike Hendry, and George Blackledge, it is said, was the only reason why the plays never started more than ten minutes late, with persistent ordering of the cast around, and making judicious cuts in Ubu during the second week.

The Wine Committee also played a part, a fine part, in the venture, for after our first performance, we found three bottles of the hard stuff waiting for us at the cottage. This, we gathered, was a sign of their respect for our hard rehearsing every night in the bar lounge. It was well appreciated.

Finally, full tribute must be paid to Jolyon Oxley and Paul Swain, for their tremendous work as director and author. Our success, critical and popular, at the festival, would not have been possible without Joly's inspired direction, and interpretation of Paul's play. Both of them were always there to reassure and advise on whatever aspect of the production, and if this was, as it appears, their swansong, it was a venture by which to be remembered. Bart's Drama will have to search hard to find their equals, if, indeed, such a thing is possible.

The Drama Society has shown that it is capable of embarking on a project of this nature, with financial, and critical success, and I hope that the enthusiasm generated by Edinburgh '71, will not go to waste, but be channelled into another successful year, to be topped perhaps, once again, by a visit to Edinburgh.

Cast: Peter Bacon, George Blackledge, Janet Dinwiddie, James Griffiths, Olivia Hudis, Wiz Mansi, Robert Robertson, Kate Walker, Nick Whyte.
Authors: Paul Swain, Alfred Jarry.
Directors: Jolyon Oxley, George Blackledge.
Music: Mike Hendry.
Lights: Patch Venables.
Costumes: Sue Lee.

BOOK REVIEWS

BED RIDDANCE
By OGDEN NASH. £1.60. Pub. Andre Deutsch

We have all been ill at some time and during that time we have all seeked relief from boredom by attempting to amuse ourselves with everything from jigsaw puzzles to construction kits. This collection of poems by Ogden Nash is ideally suited for such a captive audience, and also provides entertainment for those who are not so captive. The poems are in the typical Nash style of light verse; some are better than others but all are whimsically amusing and inventive. His perceptive eye has enabled him to derive humour and sympathy from the malfunctions of the human body and the poems reflect his personal experiences gained by becoming a hardened inmate of hospitals in this country and in the States.

This "Posy for the Indisposed" is a truly entertaining book, somewhat sparsely illustrated by Nicolas Bentley, which is guaranteed to amuse all those who choose to read it.

A. J. SEARLE

CANCER AND RADIOTHERAPY: a short guide for nurses and medical students.
By J. WALTERS.
London: J. & A. Churchill, 1971

Specialists admire those who can produce an elementary account of an intricate and developing subject which is not only interesting but concise and accurate. Their success is due in part to writing for a readership of defined scientific background. This book on oncology, by an experienced radiotherapist and medical author, is designed primarily for nurses. In fifteen chapters it covers a great deal of ground, from the broadest epidemiological aspects of cancer through tumours at specific sites to the problems of the individual patient. It contains an abundance of information, including many technical aspects of radiotherapy, and all are accurately and concisely set out. The chapter on terminal care and the relief of pain is excellent. For nurses this book is a clear and reliable guide, and it will be invaluable in any ward where radiotherapy patients are being nursed.

While aimed primarily at nurses, the title does include medical students, and in his preface the author hopes that it might lead a few to take up "this outlandish specialty". In the opinion of the reviewer such an essentially empirical presentation is less suitable for students of medicine in the 1970's. The modern Bart's man is scientifically sophisticated, and an introduction to radiotherapeutics based on cellular biology and clinical science could be more likely to sustain his interest. A more discursive development, at the expense of less factual information, would bring out the exciting concepts of modern oncology of which radiotherapeutics forms an important part.

ARTHUR JONES

Review on A DICTIONARY OF IMMUNOLOGY
Edited by W. J. HERBERT and P. C. WILKINSON
Review on GLOSSARY OF IMMUNOLOGICAL TERMS
By W. J. HALLIDAY

Since the establishment of Immunology as a separate science those involved in the subject would sometimes appear to have set out to confuse the outsider and the student of the subject by the complexity of the language. Furthermore if by chance the student of this science learns some jargon to give an illusion of knowledge it can be anticipated that the subject will change its language. An example of this are the words antigenicity and immunogenicity, antigen or immunogen (in fact the words mean the same!). An immunologist using the older words such as antigen reveals himself as much out of step as the girl wearing mini-skirts when everyone around her is wearing maxi-skirts. At least with fashion all things now seem to be acceptable but not so in immunology. For a long time there has been a need for a guide to the uninitiated to pick their way through the communication system existing within immunology.

This has curiously been recognised at the same point in time by two different sets of authors and two different publishers, hence the simultaneous publications of the above two books, the Glossary, a slim paper-back costing £1.00, and the Dictionary, a small hard-cover costing £2.25.

Basically these books have collected a large number of immunological terms and followed them by a brief definition. In the case of the book by Dr. Halliday the definitions are in general rather briefer than of the more expensive book by Herbert and Wilkinson and there are fewer of them. Sometimes this can be dangerous, e.g. Halliday gives as a definition of "Anaphylactoid", "resembling anaphylaxis in outward appearance; thus peptone injections induce anaphylactoid shock in animals." On the other hand Herbert and Wilkinson stress that anaphylactoid reaction is *not* caused by an immunological reaction.

The cheaper smaller book has an extensive list of 579 references whereas the other book has no references. It is not surprising that the more expensive book can include some simple line drawings to illustrate various points and such refinements are lacking in the cheaper book. The reviewer was particularly impressed with the inclusion of a diagrammatic presentation of the complement cascade.

If the student seeking information about a particular immunological term is perplexed by these simultaneous reviews, the immediate book of choice would be that by Herbert and Wilkinson "A Dictionary of Immunology". On the other hand for a reference to a more detailed description of a particular term, then Halliday's "Glossary of Immunological Terms" would be the book of choice. Thus both these books fill a need for those seeking clarification of an otherwise foreign language, and at these reasonable prices they merit a place on the students bookself.

D. A. WILLOUGHBY

CARDIO-RESPIRATORY RESUSCITATION
By ALAN GILSTON and LEON RESNEKAR.
William Heinemann Medical Books Ltd., £4.50.

It is a little over a decade since the twin developments of external cardiac massage, to maintain an oxygenated circulation to the brain, and electrical defibrillation, to restore the fibrillating ventricle to a coordinated rhythm, made successful resuscitation after cardiac arrest a routine occurence rather than a dramatic but rare and somewhat empirical triumph. This volume is the result of cooperation between a British anaesthetist and an American cardiologist. It considers every aspect of the practical management of cardiac arrest, from the vital immediate first aid necessary to prevent cerebral death, which must be carried out by any person, medical, nursing or lay, who happens to be with the patient at the time of arrest, through the careful, rapid but routine process of re-starting the heart by the emergency medical team, to the more scientifically calculated and physicianly after care, which is necessary to control and preserve cardio-pulmonary function once a co-ordinated rhythm is re-established.

The authors have collected together, analysed and presented their considered conclusions on the extensive literature which now surrounds this subject in a way which would enable any clinician to establish and train an efficient cardio-respiratory service without undue delay or frustration. No detail of planning has been neglected but, on the other hand, the extensive bibliography makes this a valuable reference book for the expert in the field.

It is possible to disagree with some of the details of management, for example the use of, what is to some, a rather dilute solution of calcium chloride and the omission of phenytoin from the list of antiarrhythmic agents but, on the whole, the advice is sound and follows up-to-date thought on cardiac-resuscitation. In doing so it explodes such myths as the value of nor-adrenaline and THAM which are still favoured in some quarters. There is an excellent chapter on respiratory problems including the care of the patient on the mechanical ventilator. This would be worth publication on its own as a monograph and the section on neurological sequelae is adequate and shows a sympathetic insight into this difficult problem but the authors, perhaps wisely, leave all renal therapy, except for the simplest immediate treatment, in the hands of the specialist nephrologist. The eight appendices give valuable information on equipment, cardiorespiratory, physiology and patient management and there is a full and well-compiled index.

This comparatively short and readable volume is beautifully produced with numerous clear photographs and diagrams. It is a practical book written by practical men but it is based on profound theoretical knowledge. It fulfils a valuable purpose in collating the knowledge currently available in this progressive field of modern medicine.

T. B. BOULTON.

EVERYWOMAN
By Professor D. LLEWELLYN-JONES. Faber £2.25.

The author of this book is well known for his two volumes; Fundamentals of Obstetrics and Gynaecology. In this volume, 317 pages long, he intends to convey an easily comprehensible source of information about female bodily processes, for the general public.

The contents of the book deal with adolescence, pregnancy and labour, family planning and some complications such as Rhesus iso immunisation, Gynaecological problems, and includes a whole section for improved enjoyment of female sexual athleticism—well illustrated. All sections are subdivided and well explained with the aid of 70 beautifully drawn diagrams.

I think there are two criticisms of this otherwise excellent book. Firstly, the sections of the book describing the Menstrual cycle and Conception are steeped in basic Physiology. This means that a reader must possess at least a knowledge of "O" level Biology to understand and enjoy them. Secondly, the book aims to improve a woman's understanding of her body but will necessarily appeal mostly to women who are intelligent and probably less in need of help than the majority of the female population. The book is certainly about "everywoman", but cannot be useful for everyone.

However for an interested, educated woman this is certainly an easily readable mine of information, and a must for the bookshelf.

S. M. CARTER

BART'S SPORT

BOAT CLUB REPORT

Yet again the Boat Club managed to achieve distinction by producing an VIII that was able to row in the bumps. As is custom now the VIII did not manage to boat as many times as they would have liked, but nevertheless, in the time available a crew of distinctly individual styles was welded into some sort of cohesion. The first VIII, starting third, rowed over on the first night, were bumped on the second night by a very competent Guy's crew, and rowed over on the last night to finish up fourth on the river. Special thanks are due to Simon Scott who stroked the boat with all the worries of 2nd. M.B. and Paddy Smythe who was the cox.

Every other Bart's boat apart from one managed to go down. Not our most successful year.

After the bumps a scratch IV, stroked by Tim Coyle, entered the Allom Cup and did well to reach the finals. On the same day another scratch IV went to

Evesham regatta, entering the S/J class, but got beaten in the first round.

The following week a senior IV consisting of S. Scott, N. Snell, R. Fowler, R. Thomas and a J.IV entered the River Lea Regatta. The S.IV got beaten in the first round by ½ length, and the J.IV got beaten by the eventual winner by ½ length in the second round.

The J.IV went on to row at Cambridge Regatta where they lost to the losing finalists by 1 length. On Whit Monday the same IV lost to Imperial College by 2 inches at Brent Regatta in the closest race of the day.

The following Saturday their efforts were rewarded when they won the finals of J.IV at Oxford City Royal Regatta by ½ length.

There now being 6 J/S oarsmen in the club to choose from who were willing to give up their time to row. A trial was held and a Visitors IV was formed for Henley. The IV selected rowed every night under the coaching of Dr. Brian Ayers, and went up to Henley after a disappointing defeat at Horseferry Regatta.

Whilst at Henley the crew had a week to prepare for their race. Training consisted of a run before breakfast, and three outings a day, the crew being in bed by 10 p.m. if not earlier! They were coached by Mat Stallard, Dr. Swotton, the U.L. coach, and Brian Ayers, who drive up every night from Hammersmith. Rapid progress was made during this week, despite the heavy stream that was caused by the previous week's torrential rain.

In the qualifying races Bart's on the Bucks station, were drawn against a IV from 1st and 3rd Trinity Cambridge, on Berks station. From the start until the end of Temple Island the race was very close, neither crew gaining. Immediately after Temple Island Bart's hit the wind and stream first, and quickly lost one length. Their situation remained until very close to the finish when the 1st and 3rd boats steered by the brother of one of the Bart's spare men, hit the buoys, allowing the Bart's crew to lose by ½ length. Richard Thomas, our bow-steers, held an extremely good course in a very difficult stream. After this defeat, the crew remained at Henley, rowing twice a day, pacing other IV's notably the Cambridge University IV whom Bart's could hold over a 40 stroke start.

The fortnight at Henley proved extremely valuable in greatly improving the standard of the IV, three of whom shall be rowing next year.

J. Close and J. Down went as spare men to Henley, and entered the Spare men's pairs. They did extremely well in this competition, reaching the semi-final where they lost to the eventual winners by ¼ length.

After Henley, the IV rowed at Molesey and Henley Town Regatta, without success.

In summary, the Juniors of the club had a successful season, their hard work and keenness being rewarded by two pots and some very close races, and although no J/S trophies were won, enormous improvement and encouragement was given to the Visitors IV at Henley.

Rowing throughout the season is a time consuming and costly pastime for the individual and our thanks go to all those who have helped us during this year, especially to Brian Ayers, our coach, Jim Wallace the U.L. boatman, and Chris Hudson, for arriving on so many wintry Saturdays to find an incomplete crew.

CREWS:

Bumps 1st VIII	*J.IV*	*Visitors IV*
Cox : P. Smythe	Cox : W. Elsden	Str. : R. Fowler
Str. : S. Scott	Str. : J. Down	3 : T. Dehn
7 : R. Thomas	3 : T. Dehn	2 : J. Lambley
6 : R. Fowler	2 : J. Lambley	Bow/Steers: R. Thomas
5 : J. Lambley	Bow: J. Close	*Spare Men*
4 : N. Snell		J. Close
3 : T. Dehn		J. Down
2 : J. Down		
Bow: J. Close		

SAILING CLUB REPORT

The Annual Regatta was held on the Welsh Harp reservoir on July 17th. We were lucky with the weather —plenty of sun and a gentle breeze for the whole day. Four Fireflies were rigged, including the three Bart's boats, and sailing started before lunch. The Commodore's Cup was sailed first and after some close racing between Tom Moore and Ian Jack, the Commodore duly presented his cup to the winner, Tom Moore. There were eight entries for the single-handed race, which Tony Williams won most convincingly. It was even possible to organise a Ladies' race, even though one boat did not contain a lady! The race was won by Trina Moore from Sarah Noble. Thanks must be passed on to Tom Moore and Bruce Noble for organising some good fun sailing.

The Scott Trophy (a United Hospitals' trophy) was held at Burnham-on-Crouch on September 24th/25th. Our able team consisted of David Patuck, Janet Dinwiddie, David Edwards, Trevor Soutley, Richard Wells and A. N. Other, who set out to try and complete the double this year—Bart's having won the Harvey Wright Bowl in the Spring. We drew against the Middlesex and narrowly lost the first leg, being placed 1st/4th/6th—David Patuck winning whilst Richard Wells was unfortunately detained under a moored yacht's bowsprit! The start of the second leg was chaotic, but the Middlesex slipped through to win the race. The trophy was won by Guy's. The team must be congratulated for sailing so well considering none of us had raced in a hospital capacity before!

The Bart's Enterprise has been sailed regularly through the Summer, but only by a few members and nurses. More people must be encouraged to sail, especially the Fireflies on the Welsh Harp. University sailing starts in October.

The diverse interests of the members of the club are illustrated by the considerable success gained by Chris Waite in his first year of "Contender" racing, and the substantial cruises carried out by other members around the British Isles.

RICHARD WELLS.

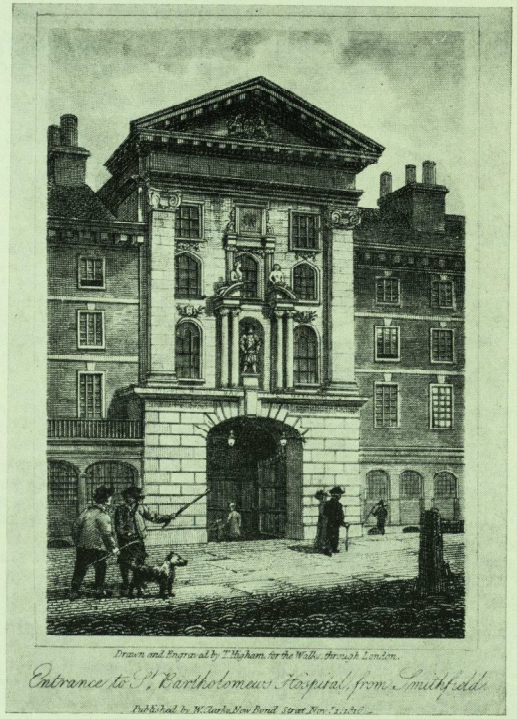
SAINT BARTHOLOMEW'S HOSPITAL JOURNAL

Founded 1893. Vol. LXXV No. 12

Editorial

For once this editorial is going to be less concerned with vague abstractions on medical education and ethics, and more with an issue that is of vital importance to us all. By now, most of you will be aware of the imminent approval of the Todd Report's recommendation that the Bart's Pre-clinical School should move out to Mile End Road and amalgamate with the London Hospital. This idea is fairly logical because after all the whole concept of undergraduate medical education is going to change as more emphasis is put on subjects allied to, but not part of, medicine, with the increasing integration of medical students with others on a multi-faculty basis. It will be a great pity to lose Charterhouse Square which is a centre for the Student Body, but presumably other facilities will be made available for the students who will go to Mile End Road, and these will come, in time, to be as well-loved and accepted as College Hall. I do not believe that a move to Mile End Road necessarily means the end of the Bart's man. However, rumour has it that the Medical College buildings at Charterhouse Square are to be taken over for non-scientific teaching. This, if it is true, is deplorable, and an idea that could only be conceived by little grey men sitting behind desks who are totally out of touch with reality. A great deal of money was raised from old Bart's-trained doctors by people such as W. Girling Ball, for the specific purpose of building a well-equipped Medical College, not for providing a college for students who will be unable to make use of research laboratories and other facilities. If we have to lose College Hall, let it be made into the post-graduate research centre for which purpose it is admirably suited. If changes are to be made, they should be realistic and well-planned or chaos and mediocrity will result. As regards facilities at Mile End Road, it appears that the building of the new Barts-London Medical College will necessitate the upheaval of a graveyard—They're Removing Grandpa's Grave To Build A Medical College?

Journal Christmas Card 1971



The Journal is again producing a new Christmas card this year which will be available throughout the Hospital.

The card will be in COLOUR and will cost 6p.

All enquiries and orders should be addressed to the Arts Editor, St. Bartholomew's Hospital Journal, St. Batholomew's Hospital, West Smithfield, London, EC1 and clearly marked "Christmas Card".

LETTERS

2 Jennifer Court,
92 The Street.
Ashtead, Surrey.
October 21st, 1971.

Dear Sir,

We have, no doubt, all come to accept that feminine modesty has become a thing of the past. Conducting examinations in a G.P's Surgery, with a five-minute appointment system is at last a feasible business. Most women, both young and old, disappear behind the screen and strip with gay abandon by the time one has picked the stethoscope off the desk. The zip-back dress has proved one of the greatest advances in medicine to the G.P. since the disappearance of combinations and the discovery of Penicillin.

However, it is occasionally heartening to encounter the old-fashioned coyness in an octogenarian. I recently experienced the ultimate in modesty.

I was attending an old lady with bronchitis and heart failure, and going through the daily pantomime of the nightdress being pulled down, and the sheets up while I tried to plant my stethoscope on a small area of bare skin between the breasts. She was quite ill and thought that she was going to die. Her daughter subsequently told me that she left a collection of sundry gifts, messages, notes about funeral arrangements, and the following instructions.

"You will find my laying-out clothes under the bed, also a clean pair of knickers. Please make sure I am wearing these before you send me to the undertaker."

I am pleased to say that this eventuality did not arise. She continues to be a living example to her sex.

Yours sincerely,
J. A. WILLIAMS.

51 Sloane Street,
London. SW1
01-235 5151

15th DECENNIAL CLUB

Dear Sir,

There appears to be considerable interest in starting this club, and all those who entered Bart's, either directly or via Oxbridge, between the years 1955 and 1964 inclusive will be eligible to join. With the growth of the medical school, the number of members will be much greater than in previous decades, and a brief look at the lists of entries for these years reveals that the organisation of the club will be outside the capabilities of one person. I should therefore be most grateful if you could give this letter some publicity in the pages of the "Journal" so that a few Bart's men interested in forming the Club would write to me to offer their services in contacting say 50 fellow members.

As a first step a preliminary meeting could be arranged at which the club would be formally established. I should be very pleased therefore to hear from anyone interested.

Yours faithfully,
JOHN IND.

STUDENTS' UNION LETTER

Abernethian Room,
St. Bartholomew's Hospital,
London, EC1

Dear Editor,

By the time this letter appears in print we will have held two Council Meetings and the AGM. However, at the time of writing, only the first Council Meeting has been held. This was a very profitable meeting and the minutes are on the notice boards. One of the problems we were faced with was the fact that the rugby club can now turn out six teams, the soccer club two, and the hockey club three, and there is still the Ladies Hockey Club to come in to the picture. At Chislehurst we have three rugby, one soccer, and one hockey pitch. Before the fight for the rugby club's third pitch begins in earnest, we are endeavouring to beg, borrow or steal a pitch from the Middlesex Hospital SA who have their grounds next to ours, or from some other club whose pitches are accessible. It would seem that we are unfortunately going to have to restrict our clubs to the capacities of the existing pitches, or at best, the existing pitches plus one.

Christmas is again fast approaching, and thoughts must be turning to the continuing question of the ward shows and this year's Pot-Pourri. The Council decided that, as for last year, any profits we can make on the Pot-Pourri would again be donated to the Bart's the Less Restoration Fund. This will add to other donations from the Students' Union, such as the profits from the music society's last concert (which was excellent and deserves our thanks), and to donations from the well run sponsored swim in which many students and certain

eminent consultants entered (who was it who swam 110 lengths?).

We had a timely reminder from your correspondent J. B. Gurney Smith in your July issue that a few years from now will be the 850th anniversary of the foundation of the Ancient Rahere Institution of Church and Hospital. We must agree with your correspondent's letter, it is not too early to form a committee to plan some events for this occasion. We are doing this in the Union and considering basing the occasion around the Barbecue Ball of 1973. Any ideas?

I would like to close my letter this month with thanks to Dr. Bowen for organising the students changing rooms that we now have beside the operating theatres on most floors of the George Vth Block. I am hoping that the few odd packages that are creeping in to them will soon be removed and not replaced by those responsible. Dr. Bowen is at present trying to organize hooks and mirrors in them all, and once this is achieved we should have useful and functional changing rooms of our own.

Yours sincerely,
JOHN WELLINGHAM.
Chairman, Students' Union.

ANNOUNCEMENTS

Births

On September 27th, to Patricia (née Burton) and Dr. Rupert Courtenay-Evans, a daughter.

Deaths

LLOYD—On September 15th. Dr. Anne Lloyd, M.B. Lond., M.R.C.P., D.C.H. Qualified 1957.

BLYTH BROOKE—On September 24th. Dr. C. O. S. Blyth Brooke, M.D., D.P.H. Qualified 1923.

Engagements

The engagement is announced between Dr. Andrew Weir and Miss Rosemary Clarke.

Change of Address

The new address of Dr. Alan Hollinrake is 5, Julian Road, Sneyd Park, Bristol G.

MACCABAEAN PRIZE AND MEDAL

Entries for the 1972 Maccabaean Prize of £30 and a bronze medal are now invited for an essay of 4,000 to 6,000 words on some aspect of the history of medicine or pharmacy. Intending candidates, who must be under the age of 30 on March 15th, 1972, may apply for further particulars to the Honorary Secretary of the Faculty of the History of Medicine, Dr. J. K. Crellin, The Welcome Institute of the History of Medicine, 183 Euston Road, London, NW1.

RECENT PAPERS BY BART'S MEN

To ensure that your papers are recorded here, please send reprints to the Librarian. Although we look through the journals received in the Library, it is not always possible to identify Bart's personnel, and contributions to other periodicals will not be seen unless reprints are received.

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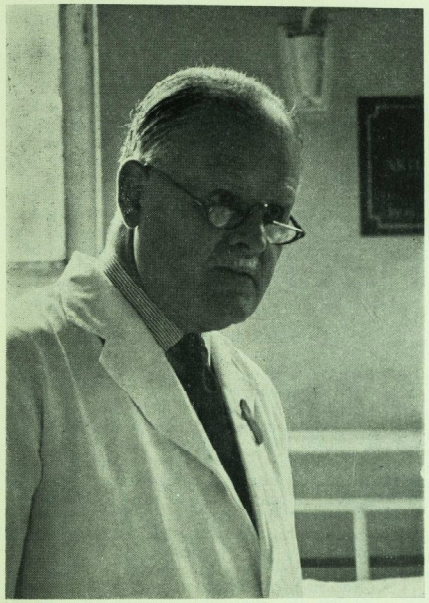
RETIREMENT

Sir Ronald Bodley Scott, K.C.V.O., D.M., F.R.C.P.



Sir Ronald Bodley Scott, Senior Physician to St. Bartholomew's Hospital retired in September this year. As a distinguished Physician to this Hospital he has done much since his election to the Staff in 1946 to enhance the reputation of St. Bartholomew's in the field of medicine, particularly by his contribution to the medical management of malignant disease.

Ronald Bodley Scott was educated at Marlborough College and Brasenose College, Oxford. He came to St Bartholomew's Hospital Medical College for his clinical studies winning the Burrow's Prize in Pathology during that time. He qualified in 1931. Two years later he gained the Membership of the Royal College of Physicians. After a short period in the family practice in Bournemouth he was recalled to his Alma Mater to be Chief Assistant to Dr. Gow in 1934. In 1937 he was appointed Chief Assistant on the Professional Medical Unit. He was awarded the degree of D.M. in 1936 for his study of the bone marrow in diseases of the haemopoietic organs. This work gave an indication of his future interests. With A. H. T. Robb-Smith he was the first to recognise the condition of histiocytic medullary reticulosis as a clinical entity.

(Unfortunately the war interrupted his research on intraocular marrow transplants in rabbits and the role of ascorbic acid in haemopoiesis. He served in Egypt and the Levant States for four and a half years, being at one time in charge of the Medical Division of No. 63 General Hospital, a large field hospital with 1,800 beds near Cairo. Even here he found time to record his experiences writing on the "Early Treatment of Wounds of the Chest in the Middle East". He was elected a Fellow of the Royal College of Physicians in the middle of the war. In August 1945 he returned home, to join the Staff of this Hospital a year later at a time of great change in the National and Medical scene.

Shortly after the war he was appointed Physician to the Household of King George VI and in 1952 became Physician to the Queen. He thus followed his predecessor Horder in this important office, keeping the privilege in the "Firm". He was awarded a knighthood in 1964.

It would be difficult to detail the many distinguished communications he has made to learned Societies. Outstanding among these are his Langdon Brown Lecture on "The Chemotherapy of Malignant Disease" in 1957, and his Croonian Lecture on "The Chemotherapy of Cancer: the First Quarter Century" in 1970. It was fitting that the later was so-titled for he has truly made this his own subject. He was Lettsonian Lecturer of the Medical Society of London in 1957 and President of the Society in 1965, President of the British Society for Haematology in 1966 and President of the Royal Society of Medicine in 1967.

A glimpse of his wide reading and appreciation of literature may be seen in an amusing and perceptive essay on "The Doctor in Contemporary Literature" published in 1955. His acknowledged mastery of English must have been in the Publisher's mind when he was asked to edit The Medical Annual and Price's Textbook of Medicine from 1959.

In what is so obviously a strenuous life in the practise of Medicine there might well be little time for colleagues or juniors. That this has never been so can be attested by all of us, especially those of us who have been privileged to enjoy his hospitality and that of his charming wife.

No appreciation can measure his achievement. The only measure must be that we all know him as a fine man and a good doctor.

J.S.M.

IN DEFENCE OF ENGLISH

The second M.B. course is a hard one and the inclusion of anything in it which will have little value to the doctor is to be avoided.

One aspect of the course that involves considerable effort on the part of the student, but which has little practical value, is the Latin nomenclature used in Anatomy. This is something that is not always fully appreciated by those who have already mastered the subject, but to a student who is studying Anatomy, the time spent in learning meaningless latin names may easily account for half the total time alloted to Anatomy, which does itself account for a very large proportion of the total time spent in 2nd M.B. study. The result, therefore, is that valuable time, which might have been spent in studying Anatomy or other 2nd M.B. sciences more comprehensively, has been needlessly wasted.

How does one account for this? To the early anatomists, who wrote naturally in latin, it was the obvious thing to name their discoveries in latin, and despite the fact we now write and speak in English, we have anomolously retained the use of a foreign language for anatomical nomenclature.

With what are we to replace it? I propose a system of naming structures according to a simple English description of their structural and topographical anatomy.

For example: The bones of the arm:

Old Latin Name	Proposed English Name
Clavicle	Collar Bone
Scapula	Shoulder Bone (Blade?)
Humerus	Arm Bone
Radius	Lateral Fore-arm Bone
Ulna	Medial Fore-arm Bone
Carpus (see below)	Wrist Bones
Phalanges	Finger Bones
Pollox	Thumb
scaphoid lunate	triquetrum pisiform
trapezium trapezoid	capitate hamate
lateral prox. lat. int. prox.	med. int. prox. medial prox.
lateral distal lat. int. dist.	med. int. dist. medial distal

Total Latin words to be learnt = 16

Total English words to be learnt = 0

As the new names are more descriptive and informative than the empirical latin ones, they tend to be longer, but the length of name, unlike the latin system, does not add to the difficulty of learning, as the name is a description of the structure that has to be learnt anyway, whereas, the longer the latin name, the more meaningless words that have to be learnt. In everyday usage, these names would prove as easy to use as the present ones (consider some of the long names we use now, which after a time present no problem) and by extending this nomenclature logically over the science of Anatomy, a situation could be reached in which everyday usage of anatomical terms, while as easy as that in use now, could prove more meaningful than the present system, and considerably easier to learn.

This being the case, there are two major objections that are often raised. The first concerns communication with foreigners. In fact, this is no problem at all, for before one can speak to foreigners one must be able to speak their language, and that mastered, no new words have to be learnt specifically for anatomy, for one merely translates from one language to another. For example, the arm bone becomes in French, l'os du bras.

The second major objection concerns the change-over period. If one generation of anatomists is to be trained under the new system, how will they communicate with previous generations? Again there is little difficulty here, for, as all the new names would be entirely logical, there would be no problem for the latin anatomists in understanding them, i.e., the lateral fore-arm bone is the radius.

But the third major objection, one that is rarely expressed, but which is strongly felt, is a certain conservativeness, a reluctance to change, and possibly even a desire to retain some mystique.!

My feeling is that, in the face of the ever increasing burden placed on the medical student, the course will soon have to be changed, either by lengthening it (an expensive option), or by reducing its content (undesirable), or by introducing yet earlier specialisation also (undesirable). Of these alternatives, that of changing the nomenclature would, in my opinion, offer the least disadvantages, and that these would only be transient, and would, in the long term, be beneficial

What would these short-term changes involve? There is at present an international committee which attempts to rationalize the nomenclature within the present framework, but this form of nomenclature evolution is not progressing at a rate fast enough to ease the ever increasing pressure (caused by new discoveries, etc.) on medical students. What is needed is a nomenclaturol revolution, backed by new text-books, etc., in which a clean break could be made with the past, and a new generation trained solely in the new system. Unfortunately, I do not see this coming in the very near future, but I look forward to the time when some medical schools may try the experiment.

To summarize, the medical student today is under increasing pressure to assimilate a large amount of information in a comparatively short time. Here is an opportunity to ease considerably the student's burden without reducing his knowledge, and in fact giving him scope to increase it.

Finally, if my arguments have failed to convince you, or you would like to discuss them further, please contact me. My name, translated into latin, is,

VESPERMACER JANICATUTUM.

POEMS

By Teifon W. Davies

EMBRYO

The half-bleached grass, close to earth,
lends itself to Summer's promise. Rainwashed,
crushed beneath the ram's foot.
Put to sheep, in season.
Aphrodisiac darkness, wind, filled with nothing,
circles, plants the seeds
of April's milksucking. Once innocent.
Children, behind steamed glass, question
the genesis of Spring. Leaves fall;
and coarse hair breaks skin's gentleness.

Windloosed sparrows shatter hanging clouds,
wheeling and dying over waters that boil.
Grapeshot. Their blackthorn shelter pricks
the falling rain of Autumn, a passing odour.
And Winter, condensed in a daydrop of darkness,
sings the half-dreamed prophecy in words
that cloud the morning. Shaking the night
from its thoughts, the earth lies waiting. Ready.

Its alchemy, the surging flow, plays
dreams on spiral, snowghost bodies. Orgastic.
A broading line of sunshine splits the
swirling images of night. The chrysalis,
itself a dream, stirs, on light alone
and breaks to give the sickened dawn a meaning.

THE VEILING OF THE BRIDE

The day of the foxglove passed quickly.
Its heavy-headed stalks soon lost
their pure lines and bowed in windswept
silence before the mansions of the moon.
Night: the moon, no longer full, arcs to cause
its last belated shadows. Grey, misty particles
gather to conceal the waving hazel, once
baptised in the blood of dawn.

Its towering shadow crumbles with each movement
of the cotton, stubborn cloudislands —
lengthening to die. Then.
The light blinds: and footmarked gutters
show an instant where rue and blackthorn
once shadowed earth and now
lie crushed. Dust to dust.
But only their petals die.

LANDSCAPE

The wind chases little flowers.

Their yellow runs and loses like fire
in the sun, now low against the earth
in waves. A single tree grips the hillside:
its knuckles clenched in black where once a wood.
Sooty leaves show me their backs.
No longer chaste. In the globe of a ripening cherry
the sun burns red against a sick, turned earth.
Houses, grey with stone, find their corners
abruptly in a mingle of bush and creeping slag.
Hunched in anger.

Fronds of cloud lace the sky, suddenly,
causing more remark than all below.

AMOR

She wakes: the morning
dreaming aloud with
sweatfilled happiness
screams at yesterday's distant
love: and yawns.

She sits in the dew
from all her memories;
her heart beats
the fervour to death
inside her.

The stream flows next door
slowly carrying the forms
of languid dreams to the waterfall
under the wood, and its
swirling vacuum draws her.

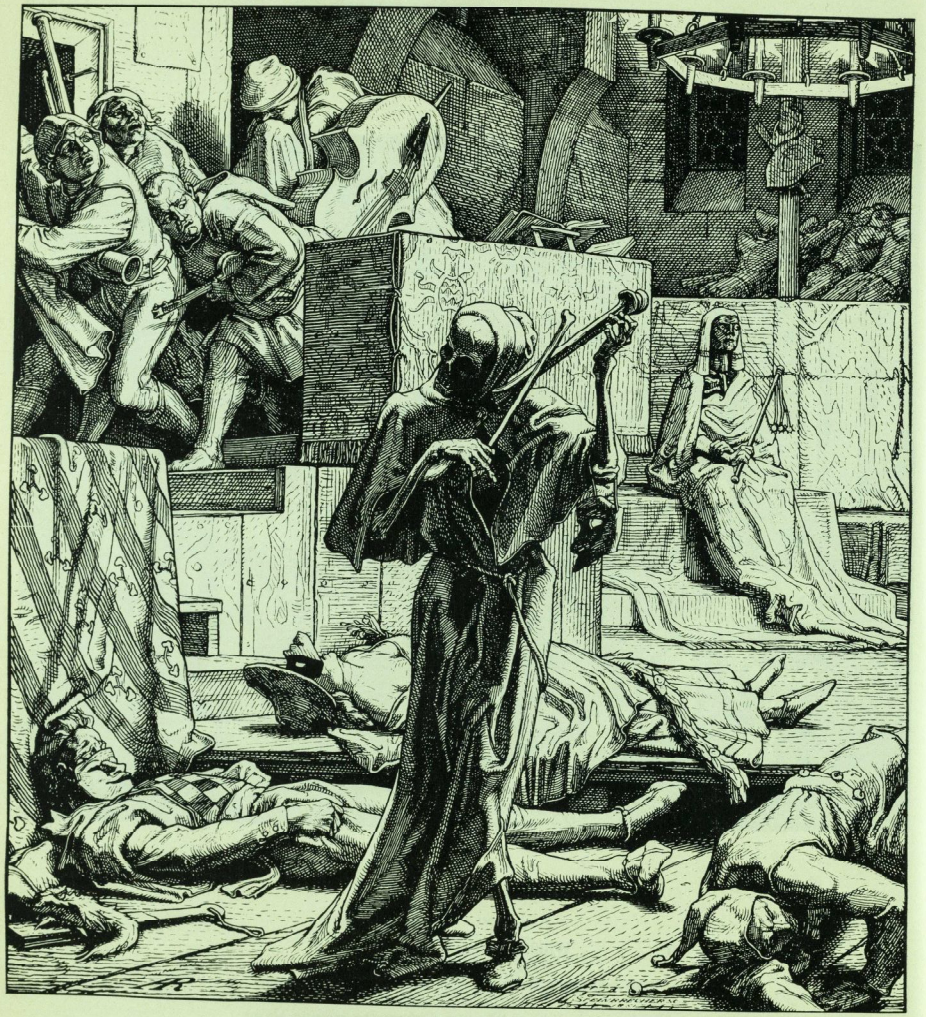
His little white ghost—
used, unheard-floats
in abject splendour
to the lake
beneath her.

MEDICINE IN ART (2) DEATH

YVONNE HIRROTT, A.L.A.
Medical College Library

1. William Hogarth (1697-1764)
THE DEATH SCENE
(An engraving from the series *A Harlot's Progress*, London, 1734)

The harlot is dying while two doctors are arguing about the respective merits of their remedies. It was said that Hogarth had satirized two notorious quacks of the day. The lean man is presumed to represent Dr. Misaubin, and the fat one to be either Dr. Rock or Dr. "Spot" Ward.



Left

2. Alfred Rethel (1816-1859)
DEATH THE DESTROYER
(A wood-engraving by Steinbrecher after Alfred Rethel, 1851)

This Dance of Death was inspired by Heinrich Heine's account of the outbreak of cholera in Paris at a masked ball on the night of Mi-carême, 1832. The gayest of the harlequins suddenly collapsed—his limbs were cold, and, underneath his mask, his face was violet-blue. Laughter died away, dancing ceased, and in a short time carriage-loads of people were hurried to the Hôtel-Dieu to die. To prevent a panic among the patients the bodies were thrust into rough graves still wearing their costumes. Soon long lines of hearses stood outside the Père-Lachaise cemetery.

Top right

3. Edvard Munch (1863-1944)
THE SICK CHILD
(The Tate Gallery)

The young girl is dying of pulmonary tuberculosis. The artist's mother and younger sister both died of this disease.
The shadows to the right of the painting appear to be symbolic of approaching death, which even the loving mother cannot hold back.

Bottom right

4. Käthe Kollwitz (1867-1945)
WOMAN AND DEATH

(Etching and sandpaper aquatint, Berlin, 1910)
This moving work shows a young mother fighting against death for the sake of her child.
The artist was the wife of a doctor who dedicated himself to practise in the slums of Berlin.

ACKNOWLEDGEMENTS

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SIMILIA SIMILIBUS CURENTUR

An article on Homeopathy by Ian Battye

I was delighted and honoured to be asked to write an article in this journal. The subject was to have been "Fringe Medicine". Unfortunately like most graduates of Bart's my opportunities for studying these valuable additions to orthodox Western Medicine have been lamentably scarce. My ignorance of the skills of Acupuncture. Osteopathy, Radiesthesia, Herbalism, the Alexander Technique to name a few, makes it impossible for me to criticize them intelligently here or to discard them in practice.

Current Orthodox Medicine

It is much easier but equally profitless to criticize orthodox medicine after seven years in a teaching hospital. The advances in patient care and treatment, particularly Surgery, and in knowledge of pathological disease over the last 50 years are inestimable and do not require citing. We are all aware also of the deficiencies and failures. The cumbersome structure of the NHS and its abuse of the Junior Hospital doctors, the interminable out-patient lists, the many diseases and patients not amenable to modern therapy. I don't need to emphasize the problems of drug side-effects, drug overdose, drug interaction, drug dependence and drug hypersensitivity—not to mention drug ignorance or for that matter drug companies.

Many patients fear the power of modern drugs and resent being treated as units of pathology rather than as whole persons. Many of course are greatly helped, many "get better in spite of treatment", many continue taking a selection of ridiculously polychromatic tablets probably for life without feeling the slightest bit better. A very useful addition to orthodox therapeutics is Homeopathy, about which I shall write.

Patients seeking Homeopathy

Patients come to Homeopathic treatment for the following reasons: They may be disillusioned with orthodox practice. They may come on the enthusiastic advice of friends who have benefited, or they may be brought up with a Homeopathic family doctor and would not change. Occasionally they come as a "last resort". They are a normal cross section of the community and do not comprise mainly cranks, hypochondriacs or rich widows. They are fully aware of any improvement or not, and say so.

Homeopathic Doctors

All recognized Homeopaths are qualified doctors. Most are in general practice many have higher qualifications, some are Consultants in NHS hospitals or even surgeons. There are about 200 Practising Homeopaths in the British Isles and over 50,000 scattered throughout Europe, India, North and South America. Homeopathic Hospitals in Great Britain are situated in London, Glasgow, Bristol, Tunbridge Wells and clinics at Bath and Manchester. Homeopathic practices are mainly private, about 20% are NHS.

Homeopaths take the same trouble to arrive at a pathological diagnosis as any other doctors using the same techniques of history taking, physical examination, laboratory and X-ray investigation, and they refer patients to specialists whether medical or surgical for treatment or opinion. They are not averse to using orthodox drugs when they consider them necessary. Doctors take an exam. in Homeopathy which requires some two years study.

Differences of Approach

The only difference of the Homeopathic approach is the greater detail taken over the history with particular attention to the constitutional make-up of the patient and the peculiar symptoms of his illness. Drugs are chosen according to the similarity of the symptoms produced by the drug in control cases of very mild chronic poisoning to the symptoms elicited in the history. The drug is then given in a fantastically small dose.

History

The principle was discovered in late 18th century in Saxony by Samuel Hahnemann. A most respected physician and chemist, he noticed the similarity of the toxic effects of some drugs used to cure illness, to the actual symptoms of that illness. He first demonstrated this with Cinchona (Quinine) used in Malaria. The unexpected point however was that the effects were more marked as the drug was increasingly diluted. Experiments with many other drugs confirmed his findings and research into the past showed the principle to have been suggested by Hippocrates and Paracelsus and used unwittingly on many occasions since. Although he lived in an age of terrible medicine his break from bleeding, blistering and poisoning of his time does not account for the worldwide fame he attained as a healer with his medicines or for the considerable following Homeopathy attracted amongst doctors for the next two centuries.

Drug Provings

The analysis of the symptom picture of a drug is not as destructive as it may sound. Examples of chronic poisoning with Arsenic, Mercury, Phosphorus, Sulphur or Silica were commonly found amongst workers and patients. Other drugs were tested in minute doses in large groups of volunteers and significant symptoms analysed to form a drug picture or "proving".

Drug Preparation

The therapeutic dose of the drug is administered in "potentized" form. This means in a dilution of one part of drug in 10^{6}–10^{200} parts of water and alcohol. This is achieved by serial dilutions and does not mean the patient gets drunk. Between each dilution the solution is "succussed", or shaken very rapidly. Without this process the drug is much less active, but what it does in terms of molecular physics is beyond me.

In soluble substances are ground up or "Triturated" with lactose to a fine powder to render them sufficiently soluble in alcohol for Homeopathic medicinal purposes.

The principle of the Homeopathic microdose would sound absurd to any sane pharmacologist. The point is that the drugs are active and the fact that it is not known how they act is no more distressing than our ignorance of the way most orthodox drugs act, on more than a rather superficial level. Homeopathy does not have the advantage of millions of pounds worth of Government sponsored research. The main test of the efficacy of the system is to use it and to judge by clinical experiences; as in orthodox medicine.

Materia Medica

The therapeutic agents used in Homeopathic practice are derived from any substance which when potentized has been found to have a clinical effect. Thus deadly poisons such as Strychnine (Nux Vomica) have as therapeutic an effect as inert substances such as Club Moss (Lycopodium) when used in potentized form where the symptoms indicate their use.

Nomenclature

There are about 1,000 fully proven drugs of which about fifty are in common use. They are called by their proper name in Latin.

These abbreviate easily, there is no confusion and the patient need not necessarily understand what he is being given.

Examples

Examples of a few common remedies follow, divided for convenience in groups which does not suggest they cover similar illnesses.

Plants:

Arnica Montana—Fall Herb
Belladonna—Deadly nightshade Atropine
Caulophyllum—Blue Cohosh
Dulcamara—Bitter Sweet
Gelsemium—Jasmine
Lycopodium—Club Moss
Phytolacca Decandra—Poke Weed
Pulsatilla—Anenome
Rhus Toxicodendron—Poison Ivy

Fauna:

Apis—Bee Sting
Sepia—Cuttlefish Ink
Crotalus Horridus—Rattlesnake Venom
Lachesis—Surukuku Snake Venom
Tarantula—Spider Venom

Metals:

Aurum, Aluminium, Cuprum, etc.

Non-Metals:

Phosphorus, Sulphur, etc.

Acids:

HCn, HCl, Picric, Phorphoric, etc.

Salts:

of Sodium, Potassium, Calcium, etc.

N.B. Though many of the drugs are derived from common herbs there is no connection with herbalism. Again, there may be confusion with Schussler's Tissue salts, commonly found in Health food shops. This is not classical Homeopathy.

Drug Presentation

The drugs are made up to the appropriate strength by the method of potentization at a Homeopathic pharmacy. They are distributed dissolved on lactose tablets or granules in identical small bottles. The drug can only be identified by the label on the bottle. A good Homeopath would carry about 100 in his bag.

Drug Costs

Because of the minute doses used, drug costs are minimal and supplies last a long time. Some drugs such as the Snake Venoms are originally rather hard to come by.

Drug Administration

All the drugs, which taste pleasantly sweet (lactose), are dissolved in the mouth. High potencies (high dilutions) of which no more than a few doses are needed are taken 3 hourly, or more frequently in an acute case, when they can be dissolved in a glass of water, and a spoonful taken ½-hourly. Low potencies may be taken T.D.S. for several weeks. The therapeutic effect of a high potency may last for several weeks or months, so a placebo (unmedicated lactose) may be given T.D.S. over that period, if the patient is conditioned by orthodox medicine to taking pills regularly.

Treatment of the Patient

A Homeopath can treat patients either constitutionally or specifically. Constitutionally all patients fit more or less into a "drug picture", e.g., a woman who is thin, quick-tempered, jealous, violent, loquacious, hot and sweaty and hating tight clothing, who wakes feeling worse and whose symptoms start on the right side and go to the left—may be of a "Lachesis" temperament and one would expect to cure her headaches, period pains, tonsillitis or general depression with lachesis. If however she was fair, plumpish, cheerful and gentle but prone to weep and better for fresh air, she would respond to Pulsatilla, and Lachesis would have no effect. I quote from a night nurse, tired out and complaining of menorrhagia and mouth ulcers given Pulsatilla: "For about a day I did not feel noticably better but I then stopped menstruating when I would normally have continued for about a week. Also I began to feel much more energetic and cheerful and all the mouth and throat ulcers disappeared".

Specifically he can treat pathological disease according to the symptoms regardless of the patient's constitutional remedy, e.g., a child with acute Otitis Media, whose symptoms arose suddenly. The pain made her scream and she looked flushed with a fever and bounding pulse. She preferred to lie on the affected side and curl up with the head covered. The drum was very inflamed and bulged slightly. I gave her Belladonna, even though her constitutional remedy were Pulsatilla. She improved dramatically over a few hours. Another child with the same pathological disease but different symptoms would respond to a different remedy, e.g. Bryonia. Very rarely would one have to resort to Antibiotics if the Homeopathic drug is well chosen. Other examples might include both acute and chronic conditions, e.g., Coronary thrombosis, heart failure, pneumonia, migraine, laryngitis, rheumatism, eczema, etc.

Choice of Drug

The first point is to become thoroughly familiar with the characteristics of each drug. This can be done by studying the books or preferably direct from an experienced Homeopathist. Courses lasting a week are run three times a year at the Royal London Homeopathic Hospital at Queen's Square. They are attended by 30-40 GPs and hospital doctors and the fees can be reclaimed from the Homeopathic Research and Education Trust or the Regional Hospital Board.

The second point is to listen to and watch the patient carefully. He will usually produce spontaneously sufficient peculiar symptoms and show a particular manner to prescribe on accurately. Occasionally the right drug will be obvious before the patient has sat down, on the other hand several consultations may be necessary.

The third and most difficult point is to match the patient with the drug. This is achieved through experience.

Peculiar points to take note of apart from the pathological diagnosis are: the response to temperature, company, weather, food idiosyncracies, time aggravations or strange fears, e.g., thunder. Is his manner restless or apathetic, shy or garrulous, is he tidy or slovenly, etc. If is important to get to know the patient.

Advantages

Many advantages of Homeopathy are obvious. A cheap and convenient method of helping the whole patient to be well rather than temporarily suppressing his symptoms. It is free of side effects or the possibility of overdosage. What are the snags? Does it work?

Clinical Evidence

Clinical experience shows that provided the correct drug is given all patients will benefit, some dramatically. The snag is choosing the right drug. Obviously Homeopathy is not a "cure all" and one would be unwise to use it to the exclusion of other therapeutic agents. Patients continue to demand Homeopathic treatment and nearly all claim their condition gets better. Maybe they would get better anyway, but then why come to the Doctor? Much is talked of placebo action and the powers of Suggestion but I fail to see why this should be any greater in Homeopathic practice than in any other branch of Medicine.

Disadvantages

As patients increase in their demand for Homeopathy there is need for more Homeopathic doctors; not working against orthodox medicine but with it. Young doctors are not impressed by the apparent lack of scientific evidence and clinical trials. This is not surprising for 2 reasons:

1. Until 10 years ago mention of Homeopathy was banned from all orthodox publication. Even now there are considerable editorial inhibitions. Vide Hospital Medicine June 1971: though this is changing. Vide Hospital Medicine October 1971.

2. Homeopathy is not easily amenable to the Double Blind crossover Clinical Trial. One is using different remedies for the same pathological disease, and doctors are not interested in comparing placebo results with an appropriate Homeopathic treatment in patients who are sick. They would lose their patients!

Research

In the Homeopathic journals of Britain and America there is a wealth of statistical and research data over the years. E.g.:

1. In the Cholera epidemic of 1854 "the aggregate statistics of results of allopathic treatment in Europe and America show a mortality rate of over 40%, statistics of Homeopathic treatment of less than 9%. This was achieved using mainly Homeopathic Camphor, Cuprum and Veratrum Album.

2. Experiments of the Special Subcommittee of the British Homeopathic Society to the Ministry of Home Security 1943 on Proplylaxis and treatment of Mustard Gas burns showed statistically that "Rhus Toxicodendron given after the person was burned offered some protection against deep burns; Mustard gas in potency given before exposure shows a definite reduction in deep and medium burns."

3. The late Dr. G. P. Barnard's work at the National Physical laboratory at Teddington 1965-67 on the nature of water polymers and Homeopathic potencies led him to conclude "Recent application of Quantum Chemistry theory to biological systems indicates that these succussed high dilutions may act via the physico-dynamic structure of their solvent phase, rather than the chemical properties of their dissolved solutes. The solvent molecules may arrange themselves into stereospecific, isotactic polymers with the ability of self replication in the absence of the initial exciting solute. Certain physical qualities of these succussed high dilutions appear to verify this conclusion."

4. At present, research is being and has been conducted in the use of Arnica in Surgery, in treatment of Asthma, Migraine, Disseminated sclerosis, Rheumatic diseases, Respiratory disease in the Battersea chest clinic and Influenza proplylaxis in industrial communities in the midlands—to cite but a few.

All these programmes are supported by the Homeopathic Research and Education Trust which is an independent charity.

Conclusion

Homeopathy lends itself best to General Practice because its use covers the whole range of diseases from conception to extremis.

I hope I have dispelled a few illusions generated by an ignorant establishment and stimulated a sympathetic even enquiring attitude towards an extremely valuable branch of Medicine.

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BOOK REVIEWS

CLINICAL HEART DISEASE
by SAMUEL ORAM
(Pp. 920; £12 William Heinemann 1971)

In the preface the author suggests that the undergraduate does not need a textbook that is essentially different from that of his more senior colleague. From the style of this book it seems to have been written with students very much in mind. There is free use of italics and the text tends to be tabulated. Some students will be attracted by the many lists, but others might prefer more continuity in their reading. A further list follows each chapter and sets out salient features.

Several chapters are worthy of individual mention. The first deals with applied embryology, anatomy and physiology. The clear diagrams and descriptions of the development of the heart rate are of particular merit and of value in understanding congenital defects. The section on physiology is equally useful but a fuller discussion of the pathogenesis of cardiac oedema would have been welcome. There follow three chapters on clinical examination, one of which dealing with history-taking and bedside examination is directed mostly to the medical student. A further chapter devoted to auscultation contains a helpful classification of both systolic and diastolic murmurs and a full explanation of added sounds and splitting of the heart sounds. Radiology of the chest is well illustrated, but it is unfortunate that more arrows have not been used, particularly where valve calcification is being shown. Many of these illustrations are perhaps unnecessarily repeated later in the book, as are several from the section on clinical examination. It seems extravagant, for instance, for the facies of congenital supravalvar aortic stensois, arcus senilis and Turner's syndrome all to appear twice. Congenital heart disease and valvular heart disease are very fully described and the rheumatic triad, infective endocarditis and pericarditis all have separate chapters. The section on dysrhythmias is well illustrated and here as in other sections all the ECG's are clearly reproduced. Some of the more practical details of

management of dysrhythmias are dealt with in the chapter on ischaemic heart disease and their inclusion under treatment of the individual rhythm abnormalities would have been preferable. Cardiac emergencies, and operations on cardiac patients are all discussed and finally there is a chapter on diseases of vessels. There is wide coverage of the subject, but some misplacing of emphasis. Libman-Sacks endocarditis, for instance present in one third of patients with systemic lupus erythematosis, is only mentioned as occurring, whereas there are four pages on the more rare condition of cardiac amyloid.

There are obvious advantages in single authorship, but the personal views of the author will often conflict with more widely accepted opinion. Not all would agree, for example, with the views held about long-acting coronary vasodilators and the preferences given for certain proprietary brands. At other times a rather too dogmatic approach is employed. This leads to statements that are controversial.—Diuretics are said to act as hypotensive agents mainly by reduction of blood volume, or to statements unsupported by evidence or explanation. Describing the treatment of chorea it is stated in italics that "even in the least severe cases the child must not be treated at home".

Notwithstanding these criticisms, it is a great achievement to have written a textbook of this size. Single-handed, the author has covered the whole field of clinical cardiology, drawing freely throughout on his own experience, and has produced a book of particular value to final year and membership students.

ROGER WHITE.

LECTURE NOTES ON PHARMACOLOGY

By J. H. BURN
(with a section on tropical diseases by L. G. Goodwin)
Heinemann. 10th Edition.

One always looks at a slim volume that would fit snugly in one's pocket with special interest because this implies that it may be read through quickly or read in circumstances, such as on a train journey, where the heavy textbook would be an encumbrance. Professor Burn's little volume has been through ten revisions since first appearing in 1948, a fact which speaks for itself. It comprises about 160 pages within covers about 8 in. x 5 in. and Professor Burn has been assisted by Dr. L. G. Goodwin who contributes in his specialised field of tropical diseases, an area which no medical can neglect in the days of universal air transport.

This book could fill two needs. Firstly, it provides, within a small compass an introduction to the subject for medical, dental, pharmacy and other students interested in Pharmacology. For these, the salient features of many topics are set out and it forms a useful springboard for further reading. Secondly, it offers (as perhaps the name implies) an aide memoire for the student who has already studied Pharmacology and who wishes to "refresh" his knowledge of the main points. In several areas, it provides brief, helpful notes on new fields, such as on trimethoprim, levodopa in Parkinsonism, and on tranquillizers like haloperidol and etorphine (which is useful to the big game trapper who wishes to be photographed riding on the back of the rhinoceros which he has tranquilized "in the bush" prior to bringing it to the UK to sell to the Wild Life Reserve of yet another Stately Home).

The text is written in the style so characteristic of Professor Burn which is lucid and provocative of further thought. Professor Burn has always been in the forefront stimulating pharmacologists to appraise critically old and new pharmacological findings, a role which he has played for more than a quarter of a century at the Scientific Meetings of the British Pharmacological Society. Appropriately therefore, the opening chapter is on sympathomimetic amines. It was the early experiments and hypotheses of Professor Burn and his Colleagues on tyramine that paved the way for our present day concepts of the role of noradrenaline as the chemical mediator at the adrenergic neurone—effector cell junction. The subjects which follow range through basic pharmacology and clinical pharmacology. A chapter on simple statistical considerations includes a section on the Chi-squared Test.

Thus, there is something for everyone in this modestly priced book (£1.25p), but it must be remembered that it is more concerned with principles than being a pharmacological reference volume. As seems almost inevitable, the occasional trade name intrudes without its official counterpart and spelling of the name of the drug, hexobarbitone, varies from one part of the text to another. It is perhaps unfortunate that the spectrum of the preparations of insulin used therapeutically is not comprehensive. However, these points are minor shortcomings and do not detract from the charm and utility of the book.

J. P. QUILLIAM.

MUSIC

CONCERT

St. Bartholomew's Hospital Music Society

For our delight the Hospital Music Society provided The London Schubert Orchestra for an autumn concert in the Great Hall, in aid of the St. Bartholomew-the-Less rebuilding fund. The London Schubert Orchestra was established in 1960. It has given a number of concerts in London and the Provinces. Mr. Bryan Brockless became Musical Director of the Orchestra in 1968 and his debut concert took place in the Queen Elizabeth Hall. The Orchestra draws young instrumentalists from most of the London Music Colleges and also has some regular professionals.

The Great Hall was totally packed out and a large queue was unable to get in; such was the response to the excellent advertising. It was a highly distinguished audience since it included Artur Rubinstein and Felicia Blumenthal (pianists), as well as Dr. Michael Bialoguski who once hired the Albert Hall and the New Philharmonia Orchestra so that he could fulfil his lifelong ambition of conducting an orchestra. These notables had come to hear Max Wilcox conduct Haydn's 44th Symphony (called "Trauer" or funeral). Mr. Wilcox has been Rubinstein's recording producer for many years and has also written record sleeve notes but this was his conducting debut. His enthusiastic direction was rewarded by a sincere and passionate orchestral response in the work and the deep feeling of the slow movement. Its yearning and sense of loss was fully communicated, as was the final repose and sunlight of the finale. The attention to orchestral balance, so important in Haydn, was also impressive. I look forward very much to hearing Mr. Wilcox again soon.

The first half of the concert had all been Mozart: the youthful A major Symphony No. 29, two soprano arias and a divertimento under the baton of the Orchestra's director. We had been promised two Schubert works but it was wisely decided that the programme was already long enough. The Great Hall makes a marvellous setting for classical music, with its beautiful stained-glass windows and decorative ceilings. One expected the Hall to have over-resonant acoustics, but, when full, this proved to be a false fear because in fact the acoustics are warm and rewarding to play in. It would make the ideal setting for Mozart's Wind music or Piano concertos.

I hope that the Music Society were encouraged by the response which this concert produced—there is clearly a need for music in Bart's. Please may we have some more soon!

"ALLEGRO."

ELGAR ON RECORD FOR £5

It was suggested that there was a place for recommended classical records in the Journal. I hope to devise each time, a way of getting the best value that £5 can buy, to give some idea of the range of a given composer. Obviously this can only give a mnior guide and must, by its very nature, be totally biased.

Elgar's music is going through a vogue at the moment, yet only ten years ago neither symphony was available on record, and even an evergreen like "The Dream of Gerontius" was only represented by a poor and ancient Sargent recording. The revival may be attributed in part to Ken Russell's magnificent BBC-TV documentary with its marvellous shots of Worcester and the green hills around. You can now buy Elgar's own versions of his two symphonies, but beware—they were recorded in 1927 and 1930. The sound is, frankly, awful but somehow the marvellous performances still come through. These are on a cheap label (World Record Club SH139 and 163 at £1.25 each). There is an added bonus on number two—you can hear Elgar rehearsing—a marvellous moment of history. Boult's latest performances are the alternative, but at full price on Lyrita. Probably Elgar's best known work is the Enigma Variations, and there is a fine record of it played by the London Symphony under Pierre Monteux, on bargain label at 99p (Decca's "World of" series SPA 121)—the sound is still demonstration class. Elgar's concertos remained popular during the famine period, particularly the lovely Cello Concerto—Jacqueline du Pre's record of this is my favourite (until Rostropovitch records it!). On the other side is an example of the art of Janet Baker, who sings the somewhat faded 'Sea Pictures" with great feeling. This is a full-price recording and worth it for Barbirolli's accompaniment and the playing of the LSO. (HMV ASD 655). For good measure, I must finish by suggesting Elgar's first chamber work—the Piano Quintet, which is recorded by Cassini and the Allegri Quartet on Revolution RCB 8—a not ideal but still enjoyable performance, at 99p. I realize that I have missed out "Gerontius", the "Musicmakers" and a host of other glorious orchestral works such as "In the South" and the "Serenade for Strings", but I hope that people who hear and enjoy the above selection may be tempted to look further.

"ALLEGRO".

BART'S SPORT

LUST

During the Summer, Lust has become somewhat of a vice! Add lust to free lager and you have a potent mixture indeed—a mixture which, left to ferment and mature through the hot Summer months, came eventually to fruition near the small Sussex town of Petersfield—but that comes later in my story.

This potent mixture was first brewed here in London, on Parliament Hill to be precise (where else?), on April 25th. It was quite an event, 1,200 spectators watched as Lust battled against "The Yeti Patrol", "Meadows", "D.H.O.", and the dreaded "Neasden Wanderers".

Having titillated your frontal lobes, I shall now let you in on a secret—wait for it—Lust is in fact your very own L.U. Ski Team, the event the first round of the "Stella Artois National Grass-Skiing Championships". Yes folks real, actual, non-mythical Grass-Skiing—but pray read further, for where, you drool, does free lager come in? Well, beer-fiends all, it came from the sponsors, Stella Artois, indeed all you could drink and served at 44°F using a special super cooler. (For connoisseurs, it is normally served at 46°F.)

So now we come to the story of "Squalid tours '71": the brave and heroic story of ten people and a Transit Van. These intrepid voyageurs departed from the great metropole, Friday, May 23rd, for the wild and wicked wastes of Windermere, arriving as the owl struck midnight. Emerging from their tents the next morning the daring ten struck out for the nearest bar but, finding it closed, had to make do with the exhilaration of grass-skiing down a mountainside from which the bulldozer was still removing boulders. When opening time loomed, however, you guessed it, there they all were assembled by the trusty Transit and panting. Four pints and a shepherd's lunch were enjoyed by all on the lawns of a beautiful pub, in the hot sunshine, on the edge of lake Windermere. With the blood level successfully lowered in the alcohol stream, a tour of the lakes was enjoyed with running commentary by squalid tours operators, Chris Trower and Jeremy Fairbank. Hyjacking some females to support our lovely foursome, a meal and party materialised in the evening. Midnight ended the day.

Morning started the next day. Rain continued it and the course was lowered from the suicidal "haute montagne" to the crippling lower course, lengthened by knocking down a stone wall and turfing over a road. Lust put up a convincing performance, Chris winning the individual event, and the drooping ten returned to the great metropole just in time to miss the last tube.

July 14th, the National Team Championships, and Lust was once again assembled at Goodwood, Sussex. After yourstrewely had done his thing in front of the T.V. cameras the races got under way. Racing first for the University Chris Trower crashed dramatically, but managed to complete the course minus ski sticks and with a dislocated shoulder, undaunted Lust came through to win the round: However with one racer bandaged together we were then knocked out by the University of East Anglia. Thanks, Jeremy, for the cider.

The next two rounds were at Edinburgh and Manchester at which yourstrewly was not present, however Chris added more points to his lead in the individual championships.

With the Summer now drawing to a close the South of England Championships were held at Brighton on September 5th. Lust battled through to second position. Large quantities of lager were quaffed down to prevent sunstroke.

The last round, September 19th, found Lust once again assembled to do battle. This was the fulfilment of a dream at last as Lust (aided by lager) raced against the toughest opposition yet and won, a fitting end to the season.

Congrats to Chris Trower, narrowly beaten at Butser Hill to come second in the National Individual Championships.

Members of Lust.—
Chris Trower (Barts)
Tony Lipscombe (Barts)
Tim Bunker (Barts)
Jeremy Fairbank (Tommies)
Roger Lee (I.C.)

ST. BARTHOLOMEW'S HOSPITAL GOLFING SOCIETY

The 36th Autumn Meeting was held at Hadley Wood Golf Club on Thursday, September 30th. Thirty-four Members played.

The winners were as follows:—

Milsom-Rees Cup (Handicap) I. Kelsey Fry (11) 40 points.

Graham Trophy (Scratch) C. Booth (6) 31 points.

Robinson Cup (Handicap 18 or more) R. D. Marshall (24) 37 points.

The next Summer Meeting will be held at Moor Park Gold Club on Wednesday, June 14th, 1972.

I. KELSEY FRY,
J. FISON,
Hon. Secretaries.

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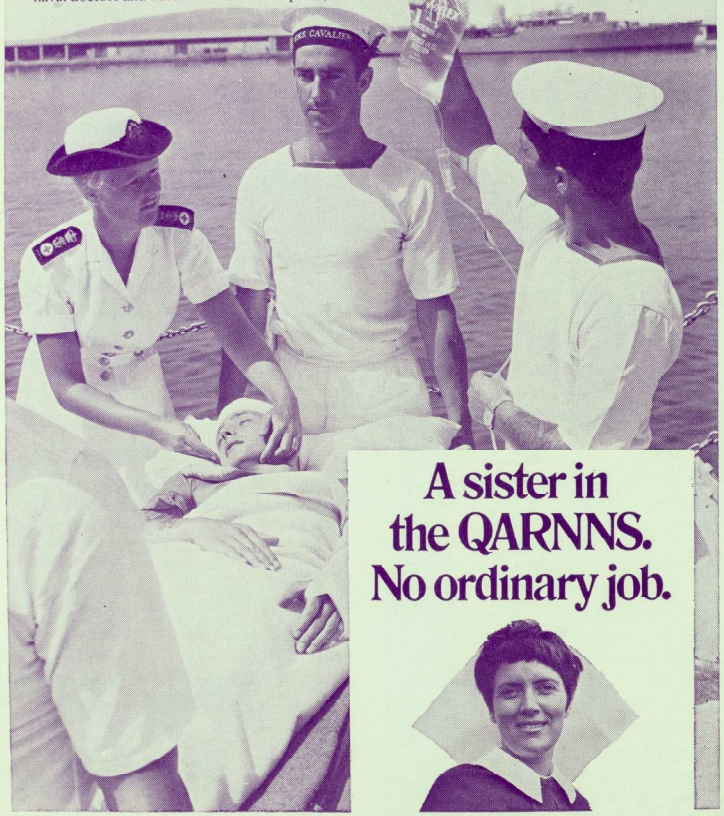

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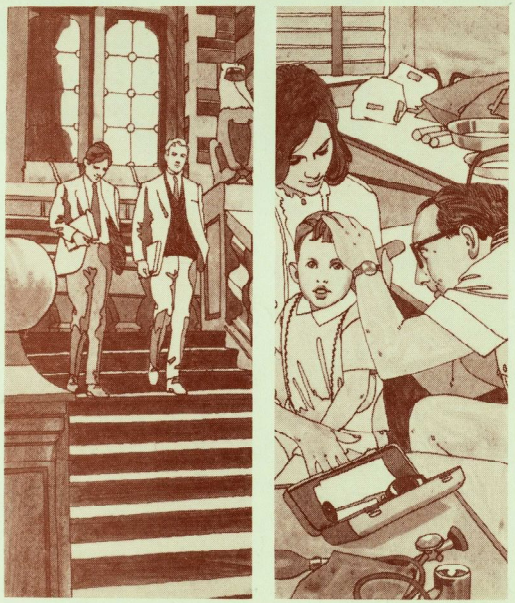

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