Social factors in health and disease, by P. E. R. Soppet and M. C. Schonhofer 85
Soppet, P. E. R., and Schonhofer, M. C.: Social factors in health and disease 85
Sport 15, 62, 95, 126, 156, 187, 224, 252, 316
Spot the lesion, by J. Goldsmith... 276
——: by J. Watkins 122
Stanner, Sister: *Portrait* 186
Stead, Zita 28
Stoy, N.: Life and works of Sir James Young Simpson, Part 1, ... 374
Strauss, Richard, bargain records, by Allegro ... 284
Stravinsky (1882–1971), bargain, by Allegro ... 219
Students' Union ... 100, 132, 133, 228, 262, 326, 358
Students' Union Chairman's report 138
Suicidal motivation measurement & meaning, by D. Schuyler 23
Summers, Jan, *see* Heath, Jackie and—
Taylor, Enid: Diabetic retinopathy 346
Tchaikovsky, bargain, by Allegro 152
Tennis Club 224
Tennis Club (Ladies') 252
Thomas, R.: Keep it clean 150
Thomson, W. McL.: Situation vacant *Corres.* ... 133
Thornton, J. L.: Robert Balthrop 53, 86
Transcendental state, some clinical evidence for, A. Peacock 231
Tulloch, A.: *Corres.* 69
Undergraduate and his career, by A. B. Gilmour... 175
Uribaggy, by F. S. Wills 243
Vandenburg, M. J.: To take, or not to take, Conjoint, that is the question 270
Verbal diarrhoea, by A. Barnsley 203
Vevers, J. J.: Fifty bob a laparotomy 272
Vick, Reginald M.: Obituary 71
Vieyra, P., *see* Millard, P. M. A., and—
Wallace, R. A. R.: *Corres.* 7
Ward shows and Pot pourri, 1971, by G. Blackledge 46
Watkins, J.: Spot the lesion 122
Watt, S. J.: Modern climbing scene 278
Weller, M. A.: T. O. McKane 198
Wellingham, J. *Corres.* 100, 132
Wellingham, J.: Students' Union Chairman's report 138
Wills, F. S.: Uribaggy 243
Wix Prize Essay, Part 1, by N. Stoy 374

EDITORS

January	MARY HICKISH
February	MARY HICKISH, ALAN SEARLE and MALCOLM VANDENBURG
March-July	ALAN SEARLE and MALCOLM VANDENBURG
August	JOHN WATKINS and MALCOLM VANDENBURG
September-December ...	JOHN WATKINS

SAINT BARTHOLOMEW'S HOSPITAL JOURNAL

Founded 1893. Vol. LXXVI No. 1

Journal Staff

Editor
Mary Hickish

Sub Editors
Articles
Mike Goldsmith
John Watkins

Sport
Oliver Bastard

Reviews
Ian Baker
Peter Smith

Manager
Bob Le Quesne

Subscriptions
Charles Hinds

Advertising
Malcolm Vandenburg
Peter Burnett

Charterhouse Representatives
Timothy Bunker
Peter Bacon
Teifion Davies
Trevor Turner

Editorial

What is the function of undergraduate medical education today, more specifically, what is the function of medical education at Barts? Is it aimed at turning out well-trained general practitioners, or at providing a general training for future specialists? If the former is true, it would appear that a great deal of time is spent on instilling facts, on e.g. vascular surgery, that will be forgotten and never used again once finals are over; if the latter, then surely three months spent on, say, Psychiatry, is necessary, unless one is of course training Psychiatrists. This is not a criticism of the Psychiatry course which I personally find excellent and very well organised, but merely an example of how proportions of time spent on various specialities could be better planned.

Bart's has always, up till now, been able to turn out the typical Barts doctor—gregarious, slightly self-opinionated perhaps, but on the whole a jolly good beer-drinking, rugger-playing chap. It is, at present, very obvious that there is a wide gap between the Finalists and Freshers, they not only look different, but appear to be different people altogether. Will Bart's be able to produce the same type of doctor, or will this new generation of more politically-aware student with greater individualism give rise to a new type of doctor with different mores and ideas? Has the Bart's mould cracked, and are we at last catching up with the mainstream of society?

I believe that Bart's will be able to go on turning out a special brand of doctor, the Mark II model perhaps, despite changing raw material, and despite alterations in the curriculum, because, as Prof. B. F. Skinner says, "Education is what survives when what has been learnt has been forgotten."

Buy your Newspaper from
FRED
on the corner of
Giltspur Street
All modern magazines in stock
For mature reading
use the codeword
"ADONIS"
he will understand

WANTED
DUE TO RETIREMENT
THE JOURNAL
NEEDS A NEW
ADVERTISEMENT
MANAGER
Apply to the Editor

TO ADVERTISE
IN THIS SPACE
AND FOR
SPECIAL RATES
CONTACT
Malcolm Vandenburg
St. Bartholomew's Hospital Journal
St. Bartholomew's Hospital
London EC1
Telephone 606 7777 Ext. 7206

The "IN" eating place for
Barts staff & students
THE NURSES CANTEEN
Superb Cuisine
Superb Decor
December's Special Menu
Includes
Crunchy Cockroach Curry
Kosher Chilli Pickle
now available

ERRATUM. December issue, page 337. Sir Ronald Bodley Scott was President of the Section of Medicine of the Royal Society of Medicine in 1967, not President of the Royal Society of Medicine as quoted. Also, for Lettsonian read Lettsomian.

LETTERS

40, Hadham Rd.,
Bishop's Stortford,
Herts.
September 15th, 1971.

Sir,

The recent decision of the USA Senate to cut foreign aid by about 85% will affect medical effort in many ways. The Senators could have been influenced by their reading of two books which I should much like to see *reviewed at length* by some of your psychiatric experts. I refer to (1) 'Suicide of the West' by James Burnham—Jonathan Cape 1965—(and several others of his) and (2) 'Random Thoughts of a Fascist Hyena' (Satirical Title) by Constantine Fitzgibbon—Cassell 1963—Author of several novels and many articles, and BBC lecturer, and anti-racialist. Your technical articles are of the mini-biological type in the aggregate, and I think the strategical overall view of our future civilisation is worth our interest, or we may revert to the state of sand covered tells, like Ur or Babylon or Jericho, or heaps of broken masonry, with roaming tribes of semi-barbarian descendants of the captive (or wage slave) destroyers, who opened the gates to the surrounding anarchist savages who sympathized with them.

The marvellous photographs in 'In Search of Lost Worlds' by Henri Paul Eydoux, (Hamlyn) tell the story, condensed by Gordon Childe in 'Social Evolution'—(Fontana 1963, foreword by Mortimer Wheeler). In 'Digging up Jericho' Kathleen Kenyon and Margaret Wheeler very amusingly describe their excavations, which showed that Jericho was once burnt and uninhabited for about 2,000 years, while the neighbourhood cemeteries were filled with new skeletons (of the victors) which resembled those of the new tribes of Bedawin warlike clans. The oldest builders were seemingly the original financiers who held the country in monetary thrall until their slaves revolted, possibly stimulated by the trumpets (of Joshua?) sounding the local Marseillais or primitive 'Red Flag', when some postern gate or aqueduct (as in Nebuchadnezzar's city), was opened to some Trojan-horselike suicide squad to let the main tribe enter. The Observer Magazine Nov. 7th describes how China has adopted some kind of Co-Operative Society with decentralization and a Social Credit which seems to be working better than Eberhardt's variety of C. D. Douglas' Social Credit (Douglas condemned Eberhardt's methods entirely). We must also remember that we are all Jack Spratts or Mrs. Jack Spratts, each with differing enzyme outfits, and modern attempts to make us all eat a universal wheat bread will poison many of us into schizophrenia and paranoia and arthritis, that our society will be burdened with mental and physical cripples. This could be the secondary class of disease due to primary enteropathy (Coeliac Disease). James Burnham thinks that citizens get too "soft-headed", with a guilt complex towards their slaves, lose their discipline on themselves and their servants, and give way so much that they become themselves despised and hated like Disraeli's enemy—"Strange—I don't remember doing him a good turn"—the exception proving the rule!

Yours etc.,
R. A. R. Wallace M.B.Chir.
(F.R.C.S. 1914 at Barts.)

P.S. "Famine 1975" by two brothers Paddock is also well worth reading, and their idea of the kind of foreign aid may well have to be adopted.

Abernethian Room,
St. Bartholomew's Hospital,
West Smithfield, E.C.1.
October 1st, 1971.

Dear Madam,

I suppose it was predictable that Mr. Ian Baker's letter in the April 1971 issue of The Journal should have been greeted by the customary burst of Bart's Apathy. What was truly surprising was that the apathy came not, as we are usually led to believe it always does, from the Students, but rather from the Powers-that-Be in the Royal and Ancient. His modest enquiry and small plea for a relatively simple piece of action were not even granted the courtesy of a reply from this august body. (This may lead one to entertain disquieting doubts—perhaps they, too, have cancelled their subscriptions to this publication!)

What reinforces my opinion that this is high time we saw some activity directed towards the cleaning of Barts, is the sheer energy and drive that is at present going into the restoration of St. Bartholomew's-the-Less. Perhaps it's time we took a lead from them. However much we bleat, it must be clear that cleaning a Hospital comes a fair way down a list of Priorities, so the necessary cash will have to be raised.

There is an object lesson in this task, the growth and completion of which are recorded in the pages of this periodical. This is well within the living memory of

several of our consultants and is the fund used to raise money for the new Preclinical buildings in Charterhouse Square before the last war. This was most ably organised by W. Girling Ball, and I can recommend his letter in the Journal (XLII, No. 9, 1/6/35).

The really crafty thing he did was to ask for contributions from all Old Barts Men, and then publish lists every so often in the Journal, showing what percentage of the total known to be in any particular county had in fact contributed. If this was 100%, then that county was printed **glowingly** in heavy type! A good example of this can be found in the same issue as the letter from Girling Ball, and you can see that all twenty-five Barts men in Worcestershire coughed up, and the total was already about £144,000. I wonder whether a similar scheme, if launched today would find that same sum (or indeed, whether the Barts men of Worcestershire would live up to their previous glory!)

Out of interest, I can't think that there are many people in Barts who realise that this dirty stone is NOT the original Bath stone that Gibbs knew. This became so eroded by the atmosphere of London that in 1844, the Surveyor was ordered to make a report on the state of the external masonry in particular. Here are some extracts from it:

St. Bartholomew's Hospital,
July 8th, 1845.

"Gentlemen,

"In obedience to the following Resolution of the House Committee that the Surveyor be instructed to make a General Survey of the Hospital particularly with reference to the state of the external masonry and report thereon, I beg leave to report that ever since I have been connected with the Hospital the state of the external masonry has been watched with great anxiety.

"The four Wings were executed from the Designs and Under the direction of Mr. James Gibbs who was then the Architect of the Hospital. The walls are built of brick but cased externally with an ashlar of stone varying in its thickness, five, six and even seven inches with occasional Bonding Stones, to which the ashlar was attached, of much greater thickness.

"The stone with which the brick walls of the building are cased was procured from the quarries in the neighbourhood of Bath, and by the Minutes it appears that in 1730 an agreement was entered into with Ralph Allen Esq., of Bath, Proprietor of the quarries, to find and provide all the stone and workmanship upon it (the scaffolding excepted) required for the buildings and under the agreement, Mr. Allen was engaged to make good any flaw or crack or any decay which might occur to the stone during the space of 30 years.

"In 1745, great difficulties appear to have arisen in the shipping of the stone from Bristol, occasioned by the War, which were not foreseen when the agreement was entered into between the Hospital and Mr. Allen, a correspondence seems to have taken place with Mr. Allen on the subject, and in consequence the erection of the third Wing was postponed until the year 1748.

"In January 1763, defects were observed in the stone, and the surveyor was ordered to take an account of them and the clerk instructed to give notice to Mr. Allen to repair the same according to his contract.

"Thus it appears within thirty years after the buildings had been commenced, defects were discovered.

"No entry appears in the Hospital Minutes whether the defects were repaired by Mr. Allen.

"Bath Stone is a very inferior building stone. It is oölite and calcerous, easily decomposed by the action of the weather and particularly by the atmosphere of London.

"At that time, the quarries not having been so much worked, the upper beds were probably used which generally are found to be of an inferior, and I have no doubt was then as it is now, the cheapest stone that could be procured for the purpose, and economy must have been the inducement to use it, for in all the other buildings which were erected under Mr. Gibbs in London, Portland Stone was invariably used.

"The whole of the external masonry of the four Wings has now become very considerably decayed and pieces occasionally fall off. It has been carefully watched and portions that have been considered dangerous have been removed so that no accident has hitherto happened, but I consider the time has now arrived when at all events it should have the careful consideration of the Governors.

"Upon giving the subject the fullest attention, which the importance of it to the Hospital deserves, I entirely coincide with my father in the opinion that to attempt a repair of the stone work would be quite fruitless. The soundest and in the end least expensive manner in which the defect in the original construction of the walls could be remedied, would be to remove the ashlar, or at all events so much of it as would admit of applying another casing six inches in thickness fastened to bond stone.

"This brings the question: What description of stone should be employed in the work? From the experience I have had I have no hesitation in recommending the stone from the Eastern Quarries of the Isle of Portland as the best suited for the purpose and the best adapted for the atmosphere of London.

"No alteration whatever ought to be made in the architecture of the building, but the whole of the Cornices, the Architraves and Mouldings should be carefully restored as Mr. Gibbs designed them.

"The expense of such a work is always most difficult to ascertain, but I beg to submit the following estimates as the probable amount of the cost:

The North Wing	£6,500
The South Wing	£6,100
The East Wing	£5,200
The West Wing	£5,200

"I have the honour to be
"Gentlemen
Your most obed. Servt.
"PHILIP HARDWICK."

This was then put out to Tender (nearly five years later). At a meeting of the House Committee in December, 1850.

"The Treasurer reported to the Committee that the recasing of the South Wing of the Hospital which was commenced in February last had been nearly completed, under the superintendence of the surveyor in a most satisfactory manner, and that the work, which had been done at the cost of £5,200, was considerably under the estimate."

The point I wish to draw is that this stone is barely 100 years old and, unlike many old buildings around London, Oxford etc., (and, incidentally, the two Gates in Barts which WERE built in Portland Stone right from the start) this stone should withstand the treatment exceptionally well.

So, who cares about these dirty old buildings? Have you ever walked through the main arch of the Market on a Sunday morning and wondered what those walls must have looked like when WHITE? Do our patients mind that these buildings are so grubby? As a heritage for future generations of Barts students, I'm sure it really doesn't matter—*they* will have *their* training in Hackney. But then, who cares about that?

Yours faithfully,
"PUNCH"

JULIANN JEWELLERY
& DIAMONDS LTD.
42½% offers BELOW USUAL RETAIL PRICES

We are manufacturers of Diamond Rings and Jewellery and are offering to supply all BART'S Staff and Students at trade prices, therefore eliminating retail profits. By doing this we will be giving you the best possible value for your money. All our Jewellery is clearly marked with the retail prices, from which we give the following discounts (inclusive of purchase tax).

42½% Diamond Engagement Rings and all Diamond Jewellery
33⅓% Gold Wedding Rings, Signet Rings, Charms, etc.
15%—Watches
Showrooms open: Weekdays 9.30—5.30
Saturdays 9.30—1.00

JULIANN JEWELLERY
& DIAMONDS LTD.
93-94 HATTON GARDEN (2nd floor)
LONDON E.C.1 ● Tel. 242 9918
Jewellery repairs carried out and your old Jewellery remodelled
We will also purchase your unwanted Jewellery

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.

ADNITT, P. I. *see* FRAYN, K. N., and ——.
BECKETT, Joy, *see* WILLOUGHBY, J. M. T., and others.
BIRNSTINGL, M., and others. The effect of short-term exposure to carbon monoxide on platelet stickiness. *Brit. J. Surg.*, 58, 1971, pp. 837-839.
BRAITHWAITE, F., (with Edwards, J. R. G.). Hypospadias. *Newcastle med. J.*, 31, 1971, pp. 301-308.
BRINSON, K., *see* BIRNSTINGL, M. A., and others.
BROOKE, B. N. Surgical techniques. *Lancet*, 2, Nov. 27, 1971, pp. 1195-1196.
*BROWN, W. R. L. The preparation of pharmaceutical products with a low level of microbial contamination in hospital pharmacy. *J. Soc. Cosmetic Chemists*, 1971, p. 9.
CHAKRABARTI, B. K., *see* BIRNSTINGL, M. A., and others.
*COLTART, D. J., and others. An electrophysiological study of human foetal cardiac muscle. *Experientia*, 27, 1971, pp. 797-799.
CONNOLLY, R. Campbell, (and Newman, P. H.). Lumbar spondylotomy. *Brit. J. Bone Jt. Surg.*, 53B, 1971, pp. 575-577.
DAWSON, A. M., *see* PAGALTSOS, A. S., and others.
——, *see also* STANLEY, P., and others.
——, *see also* WILLOUGHBY, J. M. T., and others.
DYER, N., *see* STANLEY, P., and others.
FAIRLEY, G. H. Immunity to malignant disease in man. *Brit. J. Hosp. Med.*, 6, 1971, pp. 633-644.
FRAYN, K. N., and ADNITT, P. I. Estimation of 3-0-methyl-D-glucose in the presence of glucose. *J. clin. Path.*, 24, 1971, pp. 671-672.
FRY, I. Kelsey, *see* STANLEY, P., and others.
*GARDNER-MEDWIN, D., (with others). Duchenne muscular dystrophy. *Arch. Neurol.*, 25, 1971, pp. 193-197.

HELLIER, M. D., (and others). Nephrotic syndrome: A complication of secondary syphilis. *Brit. med. J.*, Nov. 13, 4, 1971, pp. 404-405.

*HUNTER, R., (and others). Effect of folic acid by mouth on cerebrospinal fluid homovanillic concentration. *J. Neurol. Neurosurg. Psychiat.*, 34, 1971, pp. 571-575.

KINMONTH, J. B., (with others). Below- and through-knee amputations in ischaemic disease. *Brit. J. Surg.*, 58, 1971, pp. 824-826.

KNILL-JONES, R. P., (with others). Clinical and electro-encephalographic assessment of diazepam in liver disease. *Brit. med. J.*, Oct. 30, 1971, pp. 265-266.

KUMAR, Paraveen, *see* PAGALTSOS, A. S., and others.

——, *see also* WILLOUGHBY, J. M. T., and others.

*LEHMANN, H., and LIDDELL, J. Cholinesterase. In. *General Anaesthesia*, Eds. Gray, T. C. and Nunn, J. F., 3rd ed., Vol. 1, 1971, pp. 598-612.

*——, (with others). Haemoglobin J. Rajappen α90 (FG2) Lys → Thr. *Biochim. Biophys. Acta*, 243, 1971, pp. 515-519.

*——, (with others). Haemoglobin K. Woolwich (α_2 β_2 132 Lysine → Glutamine) in Ghana. *Acta Haematol.*, 45, 1971, pp. 250-258.

*——, (with others). The third variant of human myoglobin showing an unusual amino acid substitution: 138 (H16) Arginine-Tryptophan. *Biochim. Biophys. Acta*, 229, 1971, pp. 716-719.

*——, (with others). A human myoglobin variant 133 (H10) lysine → asparagine. *Biochim. Biophys. Acta*, 229, 1971, pp. 871-876.

*——, (with others). The second variant of human myoglobin; 138 (H16) Arginine → glutamine. *Brit. J. Haematol.*, 20, 1971, pp. 69-74.

*——, (with others). Molecular pathology of human haemoglobin: stereochemical interpretation of abnormal oxygen affinities. *Nature*, 232, 1971, pp. 408-413.

LLOYD, H. M., (and others). Effects of stilboestrol on growth hormone secretion and pituitary cell proliferation in the male rat. *J. Endocr.*, 51, 1971, pp. 473-481.

MELDRUM, S. J. *see* COLTART, D. J., and others.

MORISON, C. Rutherford. Mechanism of labour. 1. Normal labour. *Nursing Mirror*, Oct. 15, 1971, pp. 34-38. 2. Role of the uterine muscle, Oct. 22, pp. 27-31. 3. Other abnormal positions of the foetus, Oct. 29, pp. 19-25.

MOURANT, A. E., *see* TILLS, D., with others.

NICOL, C. S. Sequelae of sexual freedom: The sexually transmitted diseases. *Proc. Roy. Soc. Med.*, 64, 1971, pp. 1108-1111.

PAGALTSOS, A. S., and others. In vitro inhabitation of leucocyte migration by sarcoid spleen suspension in coeliac disease and dermatitis herpetiformis. *Lancet*, 2, Nov. 27, 1971, pp. 1179-1181.

*PARTINGTON, M. W. The changing clinical picture of phenylketonuria, pp. 26-28. Experience of screening for phenylketonuria in Ontario, pp. 137-139. In, *Phenylketonuria*, Eds. Bickel, H., Hudson, F. P. and Woolf, L. I. Stuttgart, 1971.

RICKHAM, P. P. Some congenital malformations necessitating emergency operations in the newborn period. *Brit. med. J.*, Oct. 30, 1971, pp. 286-290.

SALSBURY, A. J., (with others). Possible transmissibility of human myelomatosis in immunologically deficient mice. *Lancet*, Nov. 6, 1971, pp. 1009-1012.

SCOTT, D. D. Bodley. Retrieval of information from medical journals. *J. Roy. Coll. Gen. Practit.*, 21, 1971, pp. 621-623.

SLEIGHT, P., (with others). Treatment of chronic heart block with the Lucas induction coil pacemaker. *Brit. Heart J.*, 33, 1971, pp. 938-942.

SPILKER, B. A., *see* COLTART, D. J. and others.

STANLEY, P., and others. Radiological signs of ulcerative colitis and Crohn's disease of the colon. *Clin. Radiol.*, 22, 1971, pp. 434-442.

*TILLS, D., (with others). Adenylate kinase polymorphism in populations in Finland (Swedes, Finns, Lapps), in Maris, and in Greenland Eskimos. *Humangenetik*, 12, 1971, pp. 123-130.

*——, (with others). South-Sinai Beduin. A preliminary report on their inherited blood factors. *Amer. J. Phys. Anthropol.*, 34, 1971, pp. 397-408.

——, (and others). The distribution in man of genetic variants of 6-phosphogluconate dehydrogenase. *Human Heredity*, 20, 1970, pp. 523-529.

*TURNER, P. Action of methysergide on fenfluramine-induced contractions of the saphenous vein. (Corres.) *J. Pharm. Pharmac.*, 23, 1971, pp. 801-802.

*——, (with Griffin, J. P.). Preliminary studies of a new bronchodilator (WG 253) in man. *J. Clin. Pharm.*, 11, 1971, pp. 280-287.

*——, (with Kramer, R. L.). Interaction of dexamphetamine and fenfluramine on critical flicker frequency. *J. Pharm.* (Paris), 1971, pp. 48-49.

*VINSON, G. P., (with Whitehouse, B. J.). Compartmental arrangement of steroid precursors and the control of steroid hormone secretion in rat adrenal tissue in vitro. *Acta Endocrinol.*, 68, 1971, pp. 467-476.

*——, (and others). Functional zonation of adrenocortical tissue in the brush possum *(Trichosurus vulpecula)*. *J. Endocr.*, 49, 1971, pp. 131-140.

*WATERWORTH, Pamela M. The disc sensitivity test. *Med. Lab. Technol.*, 28, 1971, pp. 385-393.

WILLOUGHBY, J. M. T., and others. Controlled trial of azathioprine in Crohn's disease. *Lancet*, Oct. 30, 1971, pp. 944-947.

*——, (and others). Sarcoidosis and Crohn disease in siblings. *Amer. Rev. Resp. Dis.*, 104, 1971, pp. 249-254.

——, *see also* PAGALTSOS, A. S., and others.

WITTS, L. J. The medical professorial unit. *Brit. med. J.*, Nov. 6, 1971, pp. 319-323.

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

Septrin
a story of success

decisive action
Bactericidal against a wide range of organisms, including *Proteus* sp, *E coli, H influenzae.* Double attack on bacteria substantially reduces the chances of resistant strains developing.

rapid response
Fast absorption from the gut to give peak plasma concentrations in 2-4 hours. Quick eradication of pathogens speeds the patient's recovery.

ease of treatment
Simple dosage regimen. Available in tablet and suspension forms.

Septrin
in bacterial infections

SEPTRIN* Tablets, SEPTRIN Adult Suspension, SEPTRIN Paediatric Tablets and SEPTRIN Paediatric Suspension contain trimethoprim and sulphamethoxazole. Full information is available on request.

*Trade Mark

Burroughs Wellcome & Co.
(The Wellcome Foundation Ltd.), Dartford, Kent.

ANNOUNCEMENTS

The Journal gratefully acknowledges the extremely generous contribution from the Board of Governors.

Births

Beckett—On October 27, to Anne (née Edwards) and Dr. Peter Beckett, a son.

Keighley—On October 28, to D. Margaret (née Shepley) and Dr. Michael Keighley, a daughter.

Deaths

Richards—On August 22, Colonel P. J. Richards, D.S.O., O.B.E., M.R.C.S., L.R.C.P., A.M.S. RET. Qualified 1929.

Douglas—On November 4, Dr. Donald John Douglas, M.R.C.S., L.R.C.P. Qualified 1948.

Clarke—On November 7, Dr. Roger Heine Clarke, M.R.C.S., L.R.C.P. Qualified 1919.

Graham—On November 12, Dr. George Graham, M.D. Cantab., F.R.C.P. Qualified 1908.

Struthers—On November 21, Dr. James Arthur Struthers, M.D., M.R.C.P., D.P.H. and Barrister-at-Law.

Appointments

Mr. A. P. Fuller, F.R.C.S., D.L.O., has been appointed an Assistant Dean (dealing with the student entry).

Dr. J. Kelsey Fry, D.M., M.R.C.P., F.F.R., D.M.R.D., has been appointed Assistant Dean in Postgraduate Studies.

Mr. M. H. Irving, M.D., Ch.M., F.R.C.S., has been appointed Senior Lecturer on the Surgical Unit as from January 1st 1972.

Mr. I. P. Todd, has been appointed consultant in Proctology to the Royal Navy.

DENNY'S BOOKSELLERS LTD
01-253 5421 3 lines

2 CARTHUSIAN STREET,
LONDON, E.C.1

We stock a good selection of medical, scientific and technical books. Any other current textbooks will be obtained for you.

Our paperback section is very comprehensive—we are particularly strong in Penguins and Pelicans.

Anything in print (English or foreign) we will gladly obtain for you.

We also specialize in sending books abroad—just let us know your requirements.

Why go further when London's leading booksellers are only two minutes walk from College Hall.

JEWELLERY AND WATCHES

20%-25% DISCOUNT TO ALL HOSPITAL MEMBERS & STAFF

DIAMOND ENGAGEMENT RINGS
GOLD - Wedding and Signet Rings,
GOLD & SILVER - Cigarette cases, Powder Boxes, Bracelets, Necklaces, Charms, Brooches, Earclips, Links,
SILVER & E.P.N.S. - Teasets & Plate

10%-20% DISCOUNT TO ALL HOSPITAL MEMBERS & STAFF

on all Branded Goods — ALL SWISS WATCHES. Clocks, Cutlery, Pens and Lighters, and on Second-hand Jewellery.

Remodelling and Repairs to all Jewellery and Watch repairs

GEORGES & CO.
of HATTON GARDEN
(Entrance in Greville St. only)
88/90 HATTON GARDEN, E.C.1
405 0700 or 6431

OPEN WEEKDAYS 9.00-6.00 SATURDAYS 9.00-12.00

Special attention to order by post or phone

ST. BARTHOLOMEW'S HOSPITAL

Student's Union and Drama Society

present

POT POURRI

The best of the Christmas Ward Shows

at the

GOLDEN LANE THEATRE, Cripplegate, E.C.1

Wednesday	29th	December	7.30 p.m.
Thursday	30th	December	7.30 p.m.
Friday	31st	December	5.30 p.m.

tickets

Balcony 75p. & 50p.
Stalls 75p. & 50p.

on sale from the Hospital Library

POT POURRI PARTY

Friday 31st. December

9.30 p.m. to 2.30 a.m.

DANCING :: CABARET :: BUFFET :: BAR

Tickets: £1

available from the Hospital Library

REPORT OF THE PRESENTATION OF CERTIFICATES AND AWARDS TO NURSES

True to tradition, albeit a relatively new tradition, the old girls returned to join their colleagues still on the staff, for the annual Presentation of certificates and awards, held in the Great Hall of the Hospital on Wednesday October 27th.

Sir Roger Ormrod, deputising for Mr. Robin Brook, introduced the proceedings by requesting Miss R. M. Jones, Principal Nursing Officer, to make her report.

Miss Jones told us of the introduction of the Pupil Nurse School, under the guidance of Miss Bavin; she referred to the success of the swimming team; to the enthusiasm of the Music Society, who owe so much to the hard work of Mr. Robert Anderson. We were reminded of ward upgrading and of the building of a Coronary Care Unit. Reference was made to the moving of the Junior Nurse Training School and special thanks were given to Mr. Penny and his team for their hard work in converting areas of Queen Mary Nurses Hôme to accommodate the School. Miss Jones commented on the success of Miss Dilys Owen in winning the Daily Express Nurse of the Year Award, saying it was her friends who nominated her while she was on holiday, and that she was confident Miss Owen would make an excellent ambassador for the hospital.

Miss Collyer, Chief Nursing Officer, Department of Nurse Education, then gave her report on the events of the year within the teaching department. Referring to the transfer of the Junior School to its temporary accommodation, Miss Collyer congratulated Miss Ebdon on her success in launching yet another "Set" on its way from the new premises. She added that she was greatly looking forward to hearing the first drill that indicated the commencement of work on the building of the new school.

The report continued with reference to reorganization of timetables, allowing tutors more time for ward teaching. The new system of General Nursing Council assessing was explained and Miss Collyer thanked both ward sisters and tutors for their response in preparing to help with these assessments. The Consultants of the hospital were thanked sincerely for their enthusiastic support in nurse education. We were all reminded of how lucky we are that the Medical Staff gave so much support to nurse training.

Miss Collyer ended her report with a word for the graduate nurses, which in fact enlightened us all. She reminded us of how easy it was to do things badly, and how difficult it could be to correct, but we must try to go out in the world "To do our best to be our best."

Then followed the excellent address by Mr. John Hunt, Headmaster of Roedean. He told us how he had always previously considered nurses "only slightly lower than the angels" and after seeing some of the prize-winners, he knew why! He commented on the number of activities reported on by Miss Jones, but said that at Roedean, added to those mentioned, they included Judo as an important sport, as an "anti-handbag-stealing device"!

Mr. Hunt told us of long-standing connections between his school and the Hospital. He reminded us that a nurse's training was never wasted, even if not implemented in hospital service.

Mr. Hunt concluded by advising us not to become involved behind an administrator's desk at too early a stage, as good nurses will always be required at the bedside whether in uniform designed by Dior or not!

Mr. Hunt then presented the certificates and prizes.

We were honoured by a visit from Mr. Godfrey Saxton Oliver, The Master of the Worshipful Company of Clothworkers, who presented the medals and first year awards. The Gold Medals were awarded to Miss Lesley Johnson and Miss Victoria Tunnell who both attained First Class Honours. The bronze medal was won by Miss Claudia Nazor, who was unfortunately unable to be present.

A vote of thanks was charmingly given by Miss Johnson to the Master of the Clothworkers and by Miss Tunnell to Mr. John Hunt. This concluded the proceedings.

Mrs. D. L. Knight

BARTS SPORT

FOOTBALL CLUB REPORT

Wednesday 6th Oct.
Barts 2nd XI v Westminster 2nd XI

Although losing this match 3-2 we have great hope for the rest of the season, because of the promising showing of a number of Freshers. In the first half Westminster had us under some considerable pressure and scored early on and then on the stroke of half time to lead 2-0. Some fine goalkeeping by Pete Hull and a penalty miss by Westminster kept the score down. They scored again early in the second half, but then Barts with 6 substitutes began to exert some pressure of their own. A fine goal by Kolendo and another by Carr made it 3-2 and that is how it finished in spite of several near misses at either end.

Wednesday 13th Oct.
Barts 2nd XI v Charing Cross 2nd XI

In our opening match at Chislehurst we were able to field a somewhat better team than in previous matches and we played much better than before as a result. We surprised the cup holders by going ahead early on when Cooper scored from a centre by Dunlop. The opposition fought back however to lead 2-1 at the interval.

Schlesinger equalised in the 2nd half when he headed home a corner at the near post. Barts did themselves less than justice by giving away two rather careless goals to make the score 2-4. A fine goal from Watson re-dressed the balance somewhat but the home side were unlucky to find their hard work unrewarded by a point at the end of their first league match.

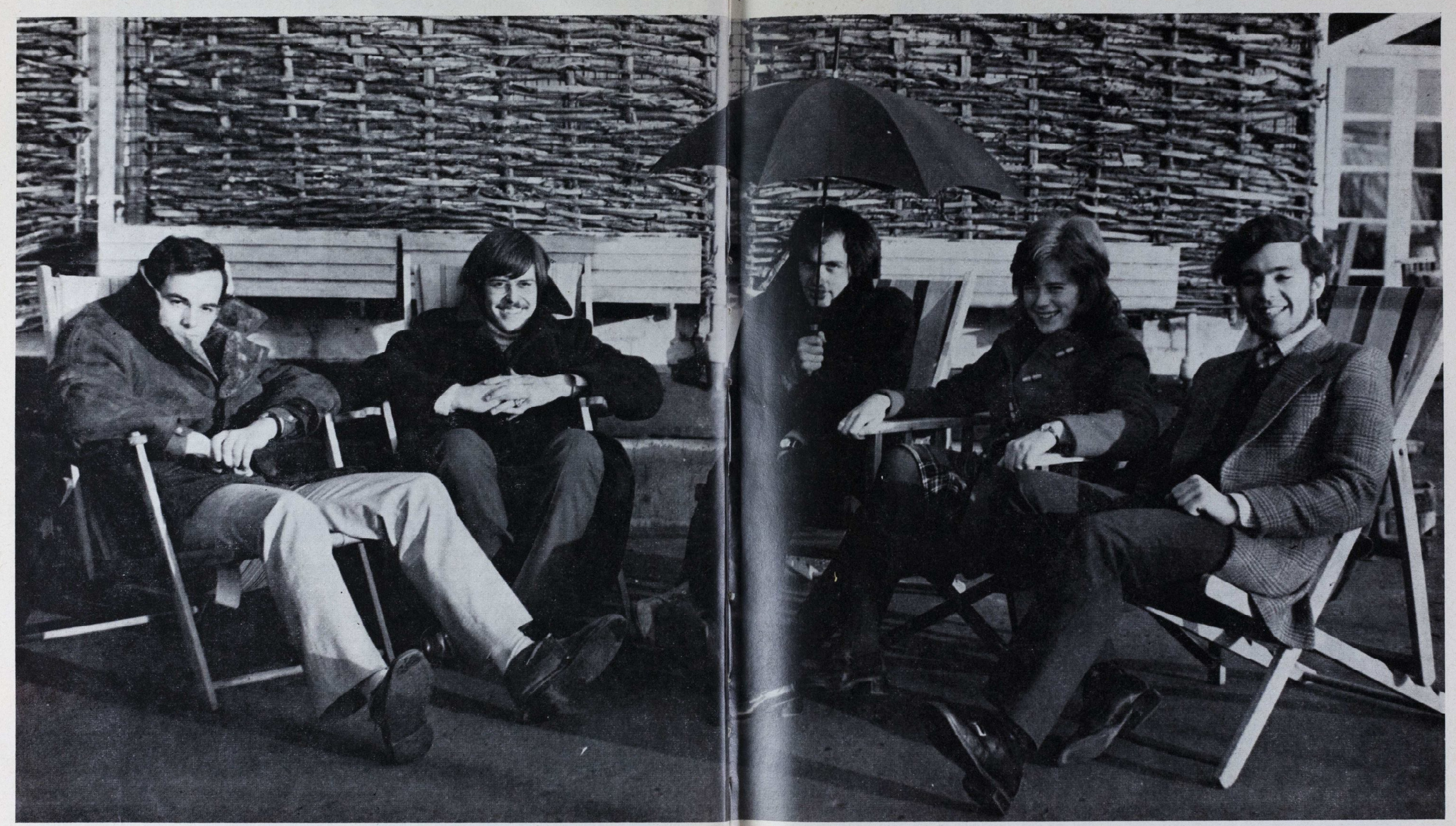
Wednesday 20th Oct. Home

Yet again Barts lost the match due to slack defensive marking so at the interval Middlesex went in 2-0 up. In the second half Barts still lacked coordination but luckily Middlesex made even less use of their many chances than they had in the first half. Meanwhile Barts attacked quite well and Rodgers hit the bar with a fine shot from 20 yards.

Cotton making his Barts debut, had a fine run from the half way line, beating three men and hitting an excellent goal. Thus we lost 1-2 and are still waiting for our first league point.

J. HOUSE.

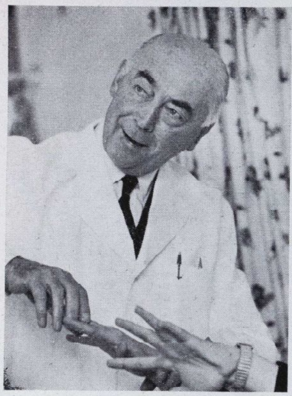
THE JOURNAL STAFF WISH ALL THEIR READERS A



HAPPY CHRISTMAS AND A SUCCESSFUL NEW YEAR

JOHN E. A. O'CONNELL, M.S., F.R.C.S.

AN APPRECIATION.



John O'Connell retired from his position as Surgeon-in-charge of the Department of Neurosurgery at Bart's on September 16, 1971 but, fortunately for the hospital and its patients, he agreed to continue working for several weeks more until Mr. John Currie, the newly appointed Consultant Neurosurgeon, was able to take up his appointment.

John O'Connell qualified from Bart's with the conjoint diploma and the M.B., B.S. in 1931. He had a distinguished undergraduate career being awarded the Corrie Prize, the Willett Medal in Operative Surgery and the Surgical Brackenbury. Following qualification he pursued the, then, accepted route to the surgical staff; house surgeon, demonstrator in anatomy, F.R.C.S. in 1933, M.S. in 1943, chief assistant to a surgical firm and a research scholarship, the Luther Holden. But there was a difference from some of his contemporaries; he had all along been interested in the nervous system, its anatomy and physiology and the diseases which affected it and when in 1935 he was awarded a Rockefeller Travelling Fellowship he went to the University of Michigan at Ann Arbor to work under Dr. Max Peet, and the University of Chicago under Dr. Percival Bailey. Here John O'Connell learned the techniques for the surgical treatment of neurological lesions. When he returned to Bart's in 1936 as a Surgical Chief Assistant circumstances made it difficult for him to use his new skills in the conditions which he would have liked but he had some opportunities to carry out neurosurgical operations. At this time also he attended the memorable post-graduate teaching rounds of Sir Gordon Holmes at the National Hospital, Queen Square to broaden his knowledge of clinical neurology.

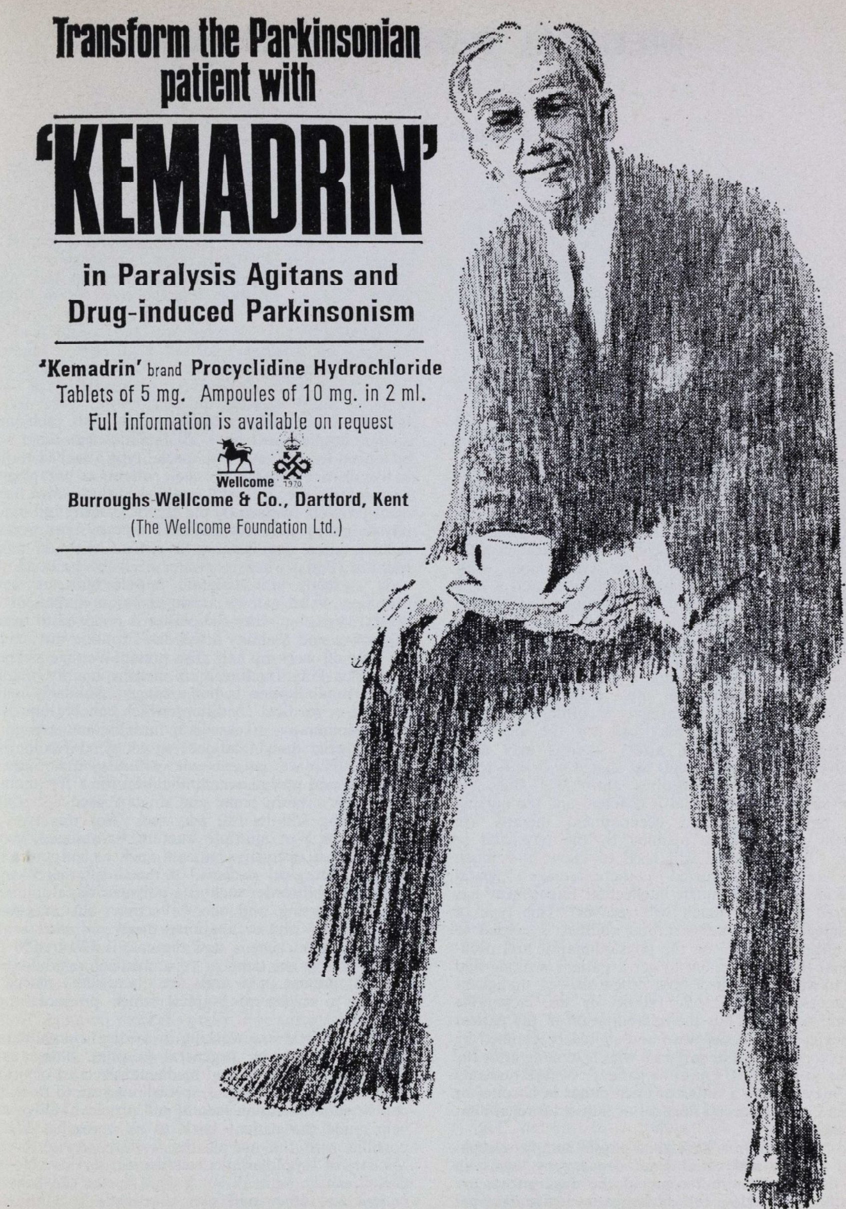
At the beginning of the last war in September 1939 he became surgeon in charge of the Bart's EMS Neurosurgical Unit at Hill End Hospital, St. Albans. This gave him the opportunity that he needed. He worked in this unit throughout the war years, apart from a period at a hospital on the south coast at the time of D Day. He developed the neurosurgical unit into one of the most important in the United Kingdom. In addition to treating large numbers of civilian air-raid casualties and casualties from the armed forces, he treated civilian neurosurgical patients. In 1946 he was appointed Neurological Surgeon to Bart's but until 1961 his in-patient work continued at Hill End. In that year the Queen Elizabeth II Block was opened and the Neurosurgical Unit moved into its present quarters. Here he has continued to treat neurosurgical patients not only from London but from many parts of England and from abroad.

John O'Connell is one of the most highly respected neurological surgeons in the country and has been awarded many professional distinctions. He was a Hunterian Professor at the Royal College of Surgeons in 1943 and 1950, is Civilian Consultant in Neurosurgery to the Royal Navy and has been President of the Section of Neurology at the Royal Society of Medicine and President of the British Society of Neurological Surgeons. Many who have worked for him have achieved distinction in neurosurgery and at present five important neurosurgical departments in the United Kingdom are directed by men who have worked in his department.

John O'Connell has an enquiring mind and over the years has made important contributions on many aspects of neurological science. He started with a paper in Brain in 1934 on the cerebral veins and in the Journal of Anatomy in 1936 on the intraneural plexus and its significance. The subjects which probably have been of major interest to him are the mechanisms of intracranial pressure, the clinical significance and treatment of protrusions of intervertebral discs and the problem of craniopagus twins. He gave a Hunterian lecture on intracranial pressure in 1943 and has developed his views over the years culminating (up till now) in his important presidential address to the Section of Neurology of the RSM in 1970 on cerebrospinal fluid mechanics. He was one of the first people in this country to realise the importance of Mixter and Barr's paper in 1934 which pointed out the role of intervertebral disc protrusions as the cause of sciatic pain. He studied the clinical syndrome and the mechanism of symptom production in detail and pointed out the importance of disc protrusions in pregnancy and as long ago as 1950 in a Hunterian lecture described his experience of 500 cases. His interest in craniopagus twins may have arisen by chance but he is probably the only surgeon to have operated on three such pairs of twins. His intensive study of the problem in conjunction with Dr. du Boulay and others resulted in the survival of one of each pair of twins.

The Journal thanks John O'Connell for all he has done for the hospital and medical college and wishes him the best of fortune in the work which he is continuing and in his subsequent retirement.

J.W.A.T.



MEDICAL REHABILITATION

By J. B. Millard, M.D., D.Phys.Med.

Medical rehabilitation really became a new branch of medicine during the 1939 war, due to the development of the Royal Air Force Medical Rehabilitation Units. Since then the concept has altered in that most doctors plan the clinical management of the patient to include the final stages of helping the patient to return to as normal a life as possible. This later aspect includes social medicine and resettlement. Until recently physical medicine was considered to be synonymous with rehabilitation but the pattern has changed and a new concept of the speciality of "rheumatology" now includes physical medicine and rehabilitation, thus reversing the tendency to think of medical rehabilitation as a separate part of medicine.

The physician who treats a patient admitted to hospital with a hemiplegia must make an accurate diagnosis and arrange treatment accordingly—a sub-arachnoid haemorrhage may call for the aid of a neurosurgeon; a carotoid artery stenosis may need vascular surgery; an embolus associated with sub-acute bacterial endocarditis requires antibiotics—thus the initial medical management is different and the nursing care, physiotherapy and occupational therapy are different and must be planned by the physician in charge. The therapists will need to know how much brain damage has occurred—is there damage to spatal appreciation?—how much intellectual impairment has occurred and how much will recover? This type of assessment of the patient's total abilities is needed to plan ahead. It is no use the physiotherapist and occupational therapist aiming to get a patient walking and back to work if he has a poor prognosis—i.e. malignant hypertension and C.V.S. failure or an inoperable cerebral tumour. Thus the rehabilitation of the patient has begun in the acute ward and should be planned by the doctor (medical or surgical) who is looking after the patient, at that time. Later the patient's overall management may pass to a different team either in hospital or at home or in a special medical or industrial rehabilitation centre.

Most hospitals now have good physiotherapy, occupational therapy and social work departments who can help most patients, but some of the departments are not able to provide a full day's treatment five days per week so special centres were built to provide these facilities. Eventually it is assumed that each new district hospital will have all facilities but there will be a need for one unit of a special type attached to one in five district hospitals for such patients as paraplegics, head injuries etc. It is well established that active treatment properly planned by the doctor, making full use of physiotherapy and occupational therapy, can reduce sickness time; for instance a patient with an ankle fracture (Potts) when in plaster needs to be taught to walk correctly and maintain muscle bulk by static exercises, which can be arranged as an outpatient on several visits, but when the plaster is removed to regain full power and mobility a full day's routine can reduce the time off work by half. The present average sickness time for a Potts fracture is six months, mainly because proper rehabilitation is not arranged. Similarly many surgical or medical conditions which can be improved by physiotherapy—to ease pain, mobilise and strengthen a limb, need daily treatment to get good results, but some of these are patients who will need some nursing attention and special accommodation for a few months before they return home and do not need a hospital bed costing £50 to £80 per week. For this type of patient—i.e. post multiple fracture, paraplegics, hemiplegics, post operative patients such as amputees, or post neurosurgical patients, or those suffering from a neurological disorder such as a polyneuritis; a unit with minimal nursing and medical cover but maximum physiotherapy and occupational therapy is necessary to gain maximum benefit, and the cost is £20 to £50 per week. This is the concept of a medical rehabilitation unit. At present these units are often badly placed in relation to a general hospital which produces some difficulties.

Most doctors now working in medical rehabilitation units also work in a general hospital, either as a rheumatologist or physical medicine specialist or orthopaedic surgeon, having a special interest to help the patient gain maximum mental and physical ability, and help guide the patient back to as normal a life as possible with the aid of the welfare service or the Ministry of Employment's resettlement services. No one person can know it all but a good doctor can help the patient and other staff plan a realistic goal knowing the clinical problem and the prognosis.

REMINISCENCES OF A FIRST-FOOTER

By Honor Munro-Faure.

It was just before we finished our pre-clinical training that the hitherto almost sacrosanct portals of the Royal and Ancient Hospital bowed to the winds of change and agreed to admit women to the Medical School.

Rumours filtering through before our arrival varied from the promise of ostracism to the endearing suggestion that the first candidates looked "OK, boys" so that it would seem logical to stockpile a goodly number against a rainy day.

As it turned out, our welcome was very friendly if perhaps a little wary. Having completed the necessary examinations at Oxford, we approached the Dean, now Sir Charles Harris, to ask if the six of us might start in April 1947 rather than in October. This caused a problem: there was no "accommodation" for women at the hospital, although some was being built at Charterhouse. With some difficulty we convinced the Dean that somehow we would manage without the need for frequent sorties to Charterhouse. So started a relationship in which he always seemed to have an air of being just out of his depth. Later a basement at the south end of the East Wing was turned into a spacious cloakroom with a bed for the duty dresser, and Mrs. Board was installed as our ministering angel.

Student days passed very rapidly and brought with them their share of episodes amusing, sad and happy. My own best remembered embarrassing moment occurred as a 1st time clerk. At this time the late Dr. Geoffrey Evans retained four beds on Luke and Harvey. The new patient in the end bed arrived shortly before the ward round. "Don't worry" said the houseman, "just read my notes." In swept the round with all its retinue. Drawing himself up to his full height, wing-collar bristling, thumbs in waistcoat, Dr. Evans viewed us over his half-lenses and demanded the identity of the clerk. Confessing that I had not examined the patient, I nervously made my way through the notes of the houseman, now Prof. T. A. J. Prankerd. But worse was to come. "Now examine the patient: take the pulse." Here came my downfall since, my watch being out of action, I was armed only with my father's old half-hunter, stuck away at the bottom of a shoulder-bag. Never mind, we had been taught that there were plenty of other points to note about a pulse apart from the obvious question of its rate. So, nonchalantly I hoped, I took the patient's wrist and did my best to look knowledgeable. But not for long. "What is the pulse rate?" came the staccato query. For answer I delved in the recesses of my bag and came up with the half-hunter. By now the entire ward-round, happily including the patient, had dissolved into near hysteria, and I was released from my ordeal, and later rewarded with an invitation to one of the great man's "At Homes".

Few of my contemporaries could not tell a personal anecdote about this remarkable physician of the old school. On one occasion, examining the patient of a fur-coated lady G.P. who had come especially, Dr. Evans decided that the ward sigmoidoscope was not satisfactory, and, whipping out his wallet called for a volunteer to hasten by taxi to his rooms in Harley Street and return with his own instrument. Yet another tells of waiting outside his consulting room and being startled to see him through the half-open door standing before a full length mirror, thumbs once again in waistcoat, rising up and down on his toes and announcing firmly "Now, my man, d'you understand, there is nothing whatever the matter with you." Each student was issued with a series of printed tracts from his pen on a variety of subjects including the conduct of medical students towards patients, the management of constipation and, most memorable of all "Aerophagie Bloquée" in which the patient was to be encouraged to overcome his problem of air-swallowing by sleeping with a champagne cork between his back teeth.

Another notable figure of this era was Dr. Eric Strauss who presided over Psychiatric Outpatients with remarkable élan, and had the ability to extract a detailed history in front of a roomful of students. In lighter vein, he was the active President of the Oxford-Barts Society, thinking nothing of participating in a moonlight bathing party after the annual dinner.

Passing through the various departments of the hospital, one consultant, Mr. Wilfrid Shaw, was moved to present a copy of his book inscribed "To the first lady medical student to perform a gynaecological examination." This was regarded as a challenge by the younger anaesthetists who pressed their chief, Dr. Langton Hewer to follow suit. From this period stems any expertise we may have acquired for quick repartee: a defence reaction to the occasional attempts to single out the women students. This tendency was balanced by other members of the staff, one of whom, Mr. John Beattie, once remarked, on finding the front row of WOPs occupied by females, "I would really much rather you sat at the back."

All too soon it was time for Finals, and with it the speculation about the possibility of getting on the house.

This was resolved in peculiar fashion. One at a time. The accommodation problem was once again solved and the first woman house physician, Joan Wheelwright, was installed in solitary splendour in a room which initially did not boast a telephone, a discrepancy which was soon remedied after one of the more timid porters had refused to call her at night.

Having completed her tenure, it was the turn of the gynaecologists, and I accordingly presented myself as house surgeon initially to four chiefs, a feat which was soon recognised as impossible and altered. The parting words of the registrar, Mr. John O'Sullivan, on that first evening were not calculated to instil confidence. "Good-night" he said in his rolling Irish brogue, "and never forget you can kill a patient with an intravenous." Thus initiated, I preceeded to call in patients for the next operating list. When my chief came to perform a list consisting of some eight D & Cs he happily curbed his tongue. Thereafter lists were more balanced affairs.

In the diminutive lab. opposite the lift on the 1st floor of the East Wing, Bert Cambridge, technician and impressario, had his domain, and in this formalin imbued sanctum each ward round formally ended. Here too, each pint of blood given in the evening or at the weekend was subjected only to slide cross-matching by the house-surgeon and duly administered.

Sister, affectionately known as "Kitty", was a great ally, and she decided from the start that her house-surgeon must be fed to keep her going. Consequently, every Sunday evening, when admitting the new patients, I was faced with an overloaded plate saved from the patients' suppers, and a large glass of creamy milk, and, by the end of the six months, a considerable increase in girth.

Quite what happened about that last preserve of male solidarity, the House Dinner, I do not remember. Beforehand there was a lot of talk about absenting ourselves immediately after the meal. In the event I can remember once being called propitiously away in my glad rags to a patient in acute retention.

With the end of the Gynaecological Appointment in sight I found myself in the office of the Dean, Dr. Eric Scowen. "Mr. Naunton Morgan is returning from Hill End and needs a senior house-surgeon." I was told. "*Not* rectal surgery" was my immediate response. "You would be very unwise to turn it down" came the reply. Thus I embarked on an unforgettable spell on the Pink Firm, where the pace of work was matched by the marvellous spirit of bonhomie.

My only previous contact with the firm had been to attend the lively outpatient sessions run by Mr. Ellison Nash, and, walking over from the East Wing to George Vth block, I speculated on what lay ahead. Standing in the corridor was Ba Saunders, then Sister Abernethy. "So you're the new house surgeon" was her greeting.

At that time the firm boasted amongst its ranks a series of embryo Barts consultants including Mr. Ian Todd, Mr. Gordon Bourne and Mr. John Griffiths, and shortly I was joined at the junior end by a natural comedian, Dr. Ivor Blakeway. A frequent visitor to Theatre C changing room at this time was Dr. Gordon Ostlere, mysteriously announcing that he was about to embark on something "quite new and different" after his handbook of Anaesthetics for Medical Students. Little did we realise what lay in store.

At the time Battersea Fun Fair was newly opened and the dressers persuaded the entire firm to join their party there. One of the dressers I recall resisted all attempts to purchase his copy of a photograph of the ward sisters with their heads stuck through compromising "can-can" cut-outs.

Years later on the other side of the Atlantic, I attended a dinner in honour of my ex-chief, after which he was subjected to the barbaric procedure of being asked in cold blood to tell funny stories: one of the less happy consequences of having a reputation as a raconteur. Running short of material (I hope) he said, with a sly glance in my direction, "Once I had a woman house-surgeon but I've never had another one since". Sic transit gloria!

Such was some of the lighter side of life on the house at Bart's. In more serious vein, the transition from student to houseman seemed then to represent a real severance of the Gordian knot in a way which I imagine no longer occurs. It was an experience I would not have missed, but at times it could be very alarming. Although there was always a duty surgical registrar sleeping in RSQ on call for emergencies in the casualty boxes, it was a matter of honour not to need help from your own registrar after hours, and any moral support needed came from one's own contemporaries or, if one was lucky enough to be able to get hold of one, with their greater fund of experience, the anaesthetic residents. I remember struggling all one night with a patient seriously ill with peritonitis who was having a revolutionary new treatment with intravenous Aureomycin. He was a full-time nursing proposition for two, but the nursing allocation for the ward was one 1st year stripe and a pro. which the night sister was unable to augment. On occasions like this one may have wished for more support, but the real benefits of a spell on the house were immeasurable.

Then comes the time to take one's leave and perhaps see something of the world at large before settling permanently somewhere. I hope I may be forgiven a few words to the present day women students, superfluous though I feel almost certain they will be in this clear-thinking age. When you qualify, the next goal is to train yourself in some sphere which will in the future fit easily around a probable role of homemaker. This, though obvious in retrospect is not always so apparent in a state of newly-qualified euphoria and star-seeking, but I believe that it merits consideration. Anyone trying to acquire such qualifications should be encouraged in her realistic attempt to stop the wastage of female medical talent, and not regarded as a worthless prospect because of future family commitments.

furniture finance free

That new suite, the fitted kitchen or bedroom or new bed you so badly want can soon be yours with up to two years to pay – WITH NO FINANCE CHARGES.

With a 25% deposit payable before delivery and the balance by 24 monthly instalments you can buy virtually any type of furniture for only the recommended retail price. There are no finance charges.

And with prices rising it makes sense to buy now and take advantage of FREE FINANCE. *So post this coupon for our free explanatory leaflet and application form.*

Name ....

Address ....

GODDARD & JENKINS (FINANCE) LTD.
29/37 NORTON FOLGATE, LONDON E1 6DG.
Telephone 01-247 7654 BHJ 1
Branches at Birmingham, Bristol and Manchester.

SUICIDAL MOTIVATION MEASUREMENT & MEANING

By Dean Schuyler, M.D.

**Staff Psychiatrist, Center for Studies of Suicide Prevention National Institute of Mental Health, Rockville, Maryland, U.S.A.*

***Formerly Honorary Clinical Assistant Hackney Hospital, London, England (March/June, 1971).*

A man stands perched on a ledge surveying the ground far below him. An adolescent sits in his room with a loaded gun pressed to his temple. A housewife swallows the contents of a bottle of barbiturates anticipating her husband's arrival from work. A young girl impulsively slashes at her wrists with a knife, then places a telephone call to her erstwhile lover. A Samaritan listens to an intoxicated man in middle age tell of plans to take his life. A registrar who authorized a pass from hospital for a depressed patient learns subsequently that the man had returned home and taken his life by hanging. A woman interviewed in Casualty Department claims she has taken three aspirin tablets in an attempt to die. All these situations have the common label of 'suicidal.' To understand them, however, we must look at motivational characteristics not immediately apparent in the situations described.

The suicidal solution has been with us throughout recorded time. Young children only very rarely take their own lives. An animal model of suicidal behavior has not been proposed. What leads man uniquely to choose the suicidal solution? Are the motivational antecedents to suicidal behavior accessible to inquiry?

Suicide has been studied by epidemiologists and the characteristics of populations at risk have been defined. Older, predominantly male, caucasian, widowed or divorced, unemployed or retired, socially isolated, urban dwellers form an extremely 'high risk' group. These characteristics, among others, are felt by some to be additive in terms of suicide potential. The more one 'fits' the description, the greater the risk of suicide. Although helpful to the clinician in assessing suicidal risk, these factors seem neither necessary nor sufficient for predicting suicidal behavior. They seem, in fact, far more suitable to the task of planning the location of a suicide prevention service than to the evaluation of an individual in distress.

There are many roads that lead to the suicidal solution. Depressed patients make up at least 50% of most studied samples of completed suicides. Alcoholics and previous suicide attempters contribute disproportionately to the statistics on suicidal death. And yet, the vast majority of patients with depressive illness or alcoholic problems do not engage in suicidal behavior.

Lover's quarrels, marital conflict, a variety of events interpreted as 'losses' or rejections, physical illness—all may be precipitants of suicidal behavior. Most often, however, such events are not followed by suicide.

Invaluable research studies have undertaken to follow-up patients who make recurrent suicide attempts. The risk of completed suicide in the year following an attempt has been found to be 1-2%[1]. Although this group, in common with depressives, alcoholics and former mental hospital patients, have a higher risk of death by suicide than does the general population, no single factor can be held accountable for the vast majority of suicidal deaths.

SUICIDAL INTENT

Where can the clinician look to guide and supplement his "intuition" in assessing the suicide potential of his patient? A logical place which has received far less attention than the factors noted above is in the area of motivation. Rubenstein has stated that an evaluation of the patients 'intent' is of central concern to the clinician[2]. Tuckman, among others, has abandoned 'intent' as inaccessible to inquiry[3]. It is the thesis of this manuscript that 'intent' may have been encouraged to die a premature death. It is my purpose to return to this area and to define its potential usefulness for the clinician while acknowledging its limitations.

Let us begin by defining 'intent' as the 'seriousness or intensity of the patient's wish to die.'[4] We shall confine our attention to people who have recently engaged in suicidal behavior and attempt to establish some guidelines relevant to a prognosis for the future. We shall relate suicidal intent to 'medical lethality' (the degree of physiologic damage incurred in a suicidal act) and 'instrumentality' (the degree to which the purpose of the suicidal behavior is to influence other persons). We will explore too, the relationship between intent and severity of depression in suicidal depressed patients.

Although some researchers have neglected suicidal motivation, most clinicians assess the intent of their patients intuitively. The end result is a quantitative determination (e.g. high, medium or low 'wish to die') without measurable qualitative components. Several reports in the literature have included such an intuitive quantitative measure of suicidal intent [5-7].

The simplest and most direct way to assess intent after a suicidal act involves asking the patient a direct question: "Were you trying to kill yourself?" The retrospective nature of the inquiry complicates the validity of the response to this question. Consider the situations described in the introduction to this manuscript. The clinician is in no case present to observe the behavior and must rely on the patient's self-report supplemented by statements of significant others. Before accepting a self-report as a valid response, several condi-

ANAFRANIL®

THE INTERNATIONAL ANTIDEPRESSANT

New, potent, tricyclic antidepressant

- rapidly relieves depressed mood and induces a sense of well-being
- effective in up to 80% of patients suffering from endogenous, reactive or neurotic depression
- no dietary restrictions
- may be combined with most other commonly used drugs (except monoamine oxidase inhibitors)
- well tolerated, side-effects being usually mild and transient

Anafranil,® 3-chloro-5-(3-dimethylaminopropyl)-10, 11-dihydro 5H dibenz [b,f] azepine (Clomipramine) hydrochloride, is available as capsules of 25 mg, syrup containing 25 mg/5ml and ampoules containing 25 mg/2 ml.

Geigy Pharmaceuticals Macclesfield Cheshire SK10 2LY

GEIGY

tions must be met. First, the interviewer assumes that the patient *formed* an intent. Experience with suicidal patients provides examples in which this is a difficult assumption to support. The patient may claim not to have thought about the consequences of his suicidal actions. He may have sought only 'sleep' or 'cessation', and may not have evaluated the probability of death as an outcome of his action. For this person, intent may be comprised of only unconscious components, indeed inaccessible to the interviewer oriented to observable rather than to inferential data.

For most patients, however, an intent is formed prior to suicidal behavior. We must next ask, if an intent is formed, is it *recalled?* The elapsed time between suicidal act and interview with the clinician may mitigate against recall. The ingestion of sedative drugs or the state of intoxication or unconsciousness may interfere with recall.

Finally, if formed and recalled, is the patient's intent transmitted accurately to the interviewer or *falsified?* For a variety of purposes—not the least of which is the perception in someone intending death that the interviewer might be an obstacle to suicide—the patient may falsify his intent.

It is not surprising in the light of these three conditions, that the self-report of intent in suicidal patients has been found by several investigators, to be unrelated to various measures of outcome [8-10].

CIRCUMSTANTIAL EVIDENCE

Perhaps we are neither asking the right question nor attending to useful behavioral clues. It seems logical that the circumstances of the suicidal act in someone intending to die would differ from a similar act by someone intending to live. Certain actions make rescue likely or inevitable—others make intervention unlikely or difficult.

A suicidal act in the presence of others is likely to be aborted unless the method assures instant lethality. A housewife swallowing some tablets in front of her husband will likely be saved. A man, excusing himself from others to hang himself in the basement likely will die. The degree of isolation is one factor that may reflect on suicidal intent.

The timing of an act so that rescue is either likely or unlikely and the precautions taken against intervention are two more measures of intent. A woman taking an overdose of tablets minutes after her husband leaves for work and therefore many hours before his anticipated return home reflects more serious intent than an ingestion moments before an expected return. Similarly, a locked door or registration at a hotel under an assumed name prior to suicidal behavior makes intervention less likely.

Action to gain help either during or subsequent to suicidal behavior reflects less serious intent than no such action. Final acts anticipating death, e.g. writing a will or arranging one's affairs, are consistent with high intent. Evidence of elaborate planning for the suicidal act or the choice of a lethal method (e.g. hanging, firearms, jumping, drowning) would seem to relate to one's intent to die as well.

The patient's concept of the lethality of his action is important to question. A pharmacist or physician may know how many tablets to take to make a fatal outcome likely or to insure survival. For someone unfamiliar with minimal lethal dosages, medical lethality may be a poor indicator of intent. The story is told of an elderly lady who tells a Casualty Department registrar that she just took "three aspirin tablets in an attempt to kill herself." He responds that she has done herself no harm and would need many more tablets to achieve a fatal result. After discharge she returns home, ingests 100 tablets, and is later found dead. While highly lethal methods usually correlate with high intent, attempts of low lethality must not be dismissed as trivial without a more detailed investigation of intent. Lethality alone has been found to be a poor predictor of future prognosis[11]. The intent factors derived from the circumstances of suicidal behavior are summarized in Table I.

Table I
SUICIDE INTENT FACTORS

SUICIDE INTENT FACTORS
Degree of Isolation
Timing
Precautions Against Intervention
Action to Gain Help
Final Acts Anticipating Death
Degree of Planning
Concept of Method's Lethality.

Instrumentality vs. Surcease

Another dimension on which suicidal motivation can be studied relates to the 'purpose' of the suicidal act. In a general way, the purpose can be viewed within the framework of the individual, or within the relationship of the individual to others. Some suicidal patients seek surcease or escape from an intolerable situation. The situation may be either internal (e.g. depressive feelings) or external (a life event). This exclusive orientation may allow no concern for the effect of the suicidal act on significant others. This is a common finding in suicidal behavior among depressed patients. In some patients, however, the consequences of suicidal behavior may be considered in detail before the act. The anticipated effects of his action on others may make a large contribution to the suicidal patient's motivation. Consider the effect on a distant, isolated husband, oblivious to his wife's feelings, when confronted with her suicide attempt. Consider the lover who has rejected his partner only to see himself labelled as 'the cause' of her subsequent suicidal behavior. The instrumental effects of such 'taboo' behavior can be immensely powerful. Some patients may conceive of achieving these instrumental goals with their death, but most anticipate survival to experience the positive consequences of their behavior.

A consideration of the relationship of the surcease-instrumentality dimension to suicidal intent offers several possible combinations. Both those patients seeking to escape by death and those seeking to affect others *by death* would be likely to make high intent suicide attempts. Those predominantly motivated to affect others and invested in survival should reflect lower intent in the circumstances of their behavior, or provide in an observable way for their rescue.

Following from the discussion of 'purpose', one would expect seriously depressed suicidal patients to reflect high intent in their suicidal behavior. A study by Silver,

et al[4] found a high positive correlation between depression as measured by the Beck Depression Inventory and intent measured by a scale consisting of many of the factors noted above.

Validation and Perspective

An approach to the assessment of suicidal intent has been proposed. We must now consider several questions. In what way can its validity be tested? How long is its predictive validity maintained? And finally, how does an evaluation of intent fit into the general assessment of the suicidal patient?

The validity of predictive variables can be tested only by prospective, longitudinal studies. A cohort of patients who have attempted suicide must be identified, intent measures recorded and outcome assessed periodically. The major outcome criterion must be death by suicide. Such studies are currently going on in Graylingwell Hospital, Chichester, United Kingdom (Dr. Sainsbury), and in Philadelphia General Hospital, Philadelphia, Pennsylvania, U.S.A. (Dr. Beck). Intent is being evaluated on the basis of a scale by Beck et al[12].

In a retrospective follow-up study of thirty-two patients who had attempted suicide two years earlier, the correlation between an intent measure and repeated suicidal behavior was examined[13]. Although sample size was small, six out of seven repeated suicide attempts were successfully predicted on the basis of high suicidal intent. Repetition as an outcome criterion, however, raises more questions than it resolves. Is the attempter who intended to die but somehow survived likely to repeat a suicide attempt? Or are the ranks of repeaters filled with those who employ suicidal behavior for its instrumental purposes?

When proposing a predictive instrument one must specify the time period within which the prediction can be expected to maintain its validity. If a suicide attempt is made because of a life situation which endures or a disease process which persists, intent to die may be expected to remain unchanged. For some patients, however, the immediate consequences of a visit to Casualty, a hospitalization or a lavage treatment are so aversive that they mitigate against further attempts. In those persons with recurrent depressive illness, is intent maintained when depression remits? If not, as appears likely, does intent reassume its initial level when the disease exacerbates? Positive life experiences would seem to have the potential to modify suicidal intent. A new relationship, employment, termination of a crisis state through psychotherapy or a relocation to a new neighborhood may all affect one's wish to live or die.

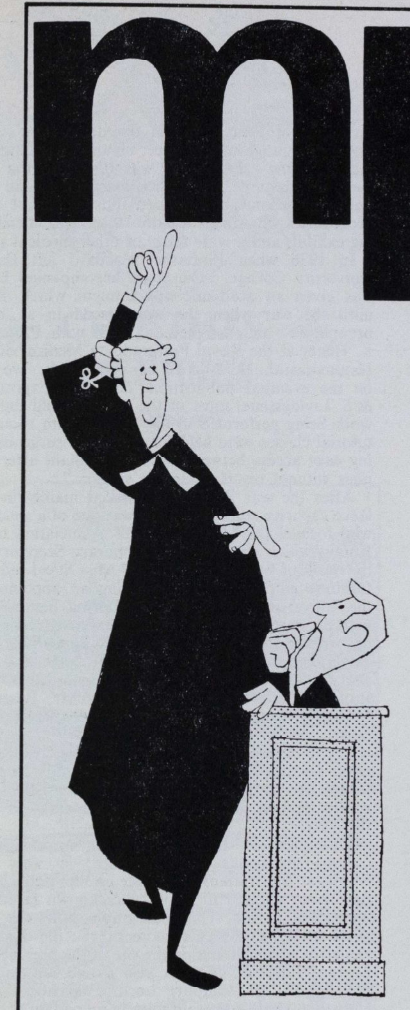
Let us try to place intent in its proper perspective with regard to an evaluation of the patient subsequent to suicidal behavior. The clinician's task would be facilitated by a classification scheme which would be helpful in determining a prognosis. No scheme can fail to note the importance of accessibility to lethal methods of self injury and the unpredictability of unanticipated intervention. In evaluating the recently suicidal patient the epidemiological description of the patient would represent a simple first step. What is his long term risk of suicidal death compared to that of the general population? Next, a consideration of medical and psychiatric diagnoses would contribute to an estimation of immediate as well as long term suicide potential. The presence of depressive illness or alcoholism are essential diagnostic determinations. A judgment of the purpose of the patient's suicidal behavior on the surcease-instrumentality dimension is an important consideration. If an instrumental factor was prominent, the response of significant persons to his action should be noted in formulating a prognosis. Finally, the patient's self report of intent, but especially those motivational clues evident in his behavior should be reviewed. These factors, when added to the clinician's understanding of the suicidal act within the context of the individual's life style should facilitate the evaluation of this most challenging patient.

REFERENCES

1. Kessel N.; McCulloch W.; "Repeated Acts of Self-poisoning and Self-injury." *Proc. Roy. Soc. Med.*, 59:89-92, 1966.
2. Rubenstein R.; Moses R.; Lidz T.; "On Attempted Suicide", *AMA Arc. Neurol. Psychiat.*, 79:103-112, 1958.
3. Tuckman J., Youngman W. F.; "Identifying Suicidal Risk Groups Among Attempted Suicides". *PHS Reports*, 78:763-66, 1963.
4. Silver M. A.; Bohnert M.; Beck A. T.; Marcus D.; "Relation of Depression to Attempted Suicide and Seriousness of Intent", *Arch. Gen. Psychiat.*, in press.
5. Hendin H.: "Attempted Suicide: A Psychiatric and Statistical Study", *Psychiat. Quart.*, 24:39-46, 1950.
6. Dorpat T. L.; Boswell J. W.; "An Evaluation of Suicidal Intent in Suicide Attempts", *Compre. Psychiat.*, 4:117-125, 1963.
7. Schmidt E. H.; O'Neal P.; Robins E.; "Evaluation of Suicide Attempts As A Guide to Therapy", *J.A.M.A.*, 155:549-57, 1954.
8. Stengel E.; *Suicide and Attempted Suicide*, Baltimore: Penguin, 1964.
9. Batchelor I. R. C., "Psychopathic States and Attempted Suicide", *Brit. Med. J.*, 1:1342-47, 1954.
10. Kessel N.; "Self-poisoning, part ii", *Brit. Med. J.*, 2:1336-40, 1965.
11. Greer S.; Lee A. A.; "Subsequent Progress of Potentially Lethal Attempted Suicides", *Acta. Psychiat. Scand.*, 43: 361-71, 1967.
12. Beck A. T.; Herman I.; Schuyler D.; "Development of Suicide Intent Scales". Paper presented at the Workshop on Measurement of Suicidal Behaviors. Philadelphia, Penna, October 14-15 1971.
13. Schuyler D.; Lewis A. G.; "The Relationship of Suicidal Intent to Repeated Attempts", Unpublished M.S., 1971.

ACKNOWLEDGEMENT

The stimulation of exchanging ideas with A. T. Beck, M.D. and Martin Seligman, Ph.D., made a major contribution to this manuscript.



mps

medical protection society est. 1892

Students!

Arrange membership now.
Full benefit immediately you qualify.
Pay later at no extra cost.

Over 50,000 members enjoy
- unlimited advice
- unlimited legal aid
- unlimited indemnity

Full details from

Secretary:
Dr. H.A. Constable, Head Office
50 Hallam Street, London, W1N 6DE
Telephone: 01-580 9241

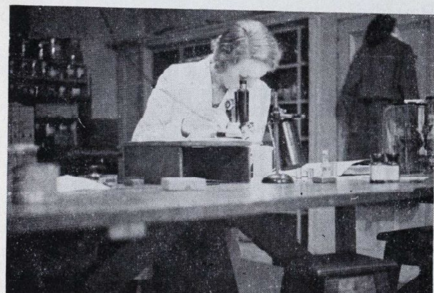
or

Regional Secretary:
Dr. P.G.T. Ford, Regional Office,
30 Park Square, Leeds 1
Telephone: 0532 42115-6

MEDICAL ARTISTS AT BARTS

Peter Cull

In an article on the subject of medical illustration which appeared in these columns in 1970 the following statement was made ". . . the first medical artist was appointed by the Medical College in 1960". Although these words were intended to be in the context of the development of the present Department of Medical Illustration, they were not unnaturally interpreted differently and in a letter from Mr. John Thornton published in a subsequent issue of the Journal it was fascinating to learn that in the early half of the last century there was at St. Bartholomew's a combined post of Librarian/Artist. W. A. Delamotte was one incumbent of this joint appointment and he was succeeded in 1852 by Thomas Godart. In 1881 the latter appealed for the posts to be separated, and he was relieved of his artistic duties in order to devote his attention exclusively to the medical library. A number of other artists have been employed at St. Bartholomew's since that time, mostly on an "occasional" or freelance basis and these include Leonard Portal Mark (1855-1830) and other well-known names such as Tom Poulton, S. A. Sewell, W. Thornton Shiells and the great A. K. Maxwell whose work is universally recognised, particularly his contributions to Gray's and other anatomical text-books.



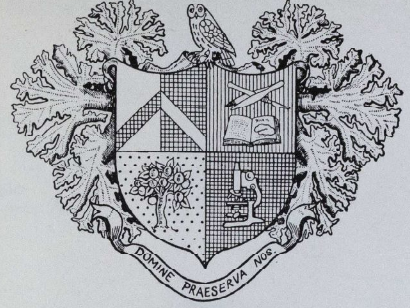
It seems probable that the first person to be appointed by the college whose job was exclusively concerned with medical illustration was Miss Zita Stead. Miss Stead, or Mrs. Blackburn to give her her correct marital name, came to Barts in 1933 with the title of artist and research assistant in the Department of Anatomy which at the time was under the direction of Professor H. H. Woollard, M.D., D.Sc., F.R.S. She had to her credit a diploma in fine art and had studied anatomy and histology at King's College, a background which, coupled with her expertise in photomicrography, was no doubt of great value in the department's current research programme on cutaneous innervation. Although the appointment was linked to the department of anatomy, her service extended to the clinical units, for whom she provided illustrations of surgical procedures, recordings of pathological specimens, teaching exhibits and a wide range of other medical artwork.

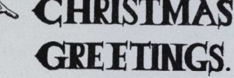
In 1936 when Professor Woollard left Barts for University College, Miss Stead accompanied him and was given an academic appointment which she held until the war when she was placed in a "reserved occupation" and assigned to work with Professor A. K. Henry at the Royal Postgraduate Medical School at Hammersmith. Here, to use her own words, "we worked on the eventual publication 'Extensile Exposure' (E. & S. Livingstone) most of the research and illustration work being performed in the post-mortem room where tutorial classes were held for paratroop surgeons, showing easy access between muscles to main arterial supplies without resort to drastic surgery."

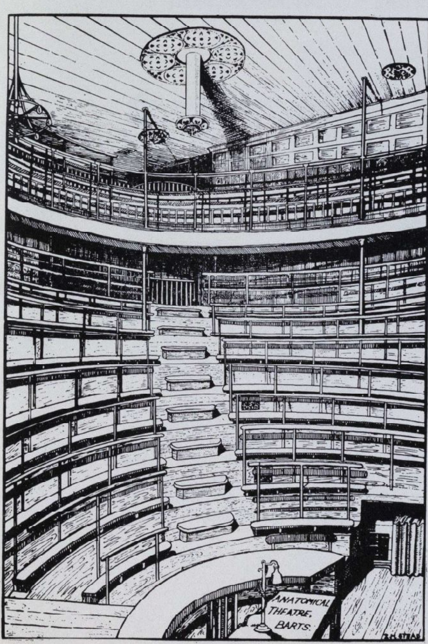
After the war Zita Stead worked mainly in a freelance capacity and in 1949 she was one of a small group who formed the Medical Artists' Association of Great Britain which she served as Honorary Secretary. After the death of her husband in 1957 Miss Stead returned to full-time employment, undertaking an appointment at the University of Manchester. During her association with St. Bartholomew's, both formal and free-lance, she has worked for Sir Thomas Dunhill, Sir Girling Ball, Sir James Patterson Ross, Mr. J. H. Roberts, and in later years for Sir Clifford Naughton Morgan, Mr. O. Tubbs, Professor Scowen, Professor Witts, Mr. Beattie, Mr. J. E. A. O'Connell, Mr. Stallard and Sir Ronald Bodley Scott.

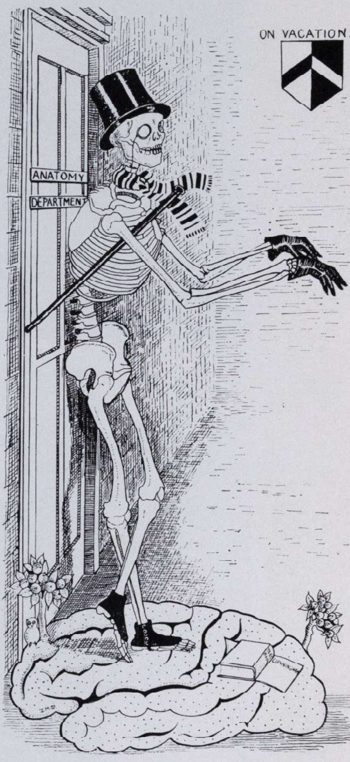
Zita Stead now lives in "retirement" in Kingston-upon-Thames where she indulges liberally in golf and fishing. Her most recent achievement consists of landing a 21lb. salmon during a piscatorial holiday in Norway this year.

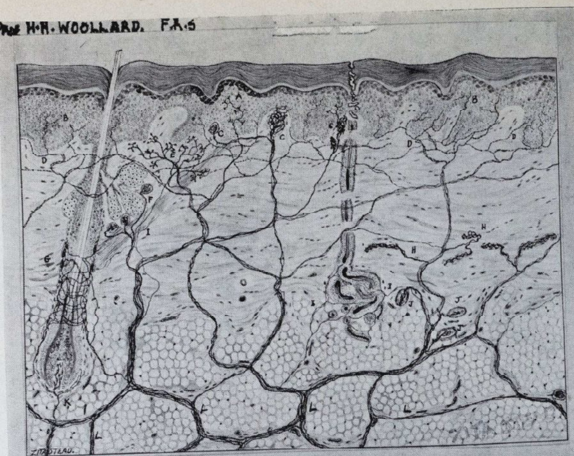
Examples of Miss Stead's work appear in many current text-books and therefore, in view of the restricted illustration space, the group published here have been selected to show lesser known facets of her abilities and work. The photograph shows the artist at work in the Professor's room of the old Anatomical Department which was on the site of the present Clinical Lecture Theatre. There is also a line drawing of the interior of the Anatomy Lecture Theatre. The two Christmas cards were sold to raise money for the department's research funds. Her ability as a photomicrographer is demonstrated in the 'aerial survey map' of intra-epidermal nerve endings and it was from this sort of material that she constructed the composite drawing of cutaneous innervation which has been used extensively in both Gray's and Cunningham's Anatomy.



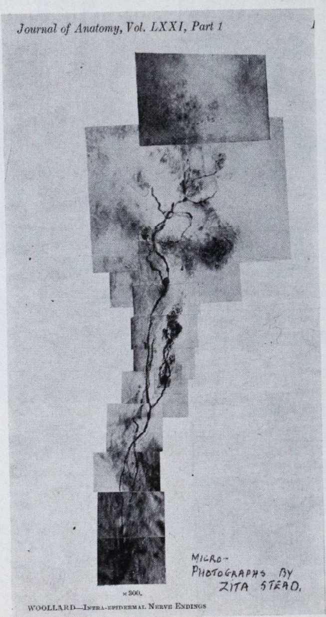








A: MERKLES DISCS. B: FREE PAIN ENDINGS. C: MEISSNER CORPUSCLES.
D: VARICOSE PAIN FIBRES, FORMING PLEXUS. E: COLD ENDING.
F: HEAT ENDINGS (GOLGI-MAZZONI) G: NERVE INNERVATING HAIR.
H. DEEP PRESSURE (RUFFINI) I SYMPATHETIC FIBRES. J DEEP PRESSU
K. FIBRES INNERVATING ROOT OF HAIR. L MAIN NERVE TRUNKS (THICK &
USED IN GRAY'S & CUNNINGHAMS ANATOMY



WOOLLARD—Intra-epidermal Nerve Endings

SAINT BARTHOLOMEW'S HOSPITAL JOURNAL

Founded 1893. Vol. LXXVI No. 2

Journal Staff

Editors
Mary Hickish
Alan Searle
Malcolm Vandenburg

Sub-Editors
Articles
Mike Goldsmith
John Watkins

Sport
Oliver Bastard

Reviews
Ian Baker
Peter Smith

Manager
Bob Le Quesne

Subscriptions
Charles Hinds

Advertising
Charles Dobree
Peter Burnett

Charterhouse Representatives
Timothy Bunker
Peter Bacon
Teifion Davies
Trevor Turner

Editorial

What sort of people should doctors be? Is it enough that they should be highly-skilled technicians enveloped in an aura of mystique dividing the population into doctors and non-doctors, or should they perhaps be people of great culture and wide general knowledge, so that communication with people from all walks of life can take place? It is very easy to become immersed in medical society, which renders mere mortals far too susceptible to the god-image. By virtue of the fact that, on qualifying, one gains the title Dr., the world immediately becomes divided into those who are with us, and those who are not—something that happens in very few other occupations, or perhaps I should say, professions.

It is very encouraging to find that, at Bart's, a prize is awarded for achievement in extra-curricular activities—congratulations to those who gained the prize this year. Nurturing talents such as these is an excellent way of producing interesting, humanitarian individuals rather than 21st century technocrats. For the same reasons, it would be a great pity to see the end of the 1st M.B. course, for this is a way of introducing an alternative to the scientific whizz-kid into medicine. Bart's can also be proud of the achievements of its Drama and Music Societies.

The *Journal* is often criticised for not including enough clinical articles, but it would seem that one only has to browse through Materia Medica to find that there is a wealth of such articles available from other sources. The function of the Journal, apart from keeping people in touch with their alma mater, is surely to cater for all tastes, which includes, of course, a certain amount of clinical articles, but also a wide spectrum of topics, cultural or otherwise.

Perhaps the age of the self-perpetuating android is not too far away, do we care enough to join the fight against the Brave New World?

LETTERS

The Abernethian Room,
College Hall,
Charterhouse Square,
London, E.C.1.

Dear Sir,

Your correspondent, Mr. Vespermacer Janicatutum, has missed the whole point of the argument for the use of Latin in anatomical nomenclature, as must seem obvious to anyone who has read the article.

The fact is that English is an illogical language, and it is this quality that makes it the finest language in the world for use in literature—the English language has no equal for this purpose.

Latin, on the other hand, is a logical language, and is entirely suited for all scientific use because of its clear cut, concise nature.

The only other, modern, language that I could recommend for use in anatomical nomenclature is French, but since this is directly derived from Latin, there would not seem to be much point in its use.

My name, sir, translated into English, is

ROBERT TREHARNE JONES.

P.O. Box 5868,
Johannesburg.
December 14th, 1971.

Dear Editor,

The letter of John Stevens in your November number came as a great surprise to me.

Are there now two classes of old Bart's men—two social classes—one the Vicars and the other the common herd sporting two different kinds of ties.

This really is a shocking state of affairs in this day and age.

One thing I would like to know is whether membership of the Vicarage is dependant on religion, political affiliation or the wearing of long hair!

I would indeed like some commentary on this from the Bart's Hierarchy.

Although you are a Student Journal I hope you will be allowed to publish this.

M. M. POSEL.

OBITUARY

AIDAN REDMOND

Aidan Redmond who was born on July 24th, 1903, in County Wexford, Eire, read medicine in Dublin and qualified in 1925. After one year's experience at Great Ormond Street Hospital he entered private practice in Chelsea. Like so many other Irishmen he was commissioned in the R.A.F. and served for the whole of World War II (1939-1945). He developed an interest in sexually transmitted diseases and was posted to various R.A.F. Special Treatment Centres and Hospitals, by the end of the war he was a Specialist Venereologist and although he returned on demobilisation to his private practice in Upper Wimpole Street, he retained his interest in Venereology. As a consequence he soon obtained an appointment at the clinic at the Royal Northern Hospital and soon afterwards was appointed SHMO to S.T.C. at St. Bartholomew's Hospital. This was the beginning of a 20-year association with this hospital during which time he was the mainstay of the department. He would undoubtedly have obtained a consultant appointment if he had had a higher medical qualification, as his experience and clinical ability in his subject were outstanding. He was a most loyal and devoted colleague and his zest for life, good humour and wit made him the most popular member of the Department. Everyone admired his courage in his later years when he was beset with ill-health, and in spite of this he continued giving of his best till his retirement when the hospital honoured him with a farewell reception. However, this was not the end of his career, as he continued to carry the burden not only of private practice, but of extensive locum work in various V.D. clinics in London. He was happy to maintain many friendships of his R.A.F. days which included Mr. Badenoch and Mr. Ellison Nash.

Since his youth he had been a racing enthusiast and he retained his interest to the time of his death. He will be sadly missed by his many good friends of the Turf, it was a pleasure to be taken by him to the racing at Kempton Park. He was devoted to his family and proud of his eldest son's achievements as a successful doctor in the U.S.A. and his younger son's successful business career and of his daughter's happy and successful marriage. He and his wife rejoiced in their numerous grandchildren, and our sympathy goes out to all of them for the loss of husband, father and grandfather.

C.S.N.

Announcements

Deaths

CALDERWOOD—On July 7th, Mr. R. W. L. Calderwood, F.R.C.S. Qualified 1944.

CLARKE—On November 7th, Mr. R. H. Clarke, M.R.C.S., L.R.C.P. Qualified 1916.

CAPPER—On December 10th, Mr. W. M. Capper, F.R.C.S., F.R.C.O.G. Qualified 1932.

STRUTHERS—On November 21st, Dr. J. A. Struthers, M.D., M.R.C.P., D.P.H. Qualified 1922.

VICK—On December 18th, Mr. Reginald Martin Vick, O.B.E.(Mil), T.D., M.Ch., F.R.C.S. Qualified 1908.

Appointments
University of London

Mr. R. W. Beard has been appointed to the Chair of Obstetrics and Gynecology tenable at St. Mary's Hospital Medical School.

Dr. G. H. Fairley has been appointed to the Imperial Cancer Research Fund Chair of Medical Oncology tenable at St. Bartholomew's Hospital Medical College.

Dr. J. Stark, M.D. Cantab., M.R.C.P., has been appointed Consultant Physician at the Nottingham General Hospital.

JEWELLERY AND WATCHES
20%-25% DISCOUNT TO ALL HOSPITAL MEMBERS & STAFF
DIAMOND ENGAGEMENT RINGS
GOLD - Wedding and Signet Rings.
GOLD & SILVER - Cigarette cases. Powder Boxes. Bracelets. Necklaces, Charms, Brooches, Earclips, Links,
SILVER & E.P.N.S. - Teasets & Plate
10%-20% DISCOUNT TO ALL HOSPITAL MEMBERS & STAFF
on all Branded Goods — ALL SWISS WATCHES. Clocks, Cutlery, Pens and Lighters, and on Second-hand Jewellery.
Remodelling and Repairs to all Jewellery and Watch repairs
GEORGES & CO.
of HATTON GARDEN
(Entrance in Greville St. only)
88/90 HATTON GARDEN, E.C.1
405 0700 or 6431
OPEN WEEKDAYS 9.00-6.00 SATURDAYS 9.00-12.00
Special attention to order by post or phone

MAPLE JEWELLERY
40%-50% DISCOUNT Off usual retail price
★ Engagement Rings ★ Diamond Jewellery
30%-35%
★ Wedding, Signet and Dress Rings
★ Gold Bracelets and Charms
We offer such a large genuine percentage as we manufacture all our Jewellery in our own workshop and sell direct to you from our own showroom on the premises. This enables us to keep costs low, cutting out wholesale middlemen and very high retail shop expenses and profits.
Hours: 9.30 - 5.30 Monday to Friday; 9.30 - 1.00 Saturday
VISIT OUR SHOWROOM
Opposite Gamages side entrance
10 Hatton Garden, London, E.C.1. 01-405 6596

TO ADVERTISE IN THIS SPACE AND FOR SPECIAL RATES CONTACT
Malcolm Vandenburg
St. Bartholomew's Hospital Journal
St. Bartholomew's Hospital
London EC1
Telephone 606 7777 Ext. 7206

SEVEN YEARS - THE RISE AND FALL OF GENERAL SURGERY

by Mr. M. L. CROSFILL

The high points of surgical history, those pinnacles upon which stand a Lister or a Billroth are well described. Much energy is likewise expended on the establishment of precedents—one is reminded of Moynihan's (apocryphal?) claim to have carried out, albeit inadvertently, the first prostatectomy, "happy nevertheless, gentlemen, to yield precedence to one who can call himself P. Freyer." Much less has been written about the way in which the great advances influenced the practise of surgery at the time. To change the metaphor, much is known about the splash in the middle of the pond, but the manner in which the ripples spread over the surface and the type of disturbance they cause at the periphery are less well documented.

One cannot be much more peripheral than in the Outer Hebrides and it is from this very limited viewpoint that I have surveyed the development of surgical techniques over the last 70 years. If the picture is distorted because the amount of material is small or because the range of cases is limited by the versatility of a single surgeon, at least it has the virtue of being a complete picture of the work of one hospital. If anyone were to enlarge the panorama by surveying the work of, say, a provincial centre such as Bath or Leicester and perhaps of a Great London Teaching Hospital I, for one, would be fascinated to see the results.

The Lewis Hospital, Stornoway, opened in 1896 with 12 beds. Its history has been recorded elsewhere[1] but from the point of view of this survey one should remember that, like many larger hospitals it was at first staffed entirely by general practitioners. In 1925 a full-time surgeon was appointed. The hospital has since grown steadily to its present size of 83 "acute" beds. There is still a single surgeon but there are now 3 other full-time consultants, 3 junior staff and representatives of 10 other specialties who visit regularly from Inverness. The 7 years of the title are 1896 and the first years of the decades from 1911 to 1961. Every patient who went to theatre in each of those years has been recorded; 1896 was chosen in preference to 1901 simply because the notes for 1901 are incomplete. For 1911 and 1921 the admission records with diagnosis, length of stay and result are complete but unfortunately details of surgical procedures are in many cases lacking and we have only the bare information that an operation was performed or an anaesthetic administered. From 1931 onwards details are available from the theatre day books and are complete.

The first three years may conveniently be taken together and are presented in Table 1. As might be expected there is a high proportion of septic and traumatic cases and a tragically large number of proven or presumed cases of tuberculosis. Abdominal surgery is conspicuous by its absence. The exceptions are the patients variously described as having typhlitis, perityphlitis and appendicitis. The latter term was coined

TABLE 1

OPERATIONS PERFORMED IN	1896	1911	1921
Manipulative reduction of fractures and dislocations ...	1	2	7
Operations for minor trauma ...	4	4	3
Drainage of abscess ...	1	—	3
Surgical tuberculosis, psoas abscess, etc. ...	4	—	1
Manipulation of ankylosed spine and joints ...	2	—	—
Mastectomy for carcinoma ...	1	2	—
Excision of carcinoma of lip ...	3	2	—
Dilatation of cervix (stenosed) ...	1	—	—
Ventricular puncture (hydrocephalus) ...	1	—	—
Amputation of digits ...	1	4	—
,, ,, leg (trauma) ...	—	1	—
Removal of small lumps ...	—	6	1
Drainage of osteomyelitis ...	—	1	—
Tonsils and adenoids ...	—	—	31

Why a 7-day treatment for threadworm?

Expelling the worms from the gut is only half-treating the condition because the threadworm eggs left in the peri-anal area can enter the gut by auto-infection.
With a course of ANTEPAR* for 7 days you can help ensure that the next generation of worms is expelled too.

Wellcome

Antepar

the decisive answer to threadworm and the one-day treatment for roundworm

Available as a pleasantly flavoured elixir of piperazine hydrate and piperazine citrate or as tablets of piperazine phosphate. Full information is available on request.

*Trade Mark

Burroughs Wellcome & Co. (The Wellcome Foundation Ltd.), Dartford, Kent DA1 5AH.

by Fitz in 1886 and I had always assumed that it replaced the older ones, yet perityphlitis was still being diagnosed as late as 1915.* In 1896 two cases of perityphlitis were admitted and stayed 35 and 16 days respectively. Both were discharged as "cured" but they were not operated upon. The first case of "appendicitis" was admitted on November 23rd, 1897, and was cured after 65 days—again without operation. The records for the next few years are incomplete but surprisingly it is not until July 29th, 1922, that the first appendicectomy was performed—and this no less than 18 days after the patient's admission. Abscesses had been drained before this date and it seems that the policy was one of the conservative treatment of the acute attack followed later by operation. That this policy was successful is seen by the fact that most patients are discharged as cured. A puzzle still remains—what happened to all those patients who, one imagines, should have died of appendicitis? Did they suffer silently at home or did they perhaps attempt the slow sea and rail journey to Glasgow? That there was an unfilled need is shown by the fact that when the new Surgeon (Mr. J. Ewart Purves) was appointed in 1925 he carried out sixteen appendicectomies in his first year; three were for abscess, seven for appendicitis and three were what we would now call interval operations. To anticipate a little, as confidence in the treatment grows the numbers treated begin to rise until in 1931 seventy-three appendicectomies were carried out. Twenty-four were for appendicitis severe enough to require drainage, twenty-six more were for undoubted acute appendicitis and a further twenty-three for what I have learned to call "notappendicitis". In 1941 the figures were 10, 40 and 23 respectively and in 1951, 16, 54 and 19. The total for 1961 was 92 and is not markedly different today.

One thus has a complex and fascinating interplay of forces resulting in a low operation rate up to 1925, a rise until 1931 and a plateau thereafter. An obvious factor is the personality of the surgeons concerned, but this can hardly be the whole answer. There is an excellent historical review of appendicitis[2] by Goldman where evidence is presented that the incidence of appendicitis did genuinely rise at the beginning of the century and that this rise was noticed more in the cities than in more remote areas. There is also, as always, the attitude of the patients and it may be that the servicemen returning from the war helped to swing the local climate of opinion. A willing surgeon is impotent without a willing patient.

*on the other hand I still cling to the term "chronic mastitis"; being discredited it is less misleading than many.

TABLE 2 (Part I)

OPERATIONS PERFORMED IN	1931	1941	1951	1961
Appendicectomy	73	73	89	92
Inguinal and femoral hernia	14	22	35	30
Piles, fissure, fistula, etc.	11	10	19	17
Varicose veins	—	2	21	21
Biopsies	—	—	10	2
Phrenic nerve crush	—	—	56	—
DOCA and other implants	—	1	8	2
Ramstedt's operation, intussusception	—	—	1	4
Removal of epithelioma of lip	7	5	6	2
Removal of other skin cancers	1	4	4	5
Removal of miscellaneous lumps and bumps	1	28	70	48
Cholecystostomy	3	—	—	—
Cholecystectomy	4	1	9	10
Suture of perforated peptic ulcer	6	9	12	4
Gastroenterostomy	5	3	2	1
Polya gastrectomy	—	—	7	3
Vagotomy and drainage	—	—	—	10
Revision operation for gastric surgery	—	—	1	2
Laparotomy	7	6	3	14
Operation for wound complications	—	7	17	7
Operation for intraabdominal complications	—	1	4	2
Laparotomy for inoperable carcinoma	1	7	6	5
Palliative laparotomy for carcinoma	4	7	10	7
"Curative" laparotomy for carcinoma	—	—	5	10
Drainage of abscess, septic hands, etc.	42	59	73	11
Excision of T.B. glands of neck	8	4	11	—
Osteomyelitis	22	—	—	—
Miscellaneous	25	30	15	22
Blood transfusion (pints)	1	8	63	?

The years 1939, 1941 and 1951 are a record of the work of Mr. E. Norman Jamieson who was appointed in 1930 and who died in harness in 1956. In a sense this article was conceived as a tribute to him and to his versatility. For long spells he was the only full-time member of the medical staff. Later he was to have a house surgeon and a registrar and later still other colleagues were appointed. I have subtitled this article "the rise and fall of general surgery"; the rise is nowhere better seen than in these years of Jamieson's when increasing experience went hand in hand with an increase in the variety and complexity of the problems presented to him, and with a steady maturation of the art of surgery.

The details of operations performed during this time and in 1961 are presented in Table 2. The constant appendicectomy rate has already been mentioned. One gains the impression that cases are diagnosed earlier because the number requiring drainage drops over the years. To continue the story of abdominal surgery, the numbers of elective operations for benign conditions—cholecystectomy for example, and operations for peptic ulcer—are at first very small. I am told that the Island's first cholecystectomy was a few years prior to 1931 and was carried out in the home, on the traditional kitchen table, with straw on the road outside to deaden the noise of the horses and notices saying, "Silence please, Surgeon operating". As regards peptic ulcer, one sees the recent strange and well documented drop in the number of perforations together with the (unconnected) rise of Polya gastrectomy and its later eclipse by vagotomy and drainage. I say unconnected rise because the age at which these patients were treated for ulcer was later than the age at which they tended to perforate.

A point not shown in the table is the appalling mortality of intestinal obstruction. The conventional explanation for this is that the improvement has come with the practise of electrolyte and fluid replacement, but I wonder whether a more important factor is early operation; this presupposes early referral and is an expression of the confidence of the patient in his doctor and of the doctor in his surgeon. By the same token the operation for malignancy—procedures such as colostomy, cholecystojejunostomy or gastrostomy. The first

TABLE 2 (Part II)

OPERATIONS PERFORMED IN		1931	1941	1951	1961
Obstetrics:	Caesarian section (classical)	3	17	21	—
	Forceps delivery	—	7	17	7
	Other	—	1	38	—
Gynaecology:	Hysterectomy, subtotal	6	4	3	—
	,, total	—	2	3	1
	D & C and manipulations through cervix	29	17	55	—
	Oophorectomy	7	5	4	2
	Other	9	15	2	—
	PERFORMED BY SPECIALIST	—	—	35	170
Dental extractions		—	8	104	10
Eye Surgery:	Operations on eye	—	11	1	—
	Removal of cysts around eye	—	5	6	—
	PERFORMED BY SPECIALIST	—	—	22	22
E.N.T.:	Tonsils and adenoids	105	40	49	—
	Mastoid operations	1	3	4	—
	Other	6	16	8	1
	PERFORMED BY SPECIALIST	—	—	101	101
Orthopaedics:	Cold cases	13	43	30	26
Accident Surgery:	Closed reduction of fracture	16	59	71	29
	Pinning of femoral neck	—	—	5	11
	Open reduction of fracture	2	7	1	10
	Dislocations	3	13	13	5
	Skin grafts	—	1	14	29
	Minor trauma	16	14	44	91
	Major trauma	2	34	5	11
	Other	2	15	15	—
Genito-	Cystoscopy	16	14	44	91
	Catheterization, bouginage, etc.	8	12	32	16
	Suprapubic cystostomy	3	11	20	—
	Prostatectomy	3	4	9	12
	Nephrectomy	2	2	6	5
	Other	10	24	23	14

early years dominated by fruitless or palliative operation for the eradication of abdominal cancer must have been between 1941 and 1951. Even today there is no room for complacency; maybe some archivist of the future will look back in sadness on our archaic and inefficient system of reliance on symptoms and clinical signs.

The table brings out also the increasing use of grafting techniques. Mostly these were split skin grafts for burns or leg ulcers but a few full thickness grafts were done and the occasional cross-leg flap. Cosmetic surgery is rare unless one includes the removal of the bubuckles and whelks and knobs and flames o' fire such as afflicted Bardolph. The cynic would add varicose veins under this heading (who was it called them varicose vains?). Here the progression is from ligation to ligation-with-injection to flush ligation and stripping. I have also included a line for blood transfusion, partly to point out that it was in the operating theatre and partly to show the use made of the technique. Cross matching would be by tile (as it was at Bart's until 1953) and the donors were bled to order. The blood was usually given through a Hamilton Bailey cannula (i.e. a cut down) although by 1951 the standard giving sets were in use. The tubing was of opaque red rubber and one wonders as one sees today's nurses ridding drips of minute bubbles how much air we sent gaily on its way around the circulation.

The Rise of the Specialties

If one excludes one wild episode in 1921 when, in two days of mayhem, thirty-one pairs of tonsils were parted from their owners, there were no visiting specialists at the Hospital until the war and they do not appear on this record until 1951. The E.N.T. surgeons, although first in the field, had to face a spirited rearguard action by the resident tonsillectomist. For a few years Eye Surgery was also performed but as this became more complex and the nursing care more specialized it was dropped and the patients are now treated at Inverness. "Cold" orthopaedic surgery has for a long time been referred to the mainland and only a small proportion done locally. The surgeon was obstetrician and gynaecologist until the outbreak of the N.H.S. when he had occasional assistance from a visiting surgeon. A full-time specialist was appointed about ten years later.

I have included two other main headings in Table 2, namely Urology and Accident Surgery. Urology is still in the process of emerging as a specialty in its own right (how long has Bart's had a Department of Urology?) and Accident Surgery is still in the chrysalis stage. As far as techniques are concerned one sees Urology at first the treatment of prostatic obstruction by suprapubic cystostomy and then the Freyer prostatectomy is added as a second stage. Until 1951 the prostatic cavity was packed for 24 hours with gauze, following which suprapubic drainage took place until healing had occurred. Looking back it is not easy to see why all this was necessary. One can perform transvesical prostatectomy today, close the bladder and, without the aid of antibiotics and without undue bleeding, obtain primary healing. Presumably patients must have come to operation much later, possibly after repeated catheterization and possibly with grossly inflamed bladders. Once again we are back to the interdependence of surgeon and patient.

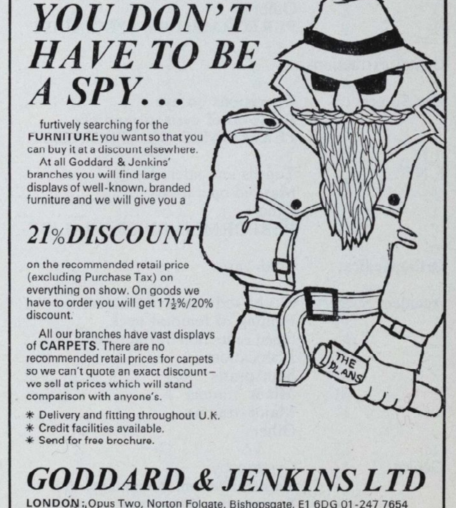
The treatment of fractures has shown relatively little change throughout the years in question, closed reduction and splintage being the mainstay all along. The exception is fracture of the neck of the femur where open fixation has taken over; a "facultative" orthopaedic surgeon might be expected to be conservative in his approach and few other open operations on fractures were done. A generation of general practitioners will have been used to treating fractures without the benefit of X-rays and without the ever present threat of litigation, so the proportion of open to closed reductions will be falsely high compared with today. One technical point is that fractures of the humerus seem to have been treated much more actively in the past than now; a number of manipulative reductions under anaesthesia with some weird and wonderful splintage was employed where today a collar and cuff and physiotherapy seem to suffice.

These are random comments on some of the operations performed. The tables hold the complete record and can speak for themselves. Only the earliest of the years I have surveyed are beginning to pass into history and I am well aware that much of what I have written could be amplified by personal reminiscence. I merely remind the reader of my very limited objective—to record the state of the art as seen from the periphery with all the distortions and illusions that a distant view implies.

REFERENCES

[1] The Lewis Hospital, Stornoway. Crosfill, M. L. Medical History (in press).

[2] Appendicitis, an Historical Survey. Goldman, M. Hospital Medicine, October 1966.



GODDARD & JENKINS LTD

LONDON:, Opus Two, Norton Folgate, Bishopsgate, E1 6DG 01-247 7654
BIRMINGHAM: Opus One, Suffolk Street, 1. 021-643 5956
BRISTOL: Opus Three, 25/27 Broadmead, 1. 0272-27357
MANCHESTER: Opus Four, 105 Deansgate, M3 2BQ. 061-834 4412.

CAKED IN MUD

By PETER GLANVILL

I was asked some time ago by one of the magazine staff to write an article on the subject of caving. After a period of 2nd M.B. exams, followed by the necessary period of recovery, etc., I thought that it was about time that I did something constructive. Hence this article comes at the tail end of a publicity campaign to form a caving club. . . .

The bulk of this description concerns a small Mendip cave and its exploration. The sump described at the end may soon be dived and the cave further extended.

The club, in the shape of 3 keen cavers had been digging on and off for several years above a resurgence in the East Mendips.

We were currently excavating at the end of the small St. Dunstan's Well Cave when one enthusiastic caver uncovered a hole from which a strong Draught emerged. (This, to a caver, is what an amphora is to a diver—a promise of greater things!) Hurriedly we procured the services of a "bang man" (one fortunate enough to possess an explosives licence in these I R A ridden times), in order to widen the hole. I should add that blasting and digging are considered perfectly legitimate ways of entering caves, especially on Mendip where one system has been excavated for practically its whole length. Having performed the bangs we emerged through the hole to peer round the inevitable corner, which, of course we could not possibly pass. Round the corner in fact was a hole in the floor filled with the rubble we'd thrown down from above. We got around the corner and one caver swore he could hear a stream—the space beyond certainly echoed . . . conjuring up visions of vast chambers beyond.

To cut a long story short the blockage was passed—the excavated hole resulting in a "U" bend half full of a very loose slurry, aptly named Domestos Bend. We arrived at the bottom of a steep slippery slope covered in knobbly stalagmites (our only means of pulling ourselves up). This was appropriately named—The Titties!

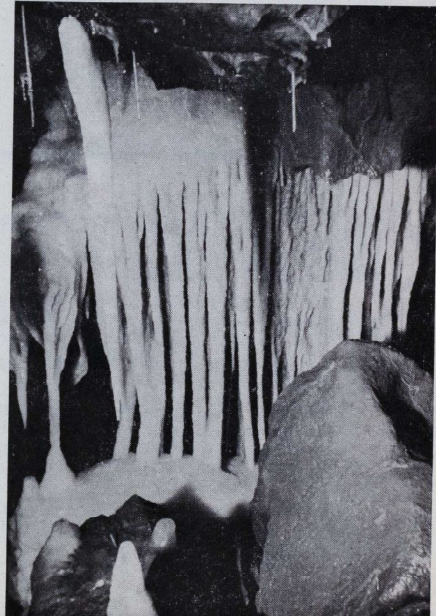
After this we squirmed across a narrow sloping fissure called Bongo Rift because of its chiming stalactite curtains. The next obstacle caused the original explorers some trouble; one of them lost his boiler suit here, and so it lies to this day, mute testimony to the name of this little corner—Shredded Squeeze. Since then the worst bits have been eliminated by judicious use of a hammer and chisel.

Shredded Squeeze is followed by a sharp, painful drop through a narrow slot (The Buttocks) after which tribulations such as Big Dipper Rift (a very narrow fissure with sides seemingly smooth as glass) and Scientific Squeeze, which challenges one with new dimensions in kyphosis and incidentally would be impossible for anyone over 6 ft. tall—I know, I've suffered there.

Eventually the sump was reached, a large deep, black-looking pool. . . . Sumps are passages filled up with water, either stagnant or flowing. Stagnant ones are often easily baled whereas one is forced to dive flowing sumps (if one has enough courage. . . !).

Sumps engender a lot of dislike in the caving world, as there is nothing so disheartening as to see one of your party disappear into the cold murky waters beyond, knowing that you have to follow.

One lecturer in Pathology at Bristol University contracted Weils' disease in a particularly watery cave (one has to dive through a sump, the surface layers of which



appear to consist of an equal mixture of diesel oil and raw sewage!). The sump, in fact, has halted us until we are able to enlist the support of that band of would-be suicides—cave-divers!

The main characteristic of the above cave-system was its narrowness (in caving jargon—tightness). Large people tend to get flustered in such caves. In contrast, a recent trip to Wales involved a walk of a mile along Main Passage, in Agen Allwedd (near Abergavenny). The floors were smooth and covered with dry mud, cracked in places like old paving stones. The passage had an ancient timeless appearance to it—not surprising when you consider that it did not look much different when Julius Caesar was busy invading England.

Agen Allwedd, the largest system in Britain at 16-18 miles, is short compared to the Holloch in Switzerland which contains a staggering 50 miles of passages.

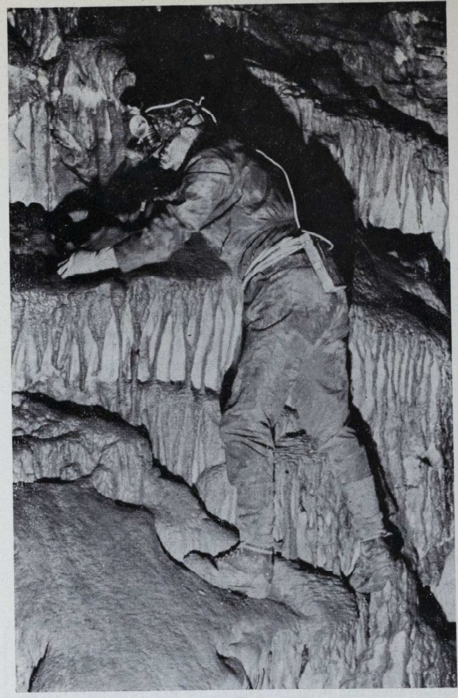
Vertical drops are just as impressive: Britain boasts Gaping Ghyll, a waterfall cascading 365 feet off the Yorkshire Moors into a system which is still being explored, although known for centuries.

The main shaft of Gouffre Pierre St. Martin in the French Alps could quite comfortably accommodate the Post Office Tower with a couple of hundred feet to spare.

Being on a long drop is a breathtaking experience—imagine one is hanging on a ladder with the walls, ceiling and floor swallowed up in darkness.

Britain possesses caves in most parts: Ireland, Scotland, North and South Wales, Yorkshire, Derbyshire, the Mendips and even Devon. (One system near Buckfastleigh, much used by the Outward Bound is 2 miles long, with new discoveries still being made.)

I am in the process of forming a caving club at Bart's and hopefully by the time this article goes to press the club should have got off the ground (or more appropriately, I should say, *under* the ground).



JUNIOR REGISTRARS IN SURGERY

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

3 posts: six months General Surgery/six months Special Department**
1 post: six months Emergency and Accident/six months General Surgery
1 post: six months Neurological Surgery/six months General Surgery

Applicants should state for which post they wish to apply and give a second choice.

The posts are tenable from June 1, 1972, and the Salary Scales are that of a Senior House Officer in the National Health Service.

Applications, with the names of two referees, should reach the undersigned by Monday, March 13, 1972. (Application forms are available from the Medical Staff Office.)

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

**Urology
Orthopaedics
Thoracic Surgery

J. W. GOODDY,
Clerk to the Governors.

SENIOR HOUSE OFFICER
EMERGENCY AND ACCIDENT DEPARTMENT

APPLICATIONS ARE ALSO INVITED for the post of SENIOR HOUSE OFFICER in the Emergency and Accident Department. The post is for six months only and dates from June 1, 1972.

Applications should reach the Clerk to the Governors by Monday, March 13, 1972, and forms are available from the Medical Staff Office.

JUNIOR REGISTRAR IN MEDICINE

APPLICATIONS ARE INVITED for the post of JUNIOR REGISTRAR IN GENERAL MEDICINE TO DR. BLACK and DR. DAWSON.

The post is tenable for one year from June 1, 1972, and the salary scale will be that of a Senior House Officer in the National Health Service.

Applications, with the names of two referees, should reach the undersigned by Monday, March 20, 1972. (Application forms are available from the Medical Staff Office.)

J. W. GOODDY,
Clerk to the Governors.

LIPMAN'S DRESSWEAR HIRE SERVICE

Complete Hire Service for all occasions

34/36 LUDGATE HILL
LONDON . E.C.4
Telephone: 01-248 1504

Keeping in Trim?

EMPIRE HOUSE BARBER SHOP
ST. MARTINS LE-GRAND
(NEXT DOOR TO LYONS)

Why not give us a ring? most of your Colleagues do.

We should be delighted to see you and attend to your requirements.

We make no charge for appointments.

606 4973

WARD SHOWS AND POT POURRI 1971

Considering the amount of time spent discussing, arguing and writing about the Ward Shows in the past year, it is as well that the standard of the shows this year was well up to scratch, and one or two were quite exceptional. Also it appears that the behaviour of the students on the wards has betrayed a modicum of respect for the fact that the occasional patient might be ill, and that there were ladies present, and thus few nurses were abducted, and I think no patients were trampled on. Neither did the hospital reek of alcoholic beverage for days after, not beer, at any rate, a fact which will no doubt be noted in the minutes of that fair, and auspicious body, the General Nursing Council.

As for the Shows themselves, Clerks and Dressers produced two excellent shows. The Clerks came up with a concoction called Patient's Progress, masterminded by Charles Russell-Smith, and whilst we have all seen Hospital sketches before, here was a well-presented slick, clever version of just what goes on at St. Bart's, with the old ward round, operating theatre jokes given an enormous amount of new life. I laughed like a drain, anyway, and so did all the patients, and the Pot Pourri audience. Remarkable moments were had by Paul Cooper, the archetypal consultant, Andrew Smith as the long suffering patient, and Brian Johnson as a small German Doctor. Altogether an excellent show.

The Dressers had the considerable talents of Jan Robinson as Little Red Riding Hood in their unorthodox pantomime. This was an amazing wander down the Memory Lane of bad jokes about Jews, female anatomy, hospitals and fairies, and worked remarkably well. The wolf was excellent, as was the amazingly irrelevant interlude with three sisters, and the fairy did all that was required of it. Both these shows show a lot of talent which I hope will be used in later years.

This year the Midder and Gynae Show was disappointing. It must be very difficult to put on a show when people are on duty, or doing residences, but I thought the standard of the show could have been better. There was a Gynae sketch, a poem about a surgeons competition, a strip with a difference, and a very good little song from Steve Piggott, about a cactus.

Following the long established tradition of last year, the D.Q.C. also did a show. Set round a nucleus of Dick Fowler, Martin Gore, Pete Burnett and Olly Else, it suffered on the ward from bad continuity, but the material in it was very funny. I liked It's a cock up, with Martin Gore as Eddie Waring, and Olly and Tony Wall as the competitors. Going for a tinkle was another good idea, but to my mind lacked the pace it should have had. Then followed a very good series of short sketches, culminating in the Pete Burnett, Martin Gore tango. Long John Silver and his luncheon vulture rounded the show off in a manner which gave everyone a chance to exercise their own speciality.

The Kids' Pantomime this year was Cinderella. Sufficient to say that Brian Cotton and Tony Wall were Ugly sisters, Anne von Bergen was Cinderella, Cynthia Smith was Prince Charming, Janet Dinwiddie and Dave Jackson were the fairy godmothers, Guy Routh was Chocolate Buttons and the whole thing was sometimes held together by Andy Hind. The kids loved it.

The Finalists were a small group this year, but produced a very good show. With Richard Moody on the piano, they went through about twenty sketches ranging from Duncan Dymond being a little stiff from Badminton, to Deirdre Lucas selling a stool to an avid Janusz Kolendo, with Howard Rotherford filling in as a trouserless policeman, and Mike White with glue in his deodorant. They managed continuity quite well, and it was good to watch.

The House Show was uneven. Some of the sketches were good, notably the bedpan men, the East Wing Boys, Tony Breeson and Justin Blake James in impeccable blazers and boaters, and the little nurses song. However, with some of the other sketches, I felt that they were there mainly to air the faces of some of our more notable resident staff, and whilst it is always good to see such people off the rugger pitch, I feel they could choose better material and act slightly better. There was a stirring opening song and a final song that left nothing to the imagination.

Judging the shows is never easy, and by the time they went to Pot Pourri, the committee had managed to trim about ten minutes off per show. Nevertheless the show lasted rather over three hours on the first night, although with judicious trimming it was under three hours by the second, and the audience seemed to enjoy them.

Overall the shows were of a high standard this year, and there was a lot of enthusiasm. I look forward to seeing them next year, for I can see no good reason this year for stopping them, for they seem to give a lot of innocent enjoyment to a lot of people at Christmas.

GEORGE BLACKLEDGE

PRE-ECLAMPSIA AND ECLAMPSIA

By P. M. A. MILLARD, B.Sc. and
P. VIEYRA, B.Sc.

"Toxaemia" is a disease process peculiar to pregnant women characterized by signs of (i) Hypertension, (ii) Proteinuria and (iii) Oedema, usually in the last trimester or early puerperium (except when associated with hydatidiform mole).

Pre-eclampsia and eclampsia are often termed "Toxaemias" of pregnancy; consequently pre-eclampsia is often termed "Pre-eclamptic toxaemia" (P.E.T.) which is probably erroneous since causal toxins have not yet been isolated. A diagnosis of pre-eclampsia is considered when any two of the above three signs are present in pregnancy, emphasis being placed on the presence of hypertension.

95% of pre-eclamptic patients develop clinical features between the 32nd week of pregnancy and the 2nd week post partum. 75% of cases are primigravidae. The pattern of the disorder varies from country to country. The cardiovascular response to pregnancy appears to be lower in countries with a high protein diet, such as Switzerland and Australia compared with Japan and Nigeria. However, in Nigeria, for instance, many primigravidae start pregnancy with blood pressures of 95/60, and a diastolic rise of more than fifteen points may indicate pre-eclampsia, so that at 140/90, the level usually considered the lower limit of the pre-eclamptic range in Europe, eclampsia may be imminent. Even in a fairly homogeneous community such as the British Isles, the incidence is higher in Scotland and Ireland than in the South. Clearly, racial differences exist, but cannot account for the higher incidence of pre-eclampsia among American Negroes than in rural West Africans of the same ethnic origin.

It is therefore important to record the blood pressure as early as possible in pregnancy, then a critical level at which pre-eclampsia should be diagnosed is found by adding 30 mm. to the systolic and 15 mm. to the diastolic pressures.

Aetiology:—

Utero-renal reflex
(Histerotonin release)
Pre-existing renal disease
Renal vessel spasm
Sodium retention
"Toxins"
Malnutrition
Thiamine deficiency
Obesity
Hydramnios
Multiple pregnancy
Diabetes
Hydatidiform mole
Rhesus Iso-immunization
Non-opening of collaterals
Primigravidity
Vascular diseases
"Central" origin
Monoamine oxidase depletion
Failure of immune mechanism
Fibrinogen degradation products
Heredity
Progesterone sensitivity

All the above factors may be implicated in the development of pre-eclampsia but no unifying theory has been found to be entirely consistent with the clinical facts of the disease.

Predisposing factors include vascular and renal disease, malnutrition, obesity, multiple pregnancy and diabetes mellitus. The high incidence with hydatidiform mole and the rare occurrence of post-partum onset in some cases indicate that presence of the fetus and placenta is not essential. The disease may also complicate extra-uterine pregnancy, so that uterine distension is not necessary. These facts mediate against toxin theories which invoke the release of vasoactive substances into the blood stream either as a result of disordered placental metabolism, or a uterorenal reflex or increased pressure in the veins draining the kidneys, or possible a central nervous system response. The controlled experiment of Tatum and Mulé does most to support these ideas. They report transient reappearance of symptoms and signs in patients auto-transfused with blood taken during severe pre-eclamptic disease. They also postulate a "Sensitized" vascular system since the phenomenon fades after the first puerperal week and cannot be elicited from the baby or normal woman.

The theory that tension either in the walls of the uterus or in the abdominal veins results in the release of vasoactive substances or hormones sensitizing the vascular tree, is consistent with the fact that the incidence is highest in primigravidae, and does not necessarily recur in subsequent pregnancies.

Fibrinogen degradation products (F.D.P.) are raised in pre-eclampsia and line vessels causing constriction (autopsy within 24 hours is confirmatory). This correlates with theories of renal vessel constriction.

If an immunological mechanism (of maternal-fetal incompatibility or placental antigen/renal antibody reaction) were responsible for the disease one would expect an increasing incidence with subsequent pregnancies, and probably permanent damage. Nevertheless, several experiments strongly suggest an immunological basis.

Rare cases of pre-eclampsia in patients also suffering from diabetes insipidus make it seem unlikely that excess A.D.H. secretion is a major factor in the aetiology of the condition.

Work done on placental monoamine oxidase levels has been conflicting, although some workers have postulated that low enzyme levels might give rise to a build-up of vasoactive amines.

There appears to be a strong familial tendency. Nearly 40% of sisters and daughters of women who had had eclampsia developed pre-eclampsia, in one survey. Another survey showed that sisters of primigravidae who develop pre-eclampsia had a higher incidence than sisters of primigravidae who had no signs of pre-eclampsia.

Pathology

The organic lesions of pre-eclampsia are not sufficient to cause death and most are reversible if the patient recovers.

Brain: Oedema, flattening of hemispheres and scattered haemorrhages.

Lungs: "Wet" with multiple minute thrombi.

Liver: Pale, mottled and firm with small subcapsular haemorrhages. Dilated capillaries around the portal spaces progressing to periportal haemorrhages, thrombi and necrosis.

Kidneys: Enlarged and pale. The cortex is blanched with multiple small haemorrhages. The glomerular vascular loop fills Bowman's capsule with large ischaemic capillaries in simplified loops with ballooned tufts. The cells are prominent but not proliferated. The basement membrane is thickened, convoluted and adhesions to the capillary rosette are typical, with vacuolization of the cells in the space beneath the basement membrane.

The tubules are dilated with proteinaceous urine, and the lining cells may show hyaline degeneration and fatty infiltration.

Placenta: No specific lesion, but small "red infarcts" are common. Dysmaturity is often incurred from the increased endarteritis and periarteritis; thinned syncytium, calcium and intervillous fibrin deposition.

Pathological Physiology

Arteriolar spasm: increased pressor (and depressor) response—labile vascular system.

Sodium and water retention: distribution of water through the body fluid "compartments" appears to be variable, but the E.C.F. and total body water are always raised with characteristically low blood volume (giving haemoconcentration that may mask an anaemia) and decreased glomerular filtration.

Proteinuria: results in low serum albumin and globulin and a low blood osmotic pressure despite haemoconcentration.

Increased excretion of corticosteroids: including aldosterone and A.D.H. suggest a larger tissue concentration than normal. Excretion of gonadotrophin is increased often to levels found in early pregnancy, while oestrial and pregnanediol excretion decreases steadily.

Symptoms

(i) Headache; severe (usually when the diastolic pressure is over 100 mm.).

(ii) Visual disturbances; photophobia and "flashing lights" (due to retinal oedema).

(iii) Vomiting; (of central origin and possibly cerebral oedema).

(iv) Epigastric pain; (due to changes in the liver).

Signs

(i) *Hypertension:* Readings taken during the third trimester (24/52 onwards) showing a rise of 30 mm. systolic and/or 15 mm. diastolic over the figures seen during the first twelve weeks of pregnancy are indicative of pre-eclampsia. The initial early booking B.P. may be high, especially in anxious primigravidae, but should settle lower over the next few visits to the ante-natal clinic.

A further physiological fall in blood pressure during the second trimester is usual; this may mask both early pre-eclampsia and essential hypertension. If the mother "books" during this period of low blood pressure obviously a true base line for the "15 mm. diastolic rise" cannot be obtained. As a guide line the value indicating pre-eclampsia is taken to be 140/90 in Caucasians and 125/75 in Negroes.

(ii) *Proteinuria:* Albumin and some globulin may be found in the urine of pre-eclamptics; the amount of protein being shown by Esbach's test. The response of the latter to treatment is important prognostically.

(iii) *Oedema:* The hands (tight rings), ankles, feet, face, sacrum, abdominal skin and ascites may be found. The oedema may be due to hypoproteinaemia and/or fluid retention. Retention of fluid is well shown by weight gain—a gain of 2 lbs. or more per week from 34/52 is indicative of pre-eclampsia. In a survey of 2,400 cases booked and delivered in Aberdeen, oedema was found in 35% of normotensives, 60% of hypertensives and 85% of patients with hypertension and proteinuria. Weight charts alone are of little help, but in conjunction with a B.P. chart they are a reliable guide to the incidence of albuminuria.

(iv) *Failure to gain weight:* Loss of weight may be evident at the ante-natal clinic and may be due to placental insufficiency. This will be confirmed by static or retrograde girth and height of fundus measurements.

(v) *Oliguria:* This is usually a very late sign in established pre-eclampsia, but in acute fulminating pre-eclampsia (seen commonly in the tropics) oliguria may develop simultaneously with hypertension, vomiting and headache.

Differential Diagnosis

Essential H/T
Chronic nephritis
Pyelonephritis
Polycystic kidney

Aortic coarctation
Phaeochromocytoma
Lupus erythematosis
Cushing's
"Pseudotoxaemia"

GAMAGES

CHANGE · MOVEMENT · NEWS

One of the functions of a department store is to change, to improve, to find new merchandise and present it differently. Here's the latest from Gamages:

AUDIO CENTRE

Records, radio, musical instruments, television and allied goodies are now in a new section on the upper first floor, Hatton Garden side.

HEAD IN THE CLOUDS

Bright young clothes for bright young things - the new season's fashions call out for attention with a bias towards primary colours.

GAMAGES, HOLBORN, ECIP IDT   Open daily 10 am - 6 pm   Thursday 7 pm   Saturday 9.30 am - 1pm

The differential diagnosis of convulsion and coma is included under the heading "Eclampsia".

Essential Hypertension: History of persistent H/T before the fifth month (except in cases of hydatidiform mole). Essential H/T complicates 10% to 15% of pregnancies. In 75% there is a family history. Blood pressure is labile to exercise, temperature, sedation and emotional stress. M.S.U. or catheter specimen rarely contains more than 1+ of protein. Amytal tests result in a marked fall of blood pressure in essential H/T, moderate fall in P.E. but no fall in renal disease.

Renal Disease: Chronic glomerulo-nephritis, pyelonephritis, and polycystic kidney disease account for only 5% of instances of H/T in pregnancy, but 50% of these are complicated by P.E. There may be a history of glomerulo-nephritis following scarlet fever, pyelonephritis following "honeymoon cystitis" or a family history of polycystic kidney disease, with gross proteinuria, cells and casts with or without H.T. and a urinary S.G. of narrow range.

Severe Anaemia: Severe anaemia from any cause may mimic P.E. by causing oedema, H/T (mainly systolic) and albuminuria. This "pseudo-toxaemia" is found particularly in areas where hookworm, malaria and haemoglobinopathies are common; if the signs do not disappear when the anaemia has been corrected, then true P.E. may have supervened.

Treatment of pre-eclampsia

The aims of treatment are to prevent eclampsia and to obtain maximum possible placental function.

Early booking is important in establishing a base line by which readings in the third trimester may be gauged. Regular attendance at the ante-natal clinic should be encouraged in all pregnant women, especially those with a past history of pre-eclampsia, eclampsia, renal disease or a family history of hypertension. In this way signs and symptoms of pre-eclampsia will be recognized at an early stage. If there is a past history of pre-eclampsia then maximum rest should be advised throughout pregnancy.

If blood pressure recordings are borderline but other signs and symptoms are absent then weekly reassessment at the ante-natal clinic is essential.

Admission to hospital

The mother should be admitted if:—

(i) Blood pressure is elevated (as before).

(ii) Proteinuria + or a trace of protein with borderline blood pressure.

(iii) Excess weight gain with or without oedema (as before).

(iv) Loss of weight with raised or borderline blood pressure.

(v) Borderline blood pressure, no proteinuria but oedema and headache or visual disturbances present.

Treatment of Mild Pre-eclampsia

(i) Admit to hospital.

(ii) Bed rest (improved venous return and improved placental function by about 20%).

(iii) Assess blood pressure without sedation for 24 hours; if the blood pressure settles then sedation is not needed.

(iv) Mild sedation. Amylobarbitone (Amytal) 200 mg. Six hourly, or Phenobarbitone 30 to 60 mg. b.d.

(v) Low calorie diet if obese.

(vi) "No added salt" diet, but these are often unpalatable!

(vii) A diuretic, such as Frusemide, may be given if severe oedema is present.

(viii) Oestriol measurements. Ideally these should be taken daily since wide fluctuations occur with fetal growth spurts; misleading results are obtained if only weekly measurements are taken. A low oestriol measurement, e.g., 9 mg./24 hrs. at 35 weeks, is not itself an indication to keep the mother in hospital, but if this low reading is associated with indications that the fetus is not growing, or with uncontrolled pre-eclampsia, then continued hospitalization is, of course, necessary.

(ix) A midstream sample of sterile urine should be taken and studied for evidence of infection, proteinuria or renal damage; any infection being treated according to sensitivities.

(x) Growth of the fetus should be checked twice weekly by fundal height and girth measurements, palpation and weighing the mother.

(xi) Assurance and encouragement. Many patients become depressed and anxious because they "don't know what is going on".

Treatment of moderate to severe pre-eclampsia

If the pre-eclampsia is not controlled by treatment described, then stronger sedation will be needed, and if this fails hypotensive agents combined with sedation may achieve short-term control, but are of no use in prolonging pregnancy. Recently the value of renal dialysis has been described.

Stronger Sedation:

(i) Quiet surroundings.

(ii) Amylobarbitone or Phenobarbitone in larger doses.

(iii) Diazepam IV drip, 50 mg. in one litre of 5% dextrose. IV Valium offers accurate control of the degree of sedation.

(iv) *Lytic cocktail:*

Pethidine 25 mg. Chlorpromazine 25 mg. Promethazine 25 mg.	+5 mls. water IV for immediate effect.	Pethidine 125 mg. Chlorpromazine 25 mg. Promethazine 25 mg.	IM for longer effect.

The IV injection is given slowly and the IM injection is given immediately after; the IM injection may be repeated four hourly as necessary. (Chlorpromazine may cause tachycardia.)

Lytic cocktail has a tendency to be used late, i.e., when eclampsia is imminent; however, lytic cocktail is not specifically anticonvulsant and should be used as the blood pressure is rising to high levels rather than when it has risen.

(v) *Magnesium Sulphate:*

Stroganoff introduced a regime of total sedation using morphine and chloral which was then modified by himself and Davidovitch to include magnesium sulphate.

Its action is three-fold causing central depression, reducing cerebral oedema and enhancing the effect of other sedatives. If used IM abscess formation may occur therefore it is injected S/C. It is now infrequently used in Britain but is commonly used in America.

(vi) *Heminevrine (chlormethiozole):* is good but may cause apnoea, especially following heavy sedation.

Hypotensive Agents suitable for use in pre-eclampsia:

Protoveratrine: is a good hypotensive agent which dilates blood vessels, causes bradycardia (Bezold-Jarish reflex), raises the G.F.R., but may cause apnoea. (Four 0.1 mg. ampoules in one litre of 5% dextrose at about 30 drops per minute.)

Hydralazine: works by dilating smooth muscle with the diastolic B.P. falling quickly. The pulse rate may rise. Tolerance may develop. S.L.E. may be associated with use of this drug.

Tribromethol: used per rectum. This is excellent in that it is both hypotensive and anticonvulsant, but has the disadvantage of being difficult to use properly and being unpleasant for the patient. Tribromethol is an oily liquid and must be warmed to 37° to 40°C. for adequate absorption to occur, however, toxic products may form especially when overheated. The presence of toxic products is shown by adding Congo Red, the liquid being discarded if it turns blue.

Reserpine: has a sedative and hypotensive action, but is little used since side effects include depression and sodium retention; taken orally reserpine has a long latent period.

Ganglion blockers and Noradrenaline release blockers cause peripheral pooling of blood, hence diminished venous return and reduced cardiac output and placental circulation. The latter also applies to Guanethidine and Alpha methyl dopa. These drugs have no place in modern treatment of pre-eclampsia.

Hypotensives will not sedate the patient, therefore they must be combined with sedative and/or anticonvulsant drugs.

Termination of Pregnancy by Induction of Labour

Severe uncontrolled pre-eclampsia is a strong indication for termination of pregnancy by induction or even Caesarian section. Termination of pregnancy at about 30 weeks gives minimal prognosis to the fetus but maternal prognosis is vastly improved—avoiding, for instance, a C.V.A.

Labour is induced in all controlled pre-eclamptic patients at about 38 weeks. Induction is necessary due to the normal physiological falls in placental function after 38 weeks which, combined with pre-eclamptic insufficiency, may lead to fetal dysmaturity and distress.

An indication for induction earlier than 38 weeks would be persistent proteinuria and serial low placental function measurements, with evidence of chronic growth retardation.

Management in Labour of Pre-eclampsia

Single room.

Blood pressure, pulse, fetal heart rate and regularity, input, output, proteinuria, ketonuria, headache, blurred vision, vomiting and epigastric pain are signs and symptoms which should be recorded. Fulminating pre-eclampsia may develop rapidly during labour, especially in West Indians.

Sedation: in mild controlled cases pethidine and promethazine. If the blood pressure rises then "Lytic cocktail" may be given; if the blood pressure continues to rise then a regime of IV diazepam together with hypotensive agents or rectal tribromethol will be required.

Following sedation, vaginal assessment of the pelvis should be made, the presentating part and its position should also be checked. A 5% dextrose drip may be required if there is evidence of dehydration or if labour is being medically induced.

If the patient remains well controlled then normal labour may continue. Usually delivery occurs within twelve hours of an A.R.M. since the uterus is more irritable in pre-eclamptics and they are prepared for childbirth. Epidural anaesthesia is useful.

If the blood pressure is not adequately controlled, or labour is not rapid, then delivery must be accelerated. If the os is less than 7 cms. then a Caesarian section will be necessary. If the os is ¾ dilated with a thin rim of cervix, then Ventouse extraction under anaesthetic may be the least traumatic technique of assisted delivery. If the cervix is fully dilated, then forceps should be applied without delay, often with general anaesthesia.

When severe pre-eclampsia develops in labour then operating staff, an anaesthetist and a paediatrician should be warned that Caesarian section may be needed at short notice.

In cases of mild controlled pre-eclampsia half the usual dose of syntometrine should be given IM with the birth of the anterior shoulder; in cases of severe pre-eclampsia oxytocin should be given IV since P.P.H. is likely in such patients. If forceps were applied and an episiotomy made, then suturing should follow delivery while the patient is still in the lithotomy position. If forceps were not applied but there is a slight rise in blood pressure post delivery, then it is advisable to delay suturing.

Post Partum Management of Pre-eclampsia

Blood pressure readings must be taken regularly for the first few hours since fulminating pre-eclampsia and eclampsia can occur for the first time post partum. If the blood pressure has been very high during labour then the room should be darkened, with sedative and hypotensive therapy continuing until the pressure settles.

Prescribed for

ASTHMA

by doctors all over the world

Felsol's widespread use and reputation rests securely on its immediate, safe and prolonged relief of bronchospasm—the chief factor in asthma, whatever the cause. Narcotic-free and easily administered, its complete effectiveness breaks the vicious circle of anxiety and apprehension, and strengthens resistance against recurring attacks. Doctors favour Felsol because it inspires the self confidence so essential to improvement in this difficult and distressing condition.

Clinical samples and literature on request.

BRITISH FELSOL COMPANY LTD.,
206/212 ST JOHN STREET, LONDON E.C.1

A nurse should be present at all times to watch for eclampsia or apnoea.

Once controlled pre-eclampsia resolves completely post partum and the mother usually returns home within ten days.

If urine microscopy and culture showed evidence of renal damage or infection during pregnancy then an I.V.P. should be performed six months after delivery.

Complications

Pre-eclampsia may progress to **eclampsia.**

1. *Eclampsia* is an epileptiform convulsive fit ending in a period of coma. 5% of pre-eclamptic patients develop eclampsia; eclampsia being preceded by pre-eclampsia in 85% of cases.

Eclampsia is classified according to the timing of the convulsions as occurring pre-partum, intra-partum or post-partum. Whereas twenty-five years ago 64% of eclamptic episodes occurred pre-partum, 19% intra-partum and 17% post-partum, present figures indicate an equal distribution in all three groups.

The more marked the symptomatology, the higher the likelihood of convulsions and coma and the higher the maternal and fetal mortality and morbidity. Convulsions multiply the maternal mortality ten times and the fetal mortality forty times. The relationship of eclampsia to prolonged labour should be noted.

Causes of maternal death due to eclampsia are circulatory failure and pulmonary oedema, cerebral haemorrhage, renal failure, pneumonia and liver failure. Fetal death may occur in utero due to hypoxia or acidosis. (Fetal growth may be retarded due to placental insufficiency, also prematurity may ensue.)

In the mother intra cranial haemorrhage may result in retinal detachment and blindness, paralysis or death.

2. Nearly half the patients with premature separation of the placenta have an association with pre-eclampsia or eclampsia.

3. During an eclamptic fit there is danger of aspiration pneumonia (Mendelson's syndrome) and also fractures of the vertebrae.

4. 15% to 20% of patients with severe pre-eclampsia or eclampsia without known pre-existing H/T or renal disease suffer recurrence during subsequent pregnancies or permanent H/T. Pre-eclampsia occurs in 50% of women with severe essential H/T, but repeated pregnancy in women with mild essential H/T, who do not develop pre-eclampsia, will not cause progression of H/T.

Management of Eclampsia

The aim is to treat the eclamptic episode and prevent further fits. Emergency treatment during fit:—

1. Ensure airway, lie patient on side.

2. Oxygen.

3. Total sedation and anticonvulsive therapy, 30 mg. IV Diazepam is the emergency treatment of choice. (Paraldehyde may be used.)

4. If not in hospital already, the flying squad should be called. The patient should be moved to hospital as soon as the blood pressure is controlled.

General: Hospitilize in single darkened room, absolute bed rest with side rails and special 24 hour nursing. No visitors or unnecessary procedures. Patient lies on her side to avoid I.V.C. syndrome and aspiration of vomit. Padded tongue blade, bulb syringe and catheter (or suction machine) on hand. Oxygen by cone or tent, if possible, since masks or catheters may stimulate fits. Blood must be typed and cross matched. Maternal blood pressure and fetal heart rate are recorded quarter or half hourly during the acute phase. The fundi are not examined.

Electrolytes, non-protein nitrogen and serum proteins are measured. If serum protein is below 5 mg.% then 25-50 ml. of salt-poor albumin is given. Urine volume and protein content are measured until the 5th day post-partum. (An indwelling catheter is usual.)

Diet and Fluids: Nothing by mouth until control well established. Fluid balance charts are kept. When controlled a high carbohydrate, high protein, low fat, low salt diet of 1500 cals. is given daily. If urine output exceeds 700 mls. per 24 hours, then this is replaced, plus 500 mls. for "invisible loss." with sodium free fluid. Varying concentrations and amounts of dextrose solution will be given proportional to the length of time the patient has been in the acute phase. (Liver protection.)

Sedation and hypotensive therapy is basically as described previously.

Delivery: An eclamptic episode is an absolute indication to end the pregnancy by induction, termination or Caesarian Section, once control has been achieved; (many people now move to Caesarian Section before control is complete). Vaginal delivery is preferable but if the patient is not at term, bleeding, or if disproportion is suspected, then Caesarian Section is performed.

Prognosis of Pre-Eclampsia and Eclampsia:-

Maternal mortality is one per 5000 births. If eclampsia supervenes on pre-eclampsia, the maternal mortality is 7% (many centres now achieve a much lower figure); mortality is higher in pre-partum eclampsia than intra- and post-partum eclampsia.

Fetal mortality is due to placental insufficiency or premature birth. In mild pre-eclampsia fetal mortality is 5%, in severe forms it is 14%; if eclampsia occurs ante-partum mortality is 47% and if intra-partum it is 9%. If one pregnancy is complicated by pre-eclampsia, then there is a 50% chance that PE will occur in the next pregnancy, likewise a 75% chance thereafter.

However, 90% of primagravida who develop eclampsia will never get a recurrence, whereas multiparous women developing eclampsia may have a recurrence in future pregnancies.

The authors would like to thank Mr. Hudson for his constructive criticisms of their "first draft" of this article.

ROBERT BALTHROP

By JOHN L. THORNTON

There are two Elizabethan monuments in St. Bartholomew-the-Less, one being a memorial tablet to Ann, the wife of Sir Thomas Bodley, founder of the Bodleian Library at Oxford, and the other an effigy-ornamented monument to Robert Balthrop, who was Serjeant-Surgeon to Queen Elizabeth I. Neither memorial attracts much attention from casual visitors, the first possibly because it is entirely in Latin, and the second because it is rather high on the wall, and not readily seen.

Robert Balthrop was never on the staff of the Hospital, but he must have been a distinguished surgeon of his period with an extensive practice. He leased a house in West Smithfield belonging to the Hospital, and within the Parish of St. Bartholomew-the-Less. Moore's *History* (1918) mentions Balthrop several times, but the main source of information is Young's *Annals of the Barber-Surgeons* (1890), which provides extensive extracts from his lengthy Will, from which the sections below are derived.

Born in 1522 Robert Balthrop (Balthrope, Baltrop, Balthroppe, etc.) was apprenticed about the year 1538 to Nicholas Alcocke (died 1550), Surgeon to Edward VI. Alcocke left in his Will 40*s*. to "Bartholomew's Hospital," and also declared: "I bequeath to Robert Balthorpe late my apprentice my booke called Guido in Englysshe;" and later: "I bequeath to Robert Balthrope some tyme my apprentice my Russett woorsted gowne faced with calabre^r and garded with velvett." (Young, 1890, pp. 527-528). Balthrop was admitted to the Freedom of the Barber Surgeons on March 3rd, 1545, to the Livery on October 20th, 1552, served as Warden in 1560 and 1564, and also served twice as Master, in 1565 and 1573. He was appointed Serjeant-Surgeon to Queen Elizabeth about 1562, and still held that office at the time of his death, which occurred on December 9th, 1591. His Will was made on November 27th, shortly before this event, and in it Balthrop directs that he should be buried in the church of St. Bartholomew-the-Less, in which parish he resided. He must have lived in the parish for some years, as suggested in the Journal of the Board of Governors of the Hospital under the following dates:

November 27th, 1557. Robert Baltropp and Thomas Farrere are chosen churchwardens for the year to come by the parishioners of St. Bartholomew the Less.

June 17th, 1559. The renter must repair the house in Smithfield in the tenure of Baltrop and Sowle, the former, thereof, must pay part of it.

August 2nd, 1561. A new party gutter must be made between "Bellocke and Soules house in the tenure of Mr. Baltrop."

June 4th, 1575. Mr. Balthrope must repair his house as was indicated in the last review of the property.

April 28th, 1576. The tiles of Mr. Sergeant Balthrop's house must be immediately repaired.

March 3rd, 1581/2. The pavement before the house of Mr. Sergeant Balthroppe must be immediately repaired.

March 6th, 1587/8. Mr. Balthrope must carry out repairs as indicated at the last view.

The Treasurer's Accounts for Michaelmas 1574 to Michaelmas 1575, and for 1575-6 and 1576-7 carry the same entry: "West Smithfield William Balthroppe yearly £7. 6. 8." but not for any other years, and it will be noted that the first name is wrongly given as William.

John Griffin was bequeathed the lease of this house in Balthrop's Will upon payment of £10, and "My fyne clothe gowne welted with velvett and faced with Damaske." Griffin was Surgeon to the Hospital (1586-1593) and was formerly Balthrop's assistant, as was also Lewis Rogers, who unsuccessfully applied for the post of Surgeon to the Hospital.

Balthrop's Will reveals a considerable estate and many varied possessions, including books, instruments, jewellery, gowns, cloaks and landed property. To his four named servants Balthrop left forty shillings each, and to his wife's maids twenty shillings. John Mason, Chirurgian, dwelling in Long Lane, was left forty shillings and other small legacies.

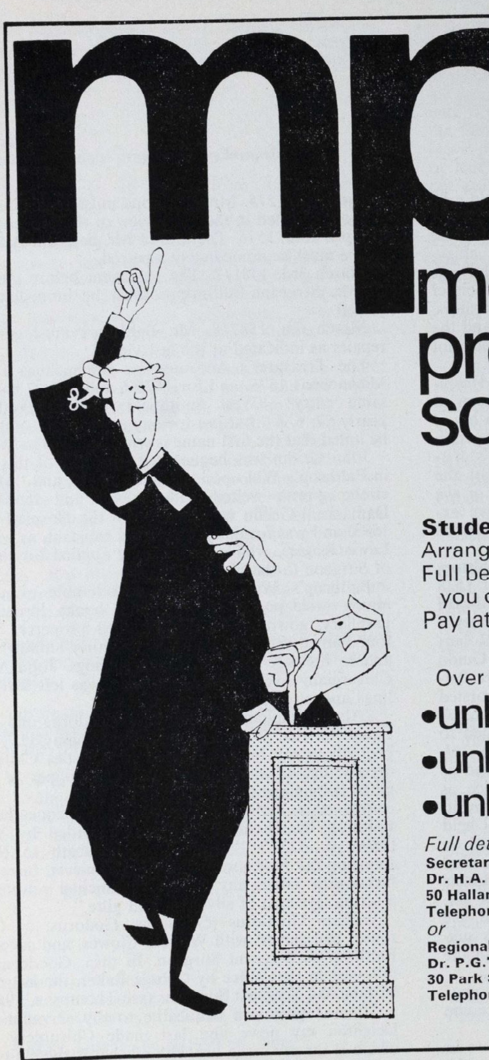
"Also I bequeth to my felowe Goodorus one of my Launcetts that is sett in golde and enamyled. Also I bequeth to my felowe Baker her maiesties Chirurgion my Syringe of silver gilted and three pypes of silver gilted belonginge to the same."

Was this syringe the same one bequeathed to Balthrop by Thomas Vicary, as recorded by Young (1890, p. 523)?: "I give and bequeath to Robert Baltropp my best gowne garded with velvet, furred and faced with Sables, my Cote of braunched velvete, and a sering (syringe) of silver, parcell gilte."

William Goodorus (Gooderus; Godorus; or Goodrouse) had served with William Clowes, and succeeded Balthrop as Sergeant Surgeon. In turn, Goodorus was followed in that office by George Baker, the last of the Elizabethan Sergeant Surgeons (see Thompson, 1960).

"Item I give and bequeathe to my servaunt John Deighton my newe and last made Chirurgery chest which is for my owne use with all that is therein except golde and silver. Also I bequeath to him my plaster boxe of leather which hath the lock hinges and barrs over yt of Copper gilted and the cysars and all the silver instrumentes therein. Also I give unto him my rownde silver salvatory and one catheter of silver and annother

mps
medical protection society est. 1892



Students!
Arrange membership now.
Full benefit immediately you qualify.
Pay later at no extra cost.

Over 50,000 members enjoy
•unlimited advice
•unlimited legal aid
•unlimited indemnity

Full details from
Secretary:
Dr. H.A. Constable, Head Office
50 Hallam Street, London, W1N 6DE
Telephone: 01-580 9241
or
Regional Secretary:
Dr. P.G.T. Ford, Regional Office,
30 Park Square, Leeds 1
Telephone: 0532 42115-6

of leade with the case wherein they are. Also I give unto him a case with silver Instrumentes therein that ys to saye a silver splatter a chockbarr of silver for the uvula a silver Syringe parcell gilted. Also I give unto him my silver precipitate box all wch thinges are in the aforesaid chest. Also I bequeath unto him all my bookes of Phisicke and chirurgery with two Dixionaries which are in my study in my house at Manfeilde parke in the parishe of Taplowe. I also bequeath unto him my Englishe bible which is at the Courte. I give and bequeath to Lewes Rogers somtyme my servaunte my greater surgery Chest which is in my Chamber here at London with all that is therein except golde and silver. Also I give unto him my plaster box which my wife hath in the Countrie with all the instrumentes therein belonginge to the same. Also I give unto him a Catheter of silver which is in the Chest that I have apointed to John Deighton my servaunte. Also I give unto him these bookes followinge Guydoes Chirugery in ffrench, Bartholomeus De proprietatibus rerum, Vidus Vidius Interpres, Valescus his practise, Albucasis Discorides, Cornelius Celsus, Johannes Mesue, Marcus Catenarcus, Guydoe in latin, Leonardus ffuschius, Gyrolanus in ffrench and Quintus Curtius in Englishe. Also I give and bequeath to my servaunt John Edwards my least Chirurgery Chest which is at the Court for the Dayly use of my servauntes with all that therein is, my plaster box of leather with ye gilted locke and hinges of silver with all the instrumentes therein to the same belonginge and these English bookes, Gemimes Anathomy, Guido and Leonard ffuschius both in written hand, John Vigo, Eliot's Dictionarie which I have lent to my felowe Goodorus, Turners herball and my byble which is at my howse in Manfeilde parke. Also I give unto him a pewter Syringe with three pypes of silver belonginge to the same. Also I give unto John Griffin somtymes my servaunt my silver salvatory percell quilted which is in the Chest that I have appointed to my servaunte Lewes. Also I bequeath to Anthony Gariswall somtyme my servaunte one bigge latin booke wherein are bounde togeather the Chirurgeries of Guido, Brumis, Theodoricus Lanfrancke and Alberti Palus. Also I give and bequeath unto the companie of the Barbors and Chirurgeons of the Cittie of London the Chirurgery of that most excellent writer John Tagaultius the lattin booke and also the English translation that I have made thereof. And also the Chirurgerie of the expert and perfect practitioner Ambrose Parey both which workes I have written into Englishe for the love that I owe unto my bretheren practisinge Chirurgerie and not understandinge the latin Tounge and given them into the Hall for theire Dayly use and Readinge both in lattin and Englishe and Desiringe that they may be kept faire and cleane for my sake which wish them all prosperous and good successe in theire workes and endevours whatsoever they take in hande to the glory of God and the advauncemente of the Arte. Also I give unto my servaunt John Edwards my Case with all the Instrumentes therein which is in my Chest which I have appointed for Deighton. Also I give unto my servaunte John Deighton my bagge with the case and all the Instrumentes and other thinges that are therein which lyeth for my Daily use of the two hospitalls Sainte Bartholomewes and ffinally my will is that myne Executrix shall give to the use of the two hospitalls Sainte Bartholomewes and Saint Thomas for the sicke and sore people there all other such medicines bookes Instrumentes bottles boxes and pottes and such like thinges belonginge to Chirurgery as are not in this Schedule bequeathed and given and such as she will reserve for her owne use, and to give to the poore for Christes sake."

Probate of Balthrop's Will was granted on December 16th, 1591, and his wife Dorothy had the residue of his lands, houses, goods, jewels and other possessions.

Robert Balthrop was buried in St. Bartholomew-the-Less on December 12th, 1591, and a monument to his memory was erected on the south wall of the Church. Norman Moore (1918, p. 841) states that this was at that time hidden by the organ which "fills up nearly the whole of the angle, and conceals the fine monument of Sergeant Balthrope, the medallion of Mary Darker, who died in 1773, and the record of the Reverend Samuel Kettilby, vicar from 1773 to 1808." The organ is now sited elsewhere, and the memorials are clearly visible.

The lettering on the monument reads:

Here Robert Balthrope lyes intombd to Elizabeth our Queene
Who Sergeant of the Surgeons sworne neere thrtye yeeres hathe beene
He died at syxtie nine of yeeres December's ninthe the daye
The yeere of Grace eight hundred twice deductinge nine a waye
Let heere his rotten bones repose till angells trompet sounde
To warne the worlde of present chaunge and raise the deade from grounde
VIVIT POST FUNERA VIRTUS

Simple arithmetic confirms the year of his death as 1591, but Norman Moore (1918, p. 282) erroneously gives this as 1589.

Acknowledgements
I wish to thank the Rev. R. H. Arnold, the Hospitaller, for permission to reproduce the photograph, which was taken by the Department of Medical Illustration. Also Dr. Nellie Kerling for providing the information from the Hospital Archives.

REFERENCES

Moore, N. **The history of St. Bartholomew's Hospital**, Vol. 2, London, 1918.

Thompson, H. R. Sergeant Surgeons to Their Majesties. **Ann. Roy. Coll. Surg., Engl.** 26, 1960, 1-23.

Young, S. **The Annals of the Barber-Surgeons of London**, London, 1890.

OUT ISLAND DOCTOR

By J. S. PEMBREY

While working in the Bahamas as a medical officer I was fortunate enough to become flying doctor to the out-islands for 2 months while the usual doctor was on holiday. Each morning for 4 days of the week, a nurse, pilot and myself boarded a light aircraft and set out for one of 15 islands that we had to visit.

Travelling to work in the morning had never before been such a pleasure. Instead of walking along long corridors or getting involved in traffic I enjoyed the exhilaration of flying and some truly breathtaking scenery. The sea that encompasses the Bahama Islands is very beautiful. An amazing variation on the colour of blue is interrupted by white sandbanks and small green coral islands surrounded by bright yellow sand. The water is extremely clear as there are no rivers to cloud it with sediment and silt. From the air you can see markings on the sea bed and spot sharks and manta rays many feet below the surface.

On our arrival at the chosen out-island we "buzzed" the small community to let them know that the clinic would be starting shortly and to let the local nurse know that she ought to start out towards the airstrip to meet us. A number of the islands were too small to have an airstrip and in these cases we travelled by seaplane. On landing, one of the fishermen would row out in a small boat and ferry us ashore.

The people on the island had been warned by way of a radio message that the doctor would be visiting that day. As he only came every 3 to 4 weeks it was a fairly important social event and the clinics were well attended.

During the 2 months we saw about 580 patients, an average of about 40 at each clinic. Sometimes there would be less than a dozen, in which case we had time to swim out and fish afterwards, but at other times we had as many as 70 people attending a clinic. Dealing with large numbers like this gave me an idea of the pressures that some of the doctors in the under-developed countries must come under and also the general practitioner here, before he had the help of appointment systems, receptionists and chemists. If you spend just 5 minutes on each of the 70 patients, you are working flat out for almost 6 hours, during which time you will be feeling that you are keeping other patients and your staff waiting an unreasonable time. For a few hours life is a blur of history, examination, dispensing medicines and giving advice. Unfortunately in this situation you do not honestly look forward to the more interesting cases because they take so much longer to deal with.

The nurse's help was invaluable and she was able to deal with a number of patients herself. Her main duties consisted of immunisation of children, checking blood pressures, dressings and preparing antenatal cases.

The patients were friendly, cheerful people living at a very slow pace of life, poor but seemingly content and on the whole very healthy. Most of the men were fishermen—selling their catch of conch and crawfish in Nassau or Miami. Others spent most of their time working in Nassau or one of the larger islands and would send money back to their families. The women weave baskets and hats for the tourists but most of their time is spent looking after their children. The average family contains about 6-8 children and pregnancy was the most common single complaint at the clinics. If a girl has not had a child by the age of 18 or 19 years, her neighbours would think there was something very wrong. There is no stigma about not getting married, but a definite stigma about not being able to prove that you can have children. The children's surnames are the same as those of their father's, and it is not uncommon to find a woman with 6 children, most of whom have different surnames. The men do not feel under any obligation to marry the woman they have made pregnant, but would lose pride and the respect of others if they did not help to support her and their child. Attitudes are changing towards increased male responsibility, female equality, stable marriages and limiting the size of the family, but it is a very slow process.

After pregnancy, Essential Hypertension was the most common adult complaint and cerebrovascular accidents in the elderly were common. Although hypertension and obesity were both common, it was interesting to note that coronary artery disease was extremely rare.

The children were well looked after and fairly healthy. The only malnutrition one sees is that associated with chronic disease such as amoebic dysentery. The fairly high incidence of worm infestations, gastroenteritis, and amoebic dysentery was a reflection on the poor hygiene and inadequate disposal of waste that existed.

Some of the expressions that patients used at the clinics were really delightful. "I have swinging in the head," "I feel haphazard," "contrary" or "weak, weak, weak," would be symptoms of feeling unwell, and could be due to anything from pregnancy, anaemia, anxiety, hypertension, excessive alcohol intake, wanting some tablets or just wanting to see what the new doctor was like. "Cascading" was a beautiful alternative to "vomiting" or "throwing up," and "operating fast" meant diarrhoea. If an old man came up and complained of "losing his life," it was not death he was worried about, but certain matrimonial difficulties. It was sometimes difficult to find out when a particular symptom started, as most people relate events to another event and not to the day or month. For example, it was difficult to deduce when a woman had her last period, when she suggested hopefully that it was when she was "sprinkled in the rain."

After we had finished the clinic, the nurse and myself were usually rewarded with ice-cold drinks and then we would make any home visits that were necessary. The islanders lived mainly in small wooden shacks raised off the ground by rocks at each corner. The space under the floorboards reduced the number of insects such as termites and cockroaches getting into the house, kept the house cool and reduced the chance of flooding after the torrential rainstorms which are common in certain seasons. Sometimes there was a wire mesh across the windows to keep out mosquitoes, but often windows were just an open space. Shutters on every window remind one that every few years hurricanes sweep near to or across the Bahamas. Being open to the elements is not a great disadvantage, because the Bahamas enjoys an excellent climate. Temperatures only vary between a mean of 60°F in the winter and 80°F in the summer. In the winter the climate is almost ideal with almost every day being as pleasant as a warm summer's day in Britain. It is only about the summer months that one can complain. With the temperature often between 80 and 90°F and humidity over 80 per cent., life is uncomfortable without air-conditioning, continuous cold drinks and frequent showers. In the larger islands there is piped water and mains electricity but on the smaller islands water is hand-pumped from artesian wells, and light is provided by kerosene lamps. A few houses have their own electricity generators and others have roofs adapted to drain the occasional rainfall into tanks in the basement. It can be seen that the islanders suffer the inconvenience of having very few of the amenities which we take for granted. On the other hand they can live life at their own pace, breathe clean air, swim in clear waters and lie on beautiful beaches in the sunshine.

Arriving back in Nassau on New Providence Island one is in a completely different world. Nassau is the capital of the Bahamas and here live over half of the hundred thousand population. It is a place of contrasts. Luxurious houses, modern apartment blocks, huge hotels and casinos at one extreme and wooden shack areas at the other. Rolls-Royces, Cadillacs, Ford Mustangs, Morris Minors and horse-drawn Surreys mingle on the overcrowded streets. Tourism is the main and apart from banking the only important industry. Bay Street is usually crowded with American tourists buying European (this includes British) goods at which must be the most expensive shopping centre in the world.

Although the Bahamas is still a British colony there has been internal self-government for many years and Independence is not far away. With "Bahamianisation" in progress it is becoming more difficult for British people to find work there. However, at the moment Britain supplies a large number of accountants, bankers and teachers and a small number of doctors, nurses, vets, architects, etc. People going out there can expect poorer working conditions, higher wages (with no income tax), relatively luxurious accommodation, excellent social life, plenty of sport (including rugby, golf, water ski-ing, yachting and motor racing) and a general feeling of being away from the rat race.

After a while—a year in my case, you begin to feel that you have been on holiday long enough. Life is too easy and rather superficial. As Confucius might have said "Sometimes it is more satisfying to battle against the current of life than float on the top."

BOOK REVIEWS

MATERIA MEDICA FOR NURSES
W. Gordon Sears and R. S. Winwood. Published by E. Arnold Ltd. £2 net.

This book, first published in 1943, now out as the seventh edition is obviously a successful venture. Dr. Winwood is now assisting in producing this book—a partnership recently used for the new edition of Medicine for Nurses.

They have dealt well with the addition of new drugs a difficult task with so many on the market at present. I like the use of smaller sized print for the reference items; it enables one to quickly see the main points in each chapter.

The diagrams and information on Physiology will also be helpful to the student nurses and makes more meaningful the action of some drugs. It is nice to see a Doctor giving nursing measures for helping patients to sleep not just advocating sedatives.

It is a pity that the basic facts about The Committee of Safety of Drugs (Scowen Committee) are not included in the legal aspects section, not because he is a Bart's man! but because it is now statutory for all new drugs to be examined by this committee.

Another alteration I would like to have seen is the removal of Table 6 on page 190 where units of insulin are shown measured in minims—a very outdated procedure. It is dangerous for nurses to use other than the British Standard Insulin Syringe when administering insulin.

Now that a practical drug assessment is becoming part of the Final State Examination I'm sure that the sales of this already popular book will increase. I think the £1 paperback edition will be more suited to the nurses' pocket (financially, I mean!) than the hard-backed edition.

C. W. LAWTON.

NOTES ON MEDICAL VIROLOGY
by Morag C. Timbury. Foreword by J. H. Subak-Sharpe. Third Edition. 75p.

The increasing popularity of this little book has no doubt prompted the appearance of this new edition. It has generally been brought up to date and a previous chapter on bacteriophage has been replaced by one on "slow" viruses and there is a new section on the Marburg agent.

It is certainly an excellent little book but it must be appreciated that it is no more than a "crammer," containing a long list of virological facts with little room for discussion or critical analysis. It should not be regarded as a substitute for standard texts, such as the excellent volume by Fenner and White, but rather—as the author suggests—as a supplement to these and lectures.

Students will no doubt find this small volume most useful in those desperate days just before examinations.

R. B. HEATH.

PERSONAL VIEW

By Mr. C. N. HUDSON

The state of pregnancy is a personal and private matter. A strong view put by a consumers' "pressure group" to the Pharmaceutical Society stated very forcibly that pharmacists had no right to deny the result of a pregnancy test to a woman to whom it mattered. Perhaps as a result of this pressurisation the Society relaxed its former rules restricting communication of test results to members of the medical profession only.

Pregnancy testing is a very lucrative sideline for retail pharmacists and also those egregious laboratories which advertise so freely on the Underground and elsewhere; a test costing no more than 40p may be charged at £2. At the same time, however, the Secretary of State for the Department of Health and Social Security has laid down that the performance of pregnancy tests comes within the terms of service of General Practitioners and thus no charge may be made by them for such tests. A curious inconsistency thus allows one branch of the Health Service to make an easy profit out of selling the result of a test direct to the public, while denying another branch the chance even to recover their expenses. Whatever the merits of these decisions by the Secretary of State and the Pharmaceutical Society, a precedent has been set which may enable the public to demand that the results of tests as varied as cervical smears or chest X-rays be given to them direct without reference to a qualified practitioner. It has always been a strict principle in the running of the "Well-Women's Clinic" at this Hospital that the result is only given in the most general terms to a patient and that the technical details are sent simultaneously to her General Practitioner. Moreover the Williamson Laboratory which offers a "pregnancy testing" service to local General Practitioners as well as within the Hospital, makes it a strict rule not to give the result to a patient or over the National Telephone. This attitude is based on the fact that there are certain potential errors associated with common pregnancy tests, some methodological and others arising from the clinical condition. The social and medical consequences dependent on the result may have far reaching implications and we believe that only a qualified practitioner may properly assess the significance of a given result in relation to any specific patient.

Modern pregnancy tests are based on the fact that it has been possible to produce specific antisera against human chorionic gonadotropin, the hormone which is excreted in the urine in the early months of pregnancy. Most manufacturers claim an accuracy of over 95 per cent. for their products, but there are some recognised intrinsic causes for error, such as chilling the reagents, contamination of the urine by bacteria or actual urinary infection, or traces of chemicals left in the vessel used to collect the urine. In continuing to allow retail pharmacists to perform tests directly for the public, the Secretary of State has perhaps overlooked the fact that pregnancy tests are not tests for pregnancy but tests for human chorionic gonadotropin. A woman who desires a pregnancy test presumably wants to know if she is expecting a baby. If, however, she is harbouring a vasicular mole she will nonetheless have a positive test, but will not in fact be expecting a baby. She is in urgent need of advice appropriate to her actual condition but unlikely to get it from a Pharmacist. The situation could be tragic if the symptoms which led a parous woman to seek a pregnancy test were not due to another pregnancy but to a malignant form of trophoblastic disease (chorioncarcinoma) which would give a positive result. The tragedy might well become worse seeing that the prognosis in this condition is directly related to the time interval between the antecedent pregnancy and effective therapy. Non-gestational chorioncarcinoma may be very rare but is a recognised feature of certain malignant ovarian teratomata and will likewise give a positive pregnancy test. These are therefore three important conditions which may all give a positive test to a woman who is not expecting a baby, and then the diagnosis and institution of correct treatment will very likely be seriously delayed if the result is not given through a General Practitioner. By the same token, there are two situations in which a woman may be carrying a baby and in which pregnancy tests are commonly negative. When a pregnancy is extra-uterine, there is sometimes a deficiency in circulating gonadotrophin so that standard tests may be negative. This does not mean that the risk of this condition is any the less, but a patient who collects the bare result from a retail chemist may incorrectly assume that her symptoms are not due to pregnancy and then fail to seek medical advice. Tubal rupture may occur so rapidly that a woman can even expire before she can seek aid. Likewise, if a developing baby dies, but is retained in the uterus the condition is called a "Missed Abortion." Pregnancy tests will usually be negative, but treatment is required because prolonged retention of a dead fetus can occasionally precipitate a serious blood coagulation failure. In both these clinical conditions a negative result given direct to a patient could delay the institution of special therapeutic measures, without which the patient may be at serious risk, even to her life.

It is reasonable to suggest that any woman seeking a pregnancy test will have some cause to suspect the possibility of pregnancy. The commonest symptom is secondary amenorrhoea which may sometimes be due to other causes. Most of these are not particularly urgent but genital tuberculosis is an obvious exception.

Perhaps the most important aspect of "open" pregnancy testing is that those members of the public who have the greatest urge to seek a "private" pregnancy test are those who in fact are most in need of medical and social counselling. The need to perform therapeutic termination in the first trimester, if possible, puts a premium on early diagnosis. Termination is, however, only legal under the Abortion Act if recommended in good faith by two registered practitioners and thus it is particularly important that a woman who might qualify should be receiving informed medical advice at the earliest opportunity. A woman who is at pains to keep the test and her condition hidden from her medical adviser is just the one most likely to go to an illegal abortionist, and this is the very situation we are all trying to avoid. It would be particularly tragic if a woman attempted to interfere with her own pregnancy through ignorance of her own position under the Abortion Act. The irony would be complete should the action be taken on the basis of a false positive result.

It is difficult to see any valid reason why tests for excretion of one particular hormone should be singled out for different ethical treatment with respect to the public at large. Only a qualified practitioner is able to judge the significance of technical medical investigations and deviation from this principle must be regarded as regrettable. If the Minister regards immunological tests for human chorionic gonadotropin as coming within the terms of service of General Practitioners and therefore to be provided without fee, it is quite illogical to allow non-medical persons to perform such tests for a fee and then to give the result direct to the public.

The
Gateway Tobacconist
and
Tuck Shop

LITTLE BRITAIN - BY BARTS THE GREAT

ALMOST IN THE HOSPITAL - ALWAYS HELPFUL

A vast selection of confectionery
and grocery always in stock
for your convenience.

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.

ADNITT, P. I., *see* FRAYN, K. N., and others.

BATES, T. Paraplegia following resection of abdominal aortic aneurysm. A report of 3 cases. *Brit. J. Surg.*, 58, 1971, pp. 913-916.

BEARD, R. W., (with others). Out Patient termination of pregnancy. *Brit. med. J.*, Dec. 4, 1971, pp. 606-610.

BESSER, G. M., *see* KNIGHT, R. A., and others.

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

*BLACK, K. O., (and King, R. C.). Anaesthesia in diabetes mellitus. In, Gray, T. C. and Nunn, J. F., *eds., General Anaesthesia*, 3rd ed., Vol. 2, pp. 54-58. 1971.

BRAITHWAITE, F. (and Frew, I.). A palatal incision. *Lancet*, Dec. 11, 1971, pp. 1294-5.

*BROWN, J. R. *Lifting as an Industrial Hazard*. Labour Safety Council of Ontario, Ontario Department of Labour. [1971].

CANTI, G., *see* OSWALD, N. C. and others.

*CASTLEDEN, W. M. Urinary infection and catheterization: a case for a catheter team. *Aust. N.Z. J. Surg.*, 41, 1971, pp. 65-68.

*——, and others. Routine screening of the urine of orthopaedic patients for bacteriuria using a dip-slide technique. *Med. J. Aust.*, 2, 1971, pp. 262-263.

COTES, J. E. Lung volume indices of airway obstruction: A suggestion for a new combined index. *Proc. Roy. Soc. Med.*, 64, 1971, pp. 1232-1235.

*DAY, G. Suicide—English style. *Perspect. Biol. Med.*, 14, 1971, pp. 290-300.

——, Personal view. *Brit. med. J.*, Dec. 25th, 1971, p. 809.

EDWARDS, Griffith. Personal view. *Brit. med. J.*, Dec. 4, 1971, p. 619.

*FERNANDO, N. I., and HEATH, R. B. Studies of the heat lability of mouse anti-Sendai virus immune sera. *Archiv. ges. Virusforsch.*, 34, 1971, pp. 295-300.

*——, and Heath, R. B. A study of non-specific inhibition of paramyxoviruses by animal sera. *Indian J. Med. Res.*, 59, 1971, pp. 537-543.

*FRANKLIN, A. WHITE. Paediatrics. In, Gibson, W.C., ed., *British Contributions to Medical Science*, London, Wellcome Institute of the History of Medicine, 1971, pp. 235-265.

FRAYN, K. N., and others. The hypoglycaemic action of metformin. *Postgrad. med. J.*, 47, 1971, pp. 777-780.

GALBRAITH, H-J. B., (with others). Controlled trial of early mobilisation and discharge from hospital in uncomplicated myocardial infarction.. *Lancet*, Dec. 18, 1971, pp. 1331-1334.

GARDNER-MEDWIN, D., (with others). Muscle fibrosis and contractures in a pethidine addict. *Brit. med. J.*, Nov. 27, 1971, pp. 532-533.

*GRAY, D. J. PEREIRA. The care of the handicapped child in general practice. Hunterian Society: Gold medal prize essay. 1971.

HACKETT, M. E. Cadaver homografts. *Proc. Roy. Soc. Med.*, 64, 1971, pp. 1292-1294.

HARPER, R. A. KEMP. The radiological spectrum of Crohn's disease. *Proc. Roy. Soc. Med.*, 64, 1971, pp. 1181-1186.

HEATH, R. B., *see* FERNANDO, N. I., and ——.

HUNTSMAN, R. G. (with others). The sickle-cell and altitude. *Brit. med. J.*, Dec. 4, 1971, pp. 593-595.

KNIGHT, R. A., and others. Tumour ACTH concentrations in ectopic ACTH syndrome and in control tissues. *Proc. Roy. Soc. Med.*, 64, 1971, pp. 1266-1267.

*LAWTHER, P. J. Air pollution and its effects on man. *Community Health*, 3, 1971, pp. 119-122.

*——. Dying for a smoke. *BP Shield*, Sept. 1971, p. 20-22.

*——. Some recent topics in air pollution and health in London. *J. Japan Soc. Pollution*, 1970, pp. 223-330.

*——. Polucion del aire y sistema cardiorrespiratorio. *Tribuna Medica*, Feb. 15, 1971, p. 32.

*——, (and Commins, B. T.). Pollution from road vehicles and health. *Proceedings of the Clean Air Conference, Southport, 20-23rd October, 1970*, National Society for Clean Air, pp. 137-143.

*——, (and Bonnell, J. A.). Some recent trends in pollution and health in London—and some current thoughts. *International Air Pollution Conference of the International Union of Air Pollution Prevention Associations, Washington, 7-11 Dec., 1970*, Central Electricity Generating Board, London, 1971.

*LUMB, G., (with others). Failure of various drugs to induce drug-metabolizing enzymes in extrahepatic tissues of the rat. *Toxicol. appl. Pharmacol.*, 19, 1971, pp. 579-589.

*——, (with others). Quantitative structural and functional changes in the hepatic endoplasmic reticulum due to reduced food intake. *Proc. Roy. Micr. Soc.*, 6, 1971, pp. 204-205.

MILLER, A. B., *see* OSWALD, N. C., and others.

OSWALD, N. C., and others. The diagnosis of primary lung cancer with special reference to sputum cytology. *Thorax*, 26, 1971, pp. 623-631.

*PARTINGTON, M. W. (and others). Motor activity in early life. I. Fries' congenital activity types. II. Daily motor activity output in the neonatal period. III. Premature babies with neonatal tyrosinaemia; a pilot study. *Biol. Neonate*, 18, 1971, pp. 94-107, 108-120, 121-128.

RATCLIFFE, J. G., *see* KNIGHT, R. A., and others.

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

*SCOTT, A. P., and others. A phylogenetic study of pituitary corticotrophic activity. *J. Endocrinol.*, 51, 1971, pp. i-ii.

THROWER, W. R. Rustic obstetrics. *Nursing Times*, Dec. 23rd, 67, 1971, pp. 1598-1599.

TURNER, P., *see* FRAYN, K. N., and others.

*WALLER, R. E. Tobacco and other substances as causes of respiratory cancer. In, *Symposium on the Prevention of Cancer*, ed., Raven, R. W., 1971, pp. 17-28.

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

BUDGET-PRICED MAHLER

Gustav Mahler's music was described only 10 years ago as vulgar, crude, and boring. Despite this most severe criticism (which even your correspondent, a "Mahler" addict, will admit has slight factual basis—at least the first two strictures) over this period the music has become extremely popular with listeners and performers alike, partly due to the stereophonic record.

Mahler's background was exceedingly complex—he was one of ten children born to a poor Moravian. Eight died in early infancy. Later in life when Mahler consulted Freud, it was established that this deeply affected his development—it might also explain his attraction for a group of poems "Kindertotenlieder" which he set to music. As a child he lived near the local barracks and heard military bands—this type of orchestration is often seen in his music, as is the rhythm (Last movement of the Resurrection symphony.) He became an outstanding conductor (GBS, that great music critic, described him as the greatest ever.) He bought many new operas to Vienna including Wagner's "Der Ring," and revised Mozart's "Cosi" and "Don Giovanni" which had remained unheard since 1791. Intrigue and anti-semitism caused him to leave Vienna and he later conducted in the U.S.A. He died in 1911 at the age of 51 of bacterial Endocarditis.

He composed spasmodically—mainly at his summer residence in the country. This perhaps explains the pre-occupation with nature sounds (fluttering wood-wind). The works are on an exceedingly large scale but often very sensitively scored. They are full of melody and folk tunes. At times there is a brashness and loudness, nevertheless it has a style, charm and beauty all of its own. It is Viennese "coffee music" but *what* "coffee music."

The first four symphonies are based on music used in an early song cycle "Das Knaben Wunderhorn" (2, 3, 4, contain a vocal part); 5, 6, and 7 are purely orchestral. 8 is on a particularly huge scale requiring 1000 performers—it is called the symphony of a 1000. The tenth was left unfinished and at least 3 "performing" versions exist—Deryck Cooke's is recorded. The rest of the output includes "Das Klagende lied," "Das Lied von der Erde" and "songs of a wayfaring lad."

Selecting records for £5 becomes difficult because many of the works take 2 records, so I have allowed myself some discretion. At the moment you can buy 2 complete cycles of the symphonies (conducted by Kubelik and by Bernstein) but as with all great music one gains by listening to different interpreters, so despite "cheap" package offers I advise elsewhere.

Few worked harder than Bruno Walter for the Mahler cause—he conducted the first performance of 9 and other works. His recording of "Das Lied Von Der Erde" with Ferrier and Patzak and the Vienna Philharmonic—a 1952 recording has for many years been essential Mahler listening—it is an incredible bargain at 99p. (Decca ACL305). You can also buy Walter's 1, 2 or 9. Jascha Horenstein is another great Mahler interpreter—he has recently recorded 1 and 3 at full price but his new 4 is on cheap label—a wonderful performance in superb sound (Classics For Pleasure CFP159). Beware his old Turnabout recordings of 1 and 9 because the sound is hideous. For the full Mahler experience try either Barbirolli's marvellously warm 5 (2 records with Janet Baker singing the 5 "Rückert" lieder on the fourth side)—(HMV ASD 2518/9) or the no. 8 under Bernstein on CBS 72491/2—a work that just defies description.

"ALLEGRO."

BOOK REVIEW

BASIC PRACTICAL SURGERY
C. Barrie Williams. Bristol: John Wright & Sons Ltd. 1971. 180 Pages. £1.75.

In the preface to this short book, the author, a senior surgical registrar, states that his aim is to help the surgeon perform his craft by describing the principles of handling tissues, obtaining good exposure and the securing of haemostasis.

The book consists of seven chapters devoted to such topics as ligatures and sutures, wound drainage, catheters and bougies and wound healing.

There are numerous illustrations of surgical instruments, identical with those seen in instrument makers' catalogues, portraying instruments as basic as dressing scissors and scalpels and as complex as Zachery Cope's intestinal clamp.

The text, though written in lucid terms is patchy and lacks continuity. Thus although fundamental details of the different types of ligature and suture materials are described and different methods of suturing are illustrated, nowhere is there any description of how to tie a knot, surely one of the most basic of surgical procedures.

The book contains little that cannot be better observed in the operating theatre or gleaned from one of the many excellent standard textbooks of operative surgery. Indeed it is difficult to see for whom this book has been written for its contents are not necessary for the undergraduate and can be obtained in more detail from elsewhere by the surgical trainee.

At £1.75 this book is expensive for what it contains and thus cannot be recommended.

M. H. IRVING.

BARTS SPORT

CROSS-COUNTRY CLUB REPORT

The first race of the season was the University College Invitation relay at Parliament Hill Fields (6 x 1¾ miles). The weather arrangements had not been made as efficiently as last year, and consequently 43 unusually wet teams took part. Of these 5 got lost (dissolved, or for other reasons best known to themselves, failed to complete the course). Barts, however, survived the adverse climatic conditions to finish 19th overall—the second U.L. college home. This impressive result was due in no small measure to excellent performances by J. Brooks, and M. Erith who overtook seven in the final lap. The individual results were (in order of running):-

B. Campbell	9 mins. 21 secs.
J. Brooks	8 mins. 20 secs.
R. Moody	9 mins. 19 secs.
D. Wainstead	9 mins. 58 secs.
S. Mann	9 mins. 13 secs.
M. Erith	8 mins. 32 secs.

The team returned to Parliament Hill a week later to find that the weather had improved considerably: also to participate in the first U.L. Leagues race of the season. Twenty-five teams from Divs. I and II took part, over the usual two-lap course totalling six miles. Bart's newcomer S. Mann finished 27th, setting a high standard of running which he has since consistently maintained.

A monotonously powerful performance by John Brooks secured 9th position. The club has been blissfully accustomed to one single figure place in University races with his help. It was very sad that that was John's last race for Barts because unfortunately he has just passed his finals. The results were as follows:

9th John Brooks	32 mins. 55 secs.
27th S. Mann	34 mins. 54 secs.
54th R. Moody	37 mins. 30 secs.
58th R. Miller	38 mins. 04 secs.
60th D. Wainstead	38 mins. 07 secs.
	99 ran

Barts finished 8th in Div. I, a very good result.

Dave Bedford was the only opposition that Barts were worried about at the start of the U.L. Leagues Div. I race at Twickenham on November 3rd. Running a tactical race, allowing him to remain in the lead until the finish, Barts crept up the University League to a commendable 7th place. M. Erith and S. Mann led the team as usual, around the 6-mile course. B. Campbell put up a good time to finish in an interesting state of collapse, only 3 places ahead of an equally exhausted R. Moody. R. Miller and M. Gillard completed the scorers.

13th M. Erith	31 mins. 06 secs.
17th S. Mann	31 mins. 24 secs.
41st B. Campbell	33 mins. 37 secs.
44th R. Moody	34 mins. 20 secs.
49th R. Miller	35 mins. 46 secs.
56th M. Gillard	38 mins. 20 secs.

The St. Marys Porrit Cup, resident in the Barts Library for the last year, was returned there (together with the base purloined for a rugby club trophy) after a decisive victory on Nov. 17. The race was over a fast course of 5½ miles around Hyde Park and Kensington Gardens and this proved to be a major triumph for Barts. Eight Barts men took part, and M. Erith, S. Mann, and B. Campbell all gave impressive performances to fill three of the first four scoring places. R. Moody was close behind in 7th place, hotly pursued by R. Miller, who finished 9th.

2nd M. Erith	29 mins. 08 secs.
3rd S. Mann	29 mins. 45 secs.
5th B. Campbell	29 mins. 59 secs.
7th R. Moody	30 mins. 23 secs.
9th R. Miller	31 mins. 20 secs.
13th M. Page	32 mins. 22 secs.
16th D. Wainstead	33 mins. 05 secs.
19th P. Acres	34 mins. 30 secs.
1st Barts	21 pts.
2nd St. Marys	48 pts.
3rd London	51 pts.

So far a very successful season with an encouraging number of people, not all mentioned above, supporting the team, both in training and races. However very limited recruiting from the freshers and total lack of support from the present 2nd M.B. year does not augur well for the future.

SAINT BARTHOLOMEW'S HOSPITAL JOURNAL

Founded 1893. Vol. LXXVI No. 3

Journal Staff

Editors
Alan Searle
Malcolm Vandenburg

Sub-Editors
Articles
John Watkins
Pat Thrower

Sport
Oliver Bastard

Reviews
Ian Baker
Peter Smith

Manager
Bob Le Quesne

Subscriptions
Charles Hinds

Editorial Assistant
Jane Hilton

Advertising
Mike Johnson
Rod Bexton

Charterhouse Representatives
Timothy Bunker
Peter Bacon
Teifion Davies
Trevor Turner

Editorial

I have never written an editorial before, so for this, my first, I thought I would aspire to inform the readers of this magazine of such subjects as "Private Insurance and the Health Service," or "Why not N.U.S.?" but I soon realised that I knew very little about these subjects (or any other for that matter). What could I do? I thought that perhaps I could find some suitable inspiration from the writings of other medical journal editors—surely they were well informed, united and knew of the burning medical issues of the day?

The first journal I picked up was that of the London Hospital. It had no editorial as such but had a section headed "Comment" in which it talked about non-smoking facilities on public transport, asked people to join in with hospital activities and to fill out their personal column a bit more by having more marriages, babies etc.

The Cardiff magazine had a golygyddol which mentioned services for patients and gave a list of some voluntary organisations.

Aberdeen mentioned some local affair, and the Newcastle Gazette had an editorial all about itself.

Guy's had a well written editorial about education and grants and Tommies talked about charges for students on duty and its effect on their students.

Mary's and The Middlesex have given up editorials, but the latter did have a very striking cover showing a skull smoking a cigarette.

This highly biased selection of medical student journals shows very little uniformity (except that some ask for more contributions and help—but that is another story) and it leaves me wondering what one should write an editorial about. Theoretically, I suppose, one's choice can cover a wide range of issues from such general topics as "The fate of the N.H.S.," to more specific subjects like "Ward space per patient." The trouble is that at both extremes of this scale one risks boring the majority of readers, yet to find a balance, especially in a magazine which is circulated to both consultants and 1st M.B. students, can at times be very difficult. Finding a "Bart's" subject with sufficiently wide appeal presents problems because such topics are usually introspective and probably of limited interest to most of our readers. On the other hand it would be pleasant to be able to write editorials along the lines of the "Personal View" columns of the national medical journals. If we had the space, the information, and the time we could possibly write polished comments about similar subjects. However, it is probably better to leave this to those with more experience in these matters.

The biggest gap one has to bridge is that between the clinical and pre-clinical schools—a difficult, if not impossible, task if one is limited solely to medical matters. So why not put to paper your thoughts on any subjects, whether or not you feel particularly strongly about them? It is not very often in life that one has such a large captive audience and I think one might as well make the best of these opportunities and write on a subject with which one is relatively well acquainted, than strive, and possibly fail, to write a well balanced medical leader within the previously described limits. One editor of the Westminster journal abandoned any notion of medical journalistic tradition and devoted his entire editorial to women's cosmetics. This is not quite what I had in mind but at least it breaks away from the accepted conformity of such authors and, most important of all, was well written.

I think I shall write about pantie hose next month.

We now have two editors who, initially anyway, will alternate the writing of editorials and share the rest of the work.

ST. BARTHOLOMEW'S HOSPITAL STUDENT'S UNION
WINE COMMITTEE

announce the X Annual

BARBECUE BALL

to be held on

FRIDAY 9th JUNE

at

COLLEGE HALL, CHARTERHOUSE SQUARE, LONDON, E.C.1

TICKETS £6·25 (Students £5·25)
AVAILABLE FROM THE SECRETARY OF THE WINE COMMITTEE

CHEQUES TO BE MADE PAYABLE TO
ST. BARTHOLOMEW'S HOSPITAL STUDENT'S UNION AND CROSSED BAR ACCOUNT

LETTERS

St. Thomas's Hospital,
Medical School,
London S.E.1.
January 1st, 1972.

Sir,

I read with interest your correspondent's article in the December Journal on homoeopathy. His understanding of the subject is probably infinitely superior to mine, and I agree with his unprejudiced approach but I must differ with him on some points.

He accepts, as sufficient evidence of the efficacy of Homoeopathy, the clinical experience of the practitioners, and implies that this is the method by which orthodox medicine is also judged.

Now, it is true to say that homoeopathy, however hard it tries, is by nature unscientific, thus the paucity (not wealth as your correspondent states) of statistical and research data; hence its dependence on subjective assessment.

Modern orthodox medicine, however, is assessed differently, it makes a valiant attempt to be scientific, by using objective measures of health and assuming these to reflect accurately the true situation.

As a result of its complexity, Homoeopathy deprives itself of the possibility of objective assessment, and is only inconsistent when it fails to recognize this. Orthodox medicine would be equally inconsistent, having opted for the scientific approach, if it utilized a subjective approach, and it would land itself in a morass of difficulty if it embraced both.

I think therefore that your correspondent is wrong to state that Homoeopathy should work with orthodox medicine. The two are mutually incompatible.

Yours faithfully,
ANGUS TULLOCH.

25 Upper Wimpole Street,
London, W1M 7TA.
January 11th, 1972.

Dear Madam,

The photograph occupying two pages of the January issue displaying the Journal staff and conveying seasonable greetings recalls a note in a number of about 35 years ago, referring to a Bart's man who sent out Christmas cards bearing his own portrait:

"Shall . . . .'s face his fortune find?
Does his likeness speak?
Does it bring his face to mind,
Or just his cheek?"

Yours faithfully,
H. J. BURROWS.

The Abernethian Room,
January 26th, 1972.

Dear Sir,

At an Extraordinary General Meeting of the Students Union held on January 20th the motion "This house is in favour of the proposed amalgamation with the London Hospital/Queen Mary's College with special reference to medical education" was defeated by 48 votes to 24 with 3 abstentions. The meeting was held at only two days notice and no formal speech in favour of the motion was made. However, the principal protagonist for amalgamation on the platform, Mr. John Wellingham, who had called the meeting and was its chairman. Many Points of Opinion, under the guise of Points of Information, were voiced. The arguments were inconclusive; the voting on the motion was not. Several points occurred to me during the course of the discussion.

At the risk of sounding complacent I should say that Bart's has a very good record for producing good doctors. The Todd report in all good faith has promulgated a wider based medical education which requires the complete restructuring of the Bart's teaching course. Should this well proven system be swept away to satisfy the vagaries of the all knowledgeable educator? Everyone present at the meeting was agreed that the present Preclinical and Clinical courses needed revision and improvement, and that a wider education would be a good thing. Could not these new courses be introduced at the present site in Charterhouse Square?

None of the speakers seemed to be against amalgamation with the London Hospital; their principal objection was to moving to QMC. I have always thought that many of the Charterhouse facilities are grossly under-utilised. Would it not be possible for Bart's and the London to combine their Preclinical courses as the Faculty of Medicine of QMC and use Charterhouse? With new buildings on the sites of the Anatomy building, the Biochemistry laboratories and tower, and over the Wellcome Research library I am sure that there would be enough room to accommodate an annual intake of 200 students, and to provide the new courses deemed necessary by the Todd report.

This could be achieved for a fraction of the cost of the proposed new multifaculty complex that would have to be built at the Mile End Road. At the same time it would retain the intimate and personal nature of the present Medical College. It would also enable the students to make use of the multi-faculty Halls of Residence and the social and recreational facilities of QMC.

Lastly, I was struck by the whole futility of the discussion—as if we could do anything to decide our future anyway. It was Mr. Morris who pointed out that if the College refused to implement the recommendations of the Todd report it would suffer financial strangulation at the hands of the Universities Grants Committee. I can only plead for the use of the traditional British method of compromise and good sense. Everyone wants a better education; No one wants to go to the Mile End Road to get it. Why can't we have a better education at Barts?

Yours Faithfully,
OLIVER BASTARD.

Announcements

Births

Freeth—On January 1st to Dr. Geraldine and Dr. Malcolm Freeth a daughter.

Engagements

Brandram-Adams—Shepherd—The engagement is announced between Dr. John H. Shepherd and Miss Alison S. Brandram-Adams.

Britton—Davies—The engagement is announced between Dr. M. G. Britton and Dr. G. V. Davies.

Francis—Courtin—The engagement is announced between Dr. H. B. Francis and Miss L. S. Courtin.

Taylor—Greig—The engagement is announced between Mr. Paul Taylor and Miss Aileen Greig.

Marriage

Goldsmith—Gayer—The marriage took place on Saturday February 5th between Michael J. Goldsmith and Miss Amand S. Gayer.

Deaths

Rushworth—On January 15th, Arthur Norman Rushworth, M.R.C.S., L.R.C.P. Qualified 1914.

Keane—On January 12th, Clarence Augustine Keane, M.R.C.S., L.R.C.P., D.P.M. Qualified 1931.

New Year's Honours

K.C.V.O.

James Cecil Hogg, C.V.O.

C.B.E. (Civil Division)

George Kenneth McKee, M.R.C.S.

O.B.E. (Military Division)

Francis Michael Kinsman. Surgeon Commander R.N.

Appointments

Dr. Mivart Thomas has been appointed Assistant Professor of Psychiatry at the College of Medicine and Dentistry of New Jersey-Rutgers Medical School.

Dr. Elizabeth J. Shaw has been appointed Senior Lecturer in Medical Microbiology as from March 1st, 1972.

Dr. R. E. Ellis has been appointed to the Chair of Medical Physics at the University of Leeds as from October 1st, 1972.

New Addresses

Dr. J. Fahey, 53, Devonia Rd., N.1.

Dr. S. Turner, 53, Devonia Rd., N.1.

Dr. Elwyn Lloyd, 115, Victoria Rd., Camps Bay, Cape Town.

CHRISTMAS FOOD PARCELS FOR OLD PEOPLE AT ST. MATTHEWS HOSPITAL

The Occupational Therapists would very much like to thank everyone who contributed to St. Matthews. They were able to make up over eighty parcels, which were distributed to the Out-Patients, who live alone and attend the Day Club at the Hospital, so everyone had a food parcel over the Christmas weekend, when meals-on-wheels stopped. Everyone of the staff, and all the patients were overwhelmed by the generosity of the gifts.

OBITUARY

MR. WILLIAM MELVILLE CAPPER

After an illness which had curtailed his activities for some years, and which he had borne with characteristic courage, William Melville Capper died on December 10th. For over a decade he had been an outstanding and popular figure in the Hospital. He came here from school in 1926 and threw himself with zest into the life of a student. He worked conscientiously, qualifying in 1932 and became an F.R.C.S. in 1936. He was an excellent athlete: at rugby football an outstanding forward playing in both the Hospital Cup winning sides in 1928 and 1931, becoming captain and obtaining a Middlesex county cap; he was an excellent cricketer and captain of the Hospital Cup winning side in 1930—a fine forcing innings of his being an important factor in the victory. After completion of his house appointments at Bart's, deciding to specialise in obstetrics and gynaecology, he went to the Bristol Royal Infirmary and was appointed to the staff there in 1938. However, his experiences in command of a surgical division during the war led to his resigning his appointment when he returned to Bristol on demobilisation, and some time later he was appointed to the staff as a general surgeon. The zest which had been apparent in his student days was seen again: an excellent surgeon with a special interest in gastro-enterology; a first-class teacher and clinical dean of the medical school; devoted to his patients and loved by them and by his students. The happiness of his home and family was generously shared with others. One will always remember the large groups of students who came there regularly to lunch on Sunday. Honours came his way—President of the Section of Surgery at the R.S.M., President of the British Society of Gastro-Enterology and the F.R.C.O.G. As befitted one who saw with such clarity the important things in life, these honours, like the earlier athletic ones, never in any way affected his unassuming modesty. In him were combined great strength with gentleness, gaiety with underlying seriousness, absolute integrity and a quiet unshakable faith. Many of those who mourn his passing will be grateful and the humbler for having known him.

J. E. A. O'C.

OBITUARY

REGINALD MARTIN VICK

Reginald Martin Vick must sound strangely formal to many of us who used to receive letters from him signed simply "With love, Reggie"—and that is the key-note of what I have to say about him; for he was above all an intensely warmhearted and friendly person, who loved doing things to help his fellows.

I do not intend to go into details about the appointments he held here at Bart's and at other hospitals. They are already well known, and easily found in the records. He did in fact make valuable contributions to this Hospital, and to the Court of the Royal College of Surgeons; but I am suggesting that *who he was*, his personality and character, should occupy our thoughts rather than just what he did.

In his early days he must have been greatly influenced by his home life in the North Country, his school days at The Leys, and then his career as an undergraduate at Cambridge before he finally arrived here to do his clinical work, and to spend the greater part of the rest of his life in intimate association with the Hospital, its staff, its patients, and its students. But the influence of the Army must not be forgotten, for he was a Territorial before the First World War, in which he had an outstanding record of service. He was always soldier-like in his bearing, spotlessly turned-out, and showing a liking for good order and discipline—which extended to mental discipline and orderliness of thought which was such an asset to him as a teacher. At the same time this attribute made him intolerant of what he regarded as lack of proper discipline, and he could be quite outspoken in his criticism of those who seemed to him to be breaking the rules of decent behaviour.

The first great opportunity of influencing students came shortly after the First War when he was made Warden of the Residential College—the fourteenth in succession to James Paget, and the last Warden of the College in Little Britain. His influence was not limited to the men resident in the College, for many of those returning from military service came to him for advice about their future careers, and had reason to be grateful to him for it. And from the start of his 15 years as Warden he had his wife to help in welcoming and entertaining his visitors.

He was a popular teacher of undergraduates and postgraduates, who appreciated the clarity of his methods, based upon his earlier work in the Path. Lab, and also the amusing stories used to fix facts in the memories of the class. But most important was what they learnt from his example—his sympathetic concern for nervous, shy or frightened patients, and his methods of giving them confidence and reassurance—for every patient was an individual person to him.

He just adored people, especially young people, and therefore enjoyed gathering them together for convivial evenings either in his own home or at meetings such as those of the Cambridge Bart's Club or his Decennial Club, of which he was secretary. Of course he looked forward to enjoying these annual events himself, but he worked hard to make all the necessary arrangements to ensure enjoyment for the rest of the company.

I said at the beginning that I wasn't going to refer to any of his appointments, but I must mention briefly his remarkable second career. He was already 68 when he was invited to undertake the direction of the Cancer Bureau in the South Western Region which had been started five years earlier by Professor Rendle Short of Bristol. It meant living away from home, either in Bristol or Plymouth, for considerable periods, and his poor wife must often have wondered where she would be expected to provide their next meal! Yet they were happy to accept these queer conditions because of the interest and the importance of the work to be done. Again his personality became the dominant factor, for he travelled widely through the lovely region of Cornwall, Devon and Somerset appealing personally to hospital staffs to make their cancer records complete (for unless complete they would be statistically unreliable), and in the 12 years he spent there he got as near as possible to 100 per cent. registration. His annual reports were therefore worthwhile contributions to cancer research, and a fitting reward for his devoted labour.

Reggie was over 80 when he gave up that work, and it was only gradually that physical infirmity interfered with his full and active enjoyment of life. It is inevitable that the body shall decay and finally pass from our sight. But the personality, the soul, is immortal: and it is for the life and the soul of Reggie Vick that we have to thank God.

FROM MASSAWA TO NKHOTAKOTA

By DR. JULIAN BIRCH

Massawa is in Northern Ethiopia, and Nkhotakota half way down the west side of Lake Malawi. It is some 4,000 miles between the two, and these miles were part of the journey undertaken by four newly qualified doctors and a physiotherapist. The object of our trip was to deliver a new Land Rover, which we had raised the money to buy, to a Mission Hospital in Malawi, where it is now being used as a mobile child welfare clinic. To reach Massawa the party had travelled across Europe to Greece, and then by sea to Haifa in Israel. After ten days in this fascinating country, the Land Rover had been shipped as deck cargo down the Red Sea from Eilat to Massawa. Unfortunately we could not go by sea, and so flew from Tel Aviv to Addis Ababa, and then travelled up to Massawa on the local buses—a three-and-a-half-day journey to meet the vehicle.

Massawa in July is hot, perhaps the hottest port on earth. We were there for only two nights but that was enough. It was too warm at night to sleep inside, and so we joined everyone else in our hotel on the veranda. Even then much of the night was spent looking forward to a shower in the morning. This like all else in the town was hot! We were therefore very glad to leave this unbearable heat behind as soon as customs had cleared our Land Rover, and climb the great plateau mass that comprises most of Ethiopia to find a cooler climate. The asphalt road from Massawa inland to Asmara climbs some 7,000 feet in less than 50 miles. It is matched only by the railway linking the same two towns as a remarkable feat of engineering. Both were built by the Italians who extensively occupied Eritrea, now the northernmost state of Ethiopia, for the decades before the last war. They, too, are responsible for Asmara's very existence, which they built from nothing in the 1890's.

After crossing the scorching coastal plain, the road starts its long twisting climb. It winds unendingly up and up, hairpin following hairpin, the view down improving with each turn. Frequent roadside crosses commemorate people who died as their cars left the road. Police and army check points are common, as Eritrea is in a state of emergency. The government is trying to eliminate the guerilla fighters who want independence for this most northern state of Ethiopia. A couple of recently burnt-out tankers emphasised this local unrest. Such checks incredibly never searched the women, which says little for Ethiopian women's lib! We also wondered if it was the women who carried the grenades! Near Asmara the mountain slopes become a solid mass of the rounded, spikey shapes of the prickly pear cactus, the fruit of which is collected and sold in Asmara. The continual stream of porters carrying or pushing incredibly heavy loads up the road, and the returning boys careering down the tarmac on their trolleys, way out of control, provide a very real hazard to the driver.

Asmara is Ethiopia's second biggest city, but is above all else an Italian city. It was planned, built, and is to a large extent still inhabited by Italians—they are either too rich to want to leave or too poor to be able to. It is remarkable how much of Italy has been incorporated into the local culture—spaghetti is *the* local dish! Despite this, it was here that we had our first truly Ethiopian meal of injura and wot. Injura comes in sheets looking, feeling, and tasting like india rubber, and it is dipped in the wot or spiced up chicken or meat. It was here too that I got asked the most disturbing question of the trip by a local youth: "How do *I* become a tourist?" It brought home with a bang how lucky we all were.

From Asmara we took the western of the two main routes to Addis via Gondar and Lake Tana. The 75 miles from Asmara to the Eritrean-Tigre border is good tarmac, but after this the surface degenerates into all-weather gravel, mostly well maintained, a difficult job during the "big rains". This is a very apt and descriptive name for the torrential downpours that occur almost daily. The cloudbursts often involved hail, and the noise it made on the Land Rover's roof was deafening. However, they only once succeeded in washing us out of our tents. Between storms the weather was overcast and misty and did little justice to the fantastic scenery through which the road passes. One plateau level drops a thousand feet to another like some giant step, while the weird, pointed shapes of the distant Adua mountains rise menacingly against the sky, and nearer the road great hundred-foot boulders create strange and wonderful formations.

Some 110 miles from Asmara we passed through Axum, which in the Third Century ranked alongside Egypt, Babylon and Rome as a centre of the civilised world. It was here that Menelik I, the Queen of Sheba's son, is claimed to have brought the Ark of the Covenant when he stole it from his father, Solomon in Jerusalem. From Axum, 225 miles of all-weather gravel took us to Gondar crossing the beautiful Tabazze Gorge on route. This gorge slices through the high mountain plateau, its steep sides covered in lush rain forest. The road twists and turns down to the swollen river at the bottom, and then hairpins its way up to its original height again. After this magnificent gorge there are many minor ascents and descents as the road crosses the Tabazze's various tributaries. It was on this section that we were lucky enough to come across a recent kill

Septrin
a story of success

decisive action
Bactericidal against a wide range of organisms, including *Proteus* sp, *E coli, H influenzae.* Double attack on bacteria substantially reduces the chances of resistant strains developing.

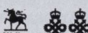
rapid response
Fast absorption from the gut to give peak plasma concentrations in 2-4 hours. Quick eradication of pathogens speeds the patient's recovery.

ease of treatment
Simple dosage regimen. Available in tablet and suspension forms.

Septrin
in bacterial infections

SEPTRIN* Tablets, SEPTRIN Adult Suspension, SEPTRIN Paediatric Tablets and SEPTRIN Paediatric Suspension contain trimethoprim and sulphamethoxazole. Full information is available on request.

*Trade Mark



Burroughs Wellcome & Co.
(The Wellcome Foundation Ltd.), Dartford, Kent.

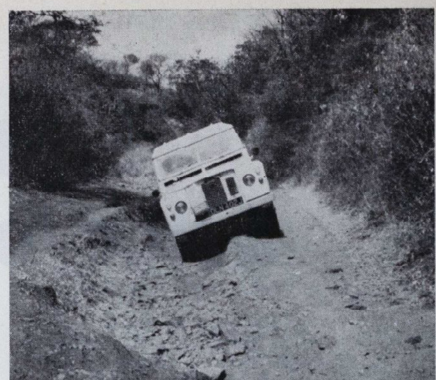
by the roadside. The killer had left, leaving his prey to the attentions of a pair of jackals and a flock of vultures. It was fascinating to watch the jackals seeing off the vultures, and the big grey-backed vultures in their turn seeing off the smaller hooded vultures.

Gondar was the Royal City of Abyssinia from the early 17th to the early 19th century, and it was here that six successive kings built castles in what is now known as the Royal Compound. Each has survived in varying states of repair, and it is remarkable how similar they are to medieval English castles. However, we found the old Church of Debre Berhan Selassie which is situated on a hill just outside the town even more fascinating. This early 17th century church contains some extremely well-preserved religious wall paintings dating from the time of its construction. The walls and ceilings are a confused jumble of old, new, and non-testament scenes, some brilliantly executed, others far more crude, and serve to indicate the confused state of the Coptic Church at the time of their completion.

From Gondar, we skirted east of Lake Tana, lying quiet and serene between the rolling hills of the Gondar plateau, and crossed the source of the Blue Nile as it flows out of the Lake. At Bahar Dar on the southernmost tip of the Lake, we made an 18-mile detour from the main road to visit the famous Blue Nile Falls. The incredible volume of dirty, brown, muddy water that thunders over the three main sections of these falls puts up a cloud of thin mist from which the Amharic name for the falls comes—Tissiat or "smoke of water". These falls alone are well worth a trip from England to see. A local armed guard seems compulsory on going to view the falls, but whether the danger is from animals or robbers we never discovered. The way our guard played with his gun gave us the impression that he was incapable of dealing with either. Perhaps it was just a government scheme to create employment!

From Lake Tana, the road makes a wide detour to the west to avoid the many river gorges that feed the Blue Nile. In doing so, it crosses the Little Abbai or Little Blue Nile as it flows into Lake Tana. Past Debre Markos, some 230 miles from Bahar Dar, the road comes to the Blue Nile Gorge. This is a 3,000-foot deep, 5-mile wide gash in the high plateau land of the area, down which hurries the soil-laden waters of the Nile on their way to the Sudan. We found this famed sight a little disappointing preferring the Tabazze Gorge for beauty and magnificence. Perhaps the Blue Nile Gorge is just too big to appreciate properly. The rapid change from a cool upland breeze to a baking tropical sun as we descended the gorge, and the change in vegetation it brought, reminded us how deep the gorge is. The road down the gorge is tarmaced, but we passed an interesting notice on the way up the southern side. It read: "Caution. Viaduct ahead has started to move and may be hazardous to traffic. All motorists are advised to drive carefully and slowly." We did not stop to photograph the notice until we were over the viaduct!

Once back on the plateau Addis is only 50 miles away. Most of this we drove in heavy rain, but it stayed dry just long enough for us to visit an old Portuguese bridge dating from the 16th century and still in use—but foot traffic only! Unfortunately the rain broke before we got back to the vehicle and so we got our worst drenching of the trip.



Main Road in Southern Ethiopia

Ethiopia's capital, Addis Ababa, or New Flower as this name means in Amharic, is only 80 years old. It sprawls widely over a large area of high plateau ranging from 7,000 feet at its lowest to 9,000 feet at its height. Side by side are immense modern sky-scraper office blocks, fine new hotels, and miles upon miles of squalid, ramshackle, poverty-stricken shanty town. It is an untidy, centreless city, its great new blocks rising out of messy areas of wasteland. Eucalyptus trees are everywhere, all "owned" by the Emperor, and give the city its other name of "city in the trees". The market was the only place of interest that we visited in the city. This noisy, crowded, colourful, covered bazaar thronged with people, all trying hard to sell you something. We achieved our best bit of bargaining here, 30 shillings to 2 shillings for a knife (for which we saw an American happily paying 60 shillings!), and also got extensively pickpocketed. Luckily we had learnt to carry nothing worth picking in our pockets!

An asphalt road leads south from Addis and descends from the heights of the capital into the Rift Valley, which boasts some of Ethiopia's finest scenery—the Lakes Region. The northernmost lake—Lake Koka—is man-made, created by the damming of the Awash River and is hence bespeckled with dead trees caught in the rising waters. We made a short diversion to see Lake Languano, brown in colour due to its dissolved minerals, and surrounded by many stretches of white sandy beach and deposits of volcanic stones which float in water. One hundred and fifty miles south of Addis is the town of Shashamane near which there are many hot springs and much lush vegetation. We stopped for lunch by the southernmost of the six lakes—Lake Awasa. It was very full, flooding over the local road in places and the home of many waterbirds and the occasional fisherman. Among the lakeside reeds we identified egrets, various storks, pelicans, and a jacuna. There was extensive and up-to-date farming in this area, one colossal community farm near Awasa having sisal plantations that lined the road for mile upon mile upon mile.

Tissiat Falls

After Awasa the next 140 miles is all-weather gravel. At Wendo, there is a choice of roads going south. We took the left fork which although longer was reputedly a better road. Leaving Wendo, the gravel road climbs up and up through many bamboo plantations, out of which the locals weave their huts, to almost heath-like countryside, and then descends down into the lush green rain forests that continue all the way to Kebre Mengist. This town is the centre of the Ethiopian Goldfields, and, as if sprung from some Cowboy movie, reminded us very much of a stylised American frontier town. Here the all-weather gravel ends, but the next 75 miles of road is improved and presents no difficulties.

Neghelli is the last town in Ethiopia of any size—some 100 miles from the Kenyan border. We took a long time to find the correct road south from here, but finally set off along one of the oldest stretches of tarmac that must be still in existence. Built by the Army many years before, it had long since lapsed into a continuous collection of immense potholes and craters, which successfully reduced our speed to less than 5 m.p.h. I have never so looked forward to getting *off* tarmac! Luckily this torture was short-lived and we soon turned off into the bush.

The 100 miles from Neghelli to Moyale on the Kenyan border was the worst road we met with and took us some 16 hours of actual driving. Had it rained the mud track would have rapidly become impassable and the 100 miles could have taken us many days. However our luck held and we made steady if somewhat slow progress. At last we were leaving the Ethiopian wet season behind and approaching the Kenyan dry. We only passed two other vehicles on this stretch of road—two local lorries keeling over precariously as they negotiated the large holes and hummocks that constituted the road. The track was not maintained and hence extremely rough, especially on one steep descent some 20 miles after leaving the tarmac. This portion of the road was engineered many years ago by the Italians, and hairpinned over numerous rocky ridges and deep water-courses. Our biggest problem, however, was the continual watch for sufficient clearance for the vehicle. Despite the very high slung chassis of the Land Rover, we managed to bang the spare wheel on the ground and bend the back door slightly. The road winds through open savannah country, the soil changing colour every few miles from red to brown to white and back to red again, and with it the density of thorn trees. This was really MMBA, or miles and miles of bloody Africa!

People are scarce in this area, the few who do live here being nomadic herdsmen. Wild animals are commoner, but the real delight are the birds. The Superb Starlings and the Rollers create brilliant flashes of colour in the trees. The turkey-like ground hornbills bustle round in troops, while their smaller relations, the yellow- and red-billed hornbills, seem to find the track a favourite digging spot for food. There are also flocks of guinea fowl and the occasional ostrich. Camping along this stretch of road, way out in the bush with just a canopy of stars and the knowledge of no other humans for miles is an unforgettable experience.

We arrived at the Kenyan border too late in the day for the Customs formalities, and had to camp the night in the Police compound in Moyale. This fair-sized border town is an Army centre for the Northern Frontier District, where in the past the Kenyan Government has had much trouble with "shifta". Despite a delayed start due to various formalities we still managed to reach Marsabit in one day, a drive of some 150 miles. The road here is rough, but better than in Southern Ethiopia. The bush scenery of the day before gives way to the hot, dry, barren semi-desert wastes of the Northern Frontier District, across which the road batters its way. On this stretch we passed the strange sight of a human skull hanging on a bush—to what end we never discovered. Several deep sand drifts added interest to the driving, and it was fascinating to see the sand behave like water and "wash" over the bonnet and windscreen.

Twenty miles north of Marsabit we reached a new all-weather gravel road that will one day it is hoped stretch all the way to Addis. This area has experienced three years' drought, and the few people living along the road a few miles out from the settlement of Marsabit rely on the government water lorry for their survival, and so spend much of their day sitting on the roadside waiting for it to pass by. The water comes from the lowest of the three crater lakes of Marsabit Mountain which has been almost emptied over the last year to provide water not only for these people but also for the workmen on the new road.

Marsabit is a remarkable place—its very existence is a marvel. It is a mountain covered in dense forest and harbouring the three lakes mentioned, right in the middle of the barren wastes of the NFD. An island of lush forest packed with animals isolated by miles of desert. We took time off from driving for an early morning drive round this game reserve, seeing elephant, buffalo, kudu, giraffe, waterbuck and baboon, despite a blanket-like morning mist over the dense forest.

Later in the day we struck off into the Kaisut Desert heading south towards Archer's Post and Samburu, some 170 miles. The new road made progress fairly rapid and we were soon leaving the NFD and approaching the fertile uplands that ring Mount Kenya, whose peak as usual was shrouded in cloud. At Archer's Post, a lot of noble-looking Samburu warriors strutted round in all their finery waiting for passing tourists on their way to Samburu Lodge to take their photos. It was depressing to see a once proud people lowered to the status of game park animals by the advancement of "civilisation".

As we skirted the Samburu Game Reserve, we saw Grevy's zebra and reticulated giraffe, species restricted to this area. Soon after this we rejoined the tarmac at Isiolo and were soon heading via Nanyuki, Nyeri and Fort Hall down to Nairobi.

Nairobi is the bustling modern capital of Kenya, with all modern facilities and an ideal climate. At its International Airport, streams of tourists arrive to tour the famous Big Game Parks of East Africa providing Kenya with its largest source of foreign exchange. However there is another side to Nairobi's outward prosperity. Its modern city centre is bordered by some filthy, overcrowded, insanitary shanty towns, the extent of which is only matched by the vast unemployment.

From Nairobi we headed north west up the main Kampala road to spend a day at and on Lake Naivasha, some 50 miles from Nairobi. Lake Naivasha is in the Great Rift Valley, and the main road descends the escarpment into the valley providing a magnificent vista with Mount Longonot in the backgrounds. It is possible to sit on top of the escarpment and to watch through binoculars giraffe on the valley floor way beneath. Once on the valley bottom the road leaves Longonot to the left and descends to bypass east of Lake Naivasha. A portion of this lake is formed from a flooded crater, part of the rim of which comprises Crescent Island—a bird sanctuary and a real paradise for wild life enthusiasts. We took a rowing boat out on the lake and in the course of a few hours saw a host of different species of birds. Goliath herons, pelicans, kingfishers, bee-eaters, fish eagles, marabou storks, and many other fascinating and colourful birds made this one of the best days of our trip.

From Naivasha we retraced out steps a few miles before turning west on to a good gravel road and had soon covered the 62 miles to Narok. We camped just before Narok near a beautiful little gorge and were told by a local that there was "much simba" (lion) in the area. Unfortunately, or fortunately, we saw none! After Narok, we turned south into the Mara Masai Game Reserve centred about Keekorok.

The Mara Masai Game Reserve bristles with game of all type and we had a superb evening drive round the rolling countryside of the reserve seeing lion, hippo, giraffe, topi, gnu, and smaller antelope. The weather lived up to the magnificence of the animals and the majestic scenery with a dark and threatening "David Shepherd" sky. This later broke into a tremendous storm with forked lightning and crashing thunder. Camping is not welcomed in this Reserve and so about sundown we drove on into Serengeti to camp at Klein's Camp.

We spent three days in Serengeti, perhaps the best known of East Africa's National Parks. The highlight of our time here was the spotting of a leopard at the end of a long day of fruitless searching. Being a shy creature, the leopard is often difficult to find, but this beautiful young animal kindly came down from his tree perch and wandered round for us. Many other hours of happy observation were provided by an enormous pride of lion with over 20 cubs between the various lionesses. It was lovely to watch the cubs playing and prowling around provoking the occasional angry slap from a long-suffering adult.

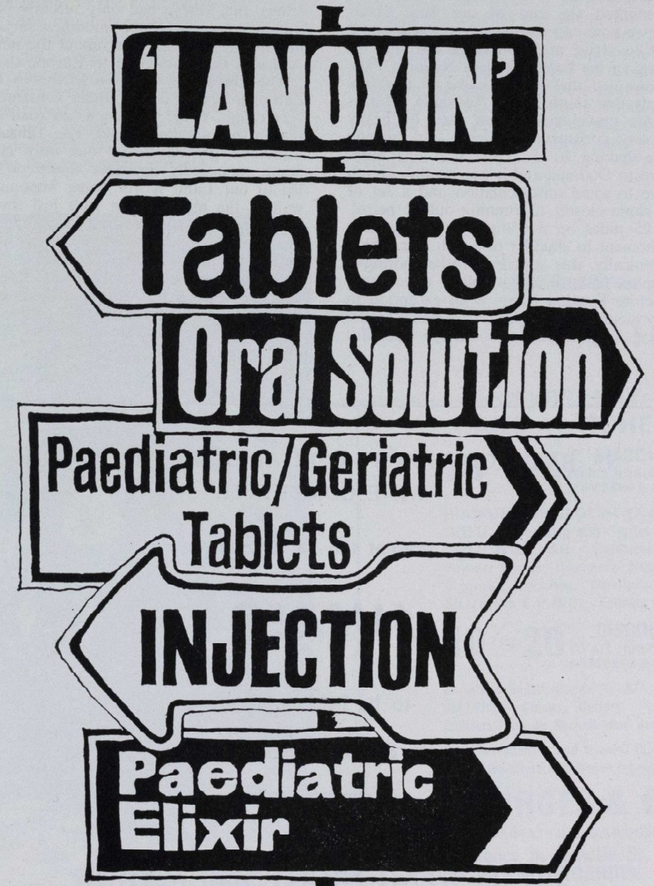
The Ngorongoro Crater was our next objective and to reach it we drove across the dry, endless expanses of

Morning Ablutions

the treeless Serengeti plains, practically deserted at this time of the year as all the game migrates up to the Park's western corridor for the duration of the dry season. The occasional rocky outcrop "contaminates" this plain, and high on the top of one of these we spotted a fine male lion gazing out, it seemed, over his domain oblivious of us in our Land Rover way below. As the gravel road leaves the plain and begins to climb towards the crater, it crosses the Olduvai Gorge where Leakey discovered his "Nutcracker Man" providing yet another unplaceable piece in man's evolutionary story. It is quite a climb up to the rim of the crater but on reaching the summit there is a remarkable view down into the crater. The crater is nine miles in diameter and 2,000 feet deep and can only be descended by four-wheel drive vehicles in the company of a guide down a steep and rugged track. We camped on the rim of the crater and started down early the next morning in dense white mist. However we were soon clear of this, and sweltering in the midday sun of the exposed crater. The density of game in the Ngorongoro Crater is very impressive. Here we saw thousands upon thou-

'Lanoxin': whenever digitalis therapy is indicated

Whatever the contingency there is a 'Lanoxin' preparation to meet it. Quality control throughout manufacture ensures pure, precise doses of digoxin in all presentations. **'Lanoxin' Digoxin** brand



Full information is available on request

Wellcome Burroughs Wellcome & Co. (The Wellcome Foundation Ltd.) Dartford, Kent

sands of flamingoes pinkening the sides of the crater's lake. These birds are constantly on the move and mutter incessantly creating a background of restless activity. Also eland, the biggest of the antelopes, their bodies so heavy for their slender legs that they suffer terrible osteo-arthritis of their knees, the click of which can be heard as they walk some 25 yards away. The waterbuck is perhaps one of the most graceful and noble animals to be seen, but like the leopard very shy. A couple of rhinos completed our day. These big, bad-tempered beasts peered blindly out of their small eyes trying hard it seemed to make out who or what we were.

Ngorongoro marked the end of our lazy game-seeing days and we now had to concentrate on a bit of speed so as not to arrive at Nkhotakota too late. So we bypassed north of the Lake Manyara National Park and had soon regained the main Arusha to Dodoma road which heads due south across Tanzania. This is a busy all-weather gravel road much used by heavy lorries and so very corrugated reducing our cruising speed to a bone-shaking 30-35 m.p.h. It is 267 miles from Ngorongoro to Dodoma and it was on this stretch of road that due to some miscalculation and a set of dry pumps we came closest to running out of petrol. We did about 25 miles on a completely empty tank expecting any moment to shudder to a halt. Incredibly we did not! Scenically, this stretch is rather boring—just miles and miles of bush and primitive agriculture. The 50 miles before Kondoa Irangi is an exception to this, some lovely mountain landscapes with dense forest, the road swinging in great curves about the beautiful valleys.

South of Dodoma, we rattled the 162 miles to Iringa in similar manner. Some splendid ancient Baobab trees, which the devil is reputed to have upended leaving their branches looking like roots, and some brilliant gay colours, mostly round the local women's waists, helped relieve the monotony of the endless miles of bush.

Past Iringa, we joined the "Hell Run". The colossal increase in big lorry traffic from the Zambian copper belt to Dar Es Salaam when Rhodesia declared UDI, made this road one of the roughest in the world. Luckily the old notorious gravel road has largely been replaced by a new tarmac strip. The 250-mile section between Iringa and Mbeya had only recently been opened and was therefore by far the smoothest surface on which we motored. The great thing about the new roads in East Africa is that compared to Europe they are deserted!

The stretch of road from Mbeya to Tunduma on the Zambian border is still under construction, and hence very rough. While building a new road there seems little reason to maintain the old. The Tanzanian customs at Tanduma proved to be our only customs hold-up. Some supposedly incorrect stamp on entering Kenya led to our Land Rover being impounded, a six-hour wait in the mid-day sun with just the deafening roar of the giant un-silenced Fiat lorries for amusement, and finally a mock court leading to a 150/- "fine". The unfriendly and unhelpful Tanzanian customs were so different from the Zambian and Malawian customs which we had to deal with later the same day. Although they had to re-open their offices as we arrived late in the day, these officials could not have been more obliging and polite.

ST. BARTHOLOMEW'S HOSPITAL STUDENT'S UNION
WINE COMMITTEE

present the IX Annual

SMOKER

to be held on the

8th & 9th MARCH

TICKETS 25p.

and the STAG NIGHT 10th MARCH

TICKETS 50p. (Punch Included)

There then remained the 500-mile drive down half the length of Malawi to reach Nkhotakota. The road was gravel the whole way but by far the best we had encountered on the whole trip—perhaps because of the absence of heavy traffic. Our first impressions of the Malawians, which we had no reason to change during our stay, were of an incredibly friendly people riding brakeless bicycles in an apparently surprisingly unpopulated land—when you consider that 4 million people live in this small country. Bicycles are everywhere, and their riders' response to an approaching vehicle equally universal. On hearing a car the cyclists will turn at right angles to the road and career out of control into the bank or off into the bush. A huge grin or friendly wave usually emerged from the resulting pile of man and bike. The policeman, grinning from ear to ear, who came rushing out of a nearby hut when we were stopped by a road barrier, typified their friendliness. "Good morning, sirs. How are you? What can I be doing for you?" came out in slow English. We were left a bit speechless. With a road barrier in front of us, we thought that was pretty obvious!

We finally reached St. Anne's Hospital, Nkhotakota, at the end of a long tiring day's driving, but were rapidly refreshed by a warm welcome. We had travelled some four thousand miles in about a month since leaving Massawa, and had one of the most unforgettable journeys of our lives as well as achieving our object of delivering the Land Rover to the place it was needed. Our short stay in Nkhotakota was a sobering education into the dedication that goes into practising medicine in such a country as Malawi. The scarcity of money, equipment, and drugs was so obvious everywhere (we were being drained of blood to give to patients within 24 hours of our arrival!), as well as the magnitude of the need the hospital was attempting to meet. We were very glad that our efforts to provide the hospital with a so-badly needed vehicle had been successful. This account must end on a note of thanks to all those individuals and companies, too numerous to mention personally, who made the trip possible. We should like to thank them all for enabling us both to give the Land Rover to the hospital and to have had a memorable summer.

At the Nkhotakota Mission Hospital

JEWELLERY AND WATCHES

20%-25% DISCOUNT TO ALL HOSPITAL MEMBERS & STAFF

DIAMOND ENGAGEMENT RINGS
GOLD - Wedding and Signet Rings.
GOLD & SILVER - Cigarette cases, Powder Boxes, Bracelets, Necklaces, Charms, Brooches, Earclips, Links,
SILVER & E.P.N.S. - Teasets & Plate

10%-20% DISCOUNT TO ALL HOSPITAL MEMBERS & STAFF

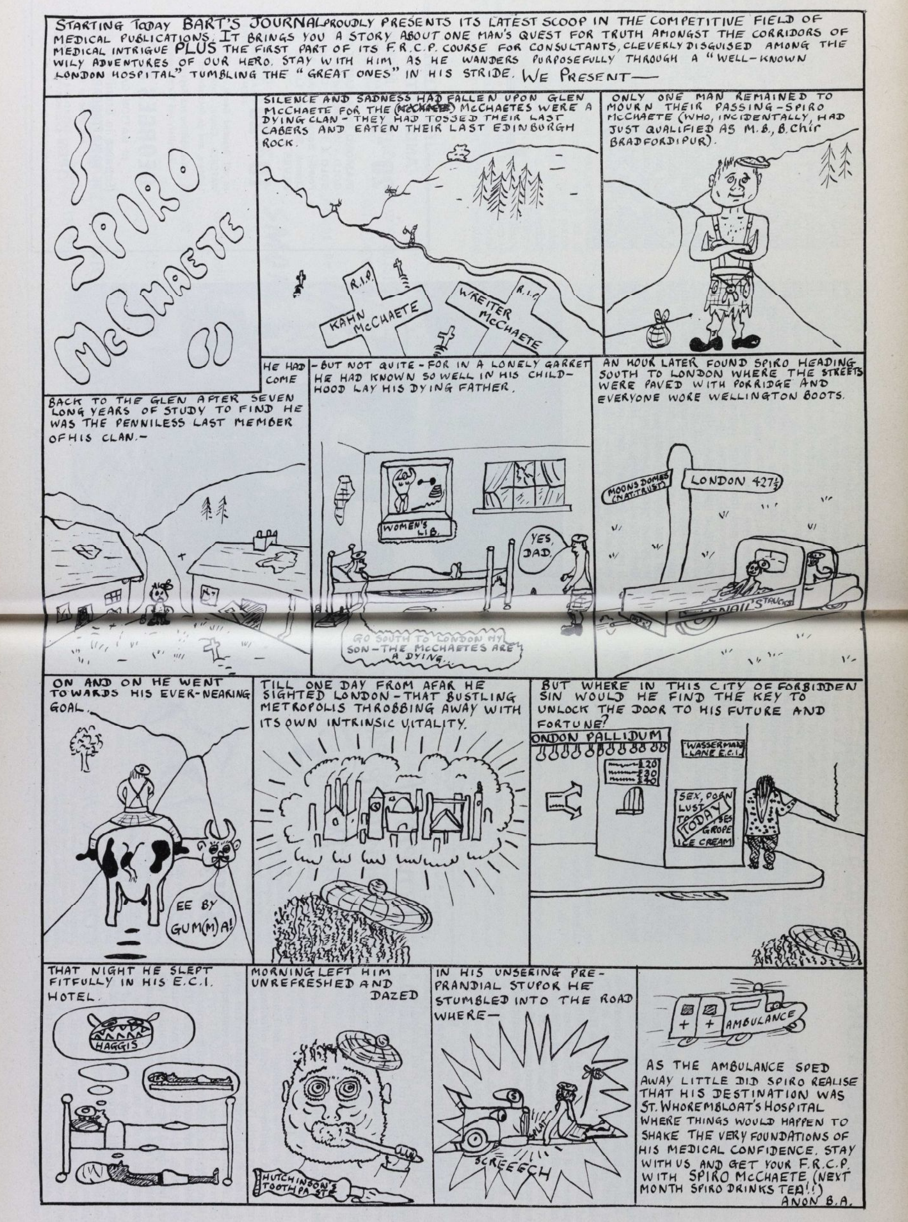
on all Branded Goods — ALL SWISS WATCHES Clocks, Cutlery, Pens and Lighters, and on Second-hand Jewellery.

Remodelling and Repairs to all Jewellery and Watch repairs

GEORGES & CO.
of HATTON GARDEN
(Entrance in Greville St. only)
88/90 HATTONGARDEN, E.C.1
405 0700 or 6431

OPEN WEEKDAYS 9.00-6.00 SATURDAYS 9.00-12.00

Special attention to order by post or phone



STARTING TODAY BART'S JOURNAL PROUDLY PRESENTS ITS LATEST SCOOP IN THE COMPETITIVE FIELD OF MEDICAL PUBLICATIONS. IT BRINGS YOU A STORY ABOUT ONE MAN'S QUEST FOR TRUTH AMONGST THE CORRIDORS OF MEDICAL INTRIGUE PLUS THE FIRST PART OF ITS F.R.C.P. COURSE FOR CONSULTANTS, CLEVERLY DISGUISED AMONG THE WILY ADVENTURES OF OUR HERO. STAY WITH HIM AS HE WANDERS PURPOSEFULLY THROUGH A "WELL-KNOWN LONDON HOSPITAL" TUMBLING THE "GREAT ONES" IN HIS STRIDE. WE PRESENT—
SPIRO McCHAETE
SILENCE AND SADNESS HAD FALLEN UPON GLEN McCHAETE FOR THE McCHAETES WERE A DYING CLAN - THEY HAD TOSSED THEIR LAST CABERS AND EATEN THEIR LAST EDINBURGH ROCK.
R.I.P. KAHN McCHAETE
R.I.P. WREITER McCHAETE
ONLY ONE MAN REMAINED TO MOURN THEIR PASSING - SPIRO McCHAETE (WHO, INCIDENTALLY, HAD JUST QUALIFIED AS M.B., B.Chir BRADFORDIPUR).
HE HAD COME BACK TO THE GLEN AFTER SEVEN LONG YEARS OF STUDY TO FIND HE WAS THE PENNILESS LAST MEMBER OF HIS CLAN.—
—BUT NOT QUITE - FOR IN A LONELY GARRET HE HAD KNOWN SO WELL IN HIS CHILDHOOD LAY HIS DYING FATHER.
WOMEN'S LIB.
YES, DAD.
GO SOUTH TO LONDON MY SON - THE McCHAETES ARE A DYING.
AN HOUR LATER FOUND SPIRO HEADING SOUTH TO LONDON WHERE THE STREETS WERE PAVED WITH PORRIDGE AND EVERYONE WORE WELLINGTON BOOTS.
LONDON 427½
ON AND ON HE WENT TOWARDS HIS EVER-NEARING GOAL.
EE BY GUM(M)A!
TILL ONE DAY FROM AFAR HE SIGHTED LONDON - THAT BUSTLING METROPOLIS THROBBING AWAY WITH ITS OWN INTRINSIC VITALITY.
BUT WHERE IN THIS CITY OF FORBIDDEN SIN WOULD HE FIND THE KEY TO UNLOCK THE DOOR TO HIS FUTURE AND FORTUNE?
LONDON PALLIDUM
TODAY
ICE CREAM
THAT NIGHT HE SLEPT FITFULLY IN HIS E.C.1. HOTEL.
HAGGIS
MORNING LEFT HIM UNREFRESHED AND DAZED
IN HIS UNSERING PRE-PRANDIAL STUPOR HE STUMBLED INTO THE ROAD WHERE—
SCREECH
AMBULANCE
AS THE AMBULANCE SPED AWAY LITTLE DID SPIRO REALISE THAT HIS DESTINATION WAS ST. WHOREMBLOAT'S HOSPITAL WHERE THINGS WOULD HAPPEN TO SHAKE THE VERY FOUNDATIONS OF HIS MEDICAL CONFIDENCE. STAY WITH US AND GET YOUR F.R.C.P. WITH SPIRO McCHAETE (NEXT MONTH SPIRO DRINKS TEA!!)
ANON B.A.

AN APPRECIATION

ROBERT KEMP HARPER

Robert Kemp Harper retired from his position as Radiologist-in-charge of the Diagnostic Radiology Department at Bart's on May 24th, 1971, a post which he held with distinction for over 25 years.

Robert Kemp Harper was born and educated in Edinburgh and graduated in medicine there in 1929. After a short spell in general practice in the Highlands he returned to the Royal Infirmary in Edinburgh and took a diploma in Radiology in 1932 and then joined the staff of the Infirmary as Assistant Radiologist.

His next post was Honorary Radiologist at Stoke-on-Trent but just before the war he returned to Scotland and became Director of the Radiology Department of the Glasgow Royal Infirmary.

In 1946 Bart's decided to divide the X-ray Department into separate diagnostic and therapy sections and Robert Kemp Harper came South to become the first Radiologist-in-charge of the Diagnostic Radiology Department. He took over quite a small department of four X-ray rooms, equipped with rather ancient apparatus and he immediately set about modernising it and expanding it. When he retired he left a department of 15 X-ray rooms all equipped with modern apparatus some of which is quite sophisticated. It is unfortunate that the department has not been able to expand on one site but it says a great deal for his administrative ability that such a scattered and fragmented department has been able to provide such an efficient service.

His achievements and distinctions are many. He has been elected Fellow of the Royal Colleges of Edinburgh, London and Glasgow. He was Secretary and Vice-President of the Faculty of Radiology and Editor of their journal. In recognition of his great contributions to radiology he was made President of the Section of Radiology of the Royal Society of Medicine and gave the Presidential Address on the day of his retirement—a fitting climax to his career.

Robert Kemp Harper has been a prolific writer with over 40 radiological publications to his credit. These cover a wide range of subjects but his main interest has always been the Alimentary Tract and in particular the pancreas and biliary systems. In addition to various papers and chapters in various books he has written a very successful book on the radiology of the duodedum. He also did original work on the X-ray changes in Diffuse Systemic Sclerosis and in diseases of the thymus.

He ran not only an efficient department but a happy department—one that people wanted to come to train and work in, and there are not many parts of the world where English is spoken where he would not find an old student. He was a good teacher and examination results from the department particularly over the last 10 or 15 years have been unequalled. He was ever eager to try new techniques. He was always available and ready to give helpful advice to the staff both lay and medical and to many he became a father figure. He exhibited typical Scottish imperturbability and would always give a problem careful consideration before giving an opinion.

Shortly after his retirement from the staff a dinner was held in his honour in the Great Hall which over 80 colleagues and former students and their wives attended, and at which he received parting gifts from those present and from former students all over the world.

He is greatly missed in the department and by his clinical colleagues. We thank Robert Kemp Harper for all he has done for Bart's and wish him an active and happy retirement.

W. D. N.

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.

BADENOCH, A. W. Chronic interstitial cystitis. *Brit. J. Urol.*, 43, 1971, pp. 718-721.

*BESSER, G. M. and others. Interaction between thyrotrophin, corticotrophin and growth hormone secretion in man. *J. Endocr.*, 51, 1971, pp. 699-706.

——, *see also* RATCLIFFE, J. G., and others.

BETHUNE, D. W., and others. Bronchoscope injectors: a design for use with pipeline oxygen supplies. *Anaesthesia*, 27, 1971, pp. 81-83.

BEVAN JONES, A. B., and others. Brain amine concentrations after monoamine oxidase inhibitor administration. *Brit. med. J.*, Jan. 1st, 1972, pp. 17-19.

BICKFORD, B. J., (with others). Long term follow-up of congenital aortic stenosis after surgery. *Brit. Heart J.*, 34, 1972, pp. 47-51.

BOYD, N. R. H., and others. The development of a radioimmunoassay for oxytocin: the extraction of oxytocin from urine and determination of the excretion rate for exogenous and endogenous oxytocin in human urine. *J. Endocr.*, 52, 1972, pp. 59-67.

BUCKLE, R. M., *see* RATCLIFFE, J. G., with others.

*BURROWS, H. JACKSON. Viscount Malvern 1883-1971: In memoriam. *J. Bone Jt. Surg.*, 53B, 1971, pp. 753-754.

CHAN, Vivian, and LANDON, J. Urinary thyroxine excretion as index of thyroid function. *Lancet*, Jan. 1st, 1972, pp. 4-6.

CHARD, T., *see* BOYD, N. R. H. and others.

——, *see also* MARTIN, M. J., with others.

COLE, P. V., and EVANS, Petra. Simple haemoglobin estimation: A comparison of available apparatus. *Anaesthesia*, 27, 1971, pp. 76-80.

COLLIS, J. M., *see* BETHUNE, D. W., and others.

COLTART, T. M., *see* GIBSON, D. G. and ——.

DISCOMBE, G. Personal view. *Brit. med. J.*, Jan. 29, 1972, p. 306.

*EDWARDS, Griffith, (and others). Drinking problems among recidivist prisoners. *Psychol. Med.*, 1, 1971, pp. 388-399.

EVANS, Petra, *see* COLE, P. V. and ——.

FORSLING, Mary L., (with others). Release of oxytocin vasopressin and neurophysin in the goat. *J. Endocr.*, 52, 1972, pp. 209-210.

——, *see also* BOYD, N. R. H., and others.

GAILER, K. A. J., and others. The relative potency of some β-adrenoceptor agonists on isolated human vein. *Europ. J. Pharm.*, 16, 1971, pp. 136-141.

GIBSON, D. G., and COLTART, D. J. Haemodynamic effects of practolol. *Brit. Heart J.*, 34, 1972, pp. 95-99.

*GILLIBRAND, I. M., (and Wyse, R.). Uptake of calcium ions and the β-adrenergic receptor site in cardiac muscle. *Biochem. J.*, 125, 1971, 105-106 P.

HADFIELD, G. J. Ureteric obstruction. *Ann. Roy. Coll. Surg. Engl.*, 50, 1972, pp. 45-53.

HAMILTON, W. J. The human placenta. *Nursing Mirror.* Jan. 28, 134, pp. 25-27.

HOLDSWORTH, C. D., (with Agnew, J. E.). The effect of fat on calcium absorption from a mixed meal in normal subjects, patients with malabsorptive disease, and patients with a partial gastrectomy. *Gut*, 12, 1972, pp. 973-977.

HOLLINGSWORTH, Stella, *see* BOYD, N. R. H., and others.

HORNSEY, Patricia A., *see* GAILER, K. A. J., and others.

JACKSON, D. B., *see* BOYD, N. R. H., and others.

*KEYNES, W. M. Equilibration of hypertonic solutions of urea and ammonia in the body fluids: Study by following levels in blood and thoracic-duct lymph. *Ann. Surg.*, 174, 1971, pp. 167-176.

KINMONTH, J. B., (with others). Lymphangiography and surgery in lymphangioma of the skin. *Brit. J. Surg.*, 59, 1972, pp. 36-41.

KNIGHT, R. A., *see* RATCLIFFE, J. G. and others.

LANDON, J., *see* RATCLIFFE, J. G., and others.

*LAWTHER, P. J. Pollution at work in relation to general pollution. *Roy. Soc. Health J.*, 91, 1971, pp. 250-253.

MALPAS, J. S. Recent advances in the therapy of acute leukaemia. *Med. News-Tribune*, Jan. 24th, 1972, p. 6.

MARTIN, M. J., with others. Simultaneous release of oxytocin and neurophysin during parturition in the goat. *J. Endocr.*, 52, 1972, pp. 213-214.

MATHUR, V. K., *see* WICKHAM, J. E. A. and

NASH, D. F. ELLISON. Bowel management in spina bifida patients. *Proc. Roy. Soc. Med.*, 65, 1972, pp. 70-71.

NIVEN, P. A. R. "Glioma" of the uterus: a foetal homograft. *Proc. Roy. Soc. Med.*, 65, 1972, pp. 98-99.

*NOBLE, M. I. M., (with Frankel, H. L.). Respiratory sensations in patients with cervical cord transection. *Paraplegia*, 9, 1971, pp. 132-136.

*——, (and others). The ability of man to detect added resistive loads to breathing. *Clin. Sci.*, 41, 1971, pp. 285-287.

*——, (and others). The role of the diaphragm in the sensation of holding the breath. *Clin. Sci.*, 41, 1971, pp. 275-283.

*——, (with others). The effect of lung deflation on breathing in man. *Clin. Sci.*, 40, 1971, pp. 451-461.

*——, (with others). The role of the vagal inflation relexes in man and other animals (pp. 17-40). Effect of selective peripheral nerve blocks on respiratory sensations. (pp. 233-252). Experimental results of vagal block in cardiopulmonary disease. (pp. 315-336). *In*, Porter, R. Ed., *CIBA Foundation Hering-Breuer Centenary Symposium; Breathing*, 1970.

*PERKINS, E. S., (with Hayreh, S. S.). The effects of raised intraocular pressure on the blood vessels of the retina and optic disc. In, *Fluorescein Angiography: Proc. int. Symp. Fluorescein Angiography*, Ed. Amalric Albi, P. 1969, pp. 323-328.

PERRY, P. M., (and others). Primary malignant lymphoma of the rectum (22 cases). *Proc. Roy. Soc. Med.*, 65, 1972, p. 72.
POWLES, R. L. The use of irradiated cells. *Med. News-Tribune*, Jan. 24, 1972, p. 7.
RATCLIFFE, J. G., and others. Tumour and plasma ACTH concentrations in patients with and without the ectopic ACTH syndrome. *Clin. Endocrinol.*, 1, 1972, pp. 27-44.
——, with others. ACTH secretion by bronchial carcinoid tumours. *Clin. Endocrinol.*, 1, 1972, pp. 3-25.
——, *see also* BESSER, G. M., and others.
STANSFELD, A. G., *see* RATCLIFFE, J. G., and others.
*THOMAS, K., (and Spencer Harrison, M.). Long-term follow up of 610 cases of Ménière's disease. *Proc. Roy. Soc. Med.*, 64, 1971, pp. 853-856.
TURNER, P., *see* GAILER, K. A. J., and others.
*WENDELL-SMITH, C. P., (with Williams, P. L.). Some additional parametric variations between peripheral nerve fibre populations. *J. Anat.*, 109, 1971, pp. 505-526.
WICKHAM, J. E. A., and MATHUR, V. K. Hypothermia in the conservative surgery of renal disease. *Brit. J. Urol.*, 43, 1971, pp. 648-657.
WILLIAMSON, R. C. N. Primary amyloidosis of the rectum. *Proc. Roy. Soc. Med.*, 65, 1972, p. 74.
*Reprints received and herewith gratefully acknowledged. Please address this material to the Librarian.

AN OLD ONE

The great day had come! Prof. C.B. had the facilities to perform his first brain transplant and Homer Ephraim Spiro was to be the first lucky man.

"Well, look here, C.B.", he said as he entered the Great Man's consulting room, "I'm sick of this old brain of mine—I need a new one—one with a bit of class."

Prof. C.B. led him into his laboratory where he took down a pot from the shelf.

"This for 40,000 dollars only, but keep quiet about this, it's the brain of Einstein!"

Homer thought for a while. "Well, I suppose he was a great guy but its not really me, besides nobody would understand me."

C.B. thought again and then from his topmost shelf he brought down a black, dust-laden container. "This," he whispered, "is the brain of Napoleon, it's yours for 80,000 dollars."

Homer thought again. "Ah, gee, Prof. I'd love it but, well, I'm left-handed."

C.B. thought for a while. "Look here, Homer, I've taken a liking to you, so I'm going to show you the brain we usually reserve for film stars and royalty." So C.B. went over to his wall safe and gingerly removed a glass pot from its cotton wool coverings. He beamed, "This for 500,000 dollars is the start of our collection —a medical student's brain."

"But what's so marvellous about that?" Homer spluttered.

"Well, my dear fellow, it's never been used."

TO ADVERTISE
IN THIS SPACE
AND FOR
SPECIAL RATES
CONTACT

Michael Johnson or Rod Bextom
St. Bartholomew's Hospital Journal
St. Bartholomew's Hospital
London EC1
Telephone 606 7777 Ext. 7206

Buy your Newspaper from
FRED
on the corner of
Giltspur Street
All modern magazines in stock
For mature reading
use the codeword
"ADONIS"
he will understand

SOCIAL FACTORS IN HEALTH AND DISEASE

By P. E. R. SOPPET and M. C. SCHONHOFER

An informal review on the conference held by the British Society for Social Responsibility in Science.

The conference was held at the London School of Economics over the weekend of January 7th to 9th, and was attended by about 150 people, including doctors, medical students, nurses, social workers and research workers.

The programme opened on the Friday evening with the topics of Pregnancy and Birth. After the introduction by Prof. Sir Richard Doll (Regius Prof. of Medicine at Oxford), Dr. Euan Ross (Lecturer in Child Health at Bristol) gave a talk on Perinatal and Infant Mortality. He informed the meeting that the perinatal mortality rate in Britain is worse than that of many developed countries, and went on to show statistically, that this is related to the quality of maternity services, and that social conditions are partly responsible for this rate. Then, Sheila Young of the Dept. of Medical Psychology (Univ. of Cambridge) discussed the Politics of Abortion, drawing on her survey of General Practitioner attitudes in one area to abortion, to illustrate, how the social and geographical background and approach of the mother seeking an abortion can affect the decision of a doctor to allow this procedure. In a series of examples of various women wanting an abortion, she illustrated, how ideological and economic issues affect the doctor's decision.

Saturday morning was concerned with the Community Environment, talks being given on the Distribution of Disease, Environmental Effects of Delinquency and Hypothermia in the Old. Trends were shown in the relationship between disease and environment in the community and statistics given on the social, geographic, economic and class distribution of disease. It was apparent that the less-well-off areas and people suffered more disease. The relationship between neighbourhood, school and family influences upon delinquent behaviour was explored, and it was shown that the school environment played the major role in determining the pattern of delinquency.

Hypothermia in the old was shown to carry a higher mortality where there was social isolation.

The Problems of a Comprehensive Dental Service in the 70's were next discussed. A dental surgeon suggested that unless patients opt for private treatment they risk inferior care.

Saturday afternoon discussions were about the Work Environment, especially factors concerned in certain occupational cancers, Asbestosis, Mercury, Cadmium and other Industrial Hazards. An example was given of a zinc melting factory in Japan which poured its industrial effluent into the nearby sea. This effluent contained Cadmium which via plankton and fish reached the stomachs of the local people. A common disease found in this area of Japan was Osteomalacia (or roughly translated "ow-ow" as called by the inhabitants). The disease resulted from the effects of Cadmium on the body, which is to deplete the bone Calcium. So it was seen that effects of industrial hazards are not only suffered by the workers themselves. Emphasis was placed on the necessity of doctors to investigate working conditions with a view to being able to pin-point the cause of such diseases in the population at risk, and draw the public's and industry's attention to such hazards.

The conference then moved on to the general subject of the Impact of Technology. In a talk about the Influence of Technological Innovation on Health and Safety, the continuing necessity for such observance was shown to be needed.

Health Consequences of Food Technology was then discussed, and although such diseases as rickets are now uncommon, the effects of our present eating habits on health are inadequately studied. The question raised was "Is the food industry today in the position of the tobacco industry of 50 years ago?".

Health Problems of Modern Urban Development, especially those of families living in high rise flats, was the next topic, followed by a talk on the changing experience of the G.P. as technocological developments tend to oust him out of his traditional "Family Doctor" role. Sunday morning was devoted to discussions in smaller groups on such subjects as Community Power and Medical Education.

Then in the afternoon, the Politics of Health were considered. The first talk in this session was on the distribution of Medical Care in Relation to Need, where it was shown that the availability of good medical care tends to vary inversely with the need of the population served, the "inverse care law".

Talks were then given on the limitations of Health Economics, Trade Unions and Health Workers and the Theory and Practice of Direct Action. The line of argument in these talks was, that if people find a need for change, then they must be prepared to organise themselves to improve the Health and Social Facilities.

We found the informative talks most thought provoking, especially the discussions after, where opinions were exchanged between the variety of people present. The main value of the conference was to supply a platform for discussion between people with different experiences of health service and other social aspects of our society. A better service would more likely be achieved with greater communication between people working in the N.H.S. and other welfare work in its broadest sense and between students training for such professions. A start in this direction is the planned move of Bart's medical students' premedical college to a site where easier contact can be made with other university students from different faculties and with a broader range of interests and ideas.

ROBERT BALTHROP

If any of you were wondering what happened to the illustrations mentioned in the article in last month's issue (pages 53 and 55) about Robert Balthrop by Mr. J. L. Thornton we are presenting them now with our apologies.

Coat of Arms of Robert Balthrop

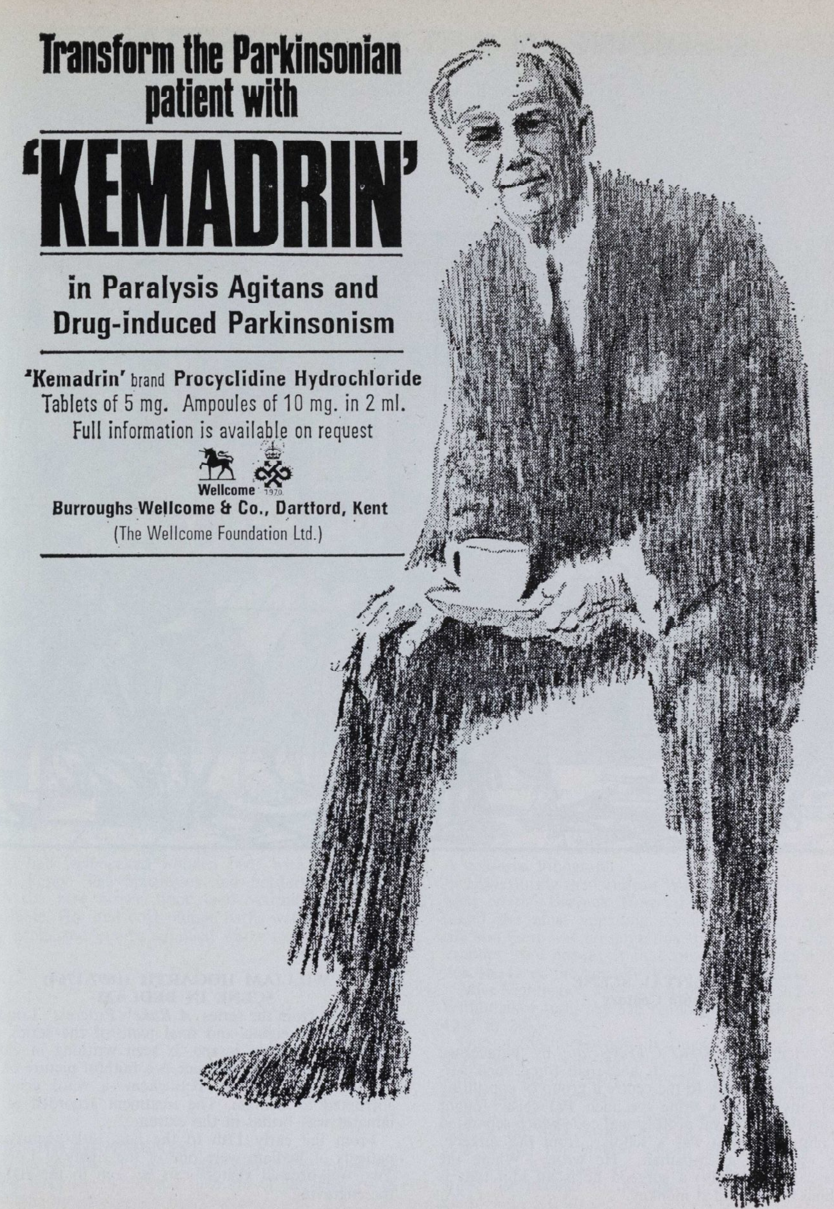
Monument to Robert Balthrop in St. Bartholomew the Less

THE MIGRAINE TRUST

RESEARCH FELLOW

(Registrar Grade)

Applications are invited from registered medical practitioners who have the M.R.C.P. for the post of Research Fellow to study gastrointestinal activity and drug absorption in patients with migraine. This work will be carried out in the City Migraine Clinic and in the Department of Clinical Pharmacology, St. Bartholomew's Hospital, with active collaboration from the Department of Gastroenterology. The project is for 2 years in the first instance and would be expected to form the basis of an M.D. thesis. Further particulars from Dr. M. Wilkinson, F.R.C.P., Director of the City Migraine Clinic, 11/12 Bartholomew Close, London E.C.1., to whom applications stating age, qualifications, experience and the names of two referees should be sent by March 21 1972.



MEDICINE IN ART No.3 HOSPITALS

By Yvonne Hibbott, A.L.A. Medical College Library

No. 1

No. 2

1. HOSPITAL SCENE
16th Century

A woodcut from *Opus Chirurgicum*, by Paracelsus, Frankfurt, 1566. In the left and right foreground surgeons are operating. In the centre a group of consulting physicians discuss a urine specimen. Paracelsus fought against the mediaeval professional code which separated the physician, who was a scholar, from the surgeon, who was only a craftsman. He wrote—'Where the physician is not also a surgeon he is an idol that is nothing but a painted monkey.'

2. WILLIAM HOGARTH (1697-1764)
SCENE IN BEDLAM

Engraving from the series *'A Rake's Progress'*, London, 1735. In the eighth and final plate of the series, the Rake, who is now insane, is seen writhing in chains in the foreground. The scene is a faithful picture of the famous insane asylum, Bethlehem—a word generally corrupted to Bedlam. The treatment accorded to the inmates was brutal in the extreme.

From the early 17th to the late 18th century the patients of Bedlam were one of the sights of London. Two well-dressed visitors can be seen to the right in the engraving.

3. RAHERE WARD, ST. BARTHOLOMEW'S HOSPITAL 1832

The south wing, containing Rahere Ward, was completed in 1740 after the designs by James Gibbs. The ward had well-spaced wooden beds with curtains of thick linsey. The mattresses and bolsters were filled with the best brown flock, and warming-pans were available. Hot and cold plunge baths were provided in this wing, and pumps supplied water to each floor.

ACKNOWLEDGEMENTS

Illustrations nos. 1 and 4 are reproduced from the originals in the Wellcome Institute of the History of Medicine by courtesy of the Trustees.

4. J. A. BENWELL
FLORENCE NIGHTINGALE IN THE BARRACK HOSPITAL, SCUTARI 1856

(Wellcome Institute of the History of Medicine)

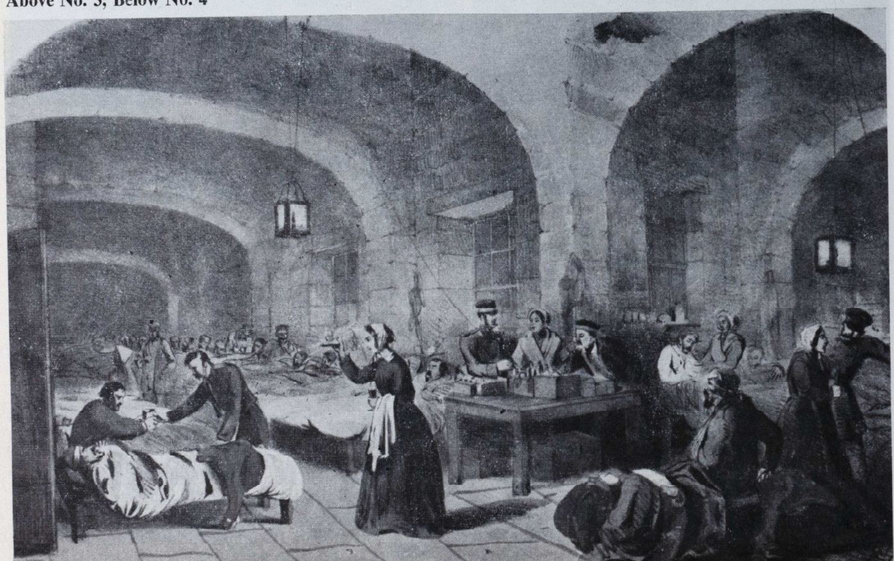
A coloured lithograph.

In 1854, during the Crimean War, Florence Nightingale went to the Barrack Hospital at Scutari where she found the most appalling conditions—dysentery was rife and there was no sanitation; patients were starving; supplies were hopelessly inadequate; and, added to all this, she faced the hostility of the Army doctors.

Miss Nightingale soon had 10,000 soldiers in her care. Within six months she had reduced the death rate from 42% to 2%.

One of the nurses described accompanying Florence Nightingale on her night rounds—'It seemed an endless walk and one not easily forgotten. As we slowly passed along the silence was profound; very seldom did a moan or cry from those deeply suffering fall on our ears. A dim light burned here and there. Miss Nightingale carried her lantern which she would set down before she bent over any of the patients. I much admired her manner to the men—it was so tender and kind.'

Above No. 3, Below No. 4



BRAHMS for £5

Hearing a live performance of the Brahms' 3rd symphony recently made me realise that the music of this master has become very much less-frequently performed of late. The reasons are complex—in part due to an increase in Mahler/Bruckner performances. This music is of such great quality that it can be overlooked on the grounds of its safety. Brahms had complete mastery over symphonic, concerto, chamber and choral music. He also composed some deeply moving songs; many also enjoy his piano music.

Brahms first won acceptance as a composer of stature with his "German Requiem" in 1868. It had not been easy. He certainly lacked confidence and the fiasco of the 1st Piano Concerto's first performance went deep. He was befriended by Schumann, not only a great composer but an important critic, and his backing caused Brahms to go on composing. The 1st symphony appeared as his opus 68, when Brahms was 43—some idea of his caution as he had burned many attempts before this. When it was mentioned that the allegro theme of the last movement bore a strong resemblance to the Beethoven 9th, he replied "any donkey can see that". He clearly felt dogged by the image of being the greatest symphonic composer since Beethoven and this reduced his output. What he did produce contains melodic music with a rugged style. It was completely conventional in that he used strict sonata form. To this extent he cannot be said to have extended the art of the symphony.

His music has been well served by the record companies and many cheap-label performances are available. The symphonic bargain still available in some shops although deleted officially is the set of Toscanini conducting the four symphonies on RCA (VCM3). Toscanini had an uncanny insight into this music and No. 4 is still my pick at any price. Bruno Walter's No. 3 is warm and loving, passionate and compelling—he truly has captured the autumnal glow—this is on CBS(61219).

The 2nd piano concerto has fast replaced the Tchaikovsky No. 1 or the "Emperor" as the most recorded piano concerto. Emil Gilels plays it powerfully yet poetically: the Chicago Symphony under Reiner accompany well and the sound is quite good. RCA (VICS1026).

To select a representative chamber is even more difficult but the Clarinet quintet is a beautifully melodious work and Boskovsky's honeyed tone is very appropriate. Decca (SDD 249).

The German Requiem is Brahm's major contribution to church music. It is a Lutherian work based on texts from the Scriptures rather than a Catholic Mass for the dead. It contains some of his most sublime music. An excellent performance comes from Rudolf Kempe with Berlin forces in mono (EMI XLP30073/4)—you get the Bruckner Te Deum as a "fill-up".

Rather than recommend a solo Piano Recital (no good ones on cheap label), I shall recommend 2 more orchestral discs. One contains my favourite Brahms Concerto that for Violin, 'Cello and Orchestra from Suk, Navarra, and the Czech Philharmonic under Ancerl (Supraphon SUAST50573). The other is my personal full price choice. It has No. 2 with the LPO under Sir Adrian Boult—enough in itself to recommend the disc—it also has Janet Baker—so 'Ferrier'-like in the "Alto Rhapsody" HMV (ASD2738).

"ALLEGRO."

17th NATIONAL STUDENT DRAMA FESTIVAL 1972

What is the point of having a Drama Festival in the middle of winter, at Bradford, devoted to amateur productions of plays of untried worth, and without any incentive of a cash or otherwise prize at the end of it? To the theatre-goer who has just been to see Abelard and Heloise for the third time there is unlikely to be any point at all, but I think that there are certain things in the National Student Drama Festival's favour. Firstly, ten plays, produced by students, have been chosen, for varying reasons, to be performed during the week. They came from all parts of the country, from colleges of widely differing disciplines, and this is the second reason, that it gives an opportunity for students doing plays, to compare their efforts with other people's, and to learn from them. Thirdly, it is a time for professionals to be able to show their skills and to teach them. And those three things happened to a large extent at Bradford this year.

The student productions varied from a mad, hectic pantomime about the rise of the railways, from York, to a somewhat unusual multi-media non-play about eating, "The Marshall McLuhan Foodshow" from Keele, who have something of a reputation for doing unusual multi-media non-plays. Other plays included a version of "The Bacchae", "MacRune's Guevara", a play about Che Guevara as seen through the eyes of a malnourished Scottish sign painter, "The Syracuse Myth" from Barts, and "The Audition", which was a sharp illustration of the stresses and strains of auditions, vivas, or interviews, and as such, horribly familiar.

There were also various fringe events, such as Street theatre, people running around in a large inflated polythene ball, performances in pubs. One item was the "first appearance outside the States" of the Macalester College Drama Chorous from Minnesota. They were very clean American teenagers and worked their way through 90 minutes of mildly liberal quotations, having been impeccably drilled by their ferocious American school ma'm figure.

One of the days was allocated to political theatre,

and there was an intensely bad seminar of political writers, all of whom jumped on their own little hobby horse, and talked furiously, ignoring everyone else. The actual plays however, were much better, "James Harold Wilson Sinks the Bismarck", being a very clever and funny iconoclastic history of the last Labour Government, and "The National Interest", being a much more committed and interesting review of many of the iniquitous short-comings of the present Tory mob. Their portrayal of certain members of the Cabinet as protection racket gangsters was apposite and amusing.

Often during the week the conversation seemed to degenerate into a poor imitation of the "you were marvellous, darling" 's of the celluloid professional theatre, but some benefit was, I am sure, gained from talking with people with vastly different ideas and styles, and, if this is what the Festival can encourage, it deserves success for the future.

SYRACUSE MYTH AT THE N.S.D.F.

Noises Off, the official newsheet of the festival.

"It started at an arbitrary point and ended on an arbitrary point, but what went on in between was well-acted, slick and expressive. In Peter Bacon and Don Gillett, Barts Drama have two fine, outstanding young actors.

"Love and friendship, the two most important things in life, were powerfully examined by the cast. Don Gillett, who acted Duncan, successfully portrayed that sickly preening for the girl's attention which was a hallmark of his detestable character. His capricious viciousness towards his friend James was equally well acted on both sides.

"This then, was unusual Drama, but nevertheless, a damn good production."

"I thought in all respects the cast was first class, not least because much of the play was unscripted, but also in their movement, expression and voice. Janet Dinwiddie took off Joan Bakewell very well.

"The boys too, Duncan and James, were well acted; great use was made of some meaningful lines. The girls' parts were also well acted as the drama itself developed.

"A fine production, and one well worthy of the festival."

The Times, Jan. 7th, 1972.

"The medical students of St. Bartholomew's Hospital brought a skilfully improvised four-hander about friendship."

"The Syracuse Myth would be a sure success in the West End. Two points worth mentioning. One, how do they create a scene with no props, no set, and only a few chairs, and two we believed in what we did or did not see, which says a lot for the acting."

Time Out, Jan. 14th, 1972.

"The Syracuse Myth stood out from the rest for reasons worth examining. Starting from a myth, it switched realities to an artificial discussion, only to switch again to an examination of the group's responses to one another within the framework of a modern parallel. It was at this point that the piece became totally absorbing. Improvising, the cast provided an extraordinary exposure of their attitudes to one another. For an hour and a quarter they took us along with them on their own terms and they were interesting and unpretentious enough to follow. We felt this was what student Drama should be going towards."

BOOK REVIEWS

PETER MILLS: THE SIGNIFICANCE OF PHYSICAL SIGNS IN MEDICINE

(H. K. Lewis, 1971).

This is a small (100 pp.) and expensive (£2.25) book, which contains a modest amount of information. The ground that Dr. Mills covers has been extensively dealt with in books which contain more useful hints but cost about the same Pappworth's Primer springs to mind. The book deals systematically with the physical signs of each part of the body, and has a useful chapter on coma, a subject which is often overlooked by medical textbook writers, but which is always difficult to diagnose. For clinical students in the early years who want a concise manual on examining patients, this book would be adequate if it were cheaper. As it is, it offers such poor value for money that it can hardly be recommended.

DISEASES OF THE URINARY TRACT.

From the B.M.J. £1.00 nett.

This book is made up of articles which originally appeared in the B.M.J. in 1970, and is intended to be an outline of current thinking on selected topics rather than a complete textbook of urology or renal medicine. The huge bulk of new information each year means that textbooks must become bigger and bigger or more selective; and now that Davidson runs to well over 1,000 pages, one blanches at the prospect of what 1980 medical students will be expected to know. Short monographs giving recent information on selected subjects must be here to stay, and the recent B.M.J. publications have demonstrated that they can be packed with facts and cheap at the same time.

Nephrologists are fond of saying that their's is the fastest expanding subject in all medicine: and after reading this book one might believe them more readily. Their work ranges from the management of childhood enuresis to that of carcinoma of the prostate, and both of these topics are well covered in this book. Dialysis and transplants have a separate chapter, and the rest of the low-down on renal failure is supplied with clarity and the minimum of fuss. Dr. Cameron's chapters are particularly helpful, and his attempts at demystifying Glomerulonephritis are largely successful.

This is a very good book; the only qualm I have is that, like the B.M.J. itself, its print is too small. Recommended to all but the most myopic students.

J. S. T.

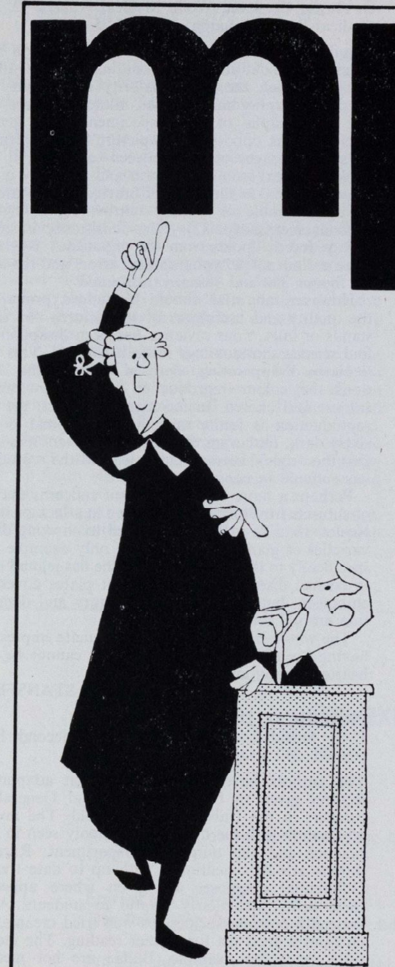
OPHTHALMOLOGY

Authors: Ian Duguid and Anne Berry. 150 Pages. Price £1.15p.

A well planned textbook, clear concise and logical in its presentation. The inclusion of the normal anatomy and physiology is adequate to ensure full understanding of the appropriate text.

The use of photographs, of which there are twelve, is good. However, greater understanding would have been possible by the use of colour prints. The nursing content covers the general syllabus requirements adequately. This book should prove a necessary addition to any Nursing Library.

mps
medical
protection
society est. 1892



Students!
Arrange membership now.
Full benefit immediately
you qualify.
Pay later at no extra cost.

Over 50,000 members enjoy
•unlimited advice
•unlimited legal aid
•unlimited indemnity

Full details from
Secretary:
Dr. H.A. Constable, Head Office
50 Hallam Street, London, W1N 6DE
Telephone: 01-580 9241
or
Regional Secretary:
Dr. P.G.T. Ford, Regional Office,
30 Park Square, Leeds 1
Telephone: 0532 42115-6

CLINICAL CHEMISTRY IN DIAGNOSIS AND TREATMENT
Joan F. Zilva and P. R. Pannall. First Edition. 430 Pages. £2.50.

This book aims to give the reader biochemical and pathological facts and theories to enable him to interpret the analysis of a department of Chemical Pathology. It does this and more. Each of the twenty-three chapters is well laid out, ending with a summary and an appendix interpretation of each one. There are clear diagrams and tables throughout the text.

At £2.50 this book may be a little expensive for the student but would be of great value in his final year. Candidates for M.R.C.P. and M.R.C.Path. examinations will benefit from owning this book and it will be a useful reference for the houseman.

PHILIP O'FLYNN.

ESSENTIAL ANATOMY
Author: Professor J. Joseph. Medical and Technical Publishing. 257 Pages.

Excellent and well presented textbook, extremely well written and logically presented.

The information contained is highly illustrated. Particular reference is made to the function of what is being described.

This book should provide adequate general information for any student nurse in training.

NURSES GUIDE TO CARDIAC MONITORING
P. J. Hubner. Balliere Tindall, 85p.

This is a helpful and informative book particularly for use in Coronary Care Units and Intensive Care Units. It has some material that would be helpful on all wards. On the whole it is written fairly simply though the latter chapters are of a more advanced nature. The diagrams are especially helpful as they are clearly set out and labelled.

R. M. MIELL.

ESSENTIAL IMMUNOLOGY
by Ivan Roitt. London Blackwell Scientific Publication. £1.50.

Professor Roitt is one of the most lucid teachers on the subject of immunology and has the ability to transmit his enthusiasm to his students. In this latest addition to the ever-growing number of textbooks on immunology he has compressed into 220 pages an incredible amount of information. The quantity of information exceeds that required by the average medical student but will form a splendid introduction to the potential post-graduate student who wishes to make use of immunology. That is not to say that by judicious selection that the undergraduate student will not benefit greatly from adding this book to his personal library. Certainly the chapter dealing with autoimmune disease and the diagnostic value of auto-antibody tests is masterly in its brevity, yet covering such an enormous field.

The indexing leaves much to be desired—often one supposes that certain key facts have been omitted only to find them by careful searching.

The line drawings are particularly informative and summarise many key processes, e.g. relationship of B and T-cell activity to different forms of hypersensitivity and immunity.

For the student wishing to acquire a wider knowledge of immunology this book is highly recommended.

D. A. WILLOUGHBY.

A COLOUR ATLAS OF GENERAL PATHOLOGY
G. Austin Gresham, Wolfe Medical Atlases—2. Wolfe Medical Books, London, 1971. £3.75.

This is the second volume to be published in a new series of medical atlases. It contains over 400 illustrations of which the great majority are colour reproductions of photomicrographs, although there are a few photographs of gross specimens. The generally brief captions opposite each picture are supplemented by short passages of text between each section of the book. This text is in digest form and accuracy is sometimes sacrificed in the cause of brevity. Some statements are questionable or frankly untrue, e.g. referring to Cascous necrosis (p. 87)—"the consistency is soft and cheesy due to lipoids from the organism." Regrettably there are not a few typographical errors and the legends for figures 388 and 389 are transposed.

However, an atlas should be judged primarily on the quality and usefulness of its pictures—by these it stands or falls. Your reviewer has been disappointed to find serious shortcomings in both respects. This is particularly disappointing, since in some of the illustrations the colour reproduction is excellent and the subject well chosen. In too many, however, the colour reproduction is faulty and the background is excessively dark, obscuring the details. In others it is evident that the original section had faded and the reproduction has suffered in consequence.

Perhaps a more serious criticism concerns the choice of subjects for illustration resulting in a lack of balance. No less than 26 plates are devoted to showing different varieties of giant cells, whilst the only example chosen specifically to illustrate atrophy is the flat jejunal mucosa in coeliac disease. There are eight plates covering fat embolism, but topics like nerve injury and demyelination are not touched upon.

The whole book leaves an unfortunate impression of having been hurriedly compiled and cannot be wholeheartedly recommended.

A. G. STANSFELD.

PRACTICAL DERMATOLOGY
I. B. Sneddon and R. E. Church. Second Edition. Arnold. 212 Pages. £1.75.

The authors have made an excellent adaptation of lectures given to Undergraduates and General Practitioners in the University of Sheffield. The text deals adequately with the diseases commonly seen in general practice and the outpatient department. Rarer conditions are also mentioned with up to date treatment. Differential diagnoses are given where appropriate: these being particularly helpful to students. A useful appendix contains recipes for well tried creams, lotions etc. and a good list for further reading. The index is a little short; for example, Bullae are not mentioned, although there is a chapter on the subject of bullous eruptions. Stevens-Johnson Syndrome is also only mentioned in the text.

However, this book is well produced on gloss paper with clear type and nearly a hundred black and white photographs. It is recommended to students and G.P.'s.

M. ROBINSON

BARTS SPORT

FOOTBALL CLUB REPORT
Saturday November 27th

Barts 2nd XI v HAC 2nd XI
(Played at Chislehurst)

Yet another bad game by Barts led to us being 3-0 down at half-time. In the second-half it was 6-0 before Southall scored a consolation goal, but HAC then scored twice to give a final score of 8-1 to HAC.

Wednesday December 1st

Barts 2nd XI v Westminster 2nd XI
(Played at Chislehurst)

Although the start did not suggest so this was to be the 2nd XI best ever game. We attacked strongly for 10 minutes but then Ryan, in passing back to his goalkeeper gave away an own goal. Undefeated Barts pressed forward and Sweeney forced the ball home in a crowded goalmouth. Sweeney scored again and Creigh-Barry scored his first before another defensive mistake let Westminster through for a half-time score of 3-2 to Barts.

Early in the second-half Westminster equalized but almost immediately Creigh-Barry scored his second. At this stage, Hull, back in goal at last brought off two magnificent saves to keep our lead intact. In the next 10 minutes the forward line went on a scoring spree. Creigh-Barry ran on to a through ball to complete his hat-trick, then Sengupta scored from a narrow angle! To finish off the afternoon Creigh-Barry scored his fourth. So Barts won 7-3.

This was altogether a much improved performance, the defence, despite conceding 3 goals were much stronger (thanks to the return of P. Hull) and consequently the forwards were able to live up to their considerable potential.

Sunday December 5th

Barts 2nd XI v A Cambridge Vets XI
(Played in Cambridge)

A rather scratch 2nd XI side assembled at College Hall and travelled up to Cambridge. The hour before the match was rather regrettably spent acquiring a liquid lunch. However, in the first-half Barts swept into a 3-0 lead due to poor shooting by the opposition and goals by Morrison, Murphy and Thompson.

In the second-half, however, the drink began to tell and the defence decided they all wanted to play centre forward. Thus, by the end of the match Barts were lucky to leave on level terms at 3 goals each.

Due to the fact that no premises open in Cambridge until 7 p.m. on a Sunday we were unable to beat the opposition round the bar and so the day ended a trifle disappointingly.

Saturday January 15th

Barts 2nd XI v Westminster 2nd XI
(Played at Chislehurst)

Barts, forced to play two 1st XI players to make up their numbers, lost to a Westminster side playing three 1st XI players; including two forwards—who scored their three goals. This proved to be the difference between the teams, Westminster taking their chances whilst Barts missed several. So we lost our first match of the term 3-0.

ART EXHIBITION

An Art Exhibition will be held in the Great Hall from April 25th to April 27th, 1972.

Entries are invited from all members of staff (medical and lay) and students. The Receiving Day for entries will be Friday, April 14th.

Further information and entrance forms may be obtained from the Medical College Library.

Wednesday January 26th

Barts 2nd XI v Westminster 2nd XI
(Played at Chislehurst)

Barts survived early pressure and then forced a corner. Middlesex failed to clear and Sengupta scored from 10 yards out. Barts proceeded to create more chances, but there was no further score before half-time. In the second-half Middlesex scored twice and hit the post, whilst Barts again missed chances. So Barts lost, yet again, this time, however, only 2-1.

ATHLETICS CLUB

You lucky people! Do you realise that at this establishment you can run for the University, United Hospitals or, if you're really good, for Bart's. You want to know more? Just ask Guy Routh (Captain) or Paul Taylor for details of training—which has already started and this season's matches. Seriously, just contact us—everybody is welcome, whatever their standard.

RUGBY UNION FOOTBALL CLUB REVIEW
P. 24, W. 15, D. 0, L. 9

During the course of the present season, we have had several notable victories against Southend, Cambridge LX Club, London University and Cambridge City. However, several excellent performances have been produced even in defeat, against London Welsh Druids, 33-16, and Metropolitan Police, 35-0.

Against the Druids, a venue we hope to add to the fixture list, we underwent severe pressure during the first half, and despite Hill leaving the field early in the second-half, our enthusiasm to impress was duly rewarded with 16 points in the last twenty minutes. McIntyre made a welcome return and inspired the pack to attain a much-improved performance.

We have been unfortunate during the last few weeks to have been without McIntyre, who has been engaged in playing for Middlesex, and we would like to extend our congratulations on his two appearances in England trials in December.

After their early season victory over London Welsh, we were all somewhat overawed at the prospect of playing Metropolitan Police. During the first-half we were unlucky not to be leading rather than being behind 8-0. The forwards admirably contained a strong police pack and were more often well on top, especially in the loose. Brain made several devastating breaks, which were pulled up only inches from the line; and it was with his ultimate departure from the pitch, with a broken ankle midway through the second-half, that the police intelligently capitalised on the weakened defence, with the removal of Else to scrum-half.

Tour

Cornish tour this year proved its usual success, more off the pitch than on it. Against Camborne, we once again threw away an early lead, gained after Griffiths had scored an excellent try, from a good run down the wing. With Else limping on the wing towards the end, Bart's were finally defeated, due to defensive errors and after a good game, 14-9.

Falmouth, as usual, produced the worst conditions that we met; playing into driving sleet and complete darkness above the 25-ft. floodlights, we scrambled home, despite little possession, through a penalty by Martin in the second-half.

The end, in every respect, came with a bad performance against Newton Abbot. Due almost entirely to the activities of the previous week, we found a single penalty was insufficient on this occasion, and we lost 7-3.

United Hospitals Challenge Cup

After Christmas, hospital rugby naturally turns its eyes towards the Cup, we are fortunate this year to have depth of talent and experience to call on from the winning cup side two years ago. Coupled with this we should like to thank John Harris for the many hours of his valuable time spent coaching us. We are very fortunate to have someone of his experience to guide us, and we all hope that we can reward him with the success that is well within our reach.

Due to the United Hospitals' drive to improve their own fixtures, our first match in the Cup, against the Royal Free, was brought forward one week, and played at Honor Oak Park on January 27th.

Conditions were not favourable for both sides. Played in a strong wind, driving rain and ankle-deep mud, both sides found great difficulty in controlling any loose play. Bart's playing with the wind in the first-half struggled hard to break the defence of a very spirited Royal Free side; and their forwards, on numerous occasions, managed to harass and spoil any possession that Bart's gained. This was not a day for controlled rugby, and most ground was won with foot rushes and uncontrolled hacks at the ball. Bart's went into an early lead with a penalty goal by Martin, and capitalised on their superior territorial advantage with a well-deserved try by Hill.

7-0 at half-time hardly seemed sufficient to contain the Royal Free, who with the elements in their favour were eager to impress a very partisan crowd. An early penalty goal in the second-half gave them renewed heart, but Bart's rallied, due very much to the steadying influence of McIntyre in the forwards and the safe defence of Martin at full-back, and were justly rewarded with a try by McIntyre under the posts, which was converted by Martin.

The game, which at one time had seemed in danger of being lost, was now won beyond any doubt. An error by the referee who, because of the thick mud, experienced great difficulty in the later stages of the game distinguishing between the sides, gave the Royal Free a penalty attempt at goal which struck the cross-bar. But this was not enough, and Bart's won this hard-fought match 13-3.

TEAM: M. Martin, M. Busk, R. Griffiths, D. Jefferson, J. Laidlow, J. Sowden, R. Hill, N. Fairhurst, N. Best, S. Sullivan, R. Brookstein, J. Carroll, O. Else, M. Britton, K. McIntyre.

Our next tie, which will be against Guy's, is to be played at Richmond Athletic Ground on Thursday, March 9th, when we hope to reverse the result of last year and achieve a place in the final on March 29th.

We would like to thank all those supporters who braved the elements to come to Honor Oak, and look forward to their vocal support at Richmond which will be very much welcomed and appreciated; we hope you will not be disappointed.

M. Martin, O. Else.

SAINT BARTHOLOMEW'S HOSPITAL JOURNAL

Founded 1893. Vol. LXXVI No. 4

Journal Staff

Editors
Alan Searle
Malcolm Vandenburg

Sub-Editors
Articles
John Watkins
Pat Thrower
Jane Knowles

Sport
Oliver Bastard

Reviews
Ian Baker
Peter Smith

Manager
Bob Le Quesne

Subscriptions
Charles Hinds
Deidre Lucas

Editorial Assistant
Jane Hilton

Advertising
Mike Johnson
Rod Bexton

Charterhouse Representatives
Timothy Bunker
Peter Bacon
Teifion Davies
Trevor Turner

Liaison
Mike Goldsmith

Editorial

Who makes a good thief? The surprising answer is a medic, a student or otherwise. The person who had lunch opposite you today may have just committed the perfect crime.

The medical school libraries lost £300 worth of text books last year. Students are not only to blame; numerous volumes of bound scientific journals were "permanently" borrowed by members of the staff.

Most of the books disappear just prior to examinations, although a few do turn up afterwards. One can only suppose that those that were lost have been found, and the ones the dog chewed up have been miraculously regurgitated in their entirety. The harm, however, has already been done. The Library has been without the books when the majority of the students needed them for revision. Once returned after a prolonged absence, frustrated borrowers whisk them away again and the vicious circle is perpetuated.

In order to satisfy potential thieves by ensuring that there were sufficient copies of all text books available, the librarian bought twice as many books this year as were stolen over the previous twelve months. All he accomplished was to supply a few more impoverished students with a text book of their own, raising this year's loss to an estimated £500.

One answer is to keep the books locked away and allowed out, even for use within the library, only when signed for, or to have everyone thoroughly searched before leaving the library. As well as smacking of "1984", this would also mean more work for the already overworked librarians.

Is it not possible for those who use the library facilities to act as responsible individuals? Is it too much for everyone to act unselfishly for a change?

At the same time let us hope that this thieving does not spread to the recently opened Audio Visual Centre. To utilise its maximum potential it should be possible for students to work there late at night and at weekends, with little or no supervision. If anything is stolen, the Centre will be opened only when it can be fully supervised, with all the contingent disadvantages. Let us hope that people don't develop a burning desire to be the first one in their flat with a tape-slide programme on peptic ulcers, or even a complete teaching machine. Dare we hope?

LETTERS

The Editor,
Bart's Journal.

February 28th, 1972.

Dear Editor,

The recommendations of the Royal Commission on Medical Education have once again been the subject if some considerable debate. The Dean was kind enough to speak to students in December concerning those recommendations affecting Barts. At the first Council Meeting of term an attempt to discuss the implications for our Students' Union of the merger of the London and Barts preclinical courses and a course at QMC provoked the questions "Do we want to move at all?" and "How do we stop the move?" An informal debate on the subject was suggested and took place in January. The move was opposed by 44 votes to 22 with 3 abstentions.

This shows considerable unrest among students concerning the new course. Our feelings were put to the Chairman of the University Grants Committee on Wednesday when he visited the college. I am hoping that a full report on this meeting will be available by the time this issue comes out. These will be put on notice-boards and if not too long, circulated to year reps. and all council members. After hearing many valid objections put to him by both staff and students, he was asked directly how he thought we might best stop the proposed amalgamation of courses. Sir Kenneth replied that in his view we could not.

I believe that whether students are for or against this new course at QMC, and however strong their feelings may be, that should anyone stand up and fight the change it is essential that someone else must look to the future situation.

Whether we are facing a fait accompli or even the chances of a failed campaign against the proposals, to miss the opportunity now of assessing any new situation is likely to lead to the collapse of our Union on the preclinical side at least, and the instigation of a new union system with its associated facilities over which we will have had no control or advisory capacity in its formation. I also feel that even a small increase in the use of outside hospitals during the clinical course, such as joint units planned between London and Barts, or increased residencies in Hackney, St. Leonards, Whipps Cross, etc. may mean that the student spends very little of his five or six years at Barts itself.

It does not take a great deal of extrapolation to arrive at the point where Barts is only one of several Hospitals at which a member of the Faculty of Medicine at QMC will do his clinical training. Such a situation must be foreseen for should it occur without forethought the cohesiveness of the student body will be lost before any compensatory moves can be made.

On May 1st the new Chairman will be taking over. I hope that whatever moves may be planned to forestall the Todd Report proposals, full consideration will be given to the new situation should the proposals go ahead. Some members of the Council should by now have already met representatives of QMC to discuss what may occur in the future.

Our present 2nd M.B. course is to be changed for the 1973 academic session. The new University regulations state that the course will have to include several extra subjects, viz. sociology, genetics, psychology and principles of biometry and medical statistics. In order that the already overloaded 2nd M.B. course is not put beyond the breaking point, subjects taught at present will not be able to be covered in the same depth. We will have to start taking note of some of the Todd recommendations such as that less time should be spent in details of pure anatomy, and that part which is essential would be best taught as an adjunct of physiology and other subjects. A time of such reorganisation is ideal for finally integrating the teaching of histology with physiology, anatomy and some fundamental pathology. Perhaps more chemical pathology related to the structural pathology being taught at any given time might give the biochemical course more clinical bias. With each department also aware of the timetables of the other departments a course with less repeated teaching and more clinical relevance could easily be instigated. Departments are at present considering how they can comply with the new regulations. I have asked the Dean that any draft plans could be sent to the Union Council for student consideration.

College Hall has once again encountered financial trouble and we have held several meetings with Mr. Morris to try and find ways of making up for a large increase in the wages bill. Ways envisaged were a fee for car parking (income would be low and profits would have to go to the UGC since they loaned us the money to buy it); increasing the hire of college hall for hops (hops are hardly making profits now anyway so this might be impractical); increase in prices of food (unanimously rejected); decrease in services in College Hall (these are probably at the minimal level now, rooms only cleaned once a week, etc.); and finally increasing the price of rooms. Since we could find no alternative we agreed on small increases in the price of rooms.

At the time of writing the audio visual aids centre is nearly finished. This should be in operation by the date of this issue, but evening opening will require student volunteers. We may be able to start a system similar to that for manning Charterhouse library in the evenings. Details will be put on SU notice boards. If anyone is interested in running such a system or doing evening duties there please let me know.

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

ANNOUNCEMENTS

Marriages

GOLDSMITH-GAYER—The marriage took place on Saturday, February 5th, between Mr. Mike Goldsmith and Miss Amanda Gayer.

Deaths

COURTENAY-EVANS—On January 29th. Dr. C. N. Courtenay-Evans, M.D., F.R.C.P. Qualified 1928.

MASON—On January 29th. Mr. M. L. Mason, F.R.C.S. Ed. Qualified 1939.

WINKFIELD—On February 19th. Mr. C. F. Winkfield, M.R.C.S., L.R.C.P. Qualified 1898.

LYSTER—On January 29th. Dr. Ronald Guy Lyster, O.B.E.(Mil.), CROIX DE GUERRE AVEC PALME, M.B., B.S. Qualified 1914.

Engagements

KRAFT-STEVENS—The engagement is announced between Dr. Thomas Kraft and Miss Jane Stevens.

Appointment

Dr. Roy E. Ellis, Reader in Physics at St. Bartholomew's Hospital Medical College, has been appointed Professor and Head of the Department of Medical Physics at Leeds University, from Octber 1st.

For Sale

Collection of framed prints of St. Bartholomew's Hospital for sale privately. From 5 to 50 guineas each. —Sue Lawson Baker. 730 0513.

THE HATTON GARDEN JEWELLERS

E Katz & Co Ltd

88-90 HATTON GARDEN, LONDON EC1

TELEPHONE 01-242 5680

25%

DISCOUNT

—Offer all BART'S Staff and Students a full 25% Discount off our large stock of Diamond Engagement Rings, Eternity, Dress and Gem Rings. Also superb selection of Wedding and Signet Rings and Jewellery to suit all tastes.

BRANDED WATCHES, ANTIQUE AND SECOND HAND JEWELLERY $12\frac{1}{2}$% OFF

Hours: 10.30 a.m. - 5.30 p.m. weekdays.
9 a.m. - 1 p.m. Saturdays

PERSONAL OPINION

Hope: that someone among all the Protestants and Catholics in Ireland might stumble upon a Christian.

GRAVE NEW WORLD

Across the Irish Sea I saw a civil little dirty war.
While at home 'tis true, there's no improvement of the view.
The usherette has syphilis.
Women's Lib and miners alike throw off their jocks and go on strike.
On a brick wall it has been writ: Ted's a fairy, Alec's a twit.
Is not the EEC amiss?
The unemployed men of '30
Were diseased, wasted and dirty;
Today the dole queues are as big
But the men are as fat as pigs.
The populace explodes, but still the wise Pope says no to the Pill.
Is the world an earth of cancer? Ask your doctor for the answer.
Sexual freedom lost and found.
There is no heaven, I can tell, but old men pray there is no hell.
And everyone seems so depressed, was Aldous Huxley really blessed?
Hate makes this grave new world go round.

THE ADRENAL WIZ-KID

I grow whiskers on my chin and hair on my chest,
Hair grows on my knee-caps; but the hair I like best,
Is the hair that grows up and down my spine
And bristles through my vest.
Mother says "it's fine, only let it not be seen".
My pater has his doubts, he thinks it is obscene
For a girl like me to be growing a beard
And still only fourteen.

Fear: that someone among all the Protestants and Catholics in Ireland might stumble upon a Christian . . . and kill him.

By PETER DUNLOP

William Hogarth's Veiw of Medical Practice

By J. E. L. SALES, F.R.C.S.

William Hogarth was born in 1697 and died in 1764. His life therefore spanned the first half of the 18th century, all of which he spent in London.* In early 18th-century London, a large number of people gave medical advice and prescribed remedies. Such practitioners fell into three main groups. Firstly, there were the physicians and surgeons. Secondly, the apothecaries. The third, and by far the biggest, group were the quacks. The reason for this ? ? ? ? was that there were just not enough physicians and surgeons to satisfy the needs of a population of 674,000. The apothecaries gave advice but their numbers too were limited. There was therefore plenty of scope for the untrained practitioner. We must remember of course that the scope of medicine was limited and there was not such a big difference between the treatment by the two groups as one would imagine.

I would first like to examine Hogarth's view of the Physicians and Surgeons, and then the Quacks. He made no significant comment on the Apothecaries.

The Physicians and Surgeons

He was born in Bartholomew Close, next to St. Bartholomew's Hospital, and spent the next 30 years of his life living close by. This undoubtedly was the reason why he developed a great interest in the hospital, and humanitarian causes in general. He became particularly friendly with John Freke, Surgeon to the hospital, and through this friendship came to know the leading medical figures in London, such as William Chessleden, and he painted portraits of Thomas Pellet, P.R.C.P., and Sir Caesar Hawkins, Master of the Company of Surgeons. He was therefore well acquainted with the medical scene.

What view of orthodox medical practice would Hogarth have got from his association with the Hospital? Two honorary physicians and three honorary surgeons and their assistants attended the hospital. A resident apothecary was later appointed. Out-patients were seen but had to show a certificate of their poverty before they were treated. By 1750 345 patients were being seen each week. The seriously ill were admitted to the wards where they were attended by both the physician and surgeon—2,600 being admitted per annum at this time. (Whitteridge & Stokes 1961.)

In 1730 James Gibb started the rebuilding of the Hospital. Hogarth was elected a Governor in 1734, and then started to paint the murals on the great staircase which he completed in 1737. On their completion he was given a vote of thanks by the Governors for his generous and free gift of the paintings, which illustrated the charity extended to the poor, sick and lame of the hospital. The Pool of Bethesda was the first to be painted. Christ is seen addressing the lame man. The painting is in the style of Dutch Protestant biblical illustration and while considered a failure from the artistic point of view, it *is* very successful and accurate in portraying the sick who attended the hospital at that time. On the extreme right the man with a thin pale face, a painful expression, and his hand on a swollen belly is suggestive of a malignant ascites. The reclining, scantily clad lady, turning her face from Christ, is said to be a portrait of Mistress Wood, a well-known city courtesan. She shows patches of psoriasis on both knees and her right elbow. The poor woman's child is suffering from rickets and shows the typical features—prominent forehead and enlarged joints. The man in the foreground is unwinding a bandage from a chronic leg ulcer, a very common complaint. Perhaps he has another on his head. The woman behind Christ, with the pained expression, is raising her right arm to reveal a breast abscess. The man with the bandaged head is probably an alcoholic—with, it has been suggested, gout. The old man with his beard and staff looks blind and perhaps has come to the Hospital to have his cataracts couched by Mr. Freke. The woman behind has pale melancholic facies. On the extreme left is an unhealthy fat girl with red cheeks, thick lips and a short nose, with an emaciated old woman. The two ladies present the two forms of consumption which used to be talked of at that time. The young girl represents the strumous or scrofulus type; the old woman, advanced phthisis. (Moore 1918, Sanders 1964)

The other mural, the Good Samaritan, is not relevant to this discussion.

In the 18th century surgery was put on a sounder anatomical basis and new operations were evolved. It still however was a very crude art and mortality was high. The aspiring surgeon became apprenticed to the Barber Surgeon's Company where he attended a seven-year course of lectures. Hogarth's engraving "The Reward of Cruelty", published in 1751, shows the body of Tom Nero—a hanged highwayman—being dissected in the Surgeon's Hall. The Hall depicted is probably a picture of the Cutlerian Hall of the Royal College of Physicians, as the Surgeon's new hall was not open at the time of the engraving and the Barbers had refused them permission to use their old hall. (Brockbank & Dobsen 1959). It shows John Freke in the chair, presiding over the dissection and surrounded by the fellows and students. If we ignore the satirical aspects of this engraving, it does give an idea of how anatomy lessons were conducted.

The Company had great difficulty in obtaining bodies for dissection. The Court of the Aldermen of the City of London helped by ordering that all bodies of executed malefactors should be taken to the Barber Surgeons' Hall. Despite this ruling they still had to compete with other interested parties, particularly the body-snatchers. The Masters gave public lectures on the anatomy of the body. Every cadaver was used to the full to ensure that it assisted in the teaching of the three main subjects—Anatomy, Pathology and Operative Surgery. They were carefully prepared: coloured waxes were injected into the arteries and veins. One side of the body was dissected to show anatomical structures and the other was used for operative surgery. The amount of pathology taught depended on what lesions were found in the body. The public were banned from these lectures in 1742. The slowness of the Barber Surgeons' course led to young aspiring surgeons going direct to the teaching hospitals where they were apprenticed to the surgeons. Here it is said they learnt more in a month than they did in a year at the Barber Surgeons!

Hogarth must have been taken by Freke to watch him operating. At St. Bartholomew's this was carried out in Cutting Ward. We have no pictorial record of the place, except that it must have been rather dark, for there is an order in the records of 1722 for a skylight to be put in to improve the light and at the same time a rail to prevent the company from pressing too closely round the surgeon. Later on in the century the number of operations averaged 55-60 per annum. The surgeons were paid 6/8d. for each operation, which were mostly for stone, amputation or cataracts. (Whitteridge & Stokes, 1961)[2]

There is a sketch by Hogarth in the Pierpont Morgan Library, New York, of an operating scene. (Fig. 1). It gives us some idea, if light-heartedly, of what went on, and was probably drawn in St. Bartholomew's. It shows a surgeon using a cautery to an ulcerated leg. The patient lying on a curtained bed has, not surprisingly, a rather pained look. The physician in attendance is gazing at a specimen of the patient's urine while his intoxicated attendant nurse sets fire to his wig with a candle—this was said to have occurred at Queen Anne's death bed. The man on the left-hand side of the picture is the box carrier who attended each surgeon and looked after his instruments. Their duties were to clean the theatres and surgeries and to prepare dressings from tow and linen. They have survived into the 20th century as the theatre orderlies.

Physicians during this period had basically little to offer their patients, except for bleeding, purgation, sweating and vomiting. A picture in the Tate Gallery, London, by Hogarth, entitled "The Doctor's Visit", was earlier known as "The Death Bed". This shows a physician taking the pulse of a rather moribund looking patient whilst examining a sample of urine. A parson prays at the foot of the bed. His services, I am sure, were frequently required! A figure seated behind the doctor could well be the apothecary who frequently accompanied doctors on their visits. They actively practised medicine despite legislation and prosecution by the physicians. They made no charge for their medical advice, but handsomely overcharged for their medicines. With advances in medical education they

Fig. 1. An operating scene.

Fig. 2. Headpiece to a power of Attorney.

were subsequently allowed to train and practice medicine—they were the forerunner of the modern general practitioner.

Hogarth had no children of his own and perhaps because of this he was especially sensitive to the appalling infant mortality among the poor and especially among the deserted bastard children. A committee of the House of Commons in 1715 found that of 1,200 such children christened in the Parish of St. Martin's in the Fields, three quarters died within the year, while the infant mortality returns of sixteen London parishes for 1750-1755 showed that of 2,239 infants born, only 168 remained alive at the end of this period (Williams 1949). So when Captain Coram, who had been agitating for years for a Foundling Hospital at last obtained a charter from George II, Hogarth enthusiastically supported him by becoming a Governor and painting pictures for the hospital. With his help, and that of people like Handel (who gave an organ), money poured in and in 1745 the building was completed and opened. As a result many infant lives were saved and many deserted children were brought up and apprenticed to trades. This hospital pioneered the development of other Foundling Hospitals in this country. Hogarth himself fostered two children from the Hospital—Susan Wyndham and Mary Woolaston—who were living with him at Chiswick when he died.

Hogarth designed a head-piece to a power of attorney to those gentlemen who were appointed to receive subscriptions for the hospital (Fig. 2). It shows Captain Coram as the principal figure. Before him the hospital beadle carries an infant whose mother having dropped a dagger, by which she might have been tempted to kill her child, kneels at his feet. On the right side of the picture is an abandoned infant by a stream. On the left are three boys coming out of the door with the King's Arms over it—holding emblems of their future employment: plummet, trowel and a card for combing wool. The children in the background are in school uniform. The three girls with the spinning wheel, sampler and broom, indicate that female accomplishments were also part of the curriculum. (Paulson 1965).

At the beginning of the 18th century, Bedlam, as the Royal Hospital of St. Mary of Bethlehem was known, was the only hospital in London for confining the mentally disturbed. When it was founded in 1547 a medical text book wrote " . . . I do advertyse everyman which is madde or lunatycke or frantycke or demonyack to be kept in safegarde in some close house or chamber where there is lytell light and that he have a keeper of which the madde man do fear." Conditions were somewhat improved when the hospital was rebuilt in 1676 and Edward Tyson was appointed physician. But the basic problem was the indifference of the medical profession and the absence of any form of therapy for the inmates except repression of those who were violent. The patients were left entirely to the mercy of the attendants, who were thoroughly inadequate in both quality and quantity.

Bedlam was one of the sights of London. The spacious walks in front of the building were a favourite meeting place and inside the visitors were amused by the antics of the inmates. Admission charges were an important source of revenue. It was not until about 1770 that it dawned on the authorities that introduction of visitors disturbed the tranquillity of the patients. Samuel Johnson and Boswell visited Bedlam and Steele took three schoolboys to see "the lions, the tombs, Bedlam and the other places which are entertainment to the raw mind, and which strike forcibly upon the imagination."

Hogarth's "Scene in a madhouse" in the Rake's Progress", engraved in 1735, gives a valuable insight into Bedlam. It is an appalling scene of human misery—a grim prison with cells and bars. The central figure is Tom Rakewell who, after his dissolute life, has gone mad. He is being manacled by two attendants because he has attempted to commit suicide by stabbing himself. He is comforted by Sarah Young, a girl he seduced while a student at Oxford. A fashionable, well-dressed lady and her maid are visitors. All the rest are lunatics of varying types. From left to right: a religious fanatic, a mad astronomer, a mad mathematician drawing on the wall. A naked man in the cell who imagines himself king is urinating: the lady is shielding her eye with her fan while the maid sniggers. A glibbering tailor, a mad musician, a man who imagines himself Pope, and finally a melancholic in love charming Betty Carless being engraved on the stair rail.

THE QUACKS

The 18th century has been described as the great age of quackery. Johnson defined them as 'boastful pretenders to arts they do not understand'. Their flamboyance and self-confidence together with the failure of the orthodox physicians to satisfy the community needs made them very prominent on the London medical scene. They included a great variety of fascinating individuals who differed widely in education, skill, character and mental stability. Hogarth's most famous satire of them is "The Company of Undertakers", originally called "The Consultation of Quacks", published in 1736. It is designed as a coat of arms for physicians—a black border indicating recent death with crossed bones at the foot. The motto is "Etplurima mortis imago" (Everywhere the Image of Death) a savage condemnation of the men it portrays.

Three figures at the top have been identified as Chevalier John Taylor, the oculist, on the left, Joshua Spot Ward on the right, and in the centre harlequin-jacketed Mrs. Mapp, the bone setter. Finley Foster, however, disputes the identification of Mrs. Mapp (Foster 1944). He feels that the central figure is a caricature of Sir Hans Sloane, Physican to George II, whom Hogarth was attacking for political reasons. Mrs. Mapp, the bone setter from Wiltshire, made a great but brief impact on the London scene. She had adopted the profession of her father, and travelled about the country calling herself Crazy Sally. Epsom was the centre of her operations. She drove to London twice a week in her chariot drawn by four horses and held her "clinics" at the Grecian Coffee House. It was here that she made her name when she cured a niece of Sir Hans Sloane, who had had a dislocated shoulder for 9 years. Within her limits she was obviously a clever operator and manipulator, setting fractures and reducing dislocations. One famous story told about her was of when a doctor sent her a bogus case to try to trick her. Examining the patient she realised that it was a hoax. With her great strength and a grim sense of humour, she dislocated the shoulder of the unfortunate patient and sent him back to his doctor—with the suggestion that he should reduce it.

John Taylor, who has been described as the prototype of all modern medical fakers, was born in 1703, the son of a Norwich surgeon. He studied medicine under Chesleden at St. Thomas's Hospital and obtained a medical degree. However he found life dull in Norwich and decided to become an itinerant oculist. He travelled widely in Europe and England and principally by his extravagant claims he was appointed oculist to George II in 1736. Oculist quacks had enjoyed Royal patronage since Charles II and Taylor succeeded Sir William Read. If one ignores his most extravagant claims, there is no doubt that he was adept at couching of cataracts. He also made attempts to correct squints and did some minor plastic surgery. Dr. Johnson however described Taylor as "the most ignorant man I have ever met and an instance of how far impudence will carry ignorance." His other claim to fame was that he succeeded in blinding J. S. Bach. It is interesting to note that his son became oculist to George III and his grandson to George III and IV.

Joshua Ward was undoubtedly the leading quack of the period. Having failed as a drysalter and spent several years in France, he returned to London and set up in practice in 1733. His real claim to fame was that he put "cure-alls" on the map. His came in two forms —the drop and the pill. The pill's chief constituent was antimony and the drop was probably made from ammoniated mercury. The action of these compounds was, to say the least, violently rough upwards and downwards. His way of persuading the public as to the efficacy of his therapy was to advertise that he had performed many marvellous and sudden cures on persons pronounced incurable at several hospitals. He accomplished this by hiring patients at 2/6d. per day to portray the appropriate symptoms. He probably killed as many people as he cured. A couplet written at the time gave the warning:

"Before you take his drop or pill
"Take leave of friends and make a will."

The pill however did become the standby of high society. He numbered the Princess Caroline, Walpole and Henry Fielding amongst his grateful patients. He was bitterly criticised by the physicians of the day but escaped the censors of the Royal College of Physicians by getting the patronage of George II, on whom he reduced a dislocated thumb. He also escaped the Apothecaries Act of 1748 which prevented unlicensed persons from compounding medicines: a special clause was inserted in the bill specifically excluding him. He left a fortune when he died.

The twelve physicians portrayed in the picture meditating upon the urinal fulfil Ireland's three criteria for recognising a physician of the period: their gravity, their cane heads and their periwigs (Ireland 1884). The gold heads of their canes held vinegar or pomander to counteract the smells of the day. They are all caricatures of contemporary physicians. The two immediately below the urinal are said to be Dr. Pierce Dodd (1683-1754), who was noted for his opposition to innoculation for the prevention of smallpox, and Dr. Bamber, who resigned as lithotomist from St. Bartholomew's Hospital in 1731 because the board of Governors would not elect his son-in-law as his assistant. Why Hogarth should include these two respectable physicians in this satire we do not know.

Dr. Misaubin

A small sketch shows Joshua Ward and introduces us to another famous quack of the day, Dr. Misaubin, who appears in two of Hogarth's engravings. The first is in "Marriage a la Mode", engraved in 1745, a satirical series of plates on upper class marriages—money for social position and its tragic end. The principal character is the Rt. Hon. Lord Viscount Squanderfield. In plate 3 (Fig. 3) the Viscount visits a quack doctor. They are said to be the rooms of Dr. Jean Misaubin who was a French quack in practice at 96 St. Martin's Lane, Westminster. Although regarded as a quack, he did in fact obtain an M.D. degree at the University of Cahors in 1697. His father, a Huguenot clergyman, was one of the estimated 40,000 french refugees who settled in London following the revocation of the Edict of Nantes (1685). Misaubin arrived in 1701, and was licensed by the College of Physicians in 1719. He is said to have "brought a famous pill for the treatment of Syphilis into England." (Avery 1970). Von Haller, who met Misaubin in London in 1727 wrote in his diary "Misaubin, a Gascon, made pills of mercury and opium which he sold for a guinea. These were supposed to effect a cure of syphilis without purging, sweating or salivation. With these pills he made a lot of money and became very wealthy". He was probably the most successful of many French quacks who were practising in London during this period.

There are several interpretations to the scene. The Viscount is holding a pill box to the quack, and playfully threatening him with his cane, presumably because they were not effective. He wants to know why they have not worked on him or the young girl who also has a box. One can surmise that the problem is probably a venereal one and it has been suggested that the young girl is holding the handkerchief to her face to hide a chancre. The large woman who has drawn her knife is said to be Misaubin's wife—or alternatively the procuress of the girl. Dr. Misaubin does not seem to be very concerned. The contents of his room show the paraphernalia of quack practice. The majority of the specimens are obviously displayed to impress the patients. The two folios on medicine at the left of the picture explain that the heavy machines are for straightening a dislocated limb and drawing a cork from a bottle. Through the door on the left is his pharmacy. At the back of the room is a fascinating collection of objects:—skeletons in the cupboard; a crocodile with an ostrich's egg hanging from its belly; (the head of a monstrous child;) a Narwhal's tusk; a tripod in the shape of the triple gallows at Tyburn. On the right is his cabinet containing his remedies.

Dr. Misaubin is also portrayed in the 5th plate of "A Harlot's Progress", published in 1732 which tells the sad tale of Mary Hackabout the country girl who

Fig. 3 Marriage-a-La-Mode (plate III.)

became the mistress of a wealthy man, fell from grace, became a prostitute and died in poverty. In this picture, "The Death of a Harlot", Dr. Misaubin is seen arguing over the efficacy of his pills and treatment with Dr. Richard Rock. Their argument is in vain for the woman has just died, attended by her faithful servant. This print may have promoted the well-known saying—"cause of death, two doctors."

Dr. Rock was another notorious quack who lived from 1690 to 1777, and practised at Ludgate Hill. Hogarth also put him in his scene of Covent Garden—called "Morning". On the right is the famous Tom King's Coffee-house, behind which is Indigo Jones Church of St. Paul. On the left there is a crowd of people surrounding Dr. Rock who is trying to sell his medicines. The board he is holding has the King's Arms just visible at the top—indicating that his practice was sanctioned by Royal letters patent. He has a vial of one of his elixirs in his other hand. His favourite medicines were "viper drops" and "cathartic antivenereal electuary", which were widely advertised, particularly in the newspapers. He was apparently the source of more abuse and satire than any other quack of his period. Pamphlets fell about his head like rain! Some of the other medicines he prescribed can be found in a Pharmacopoeia Empirica published in the Gentleman's Magazine. Vol. XVIII 1748 (Jones 1957). This gives a list of doctors with their addresses, their medicines and their cost. Listed under Dr. Rock's name are such delightful remedies as:— Elixir Gleets, which cost 3s. 6d.; Liquor Itch, 1s. 6d.; Lotio Claps, 7s. 6d.; and Tinct. Toothache, 6d. It is quite obvious from these and the other remedies listed that the venereal trade was extremely popular and a large source of income.

Finally, one of the most amusing medical scandals which attracted attention in 1726 involved Mrs. Mary Tofts of Guildford, who claimed she had been delivered of several rabbits. It led to the fall from grace of Nathaniel St. Andre, anatomist to the Royal Household and a surgeon at the Westminster Hospital.

Mrs. Tofts had had three normal children when John Howard, for 30 years surgeon and midwife in Guildford, claimed that he had delivered from her pieces of three rabbits. This soon became widely publicised. Doctors came down from London to see the spectacle. The general public were so moved that until the fraud was exposed rabbit stew and jugged hare disappeared from the menu. (Jamieson 1965.)

In the engraving entitled "Cunicularii (rabbit burrow), or the Wise men of Godlimen (Guildford) in Consultation" the amazing Mrs. Tofts is lying on the bed—with the furry products of conception running about the floor. (She did not in fact ever deliver an intact live rabbit.)

"A" is Nathaniel St. Andre, exclaiming "a Great Birth". He was a Swiss adventurer who came to London. He taught French, German, fencing and dancing. He learnt surgery, practised medicine without a licence and became a surgeon at the Westminster Hospital. Probably due to his German origin he was appointed anatomist to the Royal Household. It was his misfortune to be the first London physician to be invited by Dr. Howard ("D") to deliver one of the rabbits. Howard is seen at the door rejecting a rabbit saying "It's too big"! Andre in fact delivered several pieces of adult rabbit. He noticed that its lungs floated in water, and that her cervix was closed. Despite these clues he was taken in by the fraud. His humiliation was great and he never ate rabbit again.

Cyriacus Ablers ("C"), surgeon of His Majesty's Household was the next surgeon on the scene. He was suspicious about the pieces of rabbit, which looked as if they had been cut up with a sharp knife, and Howard would not let him examine Mrs. Tofts fully. He therefore called in Sir Richard Manningham ("B") (1690-1759), who was the best known man midwife of the day. He is exclaiming "it points, it swells, it spreads, it comes". He was convinced it was a fraud. At his suggestion Mrs. Tofts was taken to London and lodged at Lacey's Bagnio and asked to perform. Nothing happened. She at first denied the fraud despite being threatened with dire penalties and painful operations. Sir Richard Manningham apparently suggested, according to a contemporary broadsheet, that he would send a chimney sweep up her Fallopian tube! She finally confessed when a porter admitted that she had bribed him to smuggle in her 18th rabbit. She was sent to prison. The print was very popular with the medical profession.

One of the pleasures of William Hogarth's work is not only that his pictures may be enjoyed as works of art but they can also be read as a pictorial narrative of the times. His pictures give us a very clear view of the medical scene in 18th century London in all its varied forms and also of the men who practised it. He quite clearly supported the orthodox practitioners with all his energies and he used his brilliant satirical talent to expose and ridicule the quacks.

REFERENCES

1. Whitteridge, G. and Stokes, V. 1961. St. Bartholomew's Hosp. 1123—1961. The Governors of St. Bartholomew's Hosp., West Smithfield, London, E.C.1. 1 p. 36; 2 p. 37.
2. Moore, N. 1918. History of St. Bartholomew's Hospital. Vol. II. London: G. Arthur Pearson Ltd. p. 848.
3. Sanders, R. (1964). St. Bart's Hospital Journal, **68,** 157.
4. Brockbank, W., Dobson, F. 1959. J. Hist. Med., **14,** 351.
5. Williams, B. (1949). The Whig Supremacy, 1714-1760. Oxford: Clarendon Press. p. 126.
6. Paulson, R. 1965. Hogarth Graphic Works. 2 Vols. New Haven and London: Yale Univ. Press.
7. Foster, F. 1944. Bull. Med. Libr. Ass., **32,** 356.
8. Ireland, J. 1884. Hogarth Illustrated, London. p340.
9. Jones, C. E. 1957. Bull. Med. Libr. Ass., **45,** 220.
10. Avery, H. Misaubin and Veron: Butts of the caricaturists. Comunicazione presentata al *XXI Congresso Internazionale di Storia della Medicina Sienna 22-28 Septtembre 1968.*
11. Jamieson, G. 1965. App. Ther., **7,** 241.

This article is based on a paper presented to the History of Medicine Section of the Royal Society of Medicine 1st March 1970.

Fig 1 reproduced by kind permission of Pierpoint Morgan Library New York.

Fig 2 & 3 reproduced by kind permission of Trustees of British Museum.

Audio Visual Teaching Department

by JANE KNOWLES

The recently completed Audio Visual Teaching Department is due to open during the second week in March, and the head of the department, Mr. Cull, has kindly provided us with the details of the history and possibilities of this form of teaching at Barts.

It was five or six years ago that the Department of Medical Illustration was first asked to investigate the possible uses of audio visual aids in undergraduate clinical teaching. Eventually it was decided that facilities available at Barts would be put to best use in the production of Tape-Slide Programmes. Working from the author's draft, it takes at least two days to script one of these programmes, followed by two or three weeks of hard work for the artist who illustrates them. At present most of the films being produced contain about fifty or sixty pictures in twenty minutes of teaching. The audio visual department contains two artists and a secretary-production assistant at the moment, and Mr. Cull believes it will be possible to produce about thirty programmes a year. However, the department is co-operating with Guys who have started a similar scheme, and who make different programmes to "swop" with ours. Also St. George's Hospital produces some good programmes on surgery, so we shall be enjoying some of their ideas soon. These programmes are presented on a piece of apparatus which was designed and developed in the department and which now bears the name of the "Barts Audio Visual Desk". These desks are designed for individual study, and the machines can be stopped at will, if the student should require time to digest the knowledge or perhaps take a coffee break. However at the moment only six machines are available in the department, they have each been fitted with three sets of headphones, so that they may be used in groups. If the machines are to be used successfully in this way it is important to pick fellow students who will want the programme going at the same speed that you do, because the essence of this form of self-instruction is that the not-so-brilliant will have a chance to go at their own speed. Eventually it is hoped that the department will own thirty machines, and that this problem will, then, no longer occur.

The programmes already made cover a wide range of subjects, although Obs. and Gynae. are better represented than most because they went to the lengths of employing an artist to work full time for a year on this project. There is also an academic committee, comprising of Professor Taylor, Dr. Spencer and Mr. C. N. Hudson, who provide advice and backing where needed.

There are also two comfortably furnished tutorial rooms, which will soon be equipped to receive "Channel 7" Television Programmes, and plenty of extra table space for the students who wish to write notes or simply doodle in comfort.

St. Leonards have been using similar teaching machines for nearly two years and student reaction has been unanimously favourable so far. We have in Barts a much more developed system, with a greater selection of programmes, in far more luxurious surroundings, and I think we can look forward to the day when learning, under such conditions, will be a pleasure. It is important that students support the project in so far as to try it out for themselves. It is not designed to suit everyone's style of learning, but the majority of students at Barts will almost certainly benefit from a visit to the department, which they will find in the basement under Casualty.

ST. BARTHOLOMEW'S HOSPITAL JOURNAL

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

Further information may be obtained from:

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

ST. BARTHOLOMEW'S HOSPITAL PRE-REGISTRATION HOUSE APPOINTMENTS JULY, 1972

APPLICATIONS ARE INVITED FOR the appointments set out below:

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:	House Surgeon to the E.N.T. Department
3 posts:	House Surgeon to the Department of Orthopaedics
1 post:	House Surgeon Casualty
1 post:	Junior House Physician to the Department of Child Health
2 posts:	Rotating Locums

Regional Board Hospitals

CRAWLEY	House Surgeon (two posts)
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 (one post)
BATTLE HOSPITAL (Berks)	House Surgeon (one post)
WHIPPS CROSS	House Physician (two posts)
	House Surgeon (two posts)
ST. LEONARDS	House Physician (two posts)
ST. LEONARDS (ENT)	House Surgeon (one post)
PLYMOUTH GENERAL (Devonport)	House Physician (two posts)
	House Surgeon (one post)
ROYAL CORNWALL	House Physician (one post)
ROCHFORD	House Physician (three posts)
SOUTHEND	House Physician (two posts)
HEMEL HEMPSTEAD (St. Paul's Wing)	House Physician (one post)
REDHILL	House Surgeon (two posts)
METROPOLITAN	House Physician (two posts)
ST. ALBANS	House Surgeon (one post)

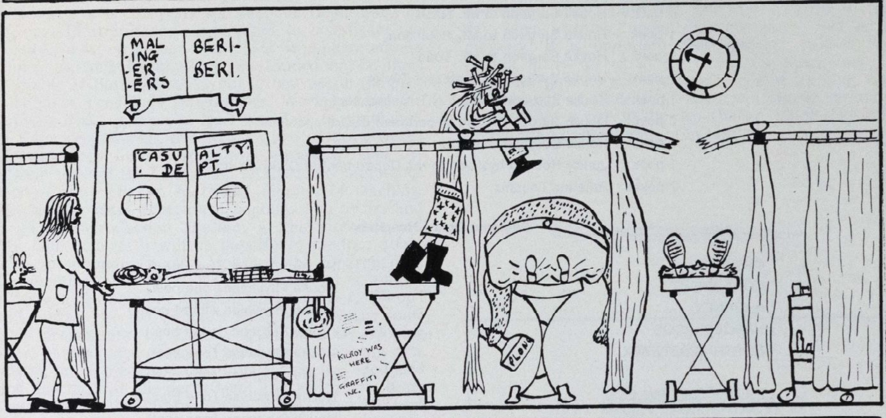
Applicants should state for which post they wish to apply and give three alternative choices.

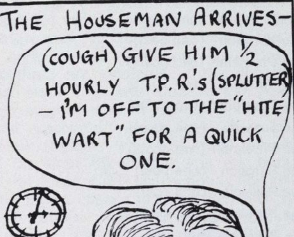
Posts are tenable from 1st July, 1972. Applications should reach the Sub-Dean's Office by *Wednesday, 17th May, 1972.*. (Application forms are available from the Sub-Dean's Office where further information may be obtained.)

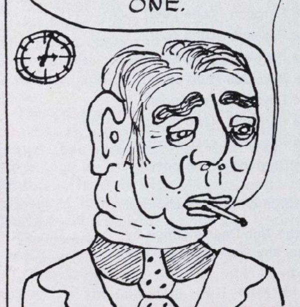
SPIRO McCHAETE (3)

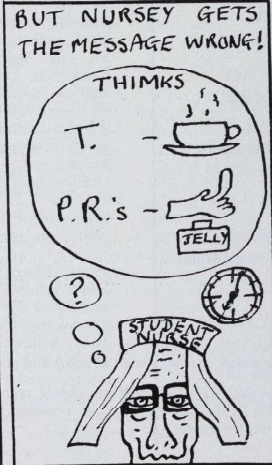
THE CONTINUING STORY OF OUR HERO (THIS MONTH WITHOUT THE CONSULTANT'S F.R.C.P. COURSE BECAUSE OF THE EASTER SEASON)

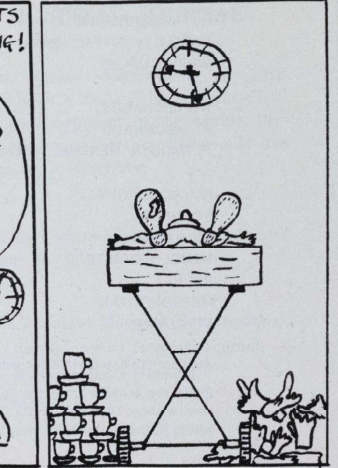
STORY SO FAR – SPIRO HAS BEEN TAKEN TO ST. WHOREMBLOAT'S HOSPITAL FOLLOWING A R.T.A. →

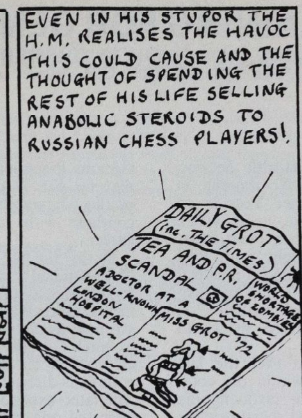


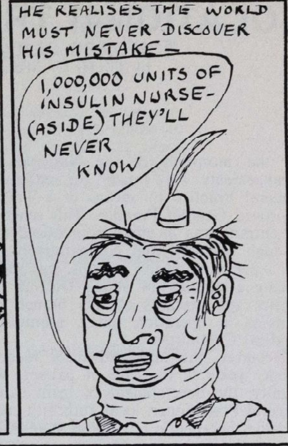


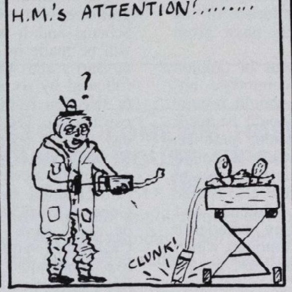


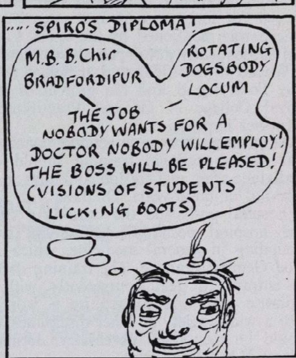


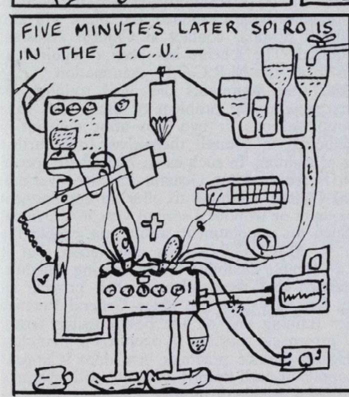


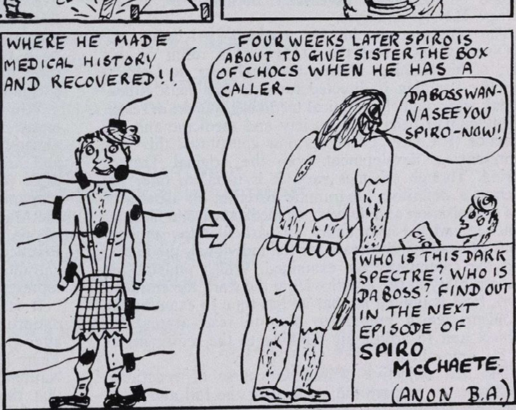












VOCATIONAL TRAINING FOR GENERAL PRACTICE

by G. H. C. MELOTTE MB. BS. FRC. G.P. Adviser in General Practice

At the inception of the National Health Service, arrangements were made for vocational training in General Practice by means of a Trainee Year in an approved General Practice. This scheme, under which an entrant was in effect apprenticed to a Practitioner of high standard and comparatively light work load for a period of twelve months, was successful in introducing a number of young Doctors to the responsibilities and rewards of this branch of medicine. It remains in operation today, administered by Local Medical Committees.

However, the rapid advances made over the last twenty years in the care of patients within the community, the development of team care involving the General Practitioner, local authority and social services and the therapeutic revolution have brought with them a need for more formal and extensive training. Such a need was mentioned by the Spens Committee (1946) and subsequently developed in Inverness (Adams 1954), in Wessex (Swift 1968), and in Belfast (McKnight 1970). The Todd report and the growth of influence of the Royal College of General Practitioners have given it further impetus.

At present there is a general concensus of opinion that such vocational training should commence immediately after registration and that it should occupy a period of three years. Of these, two should be spent in hospital posts and the third in a training practice. The hospital posts selected should ensure a sound grounding in general medicine, which is the basis of good General Practice. The training should also enable an entrant to deal competently with obstetric and pediatric care and to acquire a working experience with a wide variety of other disciplines, amongst which should be mentioned psychiatry, dermatology, gynaecology, E.N.T., and eyes.

The entrant should be enabled to essay the D.Obst.R.C.O.G. and the D.C.H. as a result of this part of his training. During the final year, in General Practice, training is directed towards five main educational areas, namely: clinical medicine, human development, human behaviour, society and medicine and the Practice (R.C.G.P. 1971). As now constituted this year represents a development from the original Trainee period. Though schemes vary, it is usual to offer the entrant a definitive programme covering all aspects of the organisation and delivery of medical care in General Practice and the community. In particular the implications of health and disease for the individual, the family and the community are examined. Whilst undertaking responsibility in the Practice from the start, the entrant's work load is limited so that he has time to examine the problems which present to him, to read around his subject and to adjust his thinking to the requirements of his new milieu.

The first objective of such a course of vocational training is to prepare the entrant for the full and satisfying professional life that is today attained by a good General Practitioner. The second is to prepare him to play his part in the immense advances of medical care in the community, already taking place and likely to continue with increased momentum throughout his career.

During the last few years there has been a burgeoning of Vocational Training Schemes up and down the country, offering as a package deal the three years of appointments necessary for complete training. Such schemes are now available to train one-third of those intending to enter General Practice. They have the advantage of an assured succession of jobs. The attention of the entrant is directed throughout towards the problems he will later experience as a General Practitioner. They offer the opportunity of contact with others following the same scheme of training. Finally, they are recognised as preparation for membership of the R.C.G.P., by which an entrant may assess his fitness as a General Practitioner of good quality.

The Medical College is now in a position to offer its graduates entry to such a three-year Vocational Training Scheme and it is expected that the first appointments will be made in July 1972. The first year will be spent at Bart's and will consist of six months in Obstetrics, followed by six months of Special Department Options (a selection from Skins, E.N.T., eyes, gynaecology and psychiatry). There will be an option to attend the half-day release course 'Scope of General Practice' at the Royal College of General Practitioners. At the beginning of the second year the entrant will move to Chelmsford Hospital, there to complete two six-month posts in General Medicine and Pediatrics. The third year will be spent in a Training Practice in the environs of Chelmsford with a detailed programme based on the five educational areas previously referred to. During this year there will be provision for the working of more than one Practice to be examined and there will also be a continued hospital contact at Clinical Assistant level if required. The scheme has been recognised as preparation to sit the M.R.C.G.P. examination.

Whilst this plan represents the ideal training for many, there remains the problem of those who have already completed one or two jobs after registration and are reluctant to commit themselves to a further three years of training. In such cases, and where special preparation is required for General Practice overseas, the Medical College continues to offer an appointment of one year, with or without a second year in a General Practice. Such an appointment would not enable the entrant to sit M.R.C.G.P. on its completion, but it represents a valuable flexibility in the training schedule.

It is intended that these schemes shall provide an opportunity for Bart's men to enter General Practice after proper training and on the best possible terms. There is at present no shortage of openings in first-class National Health Service practices, nor does it appear that the supply of well-trained entrants will overtake the demand for a decade or more.

VOCATIONAL TRAINING SCHEME FOR GENERAL PRACTICE

The Medical College is introducing a 3-year Vocational Training Scheme for General Practice in conjunction with the Chelmsford Hospital Group. The hospital posts will be at Senior House Officer level and candidates must be fully registered by July 1st, 1972, when the first two appointments will commence. The scheme is recognised by the Royal College of General Practitioners as suitable preparation for the M.R.C.G.P. Examination and it will consist of the following training programme.

1st Year at St. Bartholomew's:
A six months' appointment as a House Officer in Obstetrics (or Casualty Medicine if preferred) and six months rotating in Special Departments (a choice of three from Skins/V.D., E.N.T., Eyes, Gynaecology and Psychiatry).

2nd Year at Chelmsford:
Two rotating House Officer appointments of six months each in General Medicine and Paediatrics.

3rd Year:
As a Trainee in an approved General Practice Group in the Chelmsford area.

Application forms and further details can be obtained from the Postgraduate Assistant Dean's Office in Room G.4 of the Medical College Offices, and completed applications should be sent to the Dean not later than April 15th, 1972.

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

Applications are invited for the appointments set out below and should reach the Sub Dean's Office by *Monday, April 17th, 1972.* 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 ENT DEPARTMENT
H.P. TO THE SKIN AND V.D. DEPARTMENTS
H.S. (2) TO THE OPHTHALMIC DEPARTMENT
H.O. 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 for six months from July 1st, 1972.

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

ST. BARTHOLOMEW'S HOSPITAL AND

MEDICAL COLLEGE

ART EXHIBITION

IN

THE GREAT HALL

TUESDAY, APRIL 25th — THUESDAY, APRIL 27th

TUESDAY, APRIL 25th, 3.30 p.m. - 8 p.m.
(PRIVATE VIEWING 2 p.m. - 3.30 p.m.)

WEDNESDAY, APRIL 26th, 10 a.m. - 8 p.m.

THURSDAY, APRIL 27th, 10 a.m. - 8 p.m.

RECEIVING DAY — FRIDAY, APRIL 14th

Application forms may be obtained from the Dept. of Medical Illustration, the Flower Shop and the Medical College Library.

FROM THE SAINT BARTHOLOMEW'S JOURNAL of 50 years ago – April 1922

OUR PRIZE COMPETITION

THE grass is *never* allowed to grow under the Editorial feet, and this month we are offering a

ONE SHILLING PRIZE

in the hope of discovering another Poet Laureate at this Hospital. There is an elevating form of poem known as the limerick; this particularly lends itself to the use of medical terminology. You merely have to submit limericks containing rhymes to any of the following words:

Haematocolpos	Pneumonia	Syringomyelia	Diabetes
Actinomycosis	Haemoptysis	Dysentery	Ascites
Purpura	Acromegaly	Typhus	Whitlow

One competitor may send in any number of poems. The shilling prize will be awarded to the best poem on any of the above subjects. The Editor is at liberty to publish poems other than that winning the prize if he so pleases. In case any reader is not clear what a limerick is, we append one or two to indicate what a high standard must be attained to stand any chance of earning THE MAGNIFICENT PRIZE.

"There was an old man of Etruria,
Who had haematoporphyrinuria,
The surgeon said 'Quite,
We'll soon put you right,
We'll take out both kidneys and cure yer!'"

"A youth was gestating a thesis,
On dysdiadochokinesis,
Exams. drawing near,
He murmured 'I fear
It's nothing but pseudo-cyesis.'"

Any reader of the JOURNAL, male or female, from 9 to 90, may compete. Address letter "Competition", Journal Office, St. Bartholomew's Hospital, E.C.1, before April 20th.

THE EDITOR'S DECISION WILL BE FINAL,
and no remarks must be passed on his judgment.

The above competition was organised 50 years ago.
The *Journal* is repeating the competition but this time we are offering a grand prize of:

TWENTY-FIVE NEW PENCE

Any reader of the *Journal*, Consultant, Doctor, Student or Nurse, may compete. Please send your entry to "Competition", St. Bart's Journal, St. Bartholomew's Hospital, E.C.1.

Closing date for entries April 20th, 1972.

Once again, Editor's decision is **final.**

BARGAIN SCHUBERT

The genius of Franz Schubert is probably best expressed in his small-scale works. His songs and chamber music are full of delightfully melodic tunes. The skill is in the complexity of his modulations which are quite outlandish and daring, yet totally convincing by their result. He had an acute aural palate, one has only to listen to "The Trout" (his justly popular piano quintet), particularly the song movement variations, to appreciate this. Who else would have audaciously used a double bass in a chamber work and make it sound so much an essential part of the work, rather than an accessory?

Schubert was born in Vienna in 1797, and in his life span of 31 years he stayed in Vienna. His music reflects this in its simple, almost naive tunefulness. His works include incidental music to plays (Rosamunde), religious music including Masses and eight or nine symphonies (see later). He composed more than 500 songs, many of which are standard classics. His chamber music includes a marvellous string quintet (the first two movements are my favourite Schubert). String quartets abound—he wasn't averse to using the same tune in different works, e.g. Rosamunde and the slow movement of the A minor quartet D 804. He wrote two string trios and his piano repertory includes many sonatas (some incomplete) and beautiful smaller works including eight impromptus.

Records are numerous—again bargain boxes offering good value are available. You could get all the songs in three boxes, two sung by Fischer Dieskau and the third by Janet Baker with the ubiquitous Gerald Moore as accompanist—this would take 28 records and cost about £36. For once I would recommend bulk-buying if songs are your major interest. Nobody conveys the emotional range quite like Fischer Dieskau and Gerald Moore's accompaniment is delicate and beautiful. Janet Baker, if perhaps less experienced here, nevertheless compensates by her purity of line and beauty of tone (the two Fischer Dieskau boxes are from DGG, and the Janet Baker one is on EMI). I would personally settle for the marvellous Die Wintereisse song cycle sung by Hans Hotter with Moore (again). This cycle conveys all the emotions and longings of the tormented soul. Hotter was in his prime when this was recorded. It is available on HMV XLP30102-3 and coupled generously with Schwanengesang.

The symphonies are not really done justice at less than full price. Although the Great C Major Symphony is called No. 9, No. 7 doesn't appear—it either got lost or Schubert scrapped it—a funny orchestrated version has appeared on disc but it bears little resemblance, at least in this author's opinion, to mature Schubert. No. 8 is of course justly popular as the second movement "Unfinished", a "completed" version is also available on disc. Sir Thomas Beecham excelled at Schubert—he combined style with delicacy and grace—the RPO produced a beautiful sound for him, especially vivid in woodwind detail and although full price, I recommend his coupling of No. 3 and 5 (HMV ASD 345). If the unfinished is a "must" then Karl Bohm and the Berlin Philharmonic do justice at full price (with No. 5) (on DGG1 39162). The sound is musicianly yet vivid.

Bargain chamber music is more recommendable. The Trout Quintet is available in a gentle and refined performance from Clifford Curzon and members of the Vienna Octet (on Decca Ace of Diamonds SDD 185). Equally idiometric is the Vienna Octet performance of the Octet, with its glorious tunefulness (Sullivan was later to be inspired by this work for some of his tunes) (SDD 230). The best bargain Schubert I know is of "Death and the Maiden" Quartet from the Allegri Quartet (on Music for Pleasure CFP 171)—this work of rich maturity contains all the subtlety inherent in this composer and the performance and recording capture the whole range of this work.

Alfred Brendel's records of Schubert up to now have been available on Vox Turnabout. His Schubert style combines refinement with a fine touch. He is at his best in the impromptus and this record comes from Turnabout TV 34141 S—it is a highly poetic account.

ALLEGRO.

furniture finance free

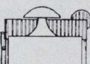
That new suite, the fitted kitchen or bedroom or new bed you so badly want can soon be yours with up to two years to pay – WITH NO FINANCE CHARGES.

With a 25% deposit payable before delivery and the balance by 24 monthly instalments you can buy virtually any type of furniture for only the recommended retail price. There are no finance charges.

And with prices rising it makes sense to buy now and take advantage of FREE FINANCE. *So post this coupon for our free explanatory leaflet and application form.*

Name ....

Address ....



GODDARD & JENKINS (FINANCE) LTD.
29/37 NORTON FOLGATE, LONDON E1 6DG.
Telephone 01-247 7654 BHJ 1
Branches at Birmingham, Bristol and Manchester.

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.

ABELL, E. Treatment of psoriatic nail dystrophy. *Brit. J. Derm.*, 86, 1972, pp. 79-82.

BATEMAN, C. J. T., *see* WHITEHOUSE, J. M. A., and others.

BEARD, M. E. J., *see* WHITEHOUSE, J. M. A., and others.

BEARD, R. W., (with others). Effect of sustained maternal hyperglycaemia on the foetus in normal and diabetic pregnancies. *Brit. med. J.*, Feb. 19th, 1972, pp. 466-469.

BEDFORD, M. A. Eye emergencies in general practice. *Med. News-Tribune*, Feb. 21st, 1972, pp. 7-10.

BIRDWOOD, G. Personal view. *Brit. med. J.*, Feb. 19th, 1972, p. 503.

BIRNSTINGL, M., *see* MORGAN, M. W. E., and ——.

BLUNT, M. J., and others. Oxidative enzyme histochemistry of immature neuroglia during myelination. *J. Anat.*, 110, 1971, pp. 421-433.

CHALSTREY, L. J. (and Edwards, G. B.). Fatal hyperpyrexia following the use of pancuronium bromide in the pig. *Brit. J. Anaes.*, 44, 1972, pp. 91-92.

CHARD, T., *see* EDWARDS, C. R. W., and others.

CROWTHER, D., *see* WHITEHOUSE, J. M. A., and others.

DYER, N. H., (with others). Synovial rupture of shoulder joint. *Brit. med. J.*, Feb. 5th, 1972, p. 356.

EDWARDS, C. R. W., and others. The development of a radioimmunoassay for arginine-vasopressin: Production of antisera and labelled hormone; separation techniques; specificity and sensitivity of the assay in aqueous solution. *J. Endocr.*, 52, 1972, pp. 279-288.

FORSLING, Mary L., *see* EDWARDS, C. R. W., and others.

FRY, I. Kelsey. The radiology of colitis. *Trans. Med. Soc. Lond.*, 87, 1971, pp. 63-67.

GARROD, L. P., and WATERWORTH, Pamela M. A study of antibiotic sensitivity testing with proposals for simple uniform methods. *J. clin. Path.*, 24, 1971, pp. 779-789.

†GREY-TURNER, E. Medicine and the European Economic Community. *J. Irish Coll. Physcns. Surgs.*, 1, 1972, pp. 77-82.

HAVARD, C. W. H. Endocrine exophthalmos. *Brit. med. J.*, February 5th, 1972, pp. 360-363.

HOLDSWORTH, C. D., and others. The effect of portacaval anastomosis on oral carbohydrate tolerance and on plasma insulin levels. *Gut*, 13, 1972, pp. 58-63.

HUNTSMAN, R. G., (with Boulton, F. E.). The detection of myoglobin in urine and its distinction from normal and variant haemoglobins. *J. clin. Path.*, 24, 1971, pp. 816-821.

JENKINS, J. S., and others. Endocrine function after external pituitary irradiation in patients with secreting and non-secreting pituitary tumours. *Quart. J. Med.*, 41, 1972, pp. 57-69.

KERSLEY, G. D. Bath, medicine and the Waters. *Hist. Med.*, 3, 1972, pp. 3-7.

KITAU, Muriel J., *see* EDWARDS, C. R. W., and others.

LANDON, J., *see* EDWARDS, C. R. W., and others.

LAST, Patricia A. Fracture of the Lippes loop *in utero*. *J. Obstet. Gyn. Brit. Commnwlth.*, 79, 1972, pp. 190-191.

LEHMANN, H., (with others). An unstable haemoglobin with reduced oxygen affinity: haemoglobin Peterborough, β111(G13) Valine Phenylalanine, its interaction with normal haemoglobin and with haemoglobin Lepore. *Brit. J. Haem.*, 22, 1972, pp. 125-134.

L'ETANG, H. The Savage affair. *Hist. Med.*, 3, 1972, pp. 12-14.

MAINGOT, R. The causes and prevention of postoperative strictures of the bile ducts. *Brit. J. clin. Pract.*, 26, 1972, pp. 53-62.

MALPAS, J. S., *see* WHITEHOUSE, J. M. A., and others.

——, *see also* WRIGLEY, P. F. M., and others.

†MEDVEI, V. C. Medicine and the Common Market. *Practitioner*, (Economics of General Practice), Feb., 1972, pp. 5-10.

MORGAN, M. W. E., and BIRNSTINGL, M. Infective aortitis with abdominal aneurysm. *Proc. Roy. Soc. Med.*, 65, 1972, pp. 165-167.

†MOURANT, A. E., (with others). The distribution in human populations of genetic variants of adenosine deaminase. *Human Heredity*, 21, 1971, pp. 60-62.

†——, (with others). Red cell phosphoglucomutase polymorphism in Finland-Swedes, Finns, Finnish Lapps, Maris (Cheremisses and Greenland eskimos, and segregation studies of PGM, types in Lapp families. *Human Heredity*, 21, 1971, pp. 140-153.

†NEWMARK, P., (and Patel, N.). The absorption of intrinsic factor concentrate to glass: Occurrence and prevention with reference to radioisotope dilution assays of vitamin B_{12}. *Blood*, 38, 1971, pp. 524-528.

NYE, Lynne, *see* HOLDSWORTH, C. D., and others.

PRANKERD, T. A. J. Enzyme assays in diseases of erythrocytes. *J. clin. Path.*, 24, 1972, Suppl. (Enzyme Assays in Medicine), pp. 71-74.

†RICKHAM, P. P., (and El Shafie, M.). Long-term results after primary repair of oesophageal atresia and tracheo-oesophageal fistula. *Z. Kinderchir.*, 9, 1971, pp. 309-316.

†——, (with Mawdsley, T.). Improvement in the post-operative mortality following early operation for open myelomeningocele. *Develop. Med. Child. Neurol.*, 13, 1971, Suppl. 25, pp. 68-70.

†——, (with Roberts, J. R.). Craniostenosis following Holter valve operation. *Hydrocephalus and Spina Bifida*, Suppl. 22, pp. 145-149.

SIMON, G., (with others). The radiological appearances of allergic alveolitis due to bird sensitivity (Bird fancier's lung). *Clin. Radiol.*, 23, 1972, pp. 1-10.

——, (with Young, D. A.). Certain movements measured on inspiration-expiration chest radiographs correlated with pulmonary function studies. *Clin. Radiol.*, 23, 1972, pp. 37-41.

TAIT, I. Acute tonsillitis; acute otitis media; congestive cardiac failure; high blood pressure: anxiety-depression. *Update*, 1, 1972, pp. 946-952.
THROWER, W. R. Diseases transmitted to man from pets. *Trans. Med. Soc. Lond.*, 87, 1971, pp. 78-89.
TILLS, D., *see* MOURANT, A. E., (with others).
†TOBIAS, J. S., (with others). The effect of sleep deprivation on signal detection parameters. *Quart. J. exp. Psychol.*, 23, 1971, pp. 449-452.
†VERBOV, J. Acrokeratosis verruciformis of Hopf with steatocystoma multiplex and hypertrophic lichen planus. *Brit. J. Derm.*, 86, 1972, pp. 91-94.
WATERWORTH, Pamela M., *see* GARROD, L. P., and ——.
WENDELL-SMITH, C. P., *see* BLUNT, M. J., and others.
WHITEHOUSE, J. M. A., and others. Andriamycin in the treatment of acute leukaemia. *Brit. med. J.*, Feb. 19th, 1972, pp. 482-483.
WILKINSON, Marcia. The care of the chronic sick: the patient. *Proc. Roy. Soc. Med.*, 65, 1972, pp. 212-214.
†WRIGLEY, P. F. M., and others. Secondary polycythaemia due to a uterine fibromyoma producing erythropoietin. *Brit. J. Haem.*, 21, 1971, pp. 551-555.

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

LIPMAN'S
DRESSWEAR
HIRE SERVICE

Complete Hire Service
for all occasions

34/36 LUDGATE HILL
LONDON . E.C.4
Telephone: 01-248 1504

Car Hire Purchase
for Doctors and Dentists

Get details of the "TRIPLE CHOICE SCHEME" for Car Hire Purchase offered to the profession by

Medical Sickness
Finance Corporation
Limited

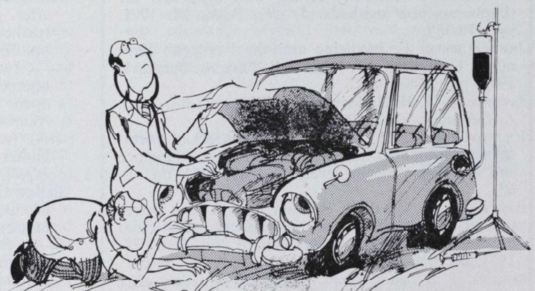
a member of the
Medical Sickness Group

✳ Minimum deposit
✳ Maximum period of repayment
✳ Payments waived on death

Send the coupon below to us at

7-10 Chandos Street, Cavendish Square,
London W1A 2LN. Telephone 01-636 1686

Name ....
Address ....
....
Occupation .... SB



BARTS DRAMA

The Merchant of Venice

Those who frequent the gym at College Hall for intellectual rather than physical gymnastics were pleased to find the seating for this term's Drama Society production much improved. The chipboard auditorium which appeared last term, and was much praised at Bradford has now been painted and upholstered.

When this term's production was announced, one might have suggested that modern and experimental theatre would be better suited than Shakespeare to the capabilities of Bart's Drama. However, it was a welcome surprise to see a virtually full house every night enjoying a sophisticated performance by a generally strong cast. The difficult "arena" was well exploited by the action so that the pacing was uninhibited. The dynamics were also helped by a classical but simple set and an array of lights emanating from an electronic "dimmer", constructed, as we were informed, by Patch Venables. The predictable use of rather characterless music did not contribute to the dramatic "tone", but served to cover some awkward scene changes. In other respects too, a certain leaning towards gimickry tended to disturb the strong and polished pattern which Mr. Blackridge assembled. The chanting choruses and automobilic cacophony of the opening scene seemed to upset the actors more than the audience. Similarly the imaginative use of a projector to display Portia's suitors was spoiled by clumsy projection and timing, so that much of the verbal comedy was lost.

Of the characters, Shylock proved the most fascinating. He must have been born under the sign of Gemini, so separate are the two sides of his nature. On the one hand, he is totally absorbed in himself, his gold and his daughter. But then again, he is able to look with a strangely humanist eye on the antics of Jews and Christians. The duality was sometimes obscured by James Griffiths' intense, rather "stiff-upper-lip" interpretation, which, however, was just right for the utter tragedy of the court scene. Indeed, his was the most convincing personality in the court scene, which got off to a good start, but then lost impetus. Antonio (Jeremy Vivers), convinced us of his sad, intense, nature almost to the point of defacement, but he soon warmed to express the subtlety of his character, which contrasted strongly with the rowdiness of some of his friends. Portia (Gila Pezeschki), and Nerissa (Kate Venables), were particularly good in the well-arranged Belmont scenes, where the light relief was provided by a "Black and White Minstrel" Duke of Morocco. However, the courtroom appearances of Portia and Nerissa were sometimes too obviously "butch". The comedy of the Gobbo's was well timed and entertaining if somewhat suggestive of Marty Feldman. Martin Gore can be relied upon to give an imaginative interpretation of almost any part, and Launcelot Gobbo suited him down to the ground! Those who were unable to get tickets and might have wished for another performance might remember the physical risks taken by Mr. Gore, whose acrobatics hopefully gave the audience as many laughs as they gave him bruises.

The other actors all gave convincing performances, which were cleverly constructed into a polished and varied production.

Portia and Nerissa

SPOT THE LESION

By J. WATKINS

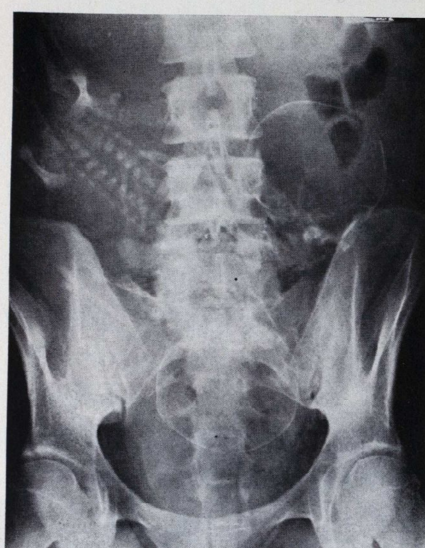


Fig. i

1. Fig. (i) shows the abdomen of a 31-year-old lady, primigravid, who was thought to be large for dates, in the third trimester of pregnancy.

Questions —

A. What is the Diagnosis?

B. What, in particular, is unusual about the uterine contents?

C. What is the correct term for this condition?

* * * *

Answers —

A. Twin pregnancy.

B. The twins are in fact conjoined at the thorax, and at the pelvis. Two distinct spinal columns, and two heads can be seen; but only one pair of lower limbs.

C. Thoracopagus. The twins did not survive.

2. Fig. (ii) shows part of a plain X-ray of the pelvis of an 18-year-old girl, who presented with dysuria.

Questions —

A. What is the diagnosis?

B. What possible complications do you know?

C. Where else are these lesions most commonly seen?

Answers —

A. A teratomatous dermoid cyst, containing teeth, in the sacro-coccygeal region.

B. A fairly large proportion become malignant, and all should therefore be removed if possible.

C. In the gonads, the retroperitoneal space, and the mediastinum.

Fig ii

BOOK REVIEWS

PSYCHOLOGY IN MEDICINE
J. E. Orme & F. G. Spear
1st Edition. £1.80
Pp. 218. Baillière Tindall 1971

In the preface to this book the authors point to the sterile academic approach of many introductions to psychology and to their concurrent lack of practical application. They claim to have organised their work so that the medical reader, especially the undergraduate and the post-graduate candidate for Part I D.P.M., would have a working knowledge of psychological principles and practice. While I think this would be an excellent book for D.P.M. candidates, I fear that the examples and practical applications are set in too psychiatric an ambience to achieve their commendable aim for the general reader. The psychiatric bias is readily apparent in the division into sections entitled: Diagnosis and Assessment, and Treatment. The treatments examined are exclusively of the kind given by practitioners in the mental health field.

Apart from these criticisms the book is otherwise excellent, and gives a sound, well-balanced survey of the different views, theories, and practices in clinical psychology and psychiatry. The authors rarely shirk contentious issues and scrupulously document evidence for both views in a dispute. Disappointingly they almost never reveal their own allegiance and this perhaps robs the book of the liveliness and impact of the kind achieved by a determined and committed exponent. I particularly liked their attempt to come to grips with the primordial issue in psychology: the body-mind problem. In their chapter on physical therapies they firmly reject the view that mind is simply an epiphenomena of the physiological structures and activity of the brain. They take a unitary view of the person but adopt a *dualistic descriptive* approach. That is, the system under observation is regarded as constant, but the attitudes and the descriptive system of the observer may vary. Which attitude and which descriptive language is used will then depend on what is convenient and economic for the observer. Thus their viewpoint in essence is that "a modification of the physical state of the system which is the individual is made by a physical procedure. As the psychological state is a description of the same system this state, too, will be changed if the system is altered".

For the general medical reader one of the most useful chapters in the book is that in Appendix 1 on Statistical Methods and Experimental Design. Again the authors have room only for a survey of the field, but acquaintance with the contents of this section may help to prevent one of the cardinal sins of the fledgling medical investigator—haphazard collection of data without any plan for the precise nature of its ultimate analysis.

The edition of the book which I read did not have a price printed anywhere on its covers, but I believe it is £1.80. At this price it would be well worth having.

J. E. DRINKWATER.

PHARMACOLOGY FOR NURSES
Rosemary E. Bailey. Third Edition. Baillière, Tindall & Cassell. 1971. Paper 90p. Hardback £1.25.

This very useful book can only be improved and enlarged by being brought up-to-date, this Miss Bailey has succeeded in doing in the third edition. It continues, therefore, to be a worthy edition to the Nurses Aid Series.

Since the second edition of Pharmacology for Nurses there have been changes in, and additions to, The British Pharmacopoeia. The Imperial System has been replaced by the Metric System, special disposable spoons are now supplied to facilitate administration of mixtures to the patient. Micrograms have replaced fractions of milligrams, these changes are all to be found in this edition.

With the introduction of the 1969 syllabus and the changes in the State Final Examination, nurses must be even more aware of the side effects of drugs and this well laid out book makes it easy for a nurse to identify the drugs in her care, this Miss Bailey has accomplished by rearrangement of the third edition. The appendix has been enlarged and is helpful in setting out the proprietary name, the approved or non-approved name, and in addition the pharmacological action and indication for the common drugs.

The legal aspects of Pharmacology, the regulations for the Dangerous Drugs Act 1965 and The Drugs (Prevention and Misuse) Act 1964 are clearly elucidated.

Perhaps Miss Bailey could have enlarged on the Dunlop Committee and Aitken Reports because it is felt that the average nurse will not be bothered to read the originals of these reports.

D. MORTON.

MULTIPLE CHOICE QUESTIONS IN HUMAN PHYSIOLOGY
I. C. Roddie and W. F. M. Wallace
1st Edition. £2.00 Lloyd-Luke 1971

At face value, the request to review a book of multiple choice examination questions is an awesome one. The task proved, however, to be both enjoyable and educational.

Whilst not the first book of its type on the market, it does offer another approach to the problem of revising for the type of examination that is becoming increasingly popular with both M.B. and fellowship examination boards.

The book itself is divided into ten main sections, nine being devoted to specific physiological systems and the tenth to general physiology. Each of these sections is further subdivided into two subsections, one being devoted to questions on the basic physiology of the system, whilst the other is concerned with the applied physiology.

In each section, four answers are offered for every question and the candidate must assess whether they are true or false. These answers are not mutually exclusive in that they usually consider different aspects of the same problem; thus all, some or none of the answers may be true. On the opposite page, the authors give their verdict. Where the answers are true, they are further qualified; where false, the error is explained.

I find two main faults with this book. The questions in each section are asked in a random manner, not following any particular line of thought. This detracts from the author's main purpose which is to "assist the understanding of physiology". Also, the absence of an index is a great disadvantage.

I think the book, published in paperback, with a convenient plastic spiral binding, would be worth having for both Fellowship and M.B. revision.

J. GAMBLE.

MEDICAL TERMS: their origin and construction.
By Ffrangcon Roberts. Fifth Edition. London: William Heinemann Medical Books Ltd. 102 pp. 75p.

The first edition of this useful little book was published in 1954, and although several paragraphs have been retained through successive editions, in this, the fifth, several sections have been rearranged and amplified. Written originally for students, nurses and auxiliaries approaching the study of medicine with no knowledge of the classics, it is intended to facilitate comprehension of the terminology by outlining the origin and mode of construction of the words employed. It is not a dictionary, although it contains an index of words in addition to an index of persons and subjects.

This book makes fascinating a subject that is considered rather dry by most of us. It facilitates the appreciation of medical terms, their construction and breakdown into sections which enable one to determine their meaning with a high degree of accuracy.

Every person connected in any way with medical terms should possess a copy of this book, which can be read through, or dipped into with advantage, and consulted for specific purposes with a high guarantee of satisfaction.

JOHN L. THORNTON.

A BIBLIOGRAPHY OF SIR WILLIAM PETTY, F.R.S., and of Observations on the Bills of Mortality by John Graunt, F.R.S.
By Geoffrey Keynes, Kt. Oxford: Clarendon Press, 103 pp., illus. £5.50.

Sir William Petty (1623-1683) had a varied career, having had experience as cabin boy, pedlar, naval cadet, medical student, reader in music, Professor of Anatomy at Oxford, ship builder, cartographer and politician. Elected F.R.S., he was referred to by the late Maynard Keynes as "the father of modern economics". This prompted Sir Geoffrey Keynes, his brother and Consultant Surgeon to this hospital, to take a bibliographical interest in Sir William's writings. Sir Geoffrey has added a study of John Graunt's *Natural and political observations made upon the Bills of Mortality*, to which Petty probably contributed, even if he was not the actual author, as has been suggested.

Each entry is annotated, and appendices are devoted to John Evelyn's account of Petty, and Aubrey's accounts of both Petty and Graunt. There are two portraits of Petty and eleven facsimiles of title pages. Bibliographies used to be dull records of writings described in terms intelligible only to other bibliographers and librarians. Sir Geoffrey Keynes was largely responsible for changing this by inventing the bio-bibliography, which clothes the bare factual material with biographical information of great interest to the historian. This most recent of a formidable array of bibliographies, including those of particular medical and scientific interest devoted to Bright, Browne, Harvey, Hooke and Ray, is worthy of a place with its predecessors.

We house in the Medical College Library *A collection of the yearly bills of mortality, from 1657 to 1758 inclusive. . . . To which are subjoined I. Natural and political observations on the bills of mortality: By Capt. John Graunt. . . . 1676. II. Another essay in political arithmetic. . . . By Sir William Petty. . . . III Observations on the past growth and present state of the city of London. . . . By Corbyn Morris. IV. A comparative view of the diseases and ages, and a table of the probabilities of life, for the last thirty years, by J[ames] P[ostlethwayte]*. London, 1759, which was believed to have been edited by Thomas Birch, but has since been attributed to William Heberden (1710-1801). This is the only item mentioned in *A bibliography of Sir William Petty* that we possess, but it is a most fascinating book, and might well lead readers to pursue the subject by finding out something about Petty and Graunt. Sir Geoffrey's book will provide the requisite references.

JOHN L. THORNTON.

SCIENTIFIC BOOKS, LIBRARIES AND COLLECTORS.
John L. Thornton and R. I. J. Tully. 3rd Edition. £7. Price to Members of the Library Association £5.60. Library Association. 1971.

This is the third edition of a book now famous for its contribution to the study of the bibliographical history of Science. There is much that is new in the third edition in discussion of the work of individual scientists and in the references.

From the dawn of civilisation man has recorded observations of a scientific nature. Babylonian texts dating from 1800 B.C. and facts about the chemistry of glass and metal production in India at about the same time have been found. The bibliography of Greek and Arabic Science is considered first, the authors then pass to the revival of curiosity about the natural world which flowered in Renaissance Europe and became more deeply rooted with the development of printing. Printing is said to have had its beginnings in Mainz in 1450 and rapidly spread throughout Europe. Although printers were concerned at first with the production of texts from the Ancients of Greece and Rome, they soon started to publish the works of outstanding contemporary mathematicians and astronomers such as Tycho Brahe, Johann Kepler and the anatomist Vesalius. It is interesting to find that artists like Albrecht Dürer wrote on anatomy and mathematics, and that his botanical illustrations were of great accuracy and scientific value.

With the coming of the 17th and 18th centuries, scientific endeavour increased and every page of the book is full of interesting vignettes of the lives and works of these early scientists. That Christopher Wren invented an automatic rain gauge, that James Parkinson, who wrote the classic description of paralysis agitans, also wrote three volumes on fossils and probably through these studies provided some of the groundwork for Darwin's brilliant theory, that the irritable microscopist Robert Hook invented the balance spring for watches, are some of the interesting facts that crowd these pages and leave one wishing the authors had more space. Some consolation may be found in the bibliography and the fact that many of the references are reasonably accessible.

Because of the vast expansion of literature in the last 70 years the 19th century is the last one in which the authors are able to make an attempt to cover the major fields. One of these is biochemistry where among many interesting comments is the observation that Wohler did not synthesise urea in 1828 and deal the final blow to Vitalism. As Dr. Douglas McKie points out it was Kolbe in 1845 who synthesised the organic compound acetic acid who is more justifiably credited with this achievement. Neither author apparently discredited Vitalism. This was achieved by Marcellin Berthelot in 1860.

The book ends with a history of the rise of scientific societies, a description of the growth of scientific periodicals and a useful account of scientific bibliographies and bibliographers, private libraries and the scientific libraries of today. It was a little surprising to see the omission of the Library of the Royal Society of Medicine which must be in the first rank of modern medical libraries.

The last chapter analyses the functions of a modern library in providing a foundation for research and details the difficulties that may be met with in doing this. The librarian can undoubtedly help the researcher, and there can be no substitute for him, but much help will be obtained from this excellent work of scholarship.

J. S. MALPAS.

There's nothing cheap about Dormie. Except the price.

Dinner Suit
£1.95

On formal occasions, once you know you're looking your best, you can sit back and relax. Just enjoy yourself.

This is the kind of confidence you get wearing top-fashion menswear, hired from Dormie. They know exactly what you'll need to wear whatever the occasion. And they have all the right accessories, too.

You'll be delighted with the quality and styling of Dormie hire-clothes. They're beautifully tailored by Sumrie in superb materials. And they're cut on the latest lines to bring out the best in you.

DORMIE
MENSWEAR LIMITED

Air Street, London, W.1.,
(off Regent St. Nr. Piccadilly Circus).
Tel: 01-437 7948
72 High Street, Hampstead, N.W.3.
Tel: 01-794 4353

BARTS SPORT

CROSS COUNTRY CLUB REPORT

Here as last is a further ruthless exposée of THE FACTS on the cross-country scene . . . a frank account of uninhibited long-distance running through the filth of Outer London.

On November 26th a crack Bart's squad made its way to the Royal Vets College, Potters Bar—an impressive rural establishment, overrun by individuals clad in blue duffle coats and gumboots. The event was a U.L. Leagues Div. I race over a six-mile course, which featured large quantities of both stiles and plough (both these to be read in a broad West Country accent). The results were as follows:—

19th. S. Mann.
26th. B. Campbell.
36th. R. Moody.
38th. M. Page.
39th. R. Miller.
40th. D. Wainstead.

Bart's finished eighth out of fifteen teams.

The Big Return of Bob Miller to big-time running took place at Parliament Hill on December 8th, when he finished second in the Bart's team at the U.L. Championships. Number one Bartsman was S. Mann. M. Erith, seduced by THE TRACK, was with us no more.

D. Wainstead deserves a paragraph to himself.

Bart's achieved sixth place amongst the six teams to complete the course: disciplinary action has been taken against the following:—

19th. S. Mann.
35th. R. Miller.
38th. B. Campbell.
58th. D. Wainstead.
61st. R. Moody.

The weather at Guildford on January 26th was very, very unpleasant, but some ninety staunch runners found their way to the well-concealed start of the U.L. League's race by 3.15 p.m. To destroy any residual euphoria, Surrey University had selected a 3 x 2 mile course over plough and swamps, with a blissful 3 x 15 feet of hard surface. After several false starts, and a myriad of obscenities from happy competitors, the race began: within half a mile the first shoes began to be lost to the highly adhesive plough. . . .

A barefooted S. Mann was seen retracing his steps and probing the mud for departed footwear, whilst interesting variations of vocabulary could be heard during frequent stops by B. Campbell to resecure a reluctant powershoe.

R. Miller led the Bart's team home, followed by an unusually dirty R. Moody. S. Mann, shoes at last recovered, gave a disgusting display of honesty and sportsmanship by completing all three laps to finish a glowing 83rd. A nasty race, but good nosh afterwards. . . .

35th.	R. Miller	33:12.
50th.	R. Moody	34:58.
56th.	B. Campbell	35:50.
77th.	M. Page	40:20.
83rd.	S. Mann	44:40.

An unknown number started: ninety finished. Bart's finished ninth in this race.

The annual fixture against Sussex University took place on February 9th: Sussex Police, I.C. and L.S.E. were also taking part. All patiently awaited the belated arrival of the Bart's squad—four in number—who arrived in the late stages of carbon monoxide narcosis due to the dashboard exhaust outlet on M. Page's race-tuned Mini 850.

The muddy five-mile course, with several unpleasant hills, proved tough going for all, but the dedicated Bart's foursome persevered to score all of eight times the Sussex University total. In spite of appearances on paper, it was a good performance by all:—

14th.	S. Mann	32:03.
19th.	B. Campbell	32:55.
25th.	R. Moody	34:33.
30th.	M. Page	37:17.

Sussex University fielded two teams: Bart's finished fifth.

The author of this report was not present at the Selwyn Road Relay on February 16th, and coincidentally (?) the team achieved a singularly good place. Twenty-six teams ran the 4 x 2.6 mile race, and Bart's finished seventh.

R. Moody, questioned for details of the event, reported that for once he had had a good run (!) and added eloquently that it was raining rubber bullets throughout the race. Other valuable information included an eye-witness account of S. Mann's narrow escape from compression by an Esso tanker during his commendable last lap. Well done all:—

1st lap	M. Erith	10th	12 mins. 59 secs.
2nd lap	R. Miller	9th	12 mins. 39 secs.
3rd lap	R. Moody	8th	13 mins. 15 secs.
4th lap	S. Mann	7th	12 mins. 50 secs.

STOP PRESS: Bart's finished 46th in the Hyde Park Relay on Saturday, February 19th. About ninety teams from all over England and from abroad were taking part. More details in our next exclusive review.

BRUCE CAMPBELL.

BARTS RUGBY

Semi-Final Hospitals' Cup v. Guys.

Bart's fielded their selected side in the Semi-final of the Hospitals' Cup Competition, and kicked-off against a slight cross wind which blew down to their left-hand corner; the conditions were near perfect for rugby football. Guy's immediately took the offensive, and with the help of their aggressive forwards, spent most of the first quarter of the game in Bart's territory. Bart's survived the critical period of the game, the covering of their back row of McIntyre, Else and Carroll and their scrum half Hill being superb. The one occasion that Bart's penetrated the Guy's half during this period nearly resulted in their scoring. The forwards worked their way up the right-hand touch line, Hill placed a perfect blind side chip-kick for Laidlow, and only desperate covering at the corner-flag prevented a try.

"GOT YOU, YOU . . ."

In the second quarter of the game Guy's opened the scoring with a beautifully struck penalty by their wing Ross from near the right hand touch line on the Bart's ten-yard line. Bart's then began to play as a team unit in contrast to their preceding disorganised performance. They became more urgent, obtained more set-piece possession, and more importantly, achieved quality ball from loose-play. Soon they scored an extremely good try. Laidlow came into the line from a set piece on the right-hand touch line in the Guy's half, the overlap was created by the speed at which the ball was passed along the line, providing Busk, on the left-wing, an opportunity to race outside the covering defence and score on the corner. Martin failed with the conversion. Thanks to an amazing decision by Guy's not to take a penalty kick at goal from almost in front of the Bart's posts, Bart's led by 4 points to 3 at half-time.

Guy's attacked from the beginning of the second half carrying play to the Bart's left-side from a kick ahead over the Bart's line, the referee ruled that a Guy's man had been impeded in the chase and awarded a penalty try, which was converted 4-9. Martin failed with a long penalty attempt after the restart but the Bart's

"WHOOPSEE"

pack were up fast forcing a scrum near the Guy's line. The defenders won the put-in against the head and kicked clear. Guy's now found their feet and passed forward into the Bart's half. This showed up a slowness in the tackle by Bart's and on one occasion Ross was allowed to run through Bart's pack before being stopped. Martin eventually kicked clear. From the ensuing play a forward rush developed up the right and Britton dived over. The conversion failed, 8-9. Bart's now gained confidence, the back row in particular hunting and handling well. A passing move started on the Guy's 25 on the right was stopped when Fairhurst was held on the left. Shortly after Bart's moved into the lead from a well struck penalty kick, by Martin 11-9. Bart's attacked again from the kick-off. Foul play on the Guy's line gave Martin an easy penalty which he converted 14-9.

Bart's now had their tails up. The pack pushed well in the tight and good loose kicking gave Hill ample good ball. He in turn kicked and passed out sensibly. From an attempted long throw by Guy's on the Bart's ten-yard line Findlay-Shillas interrupted cleverly and ran through to the Guy's line only to be stopped without support. Finally from a kick ahead Laidlow was up quickly to dive over for a well taken try 18-9.

On the day's play Bart's deserved to win the game.

JOHN HARRIES, JOHN GIBSON.

HERE WE GO

Photos by kind permission of Fleet Fotos, 3 Fleet Lane, E.C.4.

HOCKEY CLUB

Hospitals Cup—Quarter Final

St. Thomas's Hospital 0—St. Bartholomew's Hospital 1.

Although this was only the quarter-final of the hospital's cup, it will probably turn out to be the decisive match of the competition. St. Thomas's and Bart's are the two strongest sides at hockey this year. St. Thomas's have held the UH hockey cup for the past four years. Their side has contained two internationals and two blues. In past years they have provided the bulk of the United Hospital side. This year both Barts and Thomas's have four members in the UH side. In the identical match last year, again at the semi-final stage of the UH cup, St. Thomas's won 3-0, scoring two goals in the first ten minutes of short corners. However, since last year St. Thomas's have lost their international full-back and have gained no new blood. Barts on the other hand have gained two new players. Martin Gillings at centre-half, and Phil Savage in goal. The sides this year were therefore very even and the result could be expected to swing either way. The first half started strongly for St. Thomas's, and they remained with the upper hand throughout the first half. Barts did mount the occasional raid which showed the weakness of the St. Thomas's defence. The praise that they were prevented from scoring must surely go to the defence. Colin Reid and Alan Mogg at full back provided the wall, while Martin Gillings at centre-half, and Paul Millard and Jim Tweedie the captain prevented their wings from penetrating runs. Phil Savage in goal played an excellent game especially during their short corners.

The second half saw Barts taking more of the match, and for the next 30 minutes either side could have scored. The Barts forward line of Andie Young, Roddie Barclay, Jim Smallwood, Gordon Coleman and Richard Ashton started to work more together and mount more attacks. The only goal of the match came seven minutes from the end. Paul Millard took a free hit from the right outside the circle, aiming at the far post. The ball passed through the defence and the left wing, Richard Ashton, running round the back of the defence managed to push it into the goal. This was a move that had been practised at training, and for a change it came off! For the remainder of the match Barts pressed strongly, and finally managed to survive a final short corner awarded to St. Thomas's.

On recollection Thomas's were unlucky to lose, but Barts took their chance, and so go on to meet Kings in the semi-finals.

Imperial College 3—St. Bartholomew's Hospital 2.

Whereas there could be only praise for Bart's performance in beating St. Thomas's, this match was a disaster. It was scarcely the same team playing. Perhaps the semi-final of the University of London cup came too soon after the Thomas's game. This was a game Bart's should have won, they beat Imperial earlier in the season 3-2. Anyway they played as if in a dream. Imperial were always first to the loose ball, and played as if they wanted to win! Imperial's first goal came from a free hit outside the circle. An unmarked man ran on to the ball and then only had the goalkeeper to beat.

After half-time Imperial made it 2-0 from a well taken short corner. Ten minutes later Bart's replied with a good shot from a short corner by Colin Reid. After this Bart's played with a little more gusto, and succeeded in drawing level with a penalty stroke taken by Jim Smallwood. It looked as if Bart's might pull it off, but due to an intentional foul committed in the 25, a short corner was awarded. This resulted in a penalty stroke being awarded against Bart's. It was up to Phil Savage to save the shot. The shot was very weak and scarcely reached the goal. Phil who was all tensed up to save a good shot was rather taken aback by this. He dived to save the shot, but in the process dropped his stick. A goal was awarded since the goalkeeper must retain hold of his stick at all times. After this incredible piece of bad luck Bart's pressed continuously for the final ten minutes, but could not get the equaliser back. Thus Imperial go on to the final, and we wish them the best.

MAPLE JEWELLERY

40%-50% DISCOUNT Off usual retail price

★ Engagement Rings ★ Diamond Jewellery

30%-35%

★ Wedding, Signet and Dress Rings

★ Gold Bracelets and Charms

We offer such a large genuine percentage as we manufacture all our Jewellery in our own workshop and sell direct to you from our own showroom on the premises. This enables us to keep costs low, cutting out wholesale middlemen and very high retail shop expenses and profits.

Hours: 9.30 - 5.30 Monday to Friday; 9.30 - 1.00 Saturday

VISIT OUR SHOWROOM

Opposite Gamages side entrance

10 Hatton Garden, London, E.C.1. 01-405 6596

SAINT BARTHOLOMEW'S HOSPITAL JOURNAL

Founded 1893. Vol. LXXVI No. 5

Journal Staff

Editors
Alan Searle
Malcolm Vandenburg

Sub-Editors
Articles
John Watkins
Jane Knowles

Sport
Oliver Bastard

Reviews
Ian Baker
Peter Smith

Manager
Bob Le Quesne

Subscriptions
Charles Hinds
Deidre Lucas

Editorial Assistant
Jane Hilton

Advertising
Mike Johnson
Rod Bexton

Charterhouse Representatives
Timothy Bunker
Peter Bacon
Teifion Davies
Trevor Turner

Liaison
Mike Goldsmith

Editorial

There is, alas, one unfortunate characteristic which, for many people, mars the enjoyment of most of London's liberally distributed parks and squares, and that is the dog. During the day these areas are used for recreational purposes and for picnicking in finer weather. In the evenings, however, the canine population frequents these places and the evidence of their visits remains for several days afterwards preventing full enjoyment of these facilities during the day.

It is difficult to write about such a subject without appearing frivolous, yet we have all at some time been annoyed by similar canine activities, but we still manage to accept in dogs faults we would not condone in other animals or ourselves. Perhaps this is because, like Blackpool and Yorkshire pudding, dogs are part of being British, and perhaps it is also the legendary British reserve which forces us to form relationships with dogs when the human substitute they often represent is unattainable. Most of us would accept that dogs are socially necessary but few owners show a social responsibility towards other humans in their handling of their dogs. An owner may justifiably object to his neighbour lighting a bonfire on washing day, but would be quite happy to let his dog visit a local park every evening, and would be indignant when told his behaviour was socially irresponsible. Ideally then what is needed is public re-education. Fortunately dogs do not represent a great health hazard, although parks do present both an ideal reservoir of infection for Toxocara canis and a suitable means for humans to contract this parasite, so that emphasising medical dangers would have little effect in producing more social responsibility in dog owners. On the other hand it is interesting to speculate whether, if Rabies were endemic in this country, as it is in nearly all the rest of Europe, it would deter people from dog ownership.

What is really needed is to make people more aware of what they are letting themselves in for when buying a dog. Like a car it may look attractive in the shop but cost a small fortune in repairs and running costs afterwards. If the dog licence were to be increased to a figure of about five pounds (perhaps even more in suburban areas) it would not only make people think twice before purchasing the animal, but might prevent unwanted Christmas presents being "put to sleep" before the summer holidays. Further measures such as dog-catchers for strays, stiffer penalties for pavement offences and their enforcement, and also enforceable by-laws prohibiting dogs from parks could be used. In some cases such by-laws already exist but are generally ignored. Probably the only improvement likely to come about would be an increase in the dog licence fee which, even at five pounds, only represents the cost of a couple of months' food for a small dog.

Meanwhile, let us all invest in Wellington boots!