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.

SAINT BARTHOLOMEW'S HOSPITAL JOURNAL

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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!

LETTERS

PLEASE SAVE CHARTERHOUSE!!

One Orange Street,
Nantucket,
Massachusetts 02554.
March 17th, 1972.

Dear Editor,

The December issue of the *Journal* has recently reached me, transatlantic surface mail not being what it used to be. Its Editorial was quite shocking, shocking in the sense of the lamentable news it recounts. The Bart's Pre-clinical School to move out to the Mile End Road—where's that? And who's Lord Todd? And what do they know of Smithfield who only Hackney know?

But to be serious. Having lived so many years, nearly forty now, in the U.S., I am of course not au courant with medical politics in England and am in no position to argue the pros and cons of an amalgamation of the Bart's school with that of London. But I would like to ask the question—and to be told the answer, for I feel sure it must have been considered—why does Charterhouse have to go to the Mile End Road? Why cannot the Mile End Road come to Charterhouse? Particularly since I gather from your editorial that the presently proposed move will involve putting up a new building—and on Grandpa's Grave what's more! Why not make use of the lovely old Charterhouse whose buildings were made over to function as a Medical College, and have done so admirably for a number of years—or haven't they? If more space is needed, couldn't Charterhouse be expanded? You, Madam, categorize the proposed change as deplorable. It seems to me all of that.

No doubt you will be asking why is this expatriate so concerned? Well, he is concerned because he had quite a little to do with the original acquisition of the Charterhouse for the College. He was a student, H.S. and Chief Assistant to Mr. (later Sir) Girling Ball, and it was due to the latter's foresight, energy and drive that the Charterhouse buildings were acquired for the College when the Merchant Taylor's School, the then occupant, moved out into the country. The writer's part was to collect money from old Bart's men in the West Country and anybody else he might be able to con into contributing. In this he was fairly successful, as were other Bart's men in other parts of the country. In short, a great deal of effort one way and another was put into the acquisition of the Charterhouse. Is all this now to be discarded? It seems a thousand pities, and I suspect there are still around many like myself who will be deeply disappointed. After all, the ancient foundation of the Charterhouse fits in so much better with the Royal and Ancient Hospital of St. Bartholomew than does a new building on Grandpa's Grave in the Mile End Road.

May I suggest that an account be published in the Journal for the benefit of ignorant people like myself of how and why this suggestion came to pass? And is it in vain to hope that deep and serious consideration be given again, and perhaps again and again, before the venerable—and functional, be it noted—Charterhouse is cast into the discard. There is much to be said for tradition.

Yours faithfully,
E. MILES ATKINSON, M.D., F.R.C.S.

STUDENTS' UNION LETTER

Abernethian Room,
St. Bartholomew's Hospital,
London, E.C.1.
April 4th, 1972.

Dear Editor,

In accordance with the new constitution ratified at the A.G.M. last November, the new Chairman of the Students' Union was elected at the Council meeting of March 14th to take up office on May 1st. My congratulations go to Guy Routh who was unanimously elected to this post.

Since my letter to the April issue we have had another Union Council. Many of the items discussed there are included in the Chairman's report, also in this issue. However, I would like to take Charterhouse library separately. With summer exams looming up, the loss of library books is becoming critical. After discussing this with some pre-clinical students, we arrived at the following practical suggestions which were approved by the Union on March 14th.

1. Tighter control of the library. These suggestions have been agreed with Mr. Thornton and are to be carried out.

Some shelves with lockable glass fronts are to be put behind the librarian's desk at the door to the library. Certain of the more popular books will be put on these shelves and they will have to be signed for before they are released by the librarian.

The librarian's office is to be provided with a lock and more shelves. Some textbooks will be kept there and will only be available for use within the library itself.

2. Return of overdue books. In return for Mr. Thornton carrying out the first point, the Union has agreed to try to alter the present attitudes to extended borrowing of books from the libraries. This will take the form of:—

(i) A poster campaign to bring the attention of students to the seriousness of the situation.
(ii) As for glasses, a "book round" of College Hall will be made with no prior warning, but in the company of the Bursar.
(iii) A discussion will take place at Council about the ethics and feasibility of a library list to be kept by the Students' Union. After unsuccessful attempts to obtain the return of books from borrowers, the library would inform the Union, who would keep a list of offenders and the books involved. This would be corrected twice a week and kept on the Union noticeboards. If books were still not returned the Dean would finally be asked to intervene, though it is hoped that this would be a rare necessity.

Extended borrowing of books (many costing £5-£10 each) is becoming a serious problem. I hope people will be responsible enough to treat it as such.

I would finally like to thank Guy for his ever increasing help in running the Union and wish him luck for his coming term of office.

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

STUDENTS' UNION E.G.M.

College Hall,
E.C.1.

Dear Sir,

Having been present at the Extraordinary General Meeting of the Students' Union in January, in fact having been responsible for part of the inconclusive debate, I feel I ought to reply to your correspondent's observations. Regarding his opinion of the E.G.M. itself, I must agree that the argument was rather poor, particularly on my own behalf. However, with regard to your correspondent's suggestion of alternatives to the Todd recommendations, I must be severely critical.

I am not engaging in an argument as whether change from the present system is necessary or desirable, either now or in the future. This is a matter of personal opinion and expedient with regard to future planning of Medical Education in London. The class of tuition here is of the highest, and change should not be allowed to take place for its own sake. My standpoint is merely that, should changes be judged desirable, then they may not take place on this site.

There are many reasons for this belief, most of them founded in a knowledge of the geography of the square. The area is, at least in part, a designated ancient monument and is thus free from all threat of rebuilding. And a good thing that it is. This means than any expansion would be restricted to a small corner of the College site and would result in unsightly and overcrowded conditions: just what we abhor. If new buildings were to be provided on the present sites of the Anatomy or Biochemistry blocks, these departments would be deprived of teaching facilities for a period of time. This would mean that at least one pre-clinical generation would suffer handicap. Yet without such expansion it would be impossible to increase the pre-clinical population. The lecture theatres, laboratories and Library are already crowded: what would the picture be like if painted by over 200 pre-clinicals in each year? What about catering and parking facilities?

And that is only the argument against unilateral expansion. The argument against annexation of the London Hospital's pre-clinical students is even stronger. Here expansion would not be the only problem, but also the resentment of the London. The administrative engineering would need to be incredible, and I can already hear protests from the London rising in the distance. After all, why should they forfeit their hospital ties to come here? This may seem a weak argument in respect of the fact that both may need to move eventually. But to them it will be of prime importance.

The final point for the time being, regards the Hospital itself. My clinical friends complain that the size of wardrounds is already too great in some cases. I cannot imagine the effect on them if the college undertook the form of expansion envisaged by your correspondent. It is usually easy to formulate expansive plans for the "Square" from the relative safety of the Hospital. However, any change here ultimately affects the cosiness of the clinical scene.

In conclusion, may I say that although the eternal triangle of Bart's, the London and Queen Mary College seems inevitable, we should all do the best we can to get the best possible facilities for Medical Students, whatever happens.

Yours faithfully,
TEIFION W. DAVIES.
(Pre-clinical Representative of the Students' Union).

THAT PHOTO AGAIN!!

305 Cambridge Heath Road,
London, E.2.

Dear Editor,

Apropos and apposite to Mr. H. Jackson Burrows' letter reference the Christmas 1971 Journal staff photograph—which I thought was great—

"As a beauty I am not a star,
There are others more handsome by far.
But my face, I don't mind it,
For I am behind it:
It's the fellow in front gets the jar."

(I don't expect you have (a) read this far or (b) reproduced it, although you're welcome to do so.)

The rhyme was produced by a President of the U.S.A. —Woodrow Wilson. Mr. Burrows was a contemporary of mine. I retired up here to the Lake District some years ago.

Yours sincerely,
R. E. FRASER-SMITH.

SITUATION VACANT

11 King St.,
Sandy Bay,
Hobart,
Tasmania,
Australia.
March 3rd, 1972.

ASSISTANTSHIP WITH VIEW TO PARTNERSHIP

Dear Sir,

Wanted, a Bart's man to redress the balance of two Guy's men in a General Practice in Hobart.

This is a small capital city, of such a size that almost all doctors know each other by Christian name. The population is of European descent, largely from the British Isles. Although not a hot place, we pride ourselves on more hours of sunshine per annum than any other city in Australia.

We do not earn a lot of money, but are probably a little better off than our counterparts in England. My five children appear to have been satisfactorily educated at local Public (same meaning, i.e. independent, fee paying) schools, which are within walking distance. Both the preclinical school and the Hospital are within walking distance of home. Representatives from the G.M.C. came out from London last year to vet it. They gave their official approval, and informally stated they were impressed by its standards.

General practice is more interesting than it now seems to be at home. We have pleasant Surgery buildings, our own Lab., small X-Ray, E.C.G. etc. Postgraduate lectures are available pretty well every day of the week. We feel integrated with training, as we have students with us in our practice. We have access to several private hospitals, where we admit, investigate and treat our own patients. We, in fact do not do our own surgery, but this is simply a question of inclination.

Practices here, are bought and sold, as of yore, but fetch less than they used to. Financing could be arranged through the partnership. Passages out here (Air) could be arranged at £10 per head for anyone joining us with wife and family.

The harbour is two minutes walk from my front door, and sailing is excellent. We are not uncultured, boasting a Tasmanian Symphony Orchestra, and are not unknown to visiting celebrities. Newcomers from the Old Country are welcome; while the Union Jack is flown, and pictures of Her Majesty displayed rather more frequently perhaps than in the Homeland.

Bart's men are thin on the ground, but this has not prevented us from celebrating August 24th, using a splendid Menu provided by the College Librarian.

Electricity strikes seem unlikely as power is produced by Hydro Electric generators, which only seem to employ about one man per station.

Yours faithfully,

W. McL. THOMSON.

ANNOUNCEMENTS

Deaths

McKane—On February 19th, Dr. T. O. McKane, MB.BS., M.R.C.G.P. Qualified 1937.

Willoughby H. M., U.P.D., M.R.C.S., D.P.H. of—The Cliff, Budleigh Salterton, Devon, in November 1971. (Qualified 1927).

Glyn-Morgan R., M.C., M.B., B.S., (Qualified 1915). Tutor of Midwifery, St. Bart's Hospital, 1944.

Engagements

Hill—Hallson—The engagement is announced between Mr. Peter R. Hill and Miss C. Hallson.

McNinch—Nevitt—The engagement is announced between Mr. A. W. McNinch and Miss J. M. Nevitt.

Marriages

Chapman Prestwich—The marriage took place on Saturday, April 22nd, between Mr. Roger William Gibson Chapman, and Miss Gillian P. Prestwich.

Watkins—Thurling—The marriage took place on Saturday, March 11th, between Mr. John Watkins and Miss Frances Gillian Thurling.

Piper—Hilton—The marriage took place on Saturday, April 15th, between Mr. Geoffrey Piper and Miss Pamela Hilton.

Birth

Mason—On March 14th to Dr. Jane (Sadler) and Dr. Andrew Mason a son, Thomas Andrew.

Appointments

Professor H. Lehmann has been elected a Fellow of the Royal Society.

ADVICE TO THE HOUSE PHYSICIAN

given by Dr. H. Wykeham Balme

DIAGNOSIS

Be continually re-examining patients and re-taking their histories, going back to the beginning each time.

Investigate far less than other people do, it is not your job to be comprehensive in this regard.

Have as complete a knowledge as possible of the patients' home backgrounds, personalities, apprehensions, misapprehensions.

Do not hope or try to be spectacular for reliability is vastly more important.

You must expect all patients with organic disease to have functional anxiety symptoms also.

When you re-visit a patient do not say to yourself "This is a case of such-and-such" but say instead "I thought this patient had such-and-such—I wonder if I was right".

TREATMENT

Take pride in the accuracy and infrequency of your prescribing, and use as few drugs as possible.

In general avoid sedatives, tranquillisers, dihydrocodeine and drug mixtures.

Do not normally prescribe courses of drugs—go by results.

Be on your patients' side, and let them know it; strangely few doctors really are.

Do not start reassuring a patient until you have listened carefully to him first, and re-examined him.

NEVER tell the patient he is dying or has an incurable cancer, etc., without consulting me personally first.

It is usually right to be optimistic about prognosis. If you are by nature a pessimist you will never be any good as a doctor.

EDUCATIONAL

You are expected to take a full part in the post-graduate activities of the hospital.

You are also expected to be quick to offer your services for extra duties, paid or unpaid, to cover illnesses, etc., as your hours of work are much shorter than I would like and certainly shorter than is good for you.

Enjoy looking things up and acquiring a real mastery of your subject.

Enjoy mastering new concepts as they come along, remain "with it" intellectually, and never profess to be proud of your ignorance.

Enjoy refreshing your knowledge in branches of medicine and surgery that do not directly concern you.

GENERAL

Any fool can get qualified as a doctor: whether you will make a good one depends more on your personality than on your brains.

It is inefficient to be early, and offensive to be late, so acquire the ability of turning up accurately on time.

The ward sisters have been my personal friends for a long time, so do not fight with them.

So have many of the administrative staff, so you have been warned.

Try not to like your patients. Never dislike any of them.

Joke with your patients, but NEVER EVER laugh at them, whatever they may say, whatever their beliefs, whatever their opinions, whatever their religion.

Be most reluctant to criticise other doctors: dirt is on a boomerang, so don't throw it.

Never leave a patient's bedside without explaining what is going on and what is being planned—even if untrue.

Take every opportunity of discussing the patient's case with a responsible relative.

Be extremely reluctant to divulge anything to an employer, even with the patient's consent, unless it is clearly to his benefit.

When you start acting as though you and your personal affairs are more important than your work you should give up doctoring and take up something else.

Do all this, and I shall look after your future career. Don't, and I shan't.

STUDENTS UNION CHAIRMAN'S REPORT

November 2nd 1971 - April 30th 1972

by JOHN WELLINGHAM Chairman 1971/72

A constitutional amendment was passed at the AGM on November 2nd, 1971 such that the post of Chairman of the Students' Union would run from May to May. This was to ensure that after the elections in the autumn, the new Council would have an experienced Chairman.

This report is for the second half of my office since the above procedure has now been used by force of circumstance for two years.

There have been two major topics facing us over the last six months; the refinancing of Students Unions by the Department of Education and Science, and the realization of the importance and imminence of the proposed new course at Queen Mary's College (QMC). Refinancing of Student Unions will be discussed in a BMSA report to go on noticeboards in college.

QMC

My attitudes to this new course were apparent in my letter to the last journal. In accordance with these feelings we have now had two meetings with QMC Students' Union; and seen over the QMC campus which is large and the academic facilities which are good. Students rate the departmental libraries highly and there is a branch of Lewis's there. A medical library is to be built. The biological sciences building is not yet built; however, we went round their Union building which has several common room areas, a snooker room, a television room, a large bar run by permanent staff with student barmen/barmaids, a permanently running juke box, but no table footy or one-armed bandits. There is plenty of noticeboard space and the whole area is to be enlarged. The dining facilities are also to be increased. There is a waitress service dining room with higher prices to which the staff tend to congregate and also a "student refectory." Students may, if they can afford to do so, go to either. Another dining room is to be built.

Sports facilities are at Brentwood, about an hour from QMC. Residential Halls are at Woodford. There are three modern male blocks, and two female blocks, with a residential warden to each. Another block (mixed) is to be built at Woodford and we have written to request that careful consideration be given to a hall providing flatlet accommodation. There is a hall built on these lines somewhere near QMC itself.

The present course at QMC is made up of course units of six months, exams being taken at the end of the year. Several units may be taken together. One of the advantages of going to QMC would be that we could make use of their multifaculty facilities, and with such a flexible system available it is essential that the new medical course allows full use to be made of it.

One of the biggest problems for QMC and Barts' Unions to solve is how we finance the clubs at the separate colleges and which college can one represent at any particular point in the course. Needless to say this is not settled.

College Hall

There have been several changes proposed for college hall and several are due to be implemented in the near future. Teiflon Davies has been arranging for a *paperback library* which will be positioned in the room behind the bursar's office. There is an initial loan of £50 and our thanks go to Mr. Robinson who has also contributed a £25 donation. An appeal is to be launched for second-hand paperbacks to cover a variety of literature, particularly if possible the modern classics. A *coffee machine* has been requested by many pre-clinical students (including residents) who complain of no social centre outside bar opening hours. It is hoped such a machine might help one to evolve. Present reasoning has ruled out all ground floor rooms and we are thinking of placing one on the seventh floor, providing plumbing requirements can be met. It has been agreed to put a *table-tennis table* in the recreation room. Should this damage the floor a mat is to be bought. Restoration of the table in the Gym is beginning soon but bats and balls will be the responsibility of students. The SU might keep some balls for resale. A *Silly Suggestions Book* is now available for the use of all regular contributors to the suggestion book who insist on writing rhetorical articles. A Silly Suggestions Book Chairman has been elected in the person of Oliver Else. Also in College Hall a *Sunday Porter* to man the reception desk has been tried. This was tried for two successive Sundays, but has not been followed up since there was apparently no work load. *Room prices* have unfortunately been raised, the reasoning for this being given in a letter to the April *Journal*.

Other Facilities

The *library at Charterhouse* is the subject of my letter to this journal and will not be repeated. The *Audio-Visual Aid* centre which was agreed upon some time ago has been finished and opened. The facilities there are excellent with two well-equipped tutorial rooms, plenty of desks, and six Barts Desk Audio-Visual machines each with three headphone outputs. The library of programmes is in use and slowly growing, and I look forward to seeing some programmes in Medicine and Pathology. Our thanks go to all who were concerned in its design, building and finances. *The SU Calendar* is to be revised for next year. All clubs, societies and interested parties are requested to plan next year's functions well in advance and let the SU Calendar Secretary (John Fuller) know. A list is being kept of such functions to enable advance planning to avoid clashes. The final list will be published for the next academic year. We would also be grateful if anyone wishing to include regular ward rounds tutorials, or other information would also let the Secretary know. The *Flat Agency* is working well, thanks to great efforts from Simon Slaffer. We are always looking for suitable flats especially if their date of availability can be given well in advance. This will become increasingly important towards the beginning of next year. The hunt for a second *snooker table* for the hospital Abernethian Room still goes on, the last trail ended in a dead end.

Tom Dehn has now finished drafting a comprehensive introduction to Barts, its facilities and places of interest in London for *foreign students* doing clerkships or visiting Barts. These will be distributed to all such students on arrival.

Curriculum

Several important changes are coming in the curriculum both to the *2nd MB* course and to the final year. It has been agreed upon in Student/Staff meetings that some pathology could usefully be incorporated into the Charterhouse course. As I pointed out in last month's letter to the *Journal*, sociology and other extra subjects are also to be included in the 2nd MB course, preferably throughout a fully planned course and not in small course units put in either in the last term or at some other gap filling point. The 2nd MB survey has been of considerable use in putting forward student requirements for any restructuring of courses. All departments are now aware of its findings. The *final year* curriculum is also under debate. It has been agreed that orthopaedics will come forward to the second year. By using eight week modules a course allowing no teaching for a month before MB pathology and also MB Finals has been suggested. It gives eight weeks for medicine revision and eight weeks for surgery and some anaesthetics. Specials would then be spread over longer periods but several would be done at once allowing better use of student's time. All students I have discussed it with have thought it an excellent plan, but departments now have to either restructure their courses to fit or come forward with better suggestions. Finalization of the curriculum for this year will complete the revision of the curricula for all three clinical years.

Experiments on Students

An ethical Committee for Experiments on Students has now been set up. I sat as a student representative on the Working Party, set up by the College Committee, which made recommendations resulting in the setting up of the above committee. All experiments which involve students now have to be submitted to four members of this committee, one of whom is the Chairman of the Students' Union. If anyone raises an objection the committee meets in full to consider the ethics of the experiment and must reach a unanimous agreement for the experiment to be carried out. All class experiments are included, and a full list of those approved will be kept in the Students' Union office and may be seen by any student. I consider this committee an essential safety feature for students, particularly when one observes the increasing complexity of clinical experiments which require the use of "normal" volunteers; and thus would like to thank those who give their time to vetting these experiments. Full records are to be kept by the college.

Clubs and Societies

Many of our clubs and societies have had a variety of successes over the past few months. The *Music Society* has succeeded in extracting vast sums from the various benefactors to buy an excellent reconditioned Steinway piano. We are grateful to the governors for their support and to the Chaplain for the use of Barts the Less in which to house it. They have also held several extremely good concerts throughout the year for which it is building itself quite a reputation. The *Drama Society* has been living up to its reputation with several excellent productions. Inuit and the Syracuse Myth performed last November were entered for the Sunday Times sponsored NUS festival at Bradford. The latter was one of the nine selected and received a very good press. This play has since been taken to Sussex University by request and a similar request came from Essex. Tape recordings have been sent to New York and accounts of technique have been sent to several other English Universities. The Merchant of Venice performed in February was a particular success and performed to full houses for four nights during the power cuts. Their technical staff are worthy of special mention, building seats designed by George Blackledge

and Patch Venables which were taken to Bradford on request of the Sunday Times. Patch built a superb dimmer unit worth about £800 for under £50, and all their other work has been of high standard. Then from the Drama Society and the Wine Committee came one of the best smokers for some years, though it was unfortunate not to have had a better attendance on the stag night. Finally "Away from it all" was entered in the ULU One Act Festival only missing a prize since there were none awarded!

On the *sporting side* a very successful season for the Hockey club ended with a convincing win in the finals of the UH Cup, and the Rugby Club were runners up in the UH Cup, with a rather off colour and injured side unfortunately losing to a good St. Mary's XV. On another day we might well have won that also. Prospects are looking good for successes in the cricket, tennis, sailing and golf teams during the summer.

No mention of clubs and societies would be complete without extending our thanks to the *Wine Committee*. This group of devotees work constantly at stocking, stock-taking, cleaning and organising, to make sufficient money for Barbeque Balls, mystery trips, Smoker punches, etc., etc. for very little thanks and generally for criticism for not keeping the bar open 24 hours a day. The bar remains very much our social centre and this is wholly due to the efforts of the Wine Committee.

Other events

Apart from helping ourselves, the Union is becoming increasingly involved with the hospital. Several clubs and societies have now made contributions to the *Barts the Less* restoration fund and we are preparing to take as active a part as possible in the celebrations planned for the *850th anniversary* of the Hospital. This should serve as a useful publicity exercise to help mount an appeal for the rebuilding and modernisation of the hospital. We are also planning a float in the *Lord Mayor's Show* in the autumn, and we are grateful to the Governors for arranging to pay our entrance fee. It is also our intention to work out a formal financial system whereby *student nurses* can be affiliated to our Union, making use of our facilities and increasing the number of females from which our many societies can draw their numbers. One of the leaders in this field is the newly formed Gilbert & Sullivan society which has a tremendous following. I look forward to their first production on 18th, 19th and 20th May.

Before I conclude I would like to mention the retirement of Mrs. Hanslip who was our Student Union Secretary for nine years. She was a fund of knowledge and has been sorely missed. We wish her many happy years of "retirement." I would also like to thank Julict Gould, and now Margaret McClaughlin for taking over so ably.

Finally I would like to thank Mr. Robinson, our President and our Treasurers for their unfailing support throughout the year; Dr. Malpas, the Dean, and Mr. Morris the College Secretary, who have made negotiations unnecessary and given us continual support; Mr. Nixon the Bursar, and Mr. Thornton, the Chief Librarian for always being willing to discuss and instigate any changes found necessary; and last but not least to all Council members who have done the graft in running Union affairs.

Our Prize Competition

Our prize competition. Here are the winning limericks of 50 years ago. Our winners will be published next month.

FROM THE BART'S JOURNAL 50 YEARS AGO MAY 1922

The Prize—the Magnificent Prize of One Shilling—has been won by a doctor from the North of England, who has sent two excellent efforts, but who wishes to conceal his identity under the initials "W.W.". (No, suspicious reader, we haven't kept the shilling ourselves. There really is such a person.)

His first poem is truly educational:

"A lady whose name was Ophelia
Had the signs of syringomyelia.
So they tested her skin
To heat, cold, and a pin,
But each time she declared, 'I don't feel yer!'."

And what can beat this for dramatic effect?

"A professor whose playful delight is
To tap every case of ascites
Had a horrible qualm
When he heard with alarm
A pop—it was just tympanites."

Poetry Corner

THE DAY I DIED

The day I died: hallucinations:
hurled against an endless stream,
dreaming of delusions.
Walnut veneer seems
never means—mere
motions in a time machine.
Seething with pent up frustrations.
Paralysed by pain, aghast
addicted brain bent on damnation.
The Eumenides murmer across
storm tossed skies once flecked
blue now foaming grey— Horses, Helen, Hell's
games are played deceiving me.
Choked by smoke and
cigarette haze, left
dizzy, giddily, dazed.
Electric circuits blown—no fuses
put an end to living notions
releasing patterns drifting motions.
Black illusions creep and streak
before my eyes. Stop! I'm crossing
back before the day I died.

by S. OUD.

FROM THE SAINT BARTHOLOMEW'S JOURNAL of 40 years ago - May 1932

FERTILITY AND STERILITY IN MARRIAGE. By TH. VAN DE VELDE, M.D. London: William Heinemann, 1931. Pp. xx + 448. 20 plates. Price 25s.

SEX HOSTILITY IN MARRIAGE. By the same author. Pp. xix + 296. 42 illustrations. Price 17s. 6d.

These two volumes complete Dr. Van de Velde's trilogy on "synousiology", the first book being the widely-read *Ideal Marriage*, which appeared some years ago. *Fertility and Sterility in Marriage* deals with methods of achieving a desired pregnancy, causes and treatment of sterility, and finally, with enormous detail, the prevention of undesired conception. The sociological and ethical sides of contraception are discussed, and the views of the various religious sects are given and criticized.

Sex Hostility in Marriage deals with the whole problem of the unhappy marriage from the point of view of psychology. There are multitudinous references to other writers, scientific and otherwise, in both these books. The language is a curious mixture of scientific and non-scientific phraseology. The ovum is vibrating with "urges, needs and sensations", the zygote "writhes as though in parturition, a world in travail".

The amount of information contained in these two books is enormous; about half of it is interesting, and a twentieth part is practical. As a guide to married people these two books, for all their erudition, are inferior to the smaller books, whose name is legion. There is no doubt that a great deal of unhappiness and mental upset among married people can be attributed to ignorance of facts which they ought to have known. But these books will not relieve apprehension or give confidence: they are more likely to have the opposite effect, so complicated does "this woman business" appear.

As a guide to medical men the books are of some value, but the useful portion is diluted with so much unnecessary detail and periphrasis that the text provokes irritation and impatience. Many of his statements of fact are mere theory.

We have no doubt, however, that the books will find a good market among the lay public, if only for their illustrations. Dr. Van de Velde's reputation as a teacher would rest on a firmer basis had the last two legs of the tripod failed to materialize.

BOTH SIDES OF THE FENCE

by E. L. BURBIDGE F.I.C.S.

I do not now remember much about the actual moment when the coronary thrombosis struck. I do remember pleading with the firm's doctor, as he knelt over my prone body on the office floor, that in view of the fact that I had to go abroad on business in a few days' time and also had an important golf match to play at the weekend, it would be extremely inconvenient to go into Bart's "just for a check up". I remember too that my arguments were to little avail—the authority which I had been used to wielding was fast ebbing away, others were taking charge and any possible doubts on this matter were soon dispelled when I heard the bells of the City ambulance and the groan of the ambulance men as they took the strain of my 16 stones. Forty-one years I had worked in the City, countless times I must have heard the shrill bells of the ambulance and pondered upon its mission—funny how we tend to feel a personal immunity to that sort of thing—it always happened to the other chap. Well, this time it was happening to me.

Calm, kind efficiency with a touch of firmness is how I would describe my impression of the Casualty department. As the cardiograph was being done they listened sympathetically to my repeated pleas regarding business and pleasure engagements; indeed I was still protesting when they injected the sedative, wheeled me off to the ward, transferred me onto a bed, undressed me and placd me between the sheets. I remember, as I struggled against the increasing drowsiness that I was in a public ward and asking for private accommodation for which I was prepared to pay—what a snob they must have thought me and how quickly I realised how well off I was in the public ward. Indeed when a side room became free I begged to be allowed to stay where I was, where I made many friends and there was sufficient activity to keep one occupied all through the day. Thus started one of the most instructive five weeks of my life.

The first few days are but a dim memory, I was neither interested in food, my surroundings, the staff or my fellow patients—until one morning when I awoke to reality and started to take stock of the situation. I eventually broke the ice and started a conversation with the patient in the next bed. Bill was a bus conductor and my first companion and guide. He, poor chap, had both arms in supports and had been admitted with suspected rheumatic fever, but he never complained in spite of intense pain. It was Bill who explained the "cast" as the first "crocodile" appeared—Consultant, Senior Registrar, Junior Registrar, Senior House Physician, Junior House Physician, Medical Students with Sister acting as a cross between a "whipper-in" and computer memory bank.

I quickly learned to differentiate between the various nursing staff uniforms from Sister down—the different dresses, belts, caps, etc. On one point, however, I was unable to differentiate and this is the admiration I developed for them all—indeed for the whole staff of the Hospital. For example, Kit and Ada: Kit took a great pride in "her floors" which shone like glass. Ada looked after the dusting and top polishing and also helped with the lunches. What character readers they both were, born comics and hearts of pure gold. They were more than domestic staff—they were part of the therapy.

The continual activity in the ward prevented boredom. The morning and evening papers, the "trolley shop", the ward rounds, the mobile library, the dispensing of medicines and some other less pleasant forms of treatment. Then of course there were visiting days. Rows of tidy beds, tidy lockers, tidy patients, dusted and polished awaiting the moment when the flood gates were opened. We started a sweep-stake on the first three into the ward, but we got to know our horses so well that we graduated to "making book" with favourites and starting prices. There were the humorous moments—perhaps "black comedy" might be a better term: for example the discovery one day that there was no pan in the commode—the agonising wait whilst one was fetched, straight from the steriliser, the meaning of the term "hot seat" suddenly becoming crystal clear.

We were a mixed bunch of patients from widely differing backgrounds and trades. We had a parson with a parish in the hunting part of the country; a pharmacist who had the honour of being the longest stay patient—he knew all the angles and initiated all the newcomers into the ward routine. There was an accountant, a chef from a City restaurant, a tea planter from Assam, a City messenger, a retired gentleman's gentleman aged 80, and then there was "Pop". He was on his fourteenth visit and was the perfect patient. He proffered profuse and genuine thanks for everything that was done for him, the more inconvenient the time or the more painful the procedure, the greater and more heartfelt was his gratitude. The old stagers were experts on illnesses of every variety, they were particularly keen on recounting in the most intimate detail their past operations and some of the more lurid investigations and treatment which had, no doubt, become more spectacular with the passing of time. There was always a pang of jealousy when seeing other patients discharged to their homes, however that time eventually came for me. It was impossible to put into words the immense gratitude I felt for all that had been done for me and I decided that some more practical way of demonstrating this was preferable to words, no matter how sincere, voluble or impassioned, for I left the hospital with a distinct impression that within a few minutes my bed would be re-occupied and the whole machine go back into action to get some new patient back to his job and family.

When I got back into circulation in the City once again I was privileged to be asked to join the committee of the Rahere Association, and on my retirement from the City my ultimate satisfaction was being asked by the then Minister whether I would be willing to become a Governor. I accepted with much delight and have spent some of the happiest days of my retirement working in Bart's.

One has, of course, to attend endless meetings of Committees concerned with the various aspects of the Hospital's work, but I, for one, much prefer the personal contact with staff and patients to get the feel of what is going on and what needs attention.

When the National Health Service came into being in 1948 the teaching hospitals were permitted to retain their endowed funds. St. Bartholomew's Hospital could be considered a wealthy establishment in those days, and indeed in a relative sense is still so despite the fact that an enormous amount of the original money has been spent on new buildings and research. These monies are in principle under the care and discretion of the Board of Governors, but under the provisions of the National Health Service Act the expenditure of endowed funds is subject to strict government control, and Ministry permission must be sought before embarking on major capital projects like new buildings. Once such a building, financed from these private funds, is completed it becomes the property of the State, and the provision of services, staff, maintenance, etc., associated with it become a charge on public funds. Naturally enough it is often this aspect which limits or prevents rebuilding and similar projects, much as we would like, and are prepared to devote endowment funds towards their cost.

The allocation of Ministry funds is another responsibility of the Governing Board and it is one which causes many problems. Of course all the interested parties are anxious to obtain as large a slice of the cake as possible and there is never enough to go round. This means lengthy and complex deliberations by many committees in order that the distribution is as fair and just as possible to the individual claimants and at the same time meets the general needs of the hospital and Health Service. To a "City" business man, used to the immediate, snap decision based on a mixture of experience and "instinct", some of the protracted deliberations cause a certain feeling of frustration but one has constantly to remember that we are dealing with the taxpayers' money for which we are accountable to the Treasury. More important is the fact that our decisions directly affect the quality of service which the hospital renders to the patient and they therefore demand the most searching and painstaking consideration.

Anyone who has the privilege of working at Bart's or learning their chosen profession here, must be fully aware that many improvements are needed. We are practising the most sophisticated and modern techniques associated with medicine and surgery in old, and in some cases, historic buildings—not always adequate—often inconvenient, and when one looks at the massive rebuilding programmes under way at Guy's, St. Thomas's, Charing Cross and so forth, there are understandable pangs of envy. However, despite all the problems and frustrations, a great deal has been, and is being, accomplished; and we have maintained our cherished tradition and standard of service to our patients. From both sides of the fence—as a patient and as a lay governor, it's crystal clear that it's the people who work here that make and maintain the reputation of this great hospital.

SPIRO McCHAETE

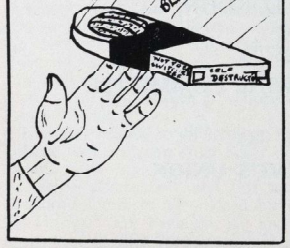
LAST MONTH- SPIRO HAD JUST RECOVERED FROM HIS ROAD TRAFFIC ACCIDENT AT SAINT WHOREMBLOATS HOSPITAL WHEN HE HAD AN UNEXPECTED CALLER. [JUST A LITTLE HELP FOR THE F.R.C.O.G. THIS MONTH]

SPIRO AND HIS CALLER FOLLOWED THE SUBTERRANEAN PASSAGES OF THE HOSPITAL—

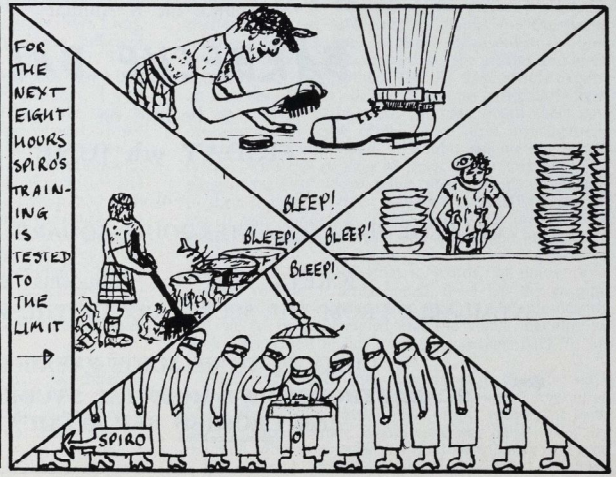
UNTIL-

McCHAETE-YES? DOCTOR-WHAT? WANT A JOB EH?-OF COURSE YOU DO-THEY ALL DO -THE FOOLS. DAY OFF WEDNESDAY, SLEEP SUNDAY, CLINIC ALL DAY WEDNESDAY. KEEP YOUR HANDS OFF THE SISTERS -THEY'RE ALL MINE. WATCH OUT FOR G.M.C. SPIES -THEY'RE EVERYWHERE. PAY -NOT WORTH HAVING. AMERICAN? NO? DAMN-NO GRASS THEN? WHAT ABOUT DIRTY POSTCARDS? NO? DAMN! RIGHT-ROTATING DOGSBODY LOCUM IT IS. BYE! CATCH!

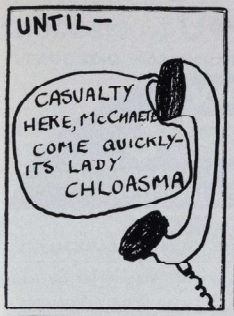
SPIRO CATCHES THE HASTILY THROWN BLEEP WHICH IMMEDIATELY COMES **ALIVE-**

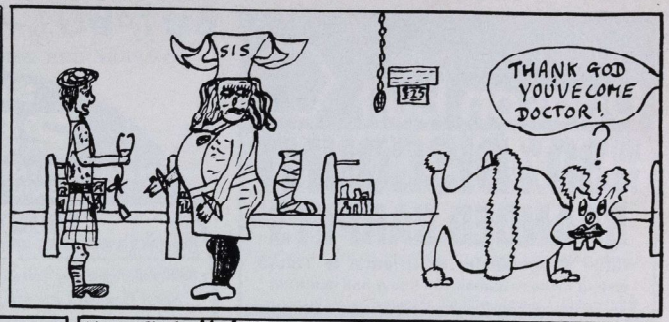


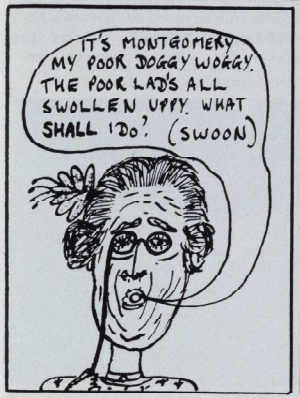
FOR THE NEXT EIGHT HOURS SPIRO'S TRAINING IS TESTED TO THE LIMIT →



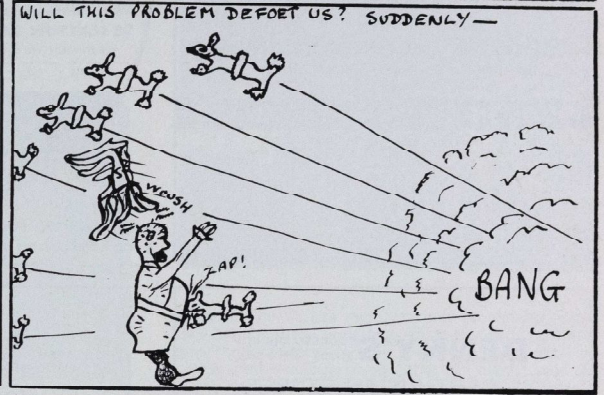
UNTIL—



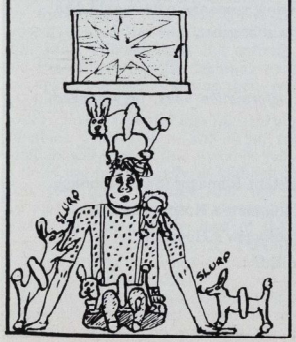




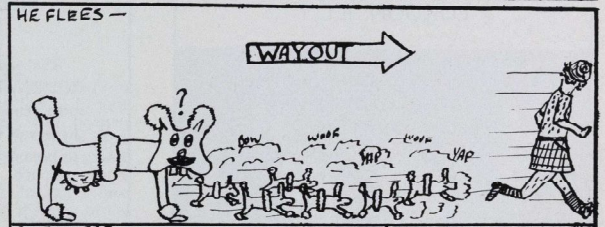
WILL THIS PROBLEM DEFEET US? SUDDENLY—



MONTGOMERY(?) DELIVERED!!! FORTUNATELY, SAVED FROM THE BLAST BY SISTER, SPIRO RECOVERS TO FIND HIMSELF COVERED WITH PUPPIES WHO THINK HE IS **MUMMY!**



HE FLEES—



BUT WHERE IS HE GOING?—

HE IS UNSUSPECTINGLY HEADING FOR THAT DECADENT DEN OF DELINQUENCY AND DESPOTISM— **HARTERCHOUSE SQUARE!!**

READ NEXT MONTH'S ISSUE - IF YOU DARE

B.A. ANON

ANNUAL SMOKER

"Everyone needs a Smoker of '72," sang the cast of the opening number in this year's Smoker, given to packed audiences in the College Recreation Room on March 8th, 9th and 10th. Be that as it may, I'm sure that those who were there had a very entertaining evening, with plenty of laughs provided by a versatile and highly talented group of seven players and their three-man backing group. The standards were higher than in the previous Smoker that I saw and there were some memorable sketches. Foremost among these, and the sketch that brought the house down, was the glorious send-up of the Rugby Club. This will undoubtedly become part

of the Bart's tradition and rumour has it that it is to be incorporated on the next LP of Rugby Songs. In fact, the second half of the show started very well, because the three-quarter line was followed by an excellent presentation of the various methods of contraception, with Janet Dinwiddie as the entirely seductive ovum, and Pete Burnett as the spermatozoon, frustrated time and again, but finally getting there with the help of the Rhythm Method.

The players received fine musical support from Patch Venables, Chris Jowett, and Brian Johnston. The solo numbers were varied and variable, but Jila Pezeshgi was in fine form in her fiendishly difficult 5/4 song and Rob Robertson quite amazing (the only word to describe his performance) in the Lavatory Attendant's Blues. What a pity that, in the heat of the moment and the frenzy of his contortions, he disconnected his microphone—battling on without it, his larynx must have been severely traumatised!

The first half ended with a Rock Opera called "Godsell," very loosely based on the adventures of Moses in Egypt. This provided an opportunity for a James Griffiths/George Blackledge duet, very different in style, but no less successful than the Edwardian one which was the highlight of the Pot Pourri this year.

It is amazing what we laugh at. There can have been few more tasteless sketches than the one in which Wiz Mansi dramatically rescued Rob Robertson from a particularly offensive nasal discharge, and yet we all loved it. It seems pointless to continue listing sketches,

as those who weren't there will only be regretting that they did not attend something which obviously provided great entertainment for this reviewer. There were of course weak sketches, or ones that just didn't come off at the particular performance I attended, but certainly

a higher proportion of them were more successful than on the average "Monty Python" show. It was a fine achievement, and well worth those days of intensive rehearsal that went into it.

BOB LE QUESNE.

RHABDOMYOSARCOMA OF THE HEAD AND NECK

by T. C. KENEFICK F.R.C.S.

The subject has been reviewed recently by Davison and he quotes Dilto and Batasakis as stating that 77.7% of patients were under 12 years at the time of diagnosis and of these 43.5% more under 5 years of age. It appears to be primarily a disease of the first decade whereas tumours of the periphery occur in the 5th and 6th decades—all have a pronounced tendency to metastasise with the exception of orbital neoplasms. In reviewing the world literature 16 cases arising in the middle ear have been described. I wish to describe two others and to briefly describe the pathology and treatment of rhabdomyosarcoma of the head and neck.

Case I

W.H. a 4½-year-old girl presented three weeks prior to beings seen by me with a painful lump in the left meatus. There was no history of acute or chronic otitis media.

On examination: Apyrexial. Soft fleshy growth present in the left meatus. No mastoid tenderness. Lymph nodes enlarged in front of and below left ear. Swab taken: Staph aureus sensitive to Erythromycin. Mastoid X-rays: N.A.D. Hb. 89%, WBC 9000, Polymorphonuclears 50%, Lymphocytes 38%, Monocytes 12%.

The opinion was that it looked like an infective aural polyp but due to absence of ear discharge, examination under microscope and biopsy it was decided to operate.

There was a necrotic haemorrhagic tumour found filling the left meatus. Biopsy was taken.

Histology report: anaplastic malignant tumour, mesenchymal tumour. Embryonal rhabdomyosarcoma. No cross striations seen.

Treatment

A course of Radical Radiotherapy.

A tumour dose of 5000 rads in 22 fractions over 29 days.

A good initial regression of the tumour.

Soon after, however she was readmitted with worsening of general condition and severe vomiting. At that time the patient was wasted and thin with multiple cranial nerve lesions—tumour had spread to involve the case of skull and a course of palliative radiotherapy to the base of the skull was started. Following this she received a short course of vincristine, but failed to respond and died.

Case II

D.F. aged 2½, was admitted to hospital with a three day history of right facial palsy which was progressive. There was no definite history of ear discharge at any time.

On examination: complete right-sided facial palsy and bulging of the right tympanic membrane, postero-superiorly. The swelling was biopsied and reported as rhabdomyosarcoma.

Tomograms: evidence of extensive destruction of external auditory meatus and middle ear cavity. The appearance suggests destruction by malignant tumour. Hb. 74%.

Three days after admission he started a six week course of CO^{60} therapy combined with intravenous Actinomycin.

On discharge soon after his blood count was satisfactory and the facial palsy was much less.

He was readmitted four weeks later with worsening of right facial palsy. In the interim period he had been keeping well apart from periodic discharge from the right ear on and off.

On examination: severe right facial palsy and discharge from right ear. Hb. 88%.

Tomograms: no significant change.

The patient was then seen by the E.N.T. Department and a right radical mastoidectomy operation was performed to remove as much neoplasm as possible. Repeat biopsies showed the tumour to be less well differentiated.

Four weeks later, while still an in-patient he had I.V. vinca leucoblastin. At this stage no evidence of enlarged cervical nodes, liver or spleen and no evidence of bone or lung metastases.

The P.A. scar was well healed but the right ear continued to discharge. Two weeks later it was noted that the co-ordination of the right arm was much less than with the left.

He showed evidence of a right VI nerve palsy, and there was evidence of recurrent tumour.

The parents were anxious to have the child home over Christmas.

Readmitted two weeks later with well marked right ptosis and the mass was obviously visible. He had further V.L.B. which failed to control progress, so Cyclophosphamide was given instead daily. Swallowing and speech became gradually more difficult.

He began to show evidence of widespread metastases and died 29.3.62 in coma eight months after first being seen.

The incidence of rhabdomyosarcoma of the middle ear is not great. The first case was described by Soderberg in 1933.

Other investigations reviewing the incidence of malignant tumours in the middle ear over long periods often do not mention rhabdomyosarcoma.

In children, however, it is commoner than either squamous cell carcinoma or glomus tumours.

It is a tumour of striated muscle occurring in the region of the head and neck in children.

It may present in different ways. e.g. swelling over the mastoid, facial weakness, bleeding polypus in the meatus, pain in the ear with a polypus in the meatus.

Stibbe and Dangean state that these tumours are rarely recognised early in their clinical course, often misdiagnosed pathologically and for the most part are lethal in outcome.

The tumour grows rapidly and causes extensive destruction of the petrous bones and base of skull. The spread is by local infiltration and by lymphoid and blood borne spread.

Despite the above facts rhabdomyosarcoma is one of the most common malignant mesenchymal neoplasms in children.

Histology

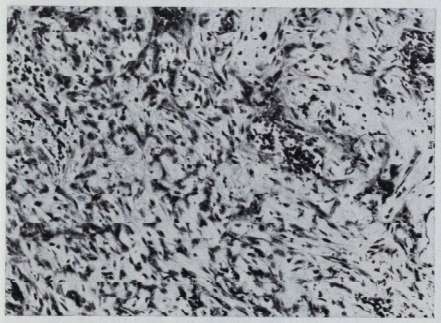
(1) Embryonal rhabdomyosarcoma.

Neoplastic growth of embryonal muscle cells analagous to similar embryonal neoplasms such as neuroblastomas medulloblastomas, retinoblastomas, nephroblastomas, etc.

Basic cell type is a long thin spindle tapering to thin bipolar processes with central nuclei and relatively abundant eosinophilic cytoplasm. The cell is often tad pole shaped. Round cells may be numerous. Longitudinal striations may be seen in the long spindle cells. The same cells frequently show distinct cross striations.

(2) Alveolar rhabdomyosarcoma which is characterised by alveoli separated by connective tissue trabeculae of varying vascularity and delicacy producing more or less a resemblance to epithelial tumours.

(3) Pleomorphic rhabdomyosarcoma which is basically a spindle cell tumour with marked pleomorphism.



Albones Saundra, Butler and Martin reviewed 85 cases of rhabdomyosarcoma—50% were embryonal, 40% alveolar, 10% pleomorphic. In their hospital, rhabdomyosarcoma comprised 20% of all soft tissue sarcomas observed. Only liposarcoma was seen more frequently.

They state the high incidence is partially attributable to an increasing recognition of the embryonal type and the alveolar form. They state that the embryonal is the most common orbital malignant neoplasm and is probably the most often observed malignant tumour of the head and neck in children and adolescents.

The pleomorphic type formerly considered to be the only existing type is actually the rarest. Of the whole 85 cases 47 were in the head and neck, 22 in the lower extremities and 16 in other anatomical sites.

Robert D. Lindberg reviewed 34 cases of rhabdomyosarcoma in 14 year olds and younger—the majority were in the head and neck.

The data presented demonstrated that the lesion arising in the head and neck region can present as one of three different clinical entities.

(1) The naso-pharyngeal lesion—because of the lack of or vagueness of symptoms the lesion is usually extensive when first diagnosed. Invasion occurs early superiorly invading the base of skull—laterally into the paranasal sinuses and orbit and inferiorly into the oropharynx. Occasionally the tumour may present in the external ears by extension along the eustachian tubes. The prognosis is poor. Radical radiation therapy, i.e. a tumour dose of 6,000 rads in six weeks. The addition of chemotherapy, i.e. actinomycin D and vincristine at the same time does not permit a lowered dose of radiotherapy to be given; thus the benefit of chemotherapy in addition to radiotherapy must be weighed against the increased local reaction.

(2) The second type of lesion is the orbital primary which carries an excellent prognosis. They are diagnosed early because of symptomatology—most are embryonal. They tend to remain confined by the bony orbital wall —nerves in the orbit may be involved but spread along them is negligible. These lesions can be controlled by radiotherapy alone or in combination with surgery. As the latter is disfiguring we prefer the former alone. By using special techniques the eye can be irradiated without significant sequelae, i.e. 5,000 rads in 5 weeks, concomitant chemotherapy is not needed.

The remaining primary lesions in the head and neck represent the remainder i.e. the maxilla, ear, etc. They infiltrate along fascial planes without restraint and metastasise frequently. Diffuse extension accounts for the high recurrence after operation. These latter group can be controlled locally by radiotherapy with the use of wide fields. Surgical resection is of little value, as the recurrence rate is very high. The value of concomitant chemotherapy has not been established.

In rhabdomyosarcoma in general, since all primary recurrences and most distant metastases are manifest after one year—this is synonymous with five year survival. Embryonal lesions in young patients carry the best prognosis.

The site of the primary lesion markedly influences the prognosis (see above).

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KEEP IT CLEAN

by RICHARD THOMAS

Once upon a time in a far away land a young man began to announce the discovery of a marvellous new kind of soap. People were sceptical at first, but they soon found that this new soap made everyone clean and happy and, because it was so powerful, it got rid of stains that had been around for years.

Because it worked so well, women found that they had more time to spend with their husbands and children. Marriages got better, people were happier, and everyone admired the young man who discovered the soap. The young man refused to charge for the soap and gave it away to all who wanted it. This bothered some rich people, but the poor people loved it. The manufacturers of rival brands of soap became very angry because their business was being hurt badly.

Soon the young man had followers who were travelling all over the country, giving away the new soap to all who wanted it. The new soap was an almost instant success. Thousands became great fans of the new soap, and they formed small groups to spread its use. The other soap manufacturers became desperate and tried to get the young man to charge for his soap, but he refused. He said that it wouldn't be fair to the poor people, and besides, "it didn't cost me anything—my father gave it to me."

When the soap manufacturers found that this strategy wouldn't work, they started a smear campaign against the young man and his followers and their soap. They said the soap made laundry too easy—that you should have to work harder to get things clean. They said that the young man and his followers were immoral and that they had been in the company of the dirtiest people in the world. These plans didn't work because the people kept saying "it works and you can't beat the price."

So finally the rival soap manufacturers plotted to kill the young man. They paid an informer to betray him, and then arrested him. They paid witnesses to perjure themselves in court, and finally they were able to have him convicted and executed. The soap manufacturers were certain that this would take care of their problem, but to their dismay the young man's followers continued to distribute the soap. Persecution didn't work either, for the followers kept spreading to new areas and kept giving away soap.

Finally the manufacturers decided to try the policy of "if you can't beat them, join them." So they analysed the young man's soap and came up with a very clever substitute which looked the same but didn't work. They used the same name for their soap that the young man had used and organised a promotion campaign to corner the market. Because of their organisation and advertising, they made great progress and even got many of the followers of the young man to join them for a time.

Soon, however, they started to charge them for the soap, and, because their distributors had largely replaced the young man's followers, most people had to buy the soap now and the substitute really didn't work! Many, however, read of the experiences of the early users of the soap and tried to discover where they could get it for free. Several of them were successful, and down through the centuries there was always a group who distributed the true soap for free.

After many years the soap manufacturers decided that they needed a publicity gag to stir up interest in their soap, so they started Soap Campaigns to go back to the homeland of the young man to try to recover the original bucket in which he had first made the soap. Mighty armies were raised because the homeland of the young man was now in the hands of some people who didn't believe in soap of any kind. These Soap Campaigns resulted in wars and the deaths of thousands of people and much destruction and heartache. Many campaigns, including children's campaigns were organised. Many true followers of the young man protested against these campaigns, but they were killed for their efforts. Finally the Soap Campaigns ceased, but they did stir up a lot of interest and sell a lot of soap.

Well, hundreds of years have gone by now, and the young man's true soap is still available free, and people are still getting clean and being happy. And there are those who try to peddle a similar but inferior kind of soap for profit and power. There are some these days who say that you can't get clean, but that soap is a good thing and everybody ought to have a little, but not go overboard. Others worship books about the original soap, and still others have the young man's true soap, and have found that only through its power can they become clean.

BOOK REVIEWS

DISEASES OF THE NERVOUS SYSTEM

W. B. Matthews and Henry Miller. Pp. 354. £3.75. Blackwell Scientific Publications.

This useful, small book should go some way towards dispelling the traditional fear of the complexities of neurology—a fear held by many medical students. It is written with the clarity which one expects from these authors. The traditional pattern of text books of neurology is not followed, in that the amount of space allotted to the various diseases in the present volume is rightly in approximate accord with their frequency.

Understandably, considerable compression of ideas is necessary in a book like this, but it sometimes results in rather nondescript and uninformative statements. For example, the lesion responsible for the Argyll Robertson pupil (spelt differently at various places in the book) is described as being "probably in the upper mid-brain, but a more peripheral site has been suggested."

The line drawings are rather bad, the X-ray plates and photographs well produced.

ANTHONY HOPKINS.

MEDICAL NURSING. NURSES AID SERIES

M. Houghton and C. M. Chapman. Eighth Edition. 384pp. Paper 90p. Bailliere Tindall.

This book is a new edition in the Nurses Aid Series and has been brought up to date with the preface written by Miss Chapman.

This book would come into the nurse's bookshelf because of the cost of it, compared with other medical nursing books. There are improvements from the previous editions and includes a small section on Drug Dependancy.

My main criticism is, that some of the diagrams are either incorrect, misleading or badly labelled. Fig. 9, shows a patient who is in an oxygen tent and appears neither to be sitting up, nor comfortable, as the text in the book states. Figs 12-13, are incorrect, it appears that the diagrams have appeared in the book in the wrong order. Fig. 18, text reads, catheter is in the right side of the heart, and this is not so. Fig. 19, these diagrams are not at all clear. Fig. 20, is labelled A.B.C.D. but text accompanying this diagram says 1.2.3. Fig. 37, text accompanying this diagram mentions A.B.C., but the diagram is not labelled.

It is a pity that such a useful book has so many mistakes, therefore, one could not advise a Student Nurse to buy it.

D. MORTON.

LECTURE NOTES ON GYNAECOLOGY

Josephine Barnes. Second Edition. Pp. 248. £1.75. Blackwell Scientific Publications, 1972.

This small book is ideal for the student while learning gynaecology and for his revision prior to finals; certainly no larger book need be owned. There are ample margins to jot further facts picked up in theatre, outpatients and on ward rounds.

It is packed full of slightly dogmatic facts, inevitable in such a short book. The illustrations are not contributory to the text and perhaps could well be replaced with a section on communicable diseases. The sections on routine examination, menstruation and the general approach to hormones and hormone therapy are excellent. This disposable book is easily read in a weekend and sure to hoist the most ungainly over the final hurdle.

DECLAN GIBBENS.

Bargain Tchaikovsky

Tchaikovsky's music is in a down phase at the moment —the cause of this comparative neglect is hard to ascertain—perhaps the Mahler craze has been in part responsible. This can only be a temporary phenomenon: his music appeals to all lovers of music be they "classically" motivated or not. It has magical melodies (some derived from Russian folk tunes) and colour. If lovers of symphonic music are critical of its lack of symphonic form, they have a point but the orchestration of all his music bears the mark of great genius, particularly his use of woodwind. Most people know the ballet music (some would say all his music is ballet music). What a great evening "Swan Lake" makes in the glorious Covent Garden production, but can anyone imagine this without that radiant score? Many people will have seen Ken Russell's film "The Music Lover" which may well have provoked a strong sense of revulsion because of dislike for the character portrayed. If Russell's film does approach the truth, and it may well do so, from the letters published between Tchaikovsky and Mrs. VanMeerk, it should not be allowed to cloud the sheer genius of the music.

He composed 7 symphonies if we include Manfred (a vast 4 movement symphonic poem of great splendour based on the Byron story). 4, 5 and 6 are amongst the most recorded of all symphonies, and 1, 2, 3 have recently had a revival of recorded interest. Recently Decca released a new, previously unreleased recording of No. 4 by the late George Szell with the London Symphony. This was recorded in 1963 and contains a performance of great distinction with some radiant playing by the LSO woodwind. The pizzicato 3rd movement is beautifully moulded and the brass impact in the 1st movement and finale are amongst the most exciting of any performances on record—unbelievably this has been released at 99p and is a bargain not on any account to be missed (SPA 206). The symphonies do tend to sprawl and symphonic development as such is notably lacking but nobody can deny the effectiveness of such music. The ever popular B flat minor piano concerto deserves its place in the repertory, if only because of the beautiful slow movement with its magical gentle beginning. There are a glut of cheap label records of this including an aggressive but brilliant American performance from Gary Griffinon that may well appeal to some. For the poetic side of the work which does not lack power, Clifford Curzon's reading is near ideal. He is well supported by the Vienna Philharmonic Orchestra under Georg Solti on Decca Ace of Diamonds (SDD 229).

Any recommendations must include some of the ballet music. Swan Lake is full of tunes and elegance. I think the full outlay for the whole ballet is worthwhile. EMI have an authentic Russian recording in their Melodiya series (HLS 795) 3 records for the price of 2. Rozdhestvensky conducts the Moscow Radio Symphony Orchestra with warmth and panache and the Russian orchestra has that earthy edge with biting Slavonic brass tone which is so appropriate to this music.

I suppose one must include the 1812 overture—a work that can really rouse an audience in the correct environment (complete with cannon, massed bells and brass). Kenneth Alwyn's record with the LSO always was an exciting performance. It is brilliantly recorded —its coupling is the March Slave and the Capriccio Italien all most vivid (Decca SDD 112) an excellent bargain again at £1.69.

Tchaikovsky composed some songs, chamber music and opera. The chamber music contains, I feel, little to really excite one—the best of it is the 1st Quartet and the piano trio, even this is repetitious and somewhat dull. The operas are a different story. I find Eugene Onegin a beautifully mellow work with its Tsarist Russian hangover—it has almost a Chekov style of melancholy but Tchaikovsky's score is full of beauty—the polonaise is one of the highlights, in the ballroom scene. An all Russian recording recorded in Paris on the Bolshoi visit 2 years ago came in for a slating by the critics yet I find it extremely enjoyable as a reminder of the Covent Garden production—not really to be missed. Vishnevskaya is the Tatiana and Rostropovitch (of cellist and pianist fame as well as Vishnevskaya's husband) conducts with exceptional skill and regard to the score. This is not cheap (£5.80 for 3 records) and yet is really the one work to give the full range of Tchaikovsky's achievement. EMI (SLS 951).

ALLEGRO.

BART'S MUSIC

GREAT HALL CONCERT
Thursday, March 2nd

At last the large and elaborate ashtray-cum-beer-swill which has for so long been masquerading as a piano in College Hall is now not the only piano within playing distance of the hospital. There is an upright and a really grand Steinway which made its debut at the Great Hall concert.

In the first item, it was played by Cynthia Fung, who led the way admirably in this occasional Haydn Trio, and kept the rhythm steady. It's a pity that Count Esterhazy was a bad cellist, because it hardly allowed scope for Matthis Gutwinski's very musical playing. If Hugh Rogers had not been afraid to use more bow, the whole sock-it-to-me-Gipsy effect would have been more certain. When he did, he produced a lovely sound.

Michael Jamison's performance of John Longmire's Reverie was beautifully poised, and a beautiful tone carried him through the Telemann Sonata, although towards the end, he didn't have the full backing of his lungs. There is no doubt that in order to play Telemann's oboe pieces, it is an advantage to possess the vital capacity of an ox, and lips of leather.

Breathless, we turned to the Mozart Quintet, which the wind instruments played musically, and even more important, in tune. There was a laxity in rhythm in the all-important piano part, which at times brought the music to the very brink of uncertainty, especially in the syncopated sections. Nevertheless, one can forgive so much if one is really enjoying the beautiful music, and thinking of the wine in the interval.

After this last event, one's critical sense somewhat dissolved in alcohol, we returned to hear Martin Gillet and Birgit Anderlan play the Dvorak violin sonatina. I am afraid that I can never take this piece very seriously, and repeated snippets from "O My Darling Clementine," including one in the minor key for luck, don't help. Notwithstanding these personal quirks, the performance was well received.

It was getting late, and we still had a Palestrina Mass to come. I glanced at the programme notes and saw them begin "Apolyphonic Composition . . ." Palestrina or Schoenberg I asked myself. I never really did find out.

JOHN MARSTON.

CONCERT, CENTRAL HALL, WESTMINSTER
March 15th

We are exceedingly lucky to have a choir attached to the hospital—this body is vigorously and excellently trained by Robert Anderson. It is by his enthusiasm that we are able to assemble an orchestra of full proportion able to perform large scale choral works. (The orchestra may well be part keen amateur but one felt that a professional nucleus was present.) Mr. Anderson's enthusiasm for English music is great witness the attractive "Gerontius" of 2 years ago.

It was very brave to mount a programme containing 3 works of Vaughan Williams of which only the "Serenade to Music" could be called popular. It gave one a chance to hear the folk mystique of Vaughan Williams. The luscious textures of the "Five Mystical Songs" were well caught by both chorus and orchestra alike; perhaps the high spot was the brilliant outburst of "Let all the world in every corner sing." The "Six Choral Songs to be sung in Time of War" opened the concert—interesting that Vaughan Williams should revert to his style of some 25 years before with the thematic style of the Sea Symphony and yet still use poems of a forthcoming work like the Symphonia Antartica—clearly an important pivot work. In this, again the sheer enthusiasm carried the choir through the work. Robert Anderson, I'm sure quite subconsciously, mirrors his choral style on Sargent—even down to the red carnation-in-buttonhole. Some of the latter's technique has brushed off too—it did however seem at times that he might fall off the rostrum when launching into yet another major climax. He is the possessor of a good beat and his technique is unfailingly clear, yet judged on this concert, what he lacks is the ability to convey any emotional feel to his orchestra. There was next to no attempt to vary dynamics or the musical flow. This was most noticeable in Richard Strauss' "Four Last Songs," a work of love and final repose where all the lilt and flow went for little. April Cantelo, sang with much less accuracy than one remembers her producing —her tendency to slide into a note may have been emphasised in her lack of rapport with the conductor.

The sparse audience enjoyed the Borodin "Polovtsian Dances" hugely and again the chorus were admirable in their response.

I see that Mr. Anderson plans on conducting "Fidelio" with the same forces in June '72—I do hope he does so with more seeming emotional commitment. I hope also he is rewarded with a full house.

ALLEGRO.

BARTS RUGBY - HOSPITAL CUP FINAL

BARTS v. MARYS at RICHMOND WEDNESDAY 29th MARCH 1972

For Barts to win this game it was vital for their forwards to dominate as they had against Guys in the Semi Final. Unfortunately they never managed to achieve this and so played at a disadvantage for most of the game.

After a good start by Barts the Marys pack were gradually allowed to get into their stride. The situation was not helped by a bad ankle injury to Hill the Barts scrum half, who though he stayed on to play a good game was unable to be the usual attacking force behind the Barts scrum.

After being let off the hook with Marys missing two easy penalties, Barts moved the ball from a loose maul allowing Best to run clear and Britton to force his way over for a try, which Martin converted. Martin later added to Barts score by kicking a penalty from in front of the posts. At this point the Barts pack produced their best attacking play with peels from the lineouts and good short passing movements.

Williams then took over as Marys place kicker and landed two good penalties. Before half-time Young, the Marys outside half made a beautiful break and Lewis went over in the corner for a try, putting Marys in the lead by 10-9.

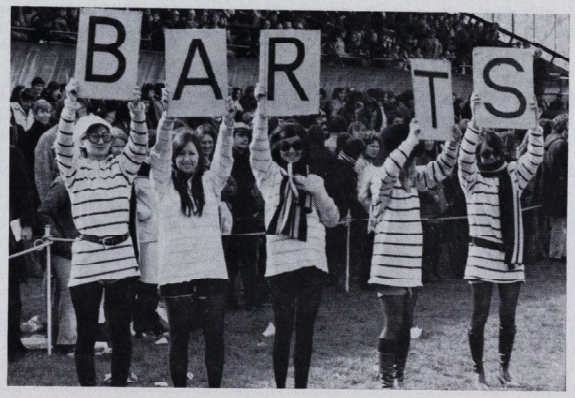
The Marys backs were now being given some good balls and were running well, only fine tackling prevented further penetration.

Barts started the second half into the wind and one point down. Good running and kicking by the Marys halfbacks meant that their pack was always moving forward to the ball. They seized their advantage willingly, repeatedly pushing the Barts scrum back and winning valuable ball. In spite of this, solid tackling by Barts kept them well in the game and prevented Marys from exploiting their advantage. Marys however went further ahead with another penalty from Williams and then Moir won the race to a touch down after a mistake on the Barts line. Williams, always a trouble to Barts

often as a decoy rather than with the ball rounded off a successful day with a final penalty from a wide angle.

Both sides are to be congratulated for playing open Rugby which has been a feature of this year's cup matches. On the day Marys were worthy winners and it was unfortunate for Barts that they were never allowed to get into the stride which carried them into the final.

J.G.



BARTS SPORT

HOCKEY CLUB

REPORT OF THE FINAL OF THE UNITED HOSPITALS' HOCKEY CUP.

St. Bartholomew's 3—Guys 3

The final of the UH cup was played on Wednesday March 8th at St. Thomas's ground near Cobham. The weather was perfect, it being a warm spring day with no cloud cover. The pitch was in perfect condition too and it was pleasant to be able to play on such a surface. St. Thomas's are very lucky to have such good grounds. Barts reached the final by beating the Middlesex in the first round 16-1, St. Thomas's 1-0 (see the April *Journal*), and King's in the semi-final 3-0. Guy's reached the final by beating the London 1-0 afer a replay. Earlier in the season Barts had beaten the London 3-0, and therefore would seem to be favourites. The strength of the Guy's side lie with their forwards, and their centre half, Bob Fell who plays for London University. The Barts side has all round strength, there being no players that excel over the rest.

Barts started the game very strongly mounting persistent attacks. No score came initially until 10 minutes were up, when Colin Reid converted his second short corner, with a well struck shot that the goalkeeper did not touch. The rest of the first half passed with both sides in the game but the Barts side managing to hold to their 1-0 lead.

The second half started again well for Barts who added one more to their score by a good move down the left of the field involving Richard Ashton, Gordon Coleman and Jim Smallwood putting the final shot in. After this Guy's started to play with more enthusiasm, and the defence became edgy. Guy's finally made their breakthrough with a penalty flick awarded when their centre-forward had broken through and was 'crunched' With the difference of only one goal, the team started to play with less conviction and Guy's were able to finally even the score with another flick three minutes from time. This was awarded when a lifted ball in the circle was palmed forward.

Extra time started with Guy's playing with more gusto and they eventually scored after five minutes. However, during the beginning of the second half of the 30 minutes extra time, Barts scored the equaliser from a short corner well taken by Colin Reid. The team continued to end the game well but did not get the winner. On reflection Barts were unlucky to have two penalty flicks awarded against them, but it should be mentioned that they did miss a flick that was awarded to them in extra time. Better luck in the replay.

REPLAY

St. Bartholomew's 2—Guy's 0

Fine weather and a firm pitch for the second successive Wednesday running combined to raise hopes for another high-scoring cup final at St. Thomas's ground in Cobham.

The opening ten minutes promised well for Barts; good quick passing and aggressive running provided several scoring chances, and Young and Barclay were unlucky not to score. Quick defence from Guy's also thwarted our first short corner shot by Reid.

Jim Tweedie in Action.

However, much to the Barts' supporters unease, their team lost control of the midfield allowing Guy's to set up many attacks down the middle and the left wing. As usual the strength and experience of the Barts defence contained most of these attacks. Under this pressure short corners for obstruction, etc. were inevitable, but Guy's failed to use these opportunities and this was to prove expensive for them. Tweedie, playing a captain's role was out far too quickly for the Guy's marksman to have anything but a hurried shot. Savage in goal also made a good save from one of these short corners.

The game had by now become a typical hospitals' cup match with both sides making far too many unforced errors, and relying on force rather than skill. The 0-0 score at half-time was a fair reflection of the game.

In the opening minutes of the second half, Barts again looked much more dangerous. After a good movement through the middle, Smallwood hit a beautiful shot into goal, only for the goal to be disallowed for an infringement outside the circle. Barts once again subsided into scrappy play, and for long periods Guy's were in and around the Barts circle. The defence held, Millard and Reid containing quite easily the Guy's left side, while Mogg and Tweedie were under more pressure from the Guy's attack on their right. These two played cool, assured hockey and helped overcome this difficult time. At this stage Barts mounted only the occasional foray and really did not look like scoring.

It seemed likely that the game would yet again have to go into extra time. However, some 10 minutes from full time, Barts mounted a more prolonged attack and were awarded their second short corner of the match. To everyone's delight Reid made no mistake this time, and with his 30oz club hit a fierce shot straight into the goal. This changed the whole tenor of the game, and the Barts forwards showed for the first time the sort of form that has brought us so much success this season. Coleman, Smallwood and Barclay (who had a particularly good game) forced through the middle, while the wing Ashton and Young repeatedly turned the Guy's defence to create scoring chances. Within minutes of the end of the second half, Ashton took a quick free hit outside the Guy's circle. He picked the ball off one of the Guy's defence, and with a fine solo run past three men shot from a narrow angle. With a little help from the goalie the ball found the far corner of the goal. That settled everything.

And so it is with considerable pride and pleasure the United Hospitals' Hockey Cup returns to Barts for the first time since the War. Gillings must finally be congratulated for his consistently outstanding fine performance at centre half. He surely is the backbone of the Barts side. Special congratulations are due to Jim Tweedie for his spirited leadership of this very good Barts side. Finally the whole team is very thankful for the large number of supporters who urged them on to success, some of whom I suspect have not watched hockey before. I hope they were not disappointed!

Teams: P. Savage; C. Reid; A. Mogg; P. Millard; M. Gillings; J. Tweedie (capt.); A. Young; R. Barclay J. Smallwood; G. Coleman; R. Ashton.

CROSS COUNTRY CLUB REPORT

Following confidential discussion at the highest level, it is felt that the public is only now ready to be told what really happened at Hyde Park on February 19th. At lunchtime that Saturday, six Barts athletes, dressed in plain clothes, and travelling in an unmarked car, left Charterhouse for their rendezvous at Imperial College. Seventy-nine other groups of hand-picked runners from all parts of the United Kingdom, and from the Continent (some spoke French, no doubt to avoid recognition) were also converging on the spot. Each Squad Captain was handed his instructions in a large brown envelope, and all set about their preparation for the grim task ahead.

. . . The Imperial College Hyde Park relay is a 6 × 3 mile event, notable for its good organisation, punctuality, and high standard. On a warm day, when the sun is shining, the birds singing and puffy little clouds float across the sky, Hyde Park is a singularly pleasant venue. The afternoon of February 19th was very cold, and the overcast heavens vaguely threatened snow. The conditions were, however, conducive to speedy completion of the course, and Barts bettered their results of past years by finishing in 47th place:—

1st lap	B. Campbell	16:10
2nd lap	S. Mann	15:24
3rd lap	R. Moody	15:56
4th lap	M. Page	17:06
5th lap	M. Erith	16.23
6th lap	R. Miller	16:10
	Total time:	97:06

HOSPITALS' CHAMPS HAT-TRICK

The Kent Hughes Inter-Hospitals Championship took place on February 26th at Hadley Wood, Barnet, and Barts triumphed for the third consecutive year. It seemed that the five-mile course had been carefully mapped out by a maniac (who was it?) with the intention of exploiting the 'Cross Country" aspect of the event to its utmost. One interesting feature of the course was a sharp 8 ft. incline, leading precipitously into a modest river which demanded crossing in best steeplechasing style. Ex-Barts Captain R. Moody, however, applying the experience of many seasons of hard cross-country to this obstacle, was seen to hurl himself face first into the torrent, to emerge soaking but triumphant on the far bank: the undoubted tactical wisdom of this approach is still uncertain. S. Mann was the first Bartsman home—beaten only by an ex-Cambridge Blue, and an amazing run by the incredible R. Miller secured third place. D. Campbell staggered home 8th, closely followed by R. Moody and M. Erith. M. Page completed the scorers and G. O'Byrne, in a commendable first appearance with the team, finished 22nd. Results in full:—

2nd	S. Mann	33:32
3rd	R. Miller	33:51
8th	B. Campell	34:55
9th	R. Moody	35:21
10th	M. Erith	35:29
16th	M. Page	37:48
22nd	G. O'Byrne	43:20

March 9th saw the final Barts fixture of this momentous season. The team forged its way to darkest New Malden, where LSE was organising the last UL Leagues Division I Match. The course—a short coachride (or marathon trot) from the changing rooms—comprised 2 x 2½ mile laps in Richmond Park. The results are as yet unknown.

BRUCE CAMPBELL.

THE ALPINE CLUB

The Alpine Club continues to thrive in a modest way, although activities appear to be concentrated among relatively few members of the college. Maybe this will change with the forthcoming summer season. A club meet will occur in North Wales during April and it is hoped that there will be further meets (examinations permitting) in the summer.

Members of the Alpine Club have climbed in many parts of Great Britain during the last year. Apart from the much frequented haunts of North Wales and Scotland, including the gabbro spires of Skye, there has been some activity in less usual places such as the granite cliffs of Cornwall and Lundy Island, (in the Bristol Channel) the limestone of Dorset at Swanage and at Cheddar Gorge. Visits have been made to Derbyshire gritstone and limestone, and most frequently of all perhaps, to the "local" sandstone of Harrison's Rocks at Tonbridge Wells.

On the foreign front some climbing and a great deal of festiving was done in the Alps, one individual climbed with an expedition in Kashmir, and, yet another was rumoured to have been seen furtively observing the amazing activities prevalent in the Tosemite Valley USA.

D. R. T. GUNDRY.

Association Football

Wednesday, February 2nd.
Barts 2nd XI v. Kings 2nd XI (Away)

Barts went 1-0 down to start with but then fought back to lead 2-1 through goals by Cooper and Sengupta. The team then fell apart and Kings led at half-time by 5-2. Barts improved in the second half and a goal from Isenberg and another from Kings made the final score 6-3 to Kings.

Saturday, February 5th
Barts 2nd XI v. Guy's 2nd XI (Home)

Barts under heavy pressure playing against a strong wind defended well until J. House failed to hold a shot and a Guy's forward ran onto the loose ball to score. Guy's then scored through two long range shots which were helped, just inside the post, by the strong wind. Just before half-time the defence failed to tackle a Guy's player who ran through to beat the goalkeeper. Guy's were thus 4-0 up at half-time. In the second half Guy's were helped by a drop in the wind and went 5 up through a penalty. A period of strong Barts pressure was then rewarded by a goal from Bouloux, and this score of 5-1 remained to the end.

Wednesday, February 9th.
Barts 2nd XI v. Georges 2nd XI (Home)

Barts, playing well to start with, gave away a goal by a bad back pass from Farrow which Turner, in goal, missed and a Georges forward had a simple task to score. However, Barts soon equalised through a penalty, taken by Creigh-Barry. Georges then fought back to score twice and thus lead 3-1 at half-time. A change round of positions in the second half gave Barts more attacking power and Barts scored again, through Creigh-Barry. Furrow then added the equaliser after making a fine run along half the length of the field. Barts were then awarded a free kick 30 yards out, A. House lifted the ball into the area and Creigh-Barry jumped well to head his hat-trick and give Barts the lead. This was short-lived as a somewhat speculative long range shot from a Georges player went over Turner's head and into the net, off the underside of the bar. The score remained at 4-4 to the end despite chances given to Georges by careless back passes. On two occasions Turner saved well, to give Barts only their 5th UH point this season.

Wednesday, February 16th.
Barts 2nd XI v. Mary's 2nd XI (Home)

No complete report available.

At half-time Barts were level at 1-1 through a goal by Southall. In the second half poor play by Barts enabled Mary's to win 4-1.

Saturday, March 4th.
Barts 2nd XI v. Chelsea College 2nd XI (Home)

A closely fought game saw Chelsea go ahead early in the first-half when the goalkeeper was unsighted and so failed to intercept a long range shot. Play was evenly distributed with brave goalkeeping by Sweeney keeping Chelsea out, and Barts own poor finishing preventing them converting a number of chances into goals. Thus the score remained at 1-0 to the end.

SAINT BARTHOLOMEW'S HOSPITAL JOURNAL

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Editorial

With the improved nutritional standards of the population, both sexes reach puberty at an earlier age. A natural progression of this is that they date, form steady relationships, and dare one say it in this permissive age — even marry earlier. And of course medical students are no exception, to judge by the number of weddings taking place around the hospital recently. The length of the course also predisposes to the fact that more medical students are getting married while still students.

However, this fact seems to have escaped the attention of local authorities, and no allowances as far as grants are concerned are made. They refuse to reassess grants if students marry during their course, although if a female student marries before the commencement of her course, her grant is based on her husband's salary (or grant) rather than her parents. The maximum joint grant therefore allowed by the local authorities is £1,200 for students married after the beginning of their course.

Perhaps this sounds a worthy sum. After all, many couples bring up a family on this money. However, accommodation is one of the main problems of the student in London, and married students are denied the financial advantages of a subsidised council flat. Unless they are prepared to live in dilapidated and soul destroying premises in Bethnal Green, or at some distance from their place of study involving perhaps a two hour journey in and out of town, they will be lucky to find a two-roomed flat for less than £10 per week. Which is at least £520 from their income before they begin to think of the little luxuries like light, heat and food. There are no facilities for married students at Barts. It would not be reasonable to expect such facilities for every married couple — after all, it is not even possible for every single student to be accommodated. But the proportion of married students should and must be taken into consideration and some married quarters provided. In fact, a few are planned at the new hall of residence at OMC, but this is only a start.

Unfortunately, the problem does not end once students qualify, as it is difficult for husbands and wives to obtain housejobs at the same hospital. At some, there are limited facilities for married couples, at others they are non-existent. The choice of hospital may become a question of which one offers married accommodation, rather than "where can I get the best medical experience?" Surely a married doctor is entitled to more than a clandestine double bed in a single room?

LETTERS

Material will not be published unless the name of the author is known to the *Journal*. We will respect the confidence of persons preferring anonymity or a pen-name.

Abernethian Room,
St. Bartholomew's Hospital.

Dear Editor,

The following letter was received from Shepperton Film studios after the last Bar B Q Ball

August 11th, 1971.

"Dear Mr. Cracknell,

I am in receipt of your letter dated 5th August, 1971 advising me that you have lost the ship's wheel which we loaned to you.

You will understand that articles such as these are irreplaceable today, and it does place me in a very difficult position as it is a very important part of our stock for any ship sequences we are filming.

As I cannot put a price on this, I cannot ask you for reimbursement, and I am sorry to have to tell you that this does destroy the relationship we have had in the past when we have been quite willing to help you out in your festivities.

Yours sincerely,
J. BOLAN,
Construction Manager."

The above letter is self explanatory. The Ship's Wheel referred to was removed during the Ball in full view of many of the people present.

I would like to remind people attending this year's Ball that we do depend to a large extent on generous loans by people such as Shepperton Studios, British Rail and Whitbreads, to decorate College Hall and provide an enjoyable Ball.

I would ask you, therefore, not to damage or remove any of the decorations, as we hope that the relationships with various companies built up over a number of years will not be harmed and we will be able to make use of their services in the future to provide an enjoyable Ball.

I. D. Cracknell.

ANNOUNCEMENTS

Births

CLARKE—On April 21st, to Angela (née Gates) and Peter Cedric Clarke, a daughter.

Engagements

The engagement is announced between Mr. Allan House and Miss Alison Burkitt.

The engagement is announced between Dr. J. R. Johnson and Miss F. E. Taylor.

Deaths

SLOT—On April 6th, Dr. G. M. J. Slot M.D., M.R.C.P., D.P.H. Qualified 1920.

MORGAN—On March 3rd, Dr. R. G. Morgan M.C., M.B., B.S. Qualified 1915.

ROBERTSON—On April 7th, Ivor Murray Robertson, F.R.C.S. Qualified 1927

GRABB—On March 31st, Willium Hoadly Grabb, O.B.E., M.B. (Cantab.), M.R.C.P. Qualified 1932.

MOYNAGH—On April 15th, Kenneth Desmond Moynagh, M.R.C.S., L.R.C.P., D.T.M. & H. Qualified 1939.

ROBERTON—On April 20th, Dr. J. A. W. Roberton, M.A.Camb., M.B., B.Ch., M.R.C.S.Eng., L.R.C.P. Qualified 1923.

MCKANE—On February 19th, Thomas Oliphant McKane, M.B., B.S., F.R.C.G.P. Qualified 1937.

Awards

H. B. Stallard, M.B.E. (Med.), T.D., M.D., M.Ch., F.R.C.S., Hon. LL.D. was elected President of the Ophthalmological Society of the United Kingdom 1972-74.

A Hospital Saving Association Nursing Scholarship for Part A of a Nursing Diploma was presented to Miss E. A. Jenner of 32 Ormond Avenue, Hampton, Middlesex. by Her Royal Highness Princess Alexandra at the Royal Festival Hall on 29th March.

This was one of twelve Scholarship given by the HSA, a non-profit making hospital contributory Association which celebrates its Golden Jubilee this year.

Miss Jenner was trained at St. Bartholomew's Hospital and has since been a Staff Nurse and a Sister here.

Barts Diving Club

Barts Diving Club was formed four years ago to enable Barts students, nurses, and other members of the Hospital staff to train in the use of the aqua-lung, and to participate in various underwater activities ranging from Mediterranean archaeology to underwater physiology. The club has been a success. We form one of the components parts of the "United London Hospitals' Diving Group", by means of which the knowledge, resources, and efforts of the various London teaching hospitals are brought together to provide the best possible facilities for medics who want to dive, but cannot afford the expense of most typical British Sub-Aqua Club branches. The ULHDG is a branch of the BS-AC, and enjoys the benefits of this — such as excellent insurance, a splendid monthly magazine, "Triton", for members, and so on.

(We charge an annual subscription of £2.00 to enable us to keep up equipment, and this is raised to £4.50 by the BS-AC subscription. Bear in mind, however, that at a typical BS-AC branch (Holborn) the training fee is £12.00, and you supply your own gear! We supply training and aqua-lungs free, charging two bob for air per session.)

It would be impossible to run a diving club on the subscriptions alone, however, and we have, over the past four years, run two projects on the problem of nitrogen narcosis ("rapture of the deeps"), which have yielded some interesting, published, results. By doing this, we have managed to beg and borrow money and equipment from British industry and money from the Hospitals and Students' unions to enable the (slow) expansion of the club. Most unions have contributed, and I am happy to say that Bart's Club have done their share in these projects, both by the Union's generous help and by the large number of Bart's students involved in these chilly underwater activities. It is always difficult to finance any inter-hospital club, and the ULHDG is no exception.

Training of prospective divers is carried out in the superb Chelsea Barracks pool, on Monday night, 8-10 p.m. Anyone interested should come along (or to the adjacent "orange" pub thereafter). Training consists of a straightforward swimming test (not difficult!), snorkel training, aqua-lung training, and lectures on equipment, safety, and underwater techniques such as navigation, search, and surveys. Our training assumes a reasonably intelligent subject, so is more rapid and informal than the "by numbers" attitude of some branches.

Cost is always uppermost in the student mind. The minimum cost of training is subscription plus mask, fins and snorkel. Sea diving requires a wet-suit, and these are now available in easy kit form from as little as £6.50. Of course, the sky is the limit in this sport, as in most, but equipment can be bought or made gradually, and the really expensive bit, the aqua-lung, comes free from us—and can be hired (when trained), for a few bob for a week-end.

This year we have an excellent project involving the use of heated wet-suits (which should produce more publications), and for which we have managed to raise no less than £600. Anyone interested in underwater activities of this nature, or just diving, should contact Tom McEwen, (1st year clinical), or Trevor Hancock (2nd year clinical), as soon as possible if they want to train this year. I hope Bart's will maintain their important part in this new and exciting field of sport and science—and this is only possible with your help.

By J. R. DAVIES

Ballroom Dancing

"At Bart's? You must be joking!"

No.

"Do you mean your actual waltz and cha-cha?"

Yes, together with other fun-type dances.

"How many people come along?"

Fifty people came to the first meeting and again fifty to the second

"But surely you could never teach a rugger-player like myself to dance?"

Dancing is easily learnt, and we have plenty of nurses to partner you.

"Really? Tell me more."

The St. Bartholomew's Hospital Ballroom Dancing Society meets in Gloucester Hall every Monday at 9.30 p.m. (this gives you time to do something else earlier in the evening before coming dancing). We finish at 11 p.m., which is a very convenient time to wander over to the College Hall bar. The society is open to everyone in the Hospital and Medical College, whether you have appeared in "Come Dancing", or if you have the two left feet, or need a break from Gray's anatomy, or just enjoy dancing. You will learn quickly, with the professional tuition, how to dance the basic steps (very useful if you go to a formal ball) together with some Go-go dancing and a Dashing White Sergeant. The music is in lush stereo but enthusiasts will be disappointed to hear that we have no Victor Silvester numbers. The society provides an opportunity to meet old friends or to make new ones, and there is always a friendly relaxed atmosphere.

N.B.: You may wear your penguin suit if you wish. Places for the Bart's formation team are strictly limited.

Combined Hospitals Ball, Commonwealth Institute, Kensington High Street, W.8. Friday, 20th October, 1972, at 8 p.m.

Student nurses and medical students from the London Teaching Hospitals have agreed to help organise this Ball in aid of the Scholarship Fund of the National Florence Nightingale Memorial Committee. Mrs. Yeo, Special Secretary, and Mr. J. Wellingham are our representatives.

This Committee, founded in 1934, among other things, raises money to award scholarships for senior British nurses to go abroad for a maximum of three months to gain more experience in their specific fields. When they return to this country they bring with them far greater knowledge, understanding and experience to the benefit of their patients and the staff who work under them. Even the doctors can gain some benefit from their new ideas.

There is an unfulfilled demand for these scholarships. Many candidates have to be turned down due to lack of funds. In 1972 fifty-five applications were received and funds were only available to award thirteen. Since 1970 four scholarships have been awarded to senior nurses at St. Bartholomew's Hospital and this year Miss Ingram has been awarded one to study Hospital Administration in the United States for three months.

The National Florence Nightingale Memorial Committee receives no Statutory provision for its work. It depends entirely on voluntary contributions. Let us make this first combined effort towards such a worth while cause a great success and raise a sizeable sum. This is a preliminary notice. **Watch for publicity in the Hospital and support us.**

A PERSPECTIVE OF ANAESTHESIA

by R. A. BOWEN F.F.A., R.C.S.

Oliver Wendell Holmes suggested the name anaesthesia to denote a state of insensibility during surgery. Attempts to achieve this with safety had been made since the dawn of that art, but it was in 1842 and in rapid succession that three agents were first used successfully in man; diethyl ether, nitrous oxide and chloroform.

Ether is a potent anaesthetic. It can produce complete muscular (and therefore respiratory) paralysis. It is very safe in short administrations in that even when pushed to the stage of respiratory arrest there is only moderate reduction of cardiac output, and reversal is always possible if the agent is discontinued and the lungs ventilated with oxygen. It is bronchodilator, and a smooth ether anaesthesia in asthmatics leads to an improved airway and loosening of secretions. It is often favoured for tonsillectomy in children where its analgesic action leads to quiet recovery. But its disadvantages have led to its decline; it has a nauseous irritant vapour which produces marked outpouring of secretions and a strong dislike in most patients. It is slow in absorption and excretion, and inflammable and dangerous in the presence of a source of ignition. In protracted use at deep levels it causes progressive arteriolar dilatation and a shock-like state. But in underdeveloped countries it is most valuable. Used with air or oxygen, its low cost and portability give it pride of place.

Nitrous oxide, in contrast, is a weak agent still widely used. Its speed of absorption and excretion plus analgesic potency make it valuable for outpatient work, and it is a useful vehicle for carrying the more powerful volatile agents. A recent addition is Entonox (the name is derived from N_2O and oxygen), a 50:50 mixture of the gases compressed in cylinders. Provided the temperature remains above—8°C. the mixture issues in constant proportions. Used with a "demand" apparatus (figure 1), Entonox provides rapid analgesia without loss of consciousness. The patient only receives gas on inspiration from a facemask, the supply ceasing on expiration. The apparatus is much used in obstetric practice and in ambulances.

Figure 1.
Part-view of Entonox apparatus showing cylinder and key, demand regulator, delivery tubing and mask.

Chloroform has virtually disappeared from use. Depressant to myocardium, vasomotor centre and vessel walls, incautious administration may cause a profound fall of blood pressure and cardiac standstill. It also increases cardiac irritability, so that ventricular fibrillation may be caused by surgical stimulation at light levels, or by the presence of adrenaline, whether injected by the surgeon or, more commonly, endogenously produced by fear. Its hepatotoxicity may lead to "delayed chloroform poisoning", an apparently normal recovery being followed by fever, jaundice, coma and a possible fatal termination.

In the 1920s the term premedication was used for the administration of drug combinations prior to anaesthesia. It had four objectives:

1. To reduce apprehension.
2. To reduce vagal tone (increased by most agents except ether).
3. To reduce the production of secretions, especially by irritant vapours.
4. To minimise nausea and vomiting.

The first is the most important. Adequate preliminary sedation is welcomed by the patient and makes the subsequent induction of anaesthesia easier.

Following its introduction in 1929, cyclopropane enjoyed increasing popularity because it was rapidly absorbed and excreted and was potent with high oxygen concentrations. It was used by the closed method, to be described later. The introduction of relaxants hastened the decline of this valuable agent whose demerits were then more clearly seen: high cost, inflammability, and a tendency to cause cardiac dysrhythmias and marked respiratory depression. But it is still popular for inducing rapid sleep in children, likewise in shocked or ill patients where it sustains cardiac output in contrast to the intravenous anaesthetics.

Although tried previously, it was in 1934 that intravenous anaesthesia gained a firm foothold following the successful use of thiopentone. Gone were the days of the old "gas, fight and choke" school, gone the dread, often expressed today by children *and* adults, of the facemask and feeling of suffocation. Most anaesthetics are induced intravenously today. Newer drugs have been introduced for short procedures, notably methohexitone and propanidid. These leave the patient more clear-headed and more rapidly fit to return home. But these drugs have drawbacks. They are slow in action and excretion and some are myocardial depressants. They should be regarded as narcotics: their scope may be greatly extended by gaseous and volatile agents.

In 1942 curare was introduced by Griffith to provide muscular relaxation in the absence of deep anaesthesia. Used at first with potent agents such as ether or cyclopropane, it was soon found easier and safer to employ anaesthetics incapable of producing deep levels. It is now standard practice to induce sleep by an intravenous drug and to continue with nitrous oxide and

oxygen. The latter's potency may be enhanced where necessary by small amounts of halothane, trichloroethylene, or pethidine.

The relaxants have changed the face of anaesthesia. They have obviated the need for deep anaesthesia with its attendant upset of body chemistry and vasomotor tone. But they have brought their own problems: it is essential to see that they are completely reversed after operation and vital to ensure that the patient is not paralysed yet awake.

Trichloroethylene, although used previously, was popularised by Langton Hewer, of this hospital, in 1941. It is an excellent analgesic and is non-inflammable in ordinary usage. Used in draw over inhalers it provides good pain relief in obstetrics and for painful dressings, e.g. burns. For general work it lacks potency, but is a valuable supplement to nitrous oxide, oxygen and relaxants.

Trichloroethylene has largely given way to halothane, first used clinically by Johnstone in 1956. This agent enjoys a huge popularity today in many countries despite its high cost. It is virtually non-irritant, and is non-flammable, potent, rapid in absorption and excretion, and has only a slight tendency to cause nausea and vomiting. A disadvantage is that is not analgesic, so that recovery is sometimes marked by restlessness (emergence delirium), or by "halothane shakes", a state characterised by increased muscle tone and shivering. It is a potent vasodilator and may cause profound hypotension in some individuals, so that care or avoidance may be necessary, e.g. in cardiac or peripheral vascular disease.

Methoxyflurane was introduced in 1960 as another non-flammable fluorinated hydrocarbon. It resembles ether in being an excellent analgesic and muscle relaxant. It is, however, very slow to be absorbed and excreted, and has an unpleasant smell. It is used for self-administration from draw-over vaporisers in obstetric and in burned patients.

Mention must be made of a new agent, Ketamine. This remarkable drug, injected intravenously or intramuscularly, produces profound analgesia, a trance-like state, normal or slightly increased blood pressure and muscle tone, with no loss of laryngeal or pharyngeal reflexes. It is not therefore necessary to support the patient's airway. In adults it may cause hallucinations; these are far less frequent in children, in whom it has been used successfully for surgical dressings or for radiotherapy. Despite its apparent promise, it is wise to regard Ketamine as a drug in the trial stage.

The Apparatus

In the open method, chloroform or ether were dropped on to gauze or lint held (usually in a metal frame—figure 2) over the patient's face. It was more than adequate for chloroform, which requires 4 per cent. in air at most, but ether, requiring 20 per cent. at times and having a high latent heat of vaporisation, caused water to condense and freeze on the gauze. This cooling produced a proportionate fall in concentration.

The semi-open method attempted to raise the inspired ether concentration. A framework was fashioned round the gauze in the form of a chimney. Heavier-than-air vapours built up at the bottom of the chimney, but expired carbon dioxide was also retained, leading to hyperventilation.

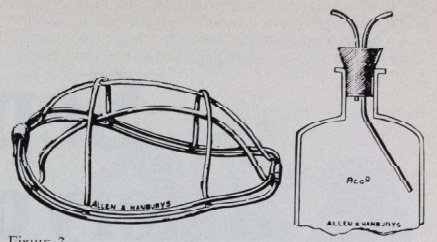

Figure 2.
Bellamy Gardner's open-ether mask and ether dropper.

These methods were supplanted by the semi-closed apparatus. The machine as we know it in this country was introduced by H. E. G. ("Cocky") Boyle, of this hospital, in 1917. Previous work in the United States, notably by Teter, Gwathmey, and Boothby and Cotton, had developed vaporisers for volatile liquids and meters for measuring gas flows. Boyle asked Messrs. Coxeter of London to combine these in a simple apparatus. The modern Boyle's machine (figure 3) is essentially similar, with detail improvements. An accurate "Rotameter" measures flows of oxygen, carbon dioxide, cyclopropane and nitrous oxide. The gases pass through vaporisers, commonly for trichloroethylene and halothane. The mixture is delivered to the patient via a Magill attachment (figure 4) comprising reservoir bag, corrugated tubing, expiratory valve, angle-piece and mask. On inspiration the expiratory valve closes and fresh gas is drawn from the bag into the lungs. On expiration the expiratory valve opens, venting expired gas to atmosphere. This system, provided the gas flow exceeds the patient's minute volume, allows minimal rebreathing of expired carbon dioxide. Its virtue is simplicity; its vice, wastefulness of gases and volatile agents.

The closed circuit, known since 1850, became popular for use with cyclopropane. At rest, basal oxygen consumption is only 250-350 ml/min. Life may therefore be supported if this volume is added to a closed system containing a carbon dioxide absorbent (com-

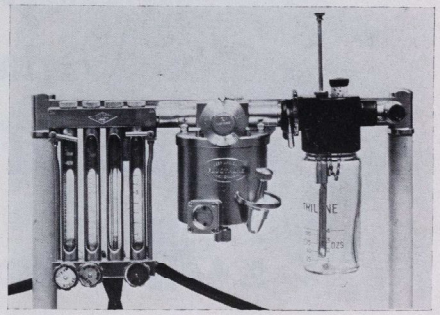

Figure 3.
Boyle head showing, from left to right, four-tube Rotameter, halothane and trichloroethylene vaporisers, and gas outlet (seen end-on).

monly soda-lime). If the oxygen flow is reduced, cyclopropane (almost entirely excreted by the lungs) may be admitted, offering the most economical use of this anaesthetic.

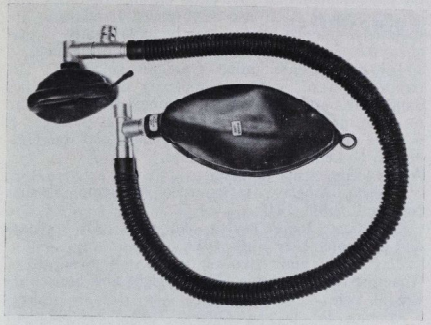

Figure 4.
Magill attachment, showing bag mount for attachment to gas outlet of Boyle machine, corrugated tubing, expiratory valve, angle-piece and mask.

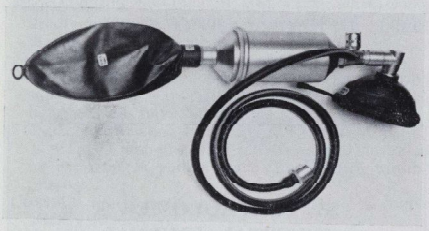

Figure 5.
Waters' canister, showing bag, canister, gas inlet tube, expiratory valve, angle-piece and mask.

The simplest apparatus is Water's canister (figure 5) which uses to-and-fro absorption. The patient breathes through a soda-lime canister into a bag, a side-tube admitting the necessary gases. The system is cheap, simple, of low resistance and easily sterilised. It must, however, be mounted close to the patient to minimise dead space (volume between soda-lime and patient), an inconvenience in the theatre. The circle system (figure 6), introduced by Sword, offered advantages. Here the heavy absorption apparatus is deployed at a distance, two tubes joined by a Y-piece leading to the patient. Inspiratory and expiratory tides are separated by unidirectional valves so that expired carbon dioxide ultimately reaches the soda-lime however far removed.

Both to-and-fro and circle systems have expiratory valves which are shut in true closed circuit administration. If left open and the gas flow increased above basal requirements, the method is known as "semi-closed anaesthesia with absorption". It is a combination of semi-closed and closed methods, the expiratory valve venting carbon dioxide and excess fresh gases to atmosphere, the soda-lime absorbing the remaining carbon dioxide. It is efficient and offers some economy at the expense of respiratory resistance. If the expiratory valve tension be suitably adjusted, intermittent manual compression of the reservoir bag allows passive lung ventilation to be performed.

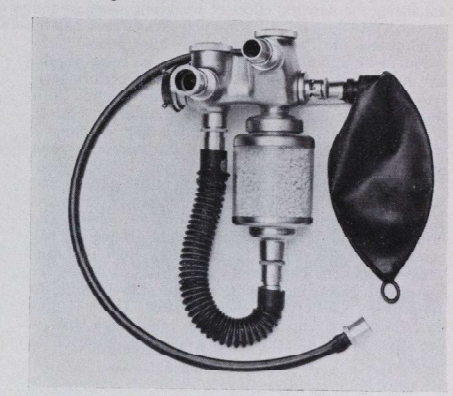

Figure 6.
Circle absorber, showing gas inlet tube, soda-lime canister, bag, and ports (seen end-on) for attachment of inspiratory and expiratory tubing. Unidirectional valves are on top of assembly.

In 1934 Guedel and Treweek found that overventilation with strong ether concentrations in a closed system produced apnoea—thereafter the pattern of ventilation could be controlled at will. This controlled apnoea requires two preliminaries; a lowered respiratory centre threshold to carbon dioxide (e.g. by opiates or anaesthetics) plus muscle relaxation induced by anaesthetics or relaxants. A variant enjoys wide use today

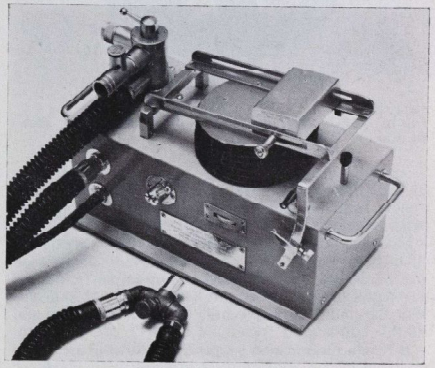

Figure 7.
Manley ventilator with bellows and weight above. At left are, from below upwards, gas inlet tube and inspiratory and expiratory tubes. Lower centre is Y-piece for connection of inspiratory and expiratory limbs to patient.

under the name intermittent positive pressure ventilation (I.P.P.V.). The inadequate respiration produced by muscle relaxants is replaced by a more than adequate pattern: a respiratory alkalosis is induced with benefits in the form of reduced cerebral blood flow, probably enhancing the narcotic effect of weak anaesthetics, and reduced muscle tone. I.P.P.V. may be carried out by hand, using the "semi-closed with absorption" technique, or by a mechanical ventilator. The latter has the advantage that it is relatively constant in performance. A variety called the Manley ventilator (figure 7) is widely used in the theatres of this hospital. In essence it comprises a concertina reservoir bag carrying a weight, two uni-directional valves, and inspiratory and expiratory tubes connected via a Y-piece to the patient. The motive force is the pressure of nitrous oxide and oxygen. In the first phase, the inspiratory tubing is closed, and gases enter the bag, lifting the weight. The inspiratory limb then opens, the weight driving the bag contents into the lungs; the expiratory limb is meanwhile closed. The bag outlet again closes to permit refilling with gases, the expiratory limb now opening to atmosphere. The cycle is then repeated. There is thus no rebreathing into the system, and soda-lime is unnecessary. It is an example of a non-rebreathing circle system.

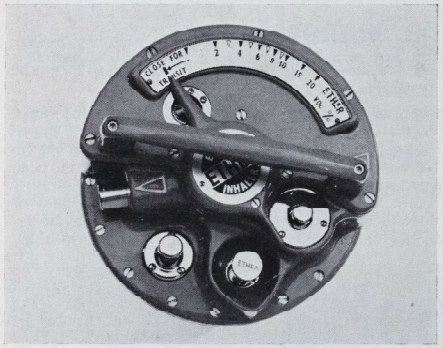

Figure 8.
Top of E.M.O. Ether vaporiser, without attachments, showing scale.

Apart from its use during anaesthesia, I.P.P.V. is standard treatment for any form of respiratory insufficiency, from poliomyelitis to poisoning. In conscious patients sedation is necessary.

In British anaesthetic practice today two varieties of circuitry are most commonly employed: semi-closed anaesthesia via a Boyle machine for simple techniques not requiring relaxation, or induction by this means with the addition of a ventilator where relaxants and I.P.P.V. are needed.

It remains to mention simple apparatus for use where problems of cost and transport prohibit the methods we enjoy. One example shall suffice. The E.M.O. ether inhaler (figure 8) was developed by Epstein and Macintosh at Oxford. It comprises a large vaporiser surrounded by a water jacket to serve as heat reservoir, and a temperature compensator to allow for the cooling of ether. It may be set to give known ether concentrations independent of gas flow and temperature. A simple circuit is added to form a draw-over apparatus; the patient inhales air over ether during inspiration and expires through a valve to atmosphere. If relaxants are required, a manual bellows may be incorporated so that air or oxygen and ether may be forced into the lungs.

This is but a bare outline of progress since 1842. The trend is towards greater complexity and in this lies danger. The art of anaesthesia stemmed from the desire to make surgery as pleasant and as safe as possible: it is more than ever necessary for kindness and watchfulness to be kept constantly in mind.

Acknowledgements are made to:—

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My thanks are due to Mr. David Tredinnick and the Staff of the Department of Medical Illustration for the photographs, and to Mrs. Richard Green of the Department of Anaesthesia for secretarial assistance.

A STUDENT'S SELECTION FROM THE ENLARGED DEVIL'S DICTIONARY OF AMBROSE BIERCE

Selected by J. R. DAVIES

ABDOMEN. *n.* A shrine enclosing the object of man's sincerest devotion. The temple of the god Stomach.

ACCOUCHEUR. *n.* The devil's purveyor.

ADAM'S APPLE. *n.* A protuberance in the throat of man, thoughtfully provided by Nature to keep the rope in place.

ADOLESCENT. *adj.* Recovering from boyhood.

APOTHECARY. *n.* The physician's accomplice, undertaker's benefactor and grave-worm's provider.

BABY. *n.* A misshapen creature of no particular age, sex, or condition.

BALD. *adj.* Destitute of hair from hereditary or accidental causes—never from age.

BELLADONNA. *n.* In Italian a beautiful lady; in English a deadly poison. A striking example of the essential identity of the two tongues.

BIRTH. *n.* The first and direst of all disasters.

BODY-SNATCHER. *n.* A robber of grave-worms. One who supplies young physicians with that with which the old physicians have supplied the undertaker.

CLINIC. *adj.* Relating to a bed. A CLINICAL LECTURE is a discourse on a certain disease, illustrated by exhibiting a patient made suitably sick for the purpose.

CONSULT. *vt.* To seek another's approval of a course already decided on.

DENTIST. *n.* A prestidigitator, who puts metal into your mouth and pulls coins out of your pocket.

DIAPHRAGM. *n.* A muscular partition separating disorders of the chest from disorders of the bowels.

DISEASE. *n.* Nature's endowment to medical schools.

DOCTOR. *n.* A gentleman who thrives upon disease and dies of health.

DROPSY. *n.* A disease which makes the patient's lease of life a kind of naval engagement.

EPIDEMIC. *n.* A disease having a sociable turn and few prejudices.

EPIDERMIS. *n.* The thin integument which lies immediately outside the skin and immediately inside the dirt.

GASTRIC-JUICE. *n.* A liquid for dissolving oxen and making men of the pulp.

GOUT. *n.* A physician's name for the rheumatism of a rich patient.

GRAVE. *n.* A place in which the dead are laid to await the coming of the medical student.

HOMEOPATHIST. *n.* The humorist of the medical profession.

HOMEOPATHY. *n.* A theory and practise of medicine which aims to cure the diseases of fools. As it does not cure them, and does sometimes kill the fools, it is ridiculed by the thoughtless, but commended by the wise.

HOSPITAL. *n.* A place where the sick generally obtain two kinds of treatment—medical by the doctor and inhuman by the superintendent.

LECTURER. *n.* One with his hand in your pocket, his tongue in your ear and his faith in your patience.

LIVER. *n.* A large red organ thoughtfully provided by nature to be bilious with.

MALE. *n.* A member of the unconsidered, or negligible sex.

MOLECULE. *n.* The ultimate, indivisible unit of matter. It is distinguished from the corpuscle, also the ultimate indivisible unit of matter, by a closer resemblance to the atom, also the ultimate, indivisible unit of matter.

OESOPHAGUS. *n.* That portion of the alimentary canal that lies between business and pleasure.

OPIATE. *n.* An unlocked door in the prison of Identity. It leads into the jail yard.

OVERDOSE. *n.* A fatal dose of medicine when administered by any other than a physician.

PERICARDIUM. *n.* A sack of membrane covering a multitude of sins.

PHYSICIAN. *n.* One on whom we set our hopes when ill and our dogs when well.

QUACK. *n.* A murderer without a licence.

RHUBARB. *n.* Vegetable essence of stomach ache.

TRICHINOSIS. *n.* The pig's reply to proponents of porcophagy.

WOMAN. *n.* An animal usually living in the vicinity of Man and having a rudimentary susceptibility to domestication. The species is the most widely distributed of all the beasts of prey.

AMBROSE GWINNETT BIERCE 1842-1914?
A biographical note

The 19th century satirist and writer Ambrose Bierce was born in 1842. He wrote regular columns, and edited, a number of newspapers, first in San Francisco and then in Washington and New York. He gained an international reputation for his cynical and irreverent attacks on the sacred cows of the time. This work was epitomised by his "Devil's Dictionary" published towards the end of his life.

In 1913 he disappeared into Mexico, then in revolution, and was never seen again.

"THE ENLARGED DEVIL'S DICTIONARY" by Ambrose Bierce. Edited by Prof. E. J. Hopkins. Published by Victor Gollancz Ltd. £1.50.

THE UNDERGRADUATE AND HIS CAREER

by A. B. GILMOUR M.B., B.S., M.R.C.G.P., MEDICAL DIRECTOR B.M.A. CAREER SERVICE

One of my more pleasant duties as Medical Director of the B.M.A. Personal Services Bureau, is visiting Medical Student Societies to talk about Careers in Medicine, both within and outside the N H S Wherever I go I am always struck not only by the relevant and sometimes searching questioning, I am subjected to, but also by the colossal need for a great deal more *realistic* information, which would enable students to begin a realistic career choice.

A question that was posed at a recent B.M.A. Symposium on Career Guidance was "What do Undergraduates really *need* at this stage of their Careers". It should certainly not be "Guidance", or even "advice" but primarily *information*. It is the dissemination and presentation of this information and the type of information needed that I shall consider in this article.

The Student speaker at the Symposium, Mr. John Wellingham advocated the need for the creation of the post of sub-dean at each medical school, whose prime responsibility it would be to collect and collate the information needed. This sentiment was not only echoed by some of the other speakers, but also embodied in the recommendations that were made to the plenary session.

I feel that one of the keynotes to the provisions of information on careers to Medical Students must be informality. Indeed, this is something that I always strive for in my own talks. The open-forum type of discussion can be of far more use than a formalised lecture. The informal discussion of information is already being greatly extended by Career Fairs organised by Students themselves. The usefulness of such events is twofold: firstly, the student who already has a firm career preference, is able to talk to specialists in that field, and secondly those students who have little or no idea of which career to enter, are able to take all the handouts which interest them, and mull over them at their own leisure at home. There is however, a major drawback to the Career Fair, in that as it usually happens but once a year — indeed if that — the service it provides is not continuous, as any useful information service must be.

The extension of the present system of personal tutorage of students using both hospital and non-hospital staff as "tutors", could well be of use in this context if the undergraduate needed "guidance" or "advice" about career choice. Such an extension would not be necessary however, if a special post with responsibility for information were created.

Whilst there can be no doubt that the informal presentation of information can be of real benefit, I do feel that there should be at the same time a very firm presentation of such information at a more formal level. There should be opportunities to learn of the very diverse opportunities in medicine at the earliest possible stage. Indeed, Professor Acheson, the Dean of the new medical school at Southampton, did just this, in his opening talk to his first intake of new students this year. Not only does this show the very wide range of careers in medicine, but also, and possibly more importantly, it gives the facts about prospects in the individual specialties.

Throughout undergraduate training there must be freely available extensive realistic information and material on all aspects of medical careers both N.H.S. *and* non-N.H.S. I feel that there should also be an extensive series of Career Profiles written by people within the specialty explaining the subject and describing the work that is done, the type of life that is led, and of course, the remuneration that one can expect. I would like to stress, however, that such Career Profiles, would need to be frequently revised in view of the rapid changes that occur in some specialties. As well as this type of literature, it would be of the greatest value were the Royal Colleges, and individual faculties, to provide full information outlining their postgraduate training schemes, and also possibly, a full list of recognised training posts; this is often the case already, but sometimes the availability of such information is not publicised enough.

With the advent of more flexible medical curricula, I think that the most decisive factor in a career choice decision, that of exposure to differing specialties whilst still a student, will gain even greater importance. Although it is useful to read what life is like in a "minor" specialty, it would be far more beneficial for students to see for themselves, and thus make their own judgement; brief attachments in some of those specialties not normally seen by students in their undergraduate training, would to a certain extent obviate the great preponderance of people trying to gain careers in the more popular specialties. Could such attachments take the form of supernumerary house posts to consultant in peripheral or District General Hospital? Moreover as more than 60% of students enter the one "specialty" of general practice, a case could be argued for a separate attachment scheme to selected and *varied* general practices, as well as a greater emphasis on careers outside the N.H.S., such as overseas medicine, occupational medicine and community and administrative medicine.

The difficulty with such schemes is of course advising when the best time would be for them to happen. Apart from General Practice where some early exposure in the clinical training would be of use, such attachments would obviously be of far more use later on in the clinical course.

By the final year much of the formal presentation of career opportunities should have been made, just as the exposure to the specialties and non-hospital careers, should be completed. I envisage then, the final year being one of consolidation of information received from the various sources. Medical Student Societies at Universities could help in this by having a series of students talking about their experience gained in their individual attachments and electives, thus allowing an interchange of information.

SPIRO McHAETE

THE STORY SO FAR :-
SPIRO IS CHASED BY Lady Chloasma's Puppy — Wuppies TO THE GATES OF HARTERCHOUSE SQUARE

Where ⟶

FOR A BRIEF MOMENT HE WAS OVER-AWED BY THE WONDROUS SPECTACLE WHICH UNFOLDED BEFORE HIS VERY EYES [THE PUPPIES VENTURED NO FURTHER AND FLED IN TERROR FROM THE ODOUR EMANATING FROM THE PHYSIOLOGY LAB] SUDDENLY—

A MERCEDES BENCE (DRIVEN BY JONES?) APPEARED AT THE MINIMUM PERMITTED HARTERCHOUSE SQ. SPEED OF 60 MPH. SPIRO LEAPED FOR COVER IN THE ANATOMY BUILDING.

UNFORTUNATELY SPIRO TRIPS UP AND FALLS ONTO A TABLE BEHIND THE CLASS

ANATOMY

WHERE ⟶

HACKSAWS STIFFS CRANIOCLASTS etc

Arm leG hEadP Fre An eYe

8006 8007 8008 8010 8011 +½ 8012 8013

12x12 CANS LUSCIOUS LIPPES LOOPS etc

LOST PROPERTY

SPIRO

PROFESSOR MYAL ONA NOW TURNS HIS ATTENTION TO SPIRO....

A POOR SPECIMEN — hum!

UNSUSPECTING SPIRO DREAMS.....

STAR

DR McHAETE WINS NOBEL PRIZE

FORTUNE

FAME!

MEANWHILE THE "PROF" CONTINUES HIS EXACTING TUTORIAL

NO 8006 M/S DERMOID, WHAT DO YOU THINK IS WRONG WITH THIS CORPSE?

UM-ER-WELL SIR, I ENCYST THAT.... UM,... ER WELL GEE, IT SEEMS TO BE BREATHING TO HE

RUBBISH !! GIRL! BREATHING eh? — THAT'S AEROBIC BACTERIA

MOVING ?? — HUMPH, THAT'S FASCICULATION

HUMPH! I THINK FROM NOW ON WE'LL STICK TO THE WRITTEN FACT — BACK TO THE BLACK BOARD!

LEFT, LEFT, LEFT RIGHT LEFT

SPIRO'S DREAM CONTINUES AWHILE.

OBEL ... — BELLE PRIZE

NUTTY NEURONES

BELL?

PRIZE?

AND CONTINUES !

ZAP

AND SO SPIRO AWAKES TO YET ANOTHER BE-OOTIFUL DAY, AND SLIPS AWAY, NOTICED ONLY BY M/S DERMOID....

GEE, I GUESS LIKE I AIN'T STUPID AFTER ALL!

LEAVING BEHIND THE FORMALISED FUMES HE STUMBLED OUT ONTO THE QUAGMIRE-LIKE COURTYARD WHERE THE DREADED ST. WHORE'S RUGBY TEAM WERE PRACTISING.

WITH APOLOGIES
WIFE
B.A. ANON.

FROM THE ST. BARTHOLOMEW'S JOURNAL
35 YEARS AGO JUNE - 1937

It would be unthinkable in a Hospital whose association with the Royal House has always been so happy and so close, whose Patron from the days of the eighth Henry has been the Monarch, and whose President his heir, were we to let so notable an occasion as the Coronation of His Majesty pass without adding to the tremendous flood of loyal good wishes our own fervent affirmation.

At the recent Coronation Ball held at Charterhouse a loyal address from the students of this Hospital was, in fact, sent to His Majesty, and we can hardly do better than to repeat its wording here:

"To Your Most Gracious Majesties, King George VI and Queen Elizabeth.

"We, the Students of the Royal Hospital of St. Bartholomew, in the City of London, on the occasion of our Ball in celebration of your Coronation, beg your Majesties to accept this expression of our most loyal affection, with the hope that your reign may be both long and happy, favoured by continued peace and prosperity, notable for the progress and welfare of your peoples, and, in particular, remarkable for the advancement of knowledge in medicine and its allied sciences.

"We earnestly hope that amongst us there are many who will play no small part in the furtherance of these objects and in the service of Your Majesties in all parts of your Empire.

"God Save the King!"

Within the hour a telegram in reply was received from the Palace:

"7.16 p.m. Buckingham Palace.

"To the Students of St. Bartholomew's Hospital.

"The King and Queen are much gratified to receive your message of congratulations on the occasion of their Majesties' Coronation. I am desired to express their warm thanks to all who joined in these good wishes.

"Private Secretary."

As we write the news reaches us that H.R.H. the Duke of Gloucester has graciously expressed his pleasure and willingness to become President of the Hospital, and in July Her Majesty Queen Mary is to honour us with a visit for the purpose of opening the new King George V Building.

So 1937 becomes a year in which the Hospital is bound even more closely to our Royal Family by those links of affection, loyalty and association which have proved so potent and so honourable a bondage in the past.

Our Prize Competition

Following an excellent response the judging of the competition took place on Thursday, April 27th. After careful consideration the following were considered safe for publication:—

* Highly Commended

A randy young girl had ascites,
Too great for her brief sexy nighties;
The "Docs" did a tap,
But something tapped back,
And twins were her bedtime delight fees.
Dr. Hughes.

* Promising Material

A distinguished amateur wine maker,
Acquired some yeast from a baker,
But his old secret process,
Caused Actinomycosis,
And trade for the town's undertaker.
M. J. Goldsmith.

* Good Potential

If you have Diabetes in Ealing,
With polyuria that just leaves you reeling,
Then I'd recommend plenty
of Soluble Lente,
To relieve your poor throats, parched and peeling.

There was a young lady called Deliah,
Who suffered with Syringomyelia,
Though her Boyfriend did try,
She started to cry,
"It' no good, dear — I just didn't feel yer!"
D. Dymond and Annette Philips.

But the honour went to Dr. Hughes for his following contribution:—

* 1st Prize

A young man his work mates called Mary,
Had diabetes and worked in a dairy,
The job didn't suit,
So he went into fruit,
The original sugar plum fairy.

His prize of 25 new pence now awaits him in the *Journal* office.

The Editors.

PUBLIC HOUSES BY THE RIVER THAMES

A New Approach using the A-Z of London
R. U. M. Punch, Anne Judy
St. B.H. Journal, 1972, LXXVI, No. 6

Summary
A survey of Thames-side pubs is presented which involved the use of an A-Z street index and a systematic search of both banks. The survey was started close to Bart's and extended eastwards and westwards. Fifty pubs have been included in the present series, of which some 17 cases require no treatment, but the remainder should be thoroughly investigated and constantly reviewed.

Materials & Methods

The investigators were a second-year clinical student (who was resident in College Hall during the summer months, with decided alcoholic tendencies, a fair-sized overdraft/draught, and a hereditary gift for "Homing" on Bart's when all other cerebral centres were paralysed), and a Young Lady who was responsible for the clinical assessment of the Gin bottles, and whose experience in Public Health work was invaluable when the grading of "Powder Rooms" was undertaken.

As this study is still continuing, we would, of course, welcome any comments or suggestions on this Guide, particularly of cases that we might have missed, or if your judgment differs enormously from ours.

PUNCH'S GUIDE TO THAMESIDE PUBS

The Anchor, Bankside, S.E.1.
Courage
Cold Snacks & Grill
Car Park
Phone: 407 1577
Tube: London Bridge
Bus: 4, 17, 45, 63, 76, 95, 182.

This pub is probably well known to you. It is certainly well on the "Beaten Track" for the Summer Tourists, which is the one big problem. (You may even have your photo taken as the "Typical Britisher"!) My advice is, if there are three or more coaches there, go elsewhere.

Apart from that it's a nice pub, with around five bars (including one upstairs), and a sort of snugroom with a door on the corner. The decor is, of course, updated Ye Olde English with a touch of the "Nauticals" thrown in.

The beer is good. Best Bitter (A.P.A. — Alton Pale Ale) is 15p a pint and Director's (D.P.A.) is 17p, which is very good value. Otherwise it's Tavern Keg, Harp and Guinness. A Gin & Tonic sets you back 24p and comes in a tumbler.

The toilets are on the first floor (which involves going through another bar and that makes it hard to come downstairs again!) and these are quite good, with H. & C., and soap in both, although there was a curious absence of plugs in the Gents! Judy gave 8/10 to the Ladies saying that it lacked the soft loo paper and had a bit of a pong!

From the upstairs bar you may ascend to the dizzy heights of the Boswell Grill on the second floor. We didn't try this out because of shortage of cash, but it is presumably plush and probably commands an excellent view of the River.

Outside, as you probably know, there is a concrete platform across the road on the river bank itself, where you may take your drinks and sit. I have never seen tables, chairs or sun umbrellas here, which I have always thought a pity. There is also a curious outside Gents here, which is worth a visit just for the shock!

The car park is far too small but there is usually plenty of room in the road and under the arches. To get there, I usually cross Southwark Bridge and turn left, following Southwark Street almost as far as London Bridge and Thomas' Street (where Guy's is to be found). Here, turn sharp left into Stoney Street and left again into Park Street then just follow the one-way circuit and park anywhere you like. If you have one, remember to retract your car aerial.

The Angel, 101, Bermondsey Wall East, Bermondsey, S.E.16.
Courage
Snacks & Restaurant
No Car Park
Phone: 237 3608
Tube: Rotherhithe
Bus: 47, 70, 188.

This pub is built right on the river and has the reputation of having been a smugglers' haven in the past. It has been completely refurbished inside and has a slightly nautical flavour with the inevitable lamps, ship's wheel, old prints—even the bar front is clinker-built, and the barmen have funny uniforms with a white anchor badge!

In the evenings, it's all a little too brightly lit, and I must say I've never been really impressed with taped music. The heavy wooden tables have lots of brass studs all over their feet and these also appear in great profusion over the chairs.

However, in the early evening, it is really pleasant to venture outside on to the wooden verandah to watch the sun go down, read the paper and have a quiet pint.

Upstairs there is the restaurant, which really does have a splendid view and is entirely lit by candles. The food is a trifle on the expensive side (I could see myself eating my way through £7 with Judy, easily!) but it's probably worth it. Anyway, ask for the Menu when you are having a beer and see what you think.

Prices are the same as the Anchor; Director's—17p, Gin & Tonic—24p. The only other beers were Alton, Tavern and Harp. The Tomato Juices were *warm* which Judy thinks is a crime that too often goes unpunished. The Tonic, however, is chilled.

The service was good and the tables and ashtrays were always kept clean. Judy thought the ladies' was too small and had no soft loo paper, either. The Gents was pretty average.

There is no car park but there is usually more than enough room in the roads nearby. To get there; cross Tower Bridge and turn left into Tooley Street. This eventually leads into Jamaica Road. Go past the first set of lights for about a quarter to half-mile and take any left turn. If you come to a T-junction with Bermondsey Wall East, turn right and you will have an interesting drive until you *have* to turn right again, and here you park. However, if you find Rotherhithe Street itself, turn left but you will have to park some way from the pub as there is only a footpath and a small public park between these two roads.

The Mayflower, 117, Rotherhithe Street, S.E.16.
Charrington's
Snacks & Restaurant
No Car Park
Phone: 237 1898
Tube: Rotherhithe
Bus: 47, 70, 188.

This is one of my favourite pubs, not just in London but anywhere. The great thing is that it hasn't received the "Two Luvli Red Doors" Treatment and (as yet) hasn't got one of those silly black plastic illuminated name signs which Charrington pubs usually have. Full marks to the brewers for keeping their eager hands off this charming building! Inside, the walls are cream with an ageing brown tinge, and the floorboards are practically bare. I can almost hear the promotion men saying, "Blimey, if they tarted this place up a bit, it could make an absolute *BOMB!*" I think London has got its Prospect of Whitby and it shouldn't need another lesson.

There are two bars with no special draught beers except that the Charrington's Bitter is poured with a hand pump and only costs you 16p. Here, at last, the Tomato Juice is cold and your Lea & Perrins is dripped into the glass before the Juice is added, thus making all forms of stirrer (mechanical or otherwise), completely superfluous.

The snacks are quite good especially the Scotch Eggs. I remember the expression on the face of a Hungarian research virologist, whom I had brought here for his first taste of a traditional English pub lunch. It transformed from suspicion and apprehension to relish at the first bite AND he had a *pint* at the second opportunity!

There is a rumour that the Mayflower's voyage really started here and *then* went to Plymouth, and there are models and bits and pieces on the walls of that age but I still don't know if it is actually true. It also happens to be the only London pub that is legally allowed to sell postage stamps.

I must admit that by the time I get here, I've usually had a few beers and feel like having a cigar and I am always disappointed by the poor selection. They only have two breeds of Henri Winterman's; the long thin Panatellas and the short little ones in boxes of five. I haven't really noticed, but I think the selection of fags is much better.

There is a wooden verandah built on wooden piles sticking out into the river. From here you can actually see the lights of the "Prospect" and just think of all those fun-loving people huddled together and the fights to get to the bar, etc.

To get there, follow Jamaica Road eastwards until you are forced into the one-way circuit going to your left, then into St. Mary's Church Street, *across* the crossroads and the first left should lead into Rotherhithe Street itself, and park near the church. The area is not as tough as it looks!

The Trafalgar, Park Row, Greenwich, S.E.10.
Watney
Snacks & 2 Restaurants
No Car Park
Phone: 858 2437
Rail: Greenwich or Maze Hill (from London Bridge)
Bus: 108b, 171a, 177, 180, 185.

Park Row passes down the east side of the Royal Naval College and at the end on the right is a rather imposing building looking more like the Admiral's House than anything else and inappropriately receiving the title of the Trafalgar *TAVERN*!

The Trafalgar is mostly famous for its restaurants, one downstairs and the other upstairs. They do the full gamut of French Cuisine and then (separately) the full range of English fare. I think it is rather expensive but it seems to be doing good business.

The bar is simple and more the sort of place where you would partake of a White Port just before going into Dinner than a beer (Special or Red). The seating is plush and there are a few model ships strewn about and at least five "Naval Types" propped up against the bar.

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

BARGAIN HAYDN

London must have been just as influential a music centre in the 1790s as it is now. The Big Attraction was the Salomon Concert seasons held at the Hanover Square rooms. Haydn was the composer in chief and also conducted these concerts from the keyboard. Salomon was a world famous violinist who became a concert agent and he had persuaded the 52-year-old composer to come to London in 1790. It was whilst here he composed his most famous 12 symphonies (No. 93 to No. 104) for these concerts. Haydn went back to Vienna in 1798 and over the next ten years of his life, he lived attached as court composer to Count Esterharzy — in this Indian Summer of his life he produced his last six masses and also the oratorio "The Seasons", all these works of extraordinary high quality. He probably did more to establish symphonic form with his 104 symphonies than any other composer — he also wrote no fewer than 103 string quartets. Mozart was so impressed by what he heard of these that he dedicated six of his mature quartets to "papa" Haydn. Haydn wrote 27 piano trios which sometimes contained transcriptions of movements out of the symphonies. His concerto output is smaller but there is a marvellous 'cello concerto in D and a sinfonia concertante to rival the Mozart one for wind. The operatic output it vast and, to this author at least, unexplored —one awaits a Covent Garden or Coliseum production of Orfeo by Haydn.

The record industry is gradually beginning to do justice to the exceptional range of Haydn's music. Decca is in the process of recording all 104 symphonies (plus a few more they have found to make 112). They have put out some 40 of the symphonies in cheap box sets in glowing performances given by the Philharmonia Hungarica conducted by Antal Dorati the present box consists of 6 records (No. 82-92 and the Symphonia Concertante) and is exceptional value for £6.20 for brand new recordings. After an initial six months offer, this set becomes 25 per cent more expensive. Two other fine bargain symphonic recommendations are of No. 93 and 94 ("the Surprise") played with fine precision and with emphasis on the inherent humour by the Cleveland Orchestra under Szell and well recorded by CBS (CBS 61052 at £1.35). Szell uses the latest Robbins-Landon versions of the scores: Professor Robbins Landon has gone back to the original manuscripts in order to alter the existing scores with considerable effect — he has reintroduced the high horn sounds of Haydn's day and where necessary introduced the concertante element. Sir Thomas Beecham whilst no great respector of the academics, used the old scores: his readings of No. 94 and No. 96 have the merit of being beautifully proportional even if the rallentandi at the end of movements ultimately becomes distracting. The recordings are good if mono (HMV HQM 1148 at £1.35) — there was a stereo set of 99-104 which EMI must surely reissue in their Legacy series.

The masses contain much of the great Haydn inspiration — the "Harmoniemesses" is arguably the best but is only available in the excellent Argo recording at full price (ZRG 515). The "Paukenmasse" is an exceptionally beautiful work also with the glorious solo 'cello line of the "et Crucifixus" — a very cheap recording is available but is not particularly well recorded with very fast tempi (on Turnabout TV 341385 at 99p) — there is a full price Kings College recording that is probably worth saving the extra for (HMV ASD 2303).

The chamber music has had rather scant regard on record — the full price Amadeus Quartet recordings of the op. 76 and op. 77 Quartets are very fine. A fine record of the Janacek Quartet is superb value at £1.40 on Decca (SDD 285) because of the superb style of this Quartet with exceptionally well balanced recording so that the viola line is truly audible. They couple the op. 3 no. 5 (Joke), op. 33 no. 2 (Serenade) and op. 76 no. 2 (Fifths) — a generous record and an excellent example of the range of this great composer's music.

Sadly none of the cheap records of the oratorios are recommendable. Even as great a conductor as Horenstein was unable to do justice to the Creation in his recording — I have reassessed this again hopefully for this review but am reinforced in my view that it is worth paying either for Karajan on DGG, or Munchinger on Decca at full price, the latter just winning for me (SET 362-363).

ALLEGRO.

RETIREMENT OF MISS VIOLET CLIFTON

ALL PAST MEMBERS OF THE "HOUSE" who have lived in R.S.Q. will remember Violet - she came to Barts in 1928 and has been the head housemaid in the Resident Staff Quarters for many years. She is retiring on 30 June, 1972, and I am trying to contact as many past residents as possible to ask for a contribution towards a farewell gift.

If you have lived in R.S.Q. and would wish to join in this gesture of appreciation, please send your contribution to me by the end of this present month (a maximum of £1.00 is suggested).

Mark Britton,
Senior Resident,
R.S.Q.,
St Bartholomew's Hospital, E.C.1.

PERSONAL VIEW
People, Society, Medicine and Ethics

by Dr. J. A. MACFARLANE

Every Paediatrician has, at some time, to make a decision as to whether or not to resuscitate a neonate with multiple abnormalities, and I have attempted below to set out some of the conflicts which surround this problem, though it is realised that there is no problem so complicated that cannot be made to seem more complicated by looking at it another way.

Ethics is the science of morals—and morals are "pertaining to the distinction between right and wrong or good and evil, in relation to actions". However, although there are personal ethics, social ethics, medical ethics and many others there is no absolute ethical standard that is common to all groups all of the time.

In New Guinea, the problem was solved in a direct way until the missionaries arrived there recently—no deformed children or twins were found in the tribes, the reason being that the mothers themselves strangled the child at birth. When asked why, the mother would reply "we don't want them to live like pigs". In Russia, handicapped children are institutionalised: the idea that the parents should have to take on the burden of the child for life is unthinkable. In Europe and America the decision is usually left to the individual doctor. Many would argue that the doctor is not well equipped to make the choice, for though he may understand the medical implications all too well, his training is far from ideal in aiding an understanding of all the future social implications. However, whichever way one argues, the decision through circumstance lies nonetheless with the doctor.

The options would seem to be:

1. To take an active step so that the child should not live.
2. To take no active step to keep the child alive.
3. To take minimal action, such as feeding the child and keeping it warm.
4. To take active medical or surgical action, such as closing a meningomyelocoele or operating on some other gross deformity more from esthetic reasons than as a life-saving process.
5. To attempt to keep the child alive "at any cost".

The first course of action of these five is undoubtedly the one about which anyone would have most reserve. Nevertheless 85,000 abortions a year are now carried out in this country and a very large number of these are on social grounds alone. At the moment our society draws a line between terminating the life of a 20-week old foetus and terminating the life of a 40-week old foetus, although, on medical grounds, there may be far better indications for termination at 40 weeks' gestation than most of the terminations carried out at 20 weeks. A mother contracting rubella in the first trimester of pregnancy has a 20 per cent. chance of having an affected offspring—this is considered an adequate reason for termination, although one may be terminating the life of 5 normal foetus for every 1 that may be affected. A child born at 40 weeks' gestation with a meningomyelocoele has only a 1 per cent. chance of growing up to be completely normal (Lorber [3]). If we could pick up meningomyelocoeles at 16 weeks' of pregnancy would not that pregnancy be considered for termination? and yet when the child reaches 40 weeks' of gestation there is a tendency to do everything within our power to preserve the baby's life.

Looking at it another way; out of 1,000 conceptions up to 150 will end in spontaneous abortion before the end of the first month (most of these because of gross abnormalities). Of the remaining 850 conceptuses, another 150 will end in a miscarriage before the end of the seventh month, the majority of these will also have abnormalities. At term some 2 per cent. of children will be still-born and a further 4 per cent. have some gross defect. 0.3 per cent. of live births in this country have spina bifida—amounting to about 3,000 new cases a year. As Slater [1] puts it: "Perhaps . . . the spina bifida baby is a mistake of nature not equipped to survive. Who suffers if he dies at birth? Certainly not the child, though if he is forced to survive he faces years of suffering. Do the parents suffer if he dies? Yes, in the disappointment of not having a baby when they had hoped for a normal little boy or girl; but in a few months they can try again. If the child survives, however, they have years of servitude, of tortured love, trying to make up to him for all his disadvantages. And society, the community? The death costs nothing; the life costs not only money but the pre-emption of precious medical, nursing, social and educational resources." He also says in the same article: "But if Britain were to provide special schools for every spina bifida child who is not being salvaged, Leach [2] estimated that it would have to build one with 50 places and staff it with about 10 skilled people, each and every month for the next 15 years."

Taking medical ethics alone, decisions of this kind are obviously easier the more knowledge there is available. For instance, it is known that all children with Tay Sachs disease are mentally retarded and that they die in early childhood. The decision, once the diagnosis has been made, not to resuscitate the child is not the same as the instance of spina bifida where one child out of a hundred may grow up to be normal. One then has the computation—is there justification in keeping 99 handicapped children alive to allow one normal case to live, or allowing one normal child who could grow up to a normal life to die in order that 99 should not suffer a life of handicap.

Many would argue that if one allows this kind of computation where does it stop? Would we start allowing babies whose I.Q. might be only 97 instead of 103 to die? Who else starts to make the selection? What other criteria should we introduce? Doesn't the smell of Naziism creep in here? However, these kind of decisions are already being made in medicine. For instance with kidney machines where supply cannot meet demand, practical decisions on the basis of many factors, which include finance, marital status, age, etc., all have to be taken into account. Surely the same decisions should be taken in the case of spina bifida unless our society can ensure the finance for all possible facilities for these children throughout life.

What other alternatives might there be? Perhaps to get the mother to sign a form early in pregnancy saying that if the child was grossly deformed no active step would be taken to keep it alive (this may be possible in the future as society's attitudes change, hopefully with doctors making more information available to people in general—a continuing demystification), or by having a communal, democratic vote among all those present, thus at least sharing the responsibility. However, owing to circumstances of time, in many cases this would not be feasible. A further way is to discuss the problem with the mother and father of the child and, obviously here, the way the doctor presents the case to the parents will much influence their decision. This method is incidentally much practised in Africa, where the midwife and the father of the child make the decision. In all these the paediatrician still plays a central role and will have to take into account as much knowledge (perhaps the majority of it not directly medical) as is available to him, for instance, is the mother of an 18-year-old unmarried girl who doesn't want the child anyhow, or a 38-year-old primagravida wife of a solicitor.

In America, in order to help out in these dilemmas, a working party at the First National House Staff Conference held in St. Louis in March 1971 came up with the following suggestions:

1. The primary ethical consideration of the physician is to his integrity as a person; implicit herein is his responsibility to his patients. In this context, the patient has the right to be informed and participate in decisions affecting his care and well-being.
2. The physician's role in society is to attend to the health and well-being of its members and to maintain and improve the quality of their lives. In this role, he must not only treat disease but also act to prevent its dissemination and/or perpetuation by biological or social forces.
3. The physician's obligation to his profession and professional organisations is best served by fulfilling his obligations to himself and society.

John Graef [4] who led the working party later wrote: "In retrospect I think it was the common experience of 'dehumanisation' in medical training that led us to suggest that the strongest ethic possible for a physician is his integrity as a person. It has been our bitter experience that nothing in our training equipped us to grow as people; that it has been a constant struggle to maintain our sense of humanity in the face of increasing erosion by technology, cut-throat competition encouraged by the system and sheer exhaustion. Again and again we returned to the thought that a mature and responsible person who is also a physician can live with the uncertainties and ambiguities of ethical dilemmas. It is a measure of our loss of identity as people that we should require codes to understand our role as physicians."

This is an American view, but I do not think the situation is different in England. The individual doctor has to make a personal decision, but he should make sure that he is maximaly equipped with not only the latest medical knowledge, but also knowledge of himself, the people he lives with and the society he lives in.

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[2] Leach, G. The Biocrats. London Cape 1970.
[3] Lorber—Results of Treatment of Myelomeningocoele. Develop. Med. Child Neurol. 1971 13 279-303.
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BARTS ART EXHIBITION

This year's Art Exhibition, held in the Great Hall, was opened on Tuesday, April 25th, by Sir John Betjeman, and ran until the following Thursday. It was opened on a pleasant afternoon with Spring quite definitely in evidence for once, and for all those who had in some way contributed to the exhibition there was a glass of wine to help them meander gently through the feast of paintings on display. In many ways this exhibition was much more satisfying to amble through than so many other amateur art exhibitions. It was held in opulent and well-lighted surroundings, as opposed to the usual dismal and clinical Red Cross Hut; and there was no obvious division between the professional canvases and the amateur efforts, no cramming of the also-rans into a dark corner. Furthermore, recognition of an artist you actually knew made many otherwise unextraordinary paintings both more interesting and revealing.

It was obvious that most exhibits had been painted for purely personal satisfaction, and were in no way attempting to impress the casual viewer who passed by with a critical eye. However, I was disappointed to see that those who had very largely mastered the basic techniques of painting showed such comparative lack of imagination in their subject-matter. As a whole the best paintings were watercolours. M. J. Simmons' sketches from the Hobbit were beautifully detailed, his use of tone absolutely correct, and his scenes of the little people fascinating and alive. Bernadette Ash

Sister Stanner and Miss Beth Jukes
Sculpture: "Duncan" by Beth Jukes.

Sir John Betjeman.

typified the artist who succeeded with watercolour, and yet failed with oils; in Grey Mist and Sunrise at Tower-bridge her pastel colouring admirably expressed the tranquillity of her subject, yet her Bart's fountain fell completely flat, Peter Cull's paintings were superb illustrations which did not pretend to be anything more. I would have enjoyed fishing for his perch. There were two paintings by J. Malpas which were characteristically exact, and meticulous. The second of these, "South Coast Road" seemed to have captured perfectly the daylight stabbing through the shimmering leaves of those tall green trees enshrouding the murky road below. If only it had been larger! Two competent oils came from Mike Dunwell, of which the "Chestnut Tree" evocatively beckoned the viewer much further than the intertwined branches suggested, and Jennifer Angell-James' paintings had a sad introspective quality that tugged at the viewer in a manner her basic technique could never have done. There were, of course, abundant floral arrangements, of which Shirley Foulds' was the best example, though perhaps a trifle highly priced at £35, and there were the humourous exhibits, of which John Pembrey's "Snoopy" and Bruce Noble's "With Apologies to Beatrix Potter' must have drawn several wry medical smiles. R. Littlewood presented a series of nudes of which we were only able to see nos. 4, 7, 8 and two others as yet unnumbered. I am not sure how fortunate or unfortunate this is, but I am certain that I could have done without "Fruit and a Jar", a

Dr. Angell-James and self-portrait.

polystyrene still-life, which, with all respect to its creator, I completely failed to appreciate. There were, in fact, few sculptures, but Nadia and Duncan by Beth Jukes were really excellent bronzes. Nadia in particular looked and felt a tired old woman, really scarred by her age. I am sure that Epstein would not have been displeased, and to my mind this was one of the best exhibits on display. Finally, at the end of the exhibition, there was a vivid painting by S. M. Arbab entitled "Afghan Horsemen", who are galloping along at a fine old pace. I could not quite understand why they were all looking to their right, towards, in fact, the Parthan Tribesman in the adjacent frame. However, I have a suspicion that he had been standing guard over the wine, which was present when the exhibition opened. Perhaps, like myself, they were smiling as they reflected on some of the pleasures they had already enjoyed.

M. C. WHITE.

BARTS SPORT

BART'S SKI CLUB
'71-72 SEASON

At the time of writing this, Thursday, April 27th, the Bart's snow skiers are just about to set out for the final fixture of this season. This is the John Player Highland Pentathlon where the participants are required not only to ski a giant slalom but to run (2,000 metres), swim (100 metres), shoot (10 rounds, .22 rifle) and put 10 stones in target curling—a technique entirely new to at least one member of the team.

This latest trip to the Scottish Highlands comes less than 2 weeks since the three Bart's members of the London University ski team returned from the British University Ski Championships with silver medals in their pockets. London's second position ahead of six strong Scottish University rivals before the next English university appeared on the result list is no mean achievement. In particular this was a success when one considers that the only team to beat them, Edinburgh consisted of an ex-Austrian junior champion, a Swiss university team member and a highly experienced Norwegian ski racer.

Again this year the inter collegiate ski race fixed for March 5th could not be run because of adverse conditions. There was not a lack of snow however this time but an 80 m.p.h. blizzard that prevented the race from taking place. It was felt by some of the Thomas' team that they should have been awarded the cup in recognition of the fact that three of their team members had struggled up the mountain in the teeth of the gale to only two from Bart's and U.C.H. Next year the cynic on Scottish ski-ing would claim we are due for a thick mist to cancel the race but we live in hope.

Individual successes this year have been achieved by Nigel Findlay-Shirras and Christopher Trower. Nigel was chosen to represent British Universities in the annual Anglo-Swiss universities race in St. Moritz, the third successive Bart's man to achieve this honour in the last three years which for a small college of 600 shows a remarkably high standard. Many thanks to the dean, may he keep the good work up! Nigel in fact had the best combined individual time of the British team.

Christopher on the other hand had his first real taste of Service life when he spent 5 weeks this winter captaining the R.A.F. ski team in Livigro. For the first time in many years the R.A.F. did not land up third in the inter Services competition but achieved a notable victory over the Royal Navy. Christopher was placed 10th in the N.A.T.O. championship, 3rd best Briton in a competition that included not only the British Services

but also teams from Italy, Germany and the United States. He also became Service Colleges and R.A.F. champion.

Ski-ing does not stop now until next winter but continues immediately with grass ski-ing, the highlight of this summer's events being the Europa Cup race at Petersfield in Hampshire on Sunday August 27th. Several Bart's skiers will no doubt be taking part.

CAVING CLUB REPORT

The Caving Club has now materialised and two trips have been made to the Mendips.

The first was made in the last weekend of February. A party of six stayed at the Cerberus Spelaeological Society's cottage near Oakhill for two days.

The cottage is next to a large and active quarry containing several cave systems. The party visited Shatter Cave—one of the largest and most impressively decorated caves in the quarry; its name is derived from the shattered state of the rock in the deeper parts of the cave (possibly due to glacial action). For some of the party this was their first time underground (i.e. unaccompanied by guides, floodlights, concrete paths and stalactites, etc.).

We left the caves to be assailed by sub-zero temperatures (in the caves the temperature is usually constant ± 50°F). The rest of the evening was spent in the local pub, devising ways and means of keeping warm (including an exploration of disused chimneys in the bar).

The next day the same intrepid explorers set out for Priddy Green to descend Swildon's Hole, the longest (4 miles) and deepest cave on the Mendips. This trip was a contrast to Shatter Cave giving the party some excercise and experience of water in plenty—one obstacle is aptly named the Lavatory Pan. We emerged to be greeted by a heavy frost which proved far more effective than aerosol laquer on our damp clothes and hair.

The second trip consisted of six again, one member of the party was joined at Taunton where he was on an obstretrics course. The party stayed at Dr. Glanvill's house in Chard in relative luxury and faced the rigours of Swildon's Hole again on the Saturday.

This time the party went down to Sump 1, 400feet underground—this involves climbing several cascades and one wet 20 foot drop on a flexible wire ladder.

The photograph in this item was taken on this trip. Ian Weller is seen climbing the larger of the famous Double Pots. These are two potholes filling the passage and containing quite deep pools. One traverses round the edge of them.

The following day we visited a small system about four miles from Taunton known as Holwell Cavern. Although small it is an extremely strenuous cave consisting of a complex maze of tiny interconnecting passages. The main chamber is filled with massive clusters of aragonite crystals.

We were accompanied on this trip by a senior house officer in the Obstetrics Department at Musgrove Park. He decided that extricating oneself from tunnels such as the "Bunghole" was eminently comparable to the second stage of labour.

We have been forwarded a small grant by the Students' Union. I hope that enthusiasm will keep at its present pitch so more ambitious trips can be made. I hope to arrange a Welsh trip before the summer is out.

On April 21st another trip was made to Eastern Mendip to stay at the Cerberus Cottage near Fairy Cave Quarry. Eight of us were in the party and everybody was persuaded to enter a cave (although for varying distances).

The weather was rather warmer than that for our last stay at the cottage which made emerging after a trip less of a chilly experience.

Shatter Cave, the main system is about a quarter mile long and beautifully decorated with stalactite formations and crystalline pools. Recently a new and larger system has been discovered nearby overtaking Shatter in length and rivalling it in its beauty. These two systems make any cave accessible to the public look tawdry; there is a fierce argument raging over the desirability of turning them into show caves.

Peter Glanvill on the Sunday was persuaded against his better judgment to explore a section of the new system. It had only recently been full of water, and consisted of 50 yards of crawling in glutinous mud. That's caving!

BOOK REVIEWS

INTRAUTERINE DEVICES

Clive Wood. First Edition. 151 pp. £1.00. Butterworth Group.

Twenty-five years ago a few older doctors, brought up on Graefenberg rings and stem pessaries may have thought any contraceptive method involved putting something, somewhere, to stay. Particularly as medical schools were so shy of even mentioning the word "contraception".

This is no longer true and the past few years have seen a great deal of dissemination of information to the general public and to postgraduates. There remains much prejudice against I.U.D.s but it seems true to say that familiarity breeds confidence rather than contempt.

Dr. Wood's book puts this across pretty well even though he tries to include rather too wide a range of readers. The message is that there is the ideal customer and also the client for whom no other method will be effective. The delay in publication has not noticeably made the information out of date, although some devices are less often used and others are still gaining popularity. The contraindications will remain true—pregnancy, pelvic infection, metrorrhagia and a seriously distorted uterine cavity.

The chapter on insertion is first-class although I would suggest that the doctor who uses a gentle levering action with sound or introducer is not likely to perforate the uterus, and, with a very mobile postpartum uterus, one need not be afraid to put on a volsellum at about 2 o'clock of the cervix.

Dr. Wood steers his way through the choppy waters of mode of action of I.U.D.s with very great skill. It does not always sound as convincing in my own ears when facing a patient about to have one put in.

In spite of the glossary I do not think it is really a book for lay readers, more for those who might be persuaded to learn to use I.U.D.s.

C. J. GLANVILL.

DO-IT-YOURSELF REVISION FOR NURSES
Books 5 and 6.

E. J. Hall and B. J. Isaacs. 60p. Bailliere Tindall. 1972.

Those already familiar with the earlier books 1-4 will welcome the addition of these two to complete the series. These deal with the more specialised aspects of nursing.

Book 5—Contents include the new subjects of Accidents, Metabolic Disorders, Radiotherapy and extra questions on Reproductive System, Alimentary tract and ward teaching.

Book 6—Contains questions on Psychiatry, Drugs, Outpatients' Department and extra material dealing with the Skeletal and Nervous Systems and the duties of a Staff Nurse.

As these are meant to be systematic study guides it is hoped that when reprinting the series the questions on systems will be regrouped so that they come together. The authors know full well the needs of the nurse and supply these admirably. The questions on ward teaching should prove especially valuable. Nurses find this type of answer difficult to word correctly and will find this section very helpful.

Some girls find the number of marks given to basic nursing care surprising. But, as nurses in general and Bart's nurses in particular are poor at stating what, to them, is obvious—attention to the marking system should be a useful eye-opener.

In the foreword the authors acknowledge that the answers are their interpretation only and are bound to cause comment. However, I've only one real criticism to offer and that is re the question on hypothermia (page 87 book 5).

Only one use of hypothermia is given for 20 per cent. of marks. I think use in head injuries, subarachnoid haemorrhage, ischaemia of limbs and preservation of tissues (outside the body) could also have been included.

Although used mainly by nurses for examination purposes these books are also useful for revision of a subject after having lectures on the same. It is important to remember that the points given to revise are only for the particular question dealt with and are not meant to be a complete review of the subject.

I know that the many understaffed Tutorial Departments will also welcome these additional books as it reduces the number of nurses' questions they have to mark and so allows more time to be spent on other aspects of their work.

In this day and age one is not surprised to note the price increase from 50p (for the earlier books of this series) to 60p for these two. However, unlike many other price rises, here one is getting real value for one's money, and I have no hesitation in recommending the books.

C. W. LAWTON.

A GENERAL TEXTBOOK OF NURSING

Evelyn Pearce. 18th Edition. £3.00. Faber. 1971.

This textbook has been a favourite with nurses for a very long time and this edition should delight them still more. The sub-title states that it is a compendium of nursing knowledge and certainly all aspects of nursing care have been included. The general format of the book is similar to that of other editions but it has been revised and rewritten. The dust cover states that 38 distinguished contributors, specialists in their own field have written chapters on their own subjects, presenting the modern viewpoint. This has greatly added to the value of the book as a textbook for student and pupil nurses. Bart's nurses will be particularly pleased to read the chapter on Diseases of the Urinary System and Surgical Conditions of the Genito-Urinary Tract by J. E. A. Wickham.

The first chapters, as before, deal with basic nursing care. The whole is well illustrated by line drawings or very clear photographs and the system of cross reference is particularly well done.

Many nurses and others will be especially grateful for the approach used in the chapter on the needs of the dying patient with the very real understanding of the loneliness of this situation.

The subject of communicable diseases is well covered to include not only those that may be seen occasionally in this country but the rarer ones that the nurse may meet due to increased travel as well as brief notes on tropical diseases.

The policy of emphasising the important points by a change of type face is particularly helpful. This book could be recommended to all the nurses about to take their final examinations. It is easy to read, it covers the whole field and it is up to date.

H. COLLYER.

OBSERVATIONS IN MIDWIFERY

by Percival Willughby (1596-1685). Edited by Henry Blenkinsop. Introduced by John L. Thornton, F.L.A. Pp. xvii, 345. £3.50. S.R. Publishers Ltd., Wakefield. 1972.

In September 1642 Dr. William Harvey, finding himself at Nottingham while in attendance on King Charles, rode over one day to Derby to visit his friend Percival Willughby, a younger son of the distinguished family centered at Wollaton Hall, Nottinghamshire. Probably they were old friends, for Willughby had practised as a doctor since 1620. He was admitted as an Extra-Licentiate of the College of Physicians in 1641, but did not take any higher degree. His practice in Derbyshire was no doubt general, though he became specially interested in obstetrics and did his utmost to save the lives of mothers and infants by using the rational method of leaving things as far as possible to Nature. Harvey was a severe critic of the current practice among the roughly trained midwives of the period, who sought to advance the rewards of their pretended skill by totally unnecessary and frequently lethal interference during labour. Harvey's opinions were not published until 1651 in the last section of his book *De generatione animalium*, but they were certainly well known long before this among his colleagues, and Willughby was his fervent disciple. "I know none, but Dr. Harvey's directions and method, the which I wish all midwives to observe and follow, and oft to read over and over again; and in so doing they will better observe, understand and remember the sayings and doings of that most worthy, good and learned Dr. whose memory ought to be had for ever in great esteem with midwives and childbearing women."[5] This sentence occurs in Willughby's handbook of obstetrics written probably during the years 1660-70. His book, a small treatise of great

originality and value, was not printed in his life-time, circulating only in manuscript form, of which several versions are extant. Willughby called his book *Observations in Midwifery. The Countrey Midwifes Opusculum or Vade Mecum*. It is indeed a severely practical *vademecum*, relating a large number of actual experiences and how difficulties were overcome, frequently by exercising restraint, persuasion and gentleness. Sometimes it becomes anecdotal and humorous, though always with inculcation of sound principles in practice, and it is throughout an intensely interesting document in medical and sociological history.

One of the manuscripts, now preserved in the library of the Royal Society of Medicine, eventually crept into print in 1863 edited by a Bart's-trained surgeon, Henry Blenkinsop—"crept" is the right word, for it was published at Warwick in an edition of only 100 copies, not many of which were sold. The book has consequently been inaccessible except in a few medical libraries. The College Librarian, Mr. John L. Thornton, is therefore to be congratulated on having arranged for the production of an excellent photographic reprint of the scarce edition of 1863, an initiative which deserves to be supported. Mr. Thornton has contributed an interesting Introduction telling the story of Willughby and his book, incidentally revealing the fact that the work was translated into Dutch and printed at Leyden in 1754, an event which understandably failed to make it better known in this country.

GEOFFREY KEYNES.

Non-Medical

THE HOPE OF PROGRESS
P. B. Medawar. £2.00. Methuen.

Sir Peter Medawar is, of course, one of the greatest men of science of our time. His contributions to present day knowledge and thought have gone far beyond the confines of his own speciality; and despite winning the Nobel Prize in Medicine in 1960 for his work on immunology, it may well be that future generations will revere him as a Historian and Philosopher of science even more than as a practising scientist. This short and exquisite book may provide part of the explanation. It consists of a series of essays, lectures and critiques and it contains some of the most elegant scientific writing imaginable. What could be more disarming than the start of the first article:

"I hope I shall not be thought ungracious if I say at the outset that nothing on earth would induce me to attend the kind of lecture you may think I am about to give."

To describe the general tone of these pieces as "scholarly" is an enormous understatement, but we do not have another, stronger word. Medawar's dexterity with the classics of scientific literature is remarkable as is his capacity for putting things in their rightful place—see, for example, the essay on "Animal Experiments in a Research Institute" (not a very promising title, I'll grant you). His skill in presenting the work of others is apparent in "Lucky Jim"—a critique of James Watson's famous account of the discovery of DNA. But above all, it is his incurable optimism—"the effecting of all things possible"—that one feels most on closing the book for the last time. Medawar at no point denies the difficulty of finding solutions to problems such as populations, pollution and genetic imperfections: but he insists that technological solutions must be found for problems largely created by the technological society. One is left with the impression that the essential Medawar is a practical not a ruminative man, and like a friend of Dr. Johnson whom Boswell quotes:

"He had tried in his time to be a philosopher, but had failed because cheerfulness was always breaking in."

J. S. TOBIAS.

Film Review

"The Hospital" starring George C. Scott and Diana Rigg

It starts with the houseman finding himself with a spare bed for the night owing to his misdiagnosis earlier in the day. He contacts his girl and they enjoy themselves "zapping" (a new one to the list?) knowing that they will not be disturbed because the only other patient in the ward is in a coma, and so the nursing staff will ignore him for the night. George C. Scott plays a suicidal physician with a ruined home life who is presented with this houseman's death on arriving at the hospital the following morning. The film then unfolds and deals with the subsequent 48 hours at the hospital when a few more mysterious deaths occur—all partly due to the incompetence of "The Hospital". Into this environment comes Diana Rigg, sadly miscast with her "Avengers'" accent as an ex-acidhead whose father came in for a check-up and now lies in a coma owing to further incompetence.

Negro demonstrators from a nearby ghetto, the "rape" of Diana by George and a "will he go away with her?" theme, provide further minor plots to the film, but essentially this is a film, as the title says, about a hospital. Someone dies from a digitalis overdose because nobody noticed him in casualty, and another victim (there is a murderer, but his weapon is "The Hospital") is left outside X-ray because that is the easiest place in the hospital to leave an unconscious body for 5 hours!

Medically the film is entirely plausible and authentic but the dialogue is possibly too medically orientated for a general audience to understand completely. It is entertaining, at times amusing, and is worth seeing, even if it may lose some of its impact by taking place across the Atlantic, but there again, it just could not happen here!

SELLU LLOYD.

SAINT BARTHOLOMEW'S HOSPITAL JOURNAL

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Editorial

One method of ensuring that medical students receive an appropriate amount of education is to have some form of recording the names of people who do not attend teaching and then threaten them with not being "signed-up" unless they attend in the future. This form of pressure is applied to students in most branches of pre-clinical and clinical training to a greater or lesser degree. At its best it means that a friendly enquiry is occasionally made about a colleague's whereabouts; at its worst students complain that they are obliged to remain with minimal time off, in an obstetrics department performing only a handful of deliveries, in order to be signed up. Between these extremes lies the majority of teaching courses, yet for all the courses, no matter what method of ensuring attendance is used, there always seems to be approximately the same number of students present, and while stiffer methods do not increase the numbers consistently, they may arouse the antagonism of those who are good attenders. Those who are going to stay away will do so regardless of the means used to encourage attendance, the only difference being that the excuse used on their next appearance is more elaborate.

By the end of the first pre-clinical or first clinical year most students have managed to discern what teaching is useful to them, what is not, and what is expected of them. Moreover, clinical students sometimes have a choice of tuition but unfortunately their selection may not be made on the grounds of good teaching value. Faced with the choice of a good lecture coinciding with a poor ward round where attendance is obligatory, students may well be inclined to attend the latter. One could also include in this choice the audio-visual teaching department, the library and the museum, where an hour well spent is worth more than several hours of mediocre teaching, not that such a choice has to be made very often because the teaching here is on the whole good, but if it is made it should be done without fear of recriminations, mild though they may be. The present system allows poor teaching to continue since our teachers can not tell whether we are attending because we want to or because we have to, so they are justified in not altering their methods. If attendance were related to teaching ability some of our teachers would have an unexpected shock, but others may be pleasantly surprised. One danger of an entirely liberal system of attendance is that some students may never attend and may employ their time in some financially worthwhile occupation. This could be avoided if more frequent internal examinations were used to ensure that the work had been done, but the choice of the teaching attended could still be left to the student.

No teaching system can ever be perfect, but for those willing to learn, non-compulsory attendance should be entirely feasible.

LETTERS

PERSONAL VIEW

95 Harley Street.
May 15th, 1972.

Dear Editor,

I would like to make a few points regarding Dr. MacFarlane's article in last month's journal.

The author cites five options for a doctor when faced with a deformed or defective child at birth. "To take no active step to keep the child alive" and the third is "to take minimal action, such as feeding the child and keeping it warm". I simply cannot see the logic in feeding a child when you are hoping it will die by withholding medical treatment. This illustrates a lack of courage and a lack of conviction, but I know how difficult it is to make the decision not to feed a child. The fifth option implies that perhaps some of us adopt this, but I am sure that with those in this country dealing with spina bifida babies at birth is not what they are attempting to do. Our request for the children to be referred as soon after birth as possible is in order that we may, with our surgical knowledge and particularly with the knowledge of the older child, make a decision as to whether surgery will help preservation of this child's function.

Last week I saw a boy I have known since he was eight and who did not have his spinal mass removed. He was not excepted to live, and spent at least six years in a long-stay geriatric hospital as a child. Following this he was transferred to more active surroundings, and ultimately had one kidney removed, and an ileal loop diversion, went through a very satisfactory schooling and is now employed in a full-time post. His latest trouble is a leak of cerebro-spinal fluid which soaks his clothing twice a day. This chap is happy and never grumbles about anything. He is one who might have fallen into the category of expected to die. As a result of this mistake in the interpretation of his disease, he has carried through life a great many burdens which he need not have had if he had been treated early. The author quotes from Slater, "the child is forced to survive; if he survives he faces years of suffering". This is simply not true. It is based on utter and entire ignorance. Many of our students and colleagues who have been to Coney Hill School or Chailey Heritage, may themselves have been disturbed to see the state of the children, but they will not find misery or suffering or discontent. The parents suffer—no one could deny. (With years of experience, I would say that parental suffering is much greater when the child's disorder is *delinquency* over which they seem to have no control.) Slater then makes an exaggerated statement which the author again quotes, "the provision for schools which would have to be made if every one spina bifida child were salvaged". Of course, this is utterly impossible, and none of us would claim that 100% can survive. On the other hand, it is equally ridiculous to say that only one in a hundred is normal. What is normal? At least 50% of those who come for operation have a good degree of physical activity, a fairly normal education and can become entirely independent. Many of them marry. Professional decisions in this field are no more difficult than they are in many other fields, particularly those in extended treatment for malignant disease. It is invidious to make comparisons. The ultimate outlook for health and survival—at least 75% of the children survive the first week of life with spina bifida—is far better than children with thalassaemia or leukaemia. It is perhaps significant that I came into this field of dealing with the neonatal spine and hydrocephalus because I had previously been involved in the salvage which had been necessary for many children who had been denied vigorous and complete treatment from birth. We would all like a rule book telling us exactly what to do when faced with an awkward decision. There are times when the most enthusiastic and compassionate doctor would like to be freed from his burden of responsibility. Nevertheless, our civilization has not yet reached the point, and it never can, when to cull uneconomic citizens would be tolerated. I have previously commented that we must not introduce the provisions of the Abortion Act into the neonatal surgery. Parents at this stage are in no state to make a decision themselves.

Perhaps all this needs saying, although anyone who has worked on my Firm has probably heard me say it already! The article does present some slightly distorted facts, serving to lessen the excellence of its presentation.

Yours sincerely,
DENIS ELLISON NASH.

ADVICE?

University Hospital of Wales,
Cardiff Royal Infirmary.
May 14th, 1972.

Sir,

I suspect that there is only one person that I could think of who would answer Dr. H. Wykeham Balme's ideal houseman, and he I believe has no registerable qualifications he answers to the name of J. Christ. Or did Doctor Wykeham Balme have his tongue in his cheek. I heartily endorse the first paragraph listed under General. (Vol. LXXVI, No. 5, May 1972.)

Yours sincerely,
LESTER COHEN.

DOGS AGAIN

"Montrose",
High Street,
Chipping Compden,
Glos.
May 27th, 1972.

Dear Editor,

I heartily agree with your excellent May editorial except that it is not only the evenings when dogs foul the pavements and parks, but all day as well, watched by their doting owners.

I keep a shovel and ashes always at the ready.

The licence should be increased to £5.

Yours sincerely,
J. T. ATKINS
(ex-Sister Heath Harrison).

ANNOUNCEMENTS

Births

On May 9th to Francis (née Gilbert) and Colin Williams, a daughter.

Deaths

LEDGER—On March 22nd, Colonel L. K. Ledger, C.I.E., O.B.E., M.R.C.S., L.R.C.P., I.M.S.(ret.). Qualified 1917.

ROBERTSON—On April 7th, Mr. I. M. Robertson, M.B., B.S., F.R.C.S.ED., D.L.O. Qualified 1927.

Engagement

The engagement is announced between Mr. S. W. Lee and Dr. M. R. Sumner.

Marriage

Peter and Dr. Maria Kaschner have announced their marriage, which took place on March 23rd, 1972.

HELP

1973 is the 850 Anniversary of St. Bartholomew's. Obviously, this auspicious occasion cannot be allowed to pass by without some sort of celebration. Consequently, as is customary on these occasions, a committee has been set up with Mr. Robinson in the chair.

It was thought that probably the best idea would be to revive the old Bart's Fair with everyone in appropriate costume, consultants in the stocks, jousting, etc., and add our own touches of some sort of pageant, perhaps some roundabouts and so on. May seems to be a good time for this event to take place and we hope that a whole week will be one of "happenings" starting with a ball and continuing with concerts, art exhibitions, son et lumière and anything else anyone can think of.

The news of this great event will be published far and wide and with a few well known celebrities and, with luck, royalty attending, there should be quite a crowd. As you can see, this will need a vast number of enthusiastic people with amazingly original ideas and a tremendous capacity for work of the Fair is to be a success.

This is where YOU come in.

This is a hospital event and as such anyone who is even vaguely concerned with Bart's will be needed to help. We wonder if each department would like to elect a representative and produce one original idea? However inadequate your ideas and help may seem to you we shall be overjoyed to hear them, for even though it is a year to go a lot of plans have to be made now, so get in touch as soon as possible. Even if you cannot think of anything but would like to help in a small way then please contact one of us.

We are:—

Mr. J. O. Robinson, (obtainable at Medical Staff Office.)
George Blackledge, College Hall
Janet Dinwiddie, W.S.C.R.
Jila Pezeshgi, W.S.C.R.
Richard Ashton, S.C.R.
Charles Wellingham, College Hall
Annabel Feroze-Din, Ext. 507.
Judy Weller, Glos. House 6-1.
Jill Taylor, Ext. 604.
Julie Wilson, Ext. 442.
John Parry, College Hall.

(Letters sent to the Editor of the *Journal* will be forwarded to one of the above.)

OBITUARIES

KENNETH DESMOND MOYNAGH

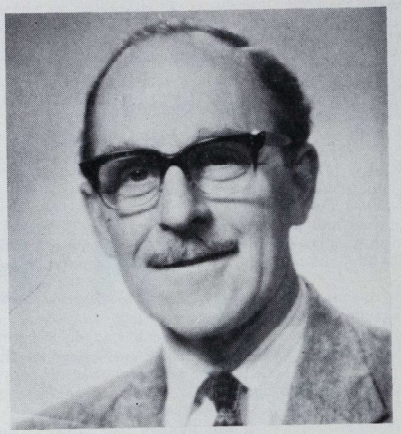
On April 15th, in the hospital he loved, Kenneth Desmond Moynagh passed peacefully from the arena in which he had so steadfastly displayed the great qualities of Christian discipline. Coming from Epsom College, he succeeded his brother Digby in the 1st Rugger XV in the mid 1930's and played consistently for the hospital until he qualified in 1939. After a resident post at Bristol he went with the R.A.M.C. to France, was involved in the Dunkirk evacuation and after a short spell in England was posted to West Africa. Subsequently he went with the West African forces to India. After demobilisation he returned to the United Kingdom and set out in pursuit of training for overseas service once again. His intention had for many years been missionary service in the country in which he was born and after obtaining the D.T.M. & H. he went to Kenya in 1947 serving in Mengo Hospital and at other places. From 1947 to 1964 he was in full-time medical missionary service in Ruanda where there had for 20 years been a succession of Bart's graduates. Rarely did he speak of his experience as a surgeon, but shortly before his death he was discussing with enthusiasm the problems of doing several gastro-enterostomies a week for months on end—a technical experience which many would have liked. The political situation in that country necessitated the Moynaghs' return to England, and Kenneth joined Dr. Coulson as Medical Officer to the nursing staff at this hospital. With the development of the City of London University came the need for a student medical service and Kenneth accepted the challenge of this, taking on the full responsibility for the development of the student medical service and subsequently assuming the full medical responsibility of "sick rooms" at Bart's. His tremendous understanding of individuals and their problems, his imperturbable nature, constant courtesy and ready sense of humour meant that wherever he went he was an outstanding friend and colleague to all.

In order to serve the City University and Bart's more adequately he decided to move into the City and had recently taken up residence in the Barbican. In a remarkable way he has carried on an unobtrusive, but very real Christian ministry in his professional work. In his desire to do more he became a lay-reader, taking an active part in the work of St. Helen's Church, Bishopsgate.

There are very many people at Bart's and among those who have left, whose problems have been lightened by the understanding of this beloved doctor whose wise counsel will be missed by both the medical and nursing student bodies and by the staff. Those who were very close to him during his final illness will carry the memory of a man whose compassion was never sentimental, but robust and reliable. We extend our sympathy to his wife Wendy and to the other members of the Moynagh family, three of whom are contemporary colleagues.

D.F.E.N.

THOMAS OLIPHANT McKANE



"You can always tell a Bart's man, but you can't tell him much."

Tom McKane, general practitioner, and a Bart's student, died suddenly at his home at Great Easton, Essex, on February 19th. He was 58.

All his adult life he was associated with Bart's, having started at the medical school in 1932. In his undergraduate years he joined in the sporting life of the hospital, being a leading member of the Bart's team in swimming and water polo from 1932-38, and Captain in 1934. He swam for the United Hospitals Swimming Team, the University of London Swimming Team, and the Otters Swimming Club Water Polo team. He was a good all-round athlete, being keen on running (quarter mile to cross country), football (Bart's first XI 1933-37) and ski-ing.

He qualified with both the Conjoint and London M.B. in 1937.

He became house surgeon to the Green Firm under Mr. R. S. Corbett and Mr. J. E. H. Roberts.

Anticipating events, he joined the R.A.M.C. on May 1st, 1939. He was one of the few doctors to have been evacuated from Dunkirk in 1940 and to re-enter France via the Normandy beaches in 1944, serving with distinction and becoming Deputy Assistant Director of Army Medical Services to the Guards Armoured Division in 1944. He finished his army service as a Trainee Surgeon at the 121st British General Hospital in Germany before coming back to Bart's as demonstrator in anatomy under Professor Hamilton, the department then being still evacuated to Cambridge.

1947 saw him back at Bart's as Chief Assistant to Mr. Rupert Corbett and Sir Geoffrey Keynes.

In 1948 he decided on a career in general practice and came to Dunmow to join a group practice, where his qualities soon became apparent not only with the high standard of his clinical judgment and medical practice, but also in his work for the profession. Education for General Practice became a strong interest. This took him back to Bart's as Advisor in General Practice from 1958 to 1963, as well as ensuring that he became a member of the British Post-Graduate Medical Federation, the Education Committee of the Council of the Royal College of General Practitioners, Provost of the Northern Home Counties Faculty of the Royal College of General Practitioners (1966-1969) and an elected Fellow of that College in 1970. From 1953 to 1955 he was Mid-Essex representative at the Annual Representative Meetings of the B.M.A. and in 1969-70 Chairman of his Division.

A good all-rounder, he was active in the St. John Ambulance Brigade, his service being recognised by the Order of the Hospital of St. John of Jerusalem when in 1969 he became a Serving Brother.

Tom McKane was born into Medicine, for both his father and his grandfather were general practitioners. A true son of Bart's he married a Bart's nurse, and two of his four daughters carry on in his fine tradition—one is now in her third year of nursing training at the hospital, and another was on the physiotherapy staff until last August.

The dominating factor in Tom McKane's life was his concern for his fellows, and this showed itself most in his devotion to the welfare of his patients. This is not to say that he did not have a full and satisfying family life—he did, but attached as he was to his wife and his four daughters, there was never any question that patients came first.

M. A. WELLER.

PUBLIC HOUSES BY THE RIVER THAMES
part 2

The Yacht, 7, Crane Street, Greenwich, S.E.10.
Watney
Snacks & Meals (Lunch is best)
No Car Park
Phone: 858 0175
Rail: Greenwich or Maze Hill
Bus. 108b, 171a, 177, 180, 185.

This is where I went after leaving the Trafalgar and this is where I stayed until I had to go at ten past eleven! Another of those pubs with real atmosphere. The beer is good (Special) and get a load of that Wine List! I saw this wine rack full up to the eyebrows, so I asked to see the list. Wine is sold by bottle and glass with lunch but not (unfortunately) in the evenings.

The walls are panelled in wood and covered with old photos and prints of a sailing nature. But these are real collectors' items with old photographs of the America's cup Winner for 1904, etc. The decor continues in a yachting line except for the rather bizarre appearance of a model railway which runs at gin bottle level round the length of the phalanx-like bar, to disappear for a short while as it goes through a tunnel in the wall at one end!

Yet again I cannot remember what on earth the loos were like but somehow this very omission is becoming an indicator of a Good Pub in this guide! You park your car in Park Row as if you are going to the Trafalgar and just before this pub there is a little street off to the right which will lead you to this wonderful establishment.

The Cutty Sark, 5, Ballast Quay, Pelton Road, Greenwich. S.E.10.
Free House.
Snacks and Meals possibly in Summer.
Car Park.
Phone: 858-3746.
Rail: Greenwich from London Bridge.
Bus: 108b, 171a, 177, 180, 185.

I have only been here twice, both times after dark and in winter. I have seen the Sark at its best, or its worst. Its best because it was winter and it was full of obviously local people (except us and we felt out of place for a full half minute!) all intent on having a great time. The atmosphere was fantastic. Somehow, I barely noticed the lino floor, the cream walls or the Schweppes adverts dating from 1952, I was too busy getting swept up in their happy mood! It could have been its worst because it was dark so I couldn't appreciate the outside of the building nor the space that is available for "Patrons" across the narrow road that runs past the front door. Also, in winter, the upstairs bar is shut, so I would be grateful if some one could let me know what this is like.

The first time I went there I stayed too long and so I *had* to return in order to complete my review. Much the same thing happened, with the result that I still cannot remember what the loo was like but I have fairly clear recollections of good Bass on draught (16p) and Worthington E and only hazy ones of the other beers.

If you go the Greenwich way to Chislehurst, I really do think that The Trafalgar or The Cutty Sark would be good places to stop on the way back (or on the way there, for that matter!) and they've got plenty of room, so don't be afraid to go in a gang — just aim for Blackheath or Greenwich and take all signs to the Blackwall Tunnel! Park the car pointing towards Home.

The Cooper's Arms, 120, High Street, Woolwich, S.E.18.
Free House
Snacks.
Car Park —across the road.
Phone: 437-2000.
Rail: Woolwich Dockyard from London Bridge.
Bus: 51a, 96, 161, 161a, 171a, 177, 180.

This is a really odd building for a pub, so much so that I steamed past it twice, not realising that the little lantern hanging outside (about HALF the size of the Blue Ones you know so well!) actually did all the advertising that anyone thought necessary! With its dingy brickwork and almost Elizabethan windows, it looks much more like what it in fact used to be — a Wine Lodge. And if you look carefully enough, you'll see that it still has its old name of "Plaisted's wine house" because he used to supply ships' stores in days of yore.

I wasted valuable time by walking round the building, trying to make up my mind which door I should use to effect my entry. This matters little as there is only one bar (boo!) but not to worry, it sports about six proper pump-handles (hurray!) and a few keg outlets besides.

The interior is heavily panelled in very dark wood, and the benches and tables round these walls are of a similar shade. The gloom is alleviated in two places: over the bar, where about four spotlights shine vertically downwards, and high up at one end where there is a Colour Telly. Needless to say, the Locals all gather diagonally opposite the latter, and within easy striking-distance of the former!

Not being a native of Newcastle, I spent the evening in widening my education, and I found the Scottish & Newcastle Mild (called, I think, No. 3 Scotch Ale) absolutely delightful, both in flavour and price (14p). Much more than this I can't remember, except, perhaps, "Beef" crisps that tasted like Bovril. I suggest you go for the evening and leave the girl friend behind.

R.U.M. PUNCH

VERBAL DIARRHOEA

By ARNOLD BARNSLEY

We all know that Medical Science has made great strides in the last fifty years. Many diseases, such as Plague, Leprosy and Tuberculosis, tend to become less virulent, and even to disappear completely in time.

Such are two afflictions which used to affect Public Speakers; I refer to "Umitis" and "Eritis." Opening gambits such as "I—um—don't think—um—that this—er—question is quite—er—fair" are now virtually obsolete. In their place some new complaints have reared their ugly heads. The first is:

The Y'know Syndrome

This is a disease which has appeared insidiously during the last few years, especially amongst the young though it is quickly infecting higher age-groups.

It might be helpful to present the case-history and symptoms of a chronic sufferer from the complaint:-

Mr. X was asked by an interviewer on Television what he thought of the result of the Cup Final. "Well, y'know," he said, "I thought the second goal, y'know, was a bit doubtful. I thought he was off-side, y'know," and so on. One wonders why the questioner did not break in with "Of course I don't know, my boy; otherwise I wouldn't be asking, would I?"

Which brings me to the second prevalent disease of the 'seventies. I refer to:-

Wellitis

Have you ever noticed the number of people interviewed before the Television cameras who start their reply with "Well . . ." probably in order to collect their thoughts? I have devised a most entertaining parlour game for my family, which takes the boredom out of such programmes. We select a likely occasion, and toss up for the "Wells" versus the "Non-wells". Each time the victim before the cameras starts a sentence with "Well . . ." the "Wells" score a point. They usually win hands down.

The Westminster Disease

Politicians are masters of equivocation; after all, it is their job. They seldom use the "Well . . ." technique, but they usually have some stock phrase while they think of a pithy reply to an interviewer's question, such as "I'm glad you asked me that; it's an interesting point," or "That's a question to which I've given a great deal of thought." (One can almost imagine balloons coming out of their heads, in the manner of a strip-cartoon, with "THINKS" written on them.)

During the last General Election but one three Political Leaders were interviewed by (I think) Robin Day, who asked them for a definite "yes" or "no" to some question. Two of them prefaced their answer in the above way, but the third (I think it was Mr. Grimond) came out with a definite "NO". Anyway, he got my vote.

Another time-saving gambit is to reiterate the personal pronoun while they think of a suitable reply:- "I—I—I—think that . . " etc.

And why do they always refer to the Government and the Houses of Parliament as "The Gubment" and "The Uzzaparlt"?

Lapsus Grammatici

At the risk of being called "square," or even "cuboid"; I must point out that there are several grammatical gaffes in our everyday conversation — and even on the B.B.C. with its immaculate English — that irritate me.

The first is the word "unique" — a common solecism. One hears people say that so-and-so is "very unique". For something to be unique, there must be only one of it; a thing cannot be "very unique"; it can be "nearly unique", or "quite unique", but not "most" or "very". To my mind Winston Churchill was unique, and so was Beethoven, but the sun and moon are not.

And then again, on my black list are those who say "different to" instead of "different from," "under the circumstances" for "in the circumstances," and "compared to" as against "compared with". And "bye-bye;" this means nothing, "Goodbye," a corruption of "God be with you" and "Farewell" both express a pious wish. And why in our language have we no equivalent for Au Revoir, Auf Wiedersehen and A Rivederci, but "So Long?"

And what about "I wouldn't be surprised if he Didn't" do so-and-so, when what is really meant is "I wouldn't be surprised if he *did*?", and "Those sort of things" when what should be said is "*That* sort of things?"

Another irritating modern trend is the habit of saying "I would have thought." Presumably one has to imagine the protasis of a conditional sentence — "(If I'd been asked) I'd have thought." But the person *is* being asked, so why say it? And when someone says to me "To cut a long story short" I well know that a long and pointless anecdote will follow.

It would indeed be the height of pedanty to pronounce Cinema and Cenotaph according to their Greek derivation. I very much doubt whether a boy inviting his girl-friend to the Kyneema or to meet him by the Kennotaph would be readily understood; and the unhappy God of love Eros, in Piccidally Circus, would turn in his grave to hear himself referred to as Ecros when he knows that he used to be pronounced Errose (epws) with a short e and a long o, on Olympus.

Finally, I come to that ill-used word "hierarchy". To quote from The Oxford Dictionary, "Hierarchy: Each of three divisions of Angels, (Heath, Wilson and Thorpe?). The Angels; priestly government; organized priesthood in progressive grades." When I read of "The Labour Hierarchy" I find it difficult to envisage Harold Wilson in cope and chasuble.

Let's face it; Verbal Diarrhoea, like the common cold, is with us for ever, and there is little we can do about it.

ADOLESCENT MEDICINE TODAY

By JANET PHILLIPS KRAMER, M.D.
Fellow in Adolescent Medicine
Wilmington Medical Center,
Wilmington, Delaware

Twenty years ago in Boston, Massachusetts, J. Roswell Gallagher founded the first adolescent medicine clinic in the United States at The Boston Children's Hospital. Since then there has been a growing interest in adolescent medicine and today there are more than seventy hospitals and medical centers in the United States with special clinics or wards for teenagers.

What is the reason for this growing interest in the adolescent? Actually the adolescents comprise a generally healthy group; however, adolescents do differ physiologically and psychologically from children and adults, and adjustment difficulties are not uncommon. Problems which arise in adolescents, if not recognized and treated immediately, may later affect the individual's adult life and the lives of those dependent upon him. The aim of adolescent medicine is not just to eradicate disease, but to help establish health—medical, mental, and social—in the developing adult human being. With this goal before it, the discipline of adolescent medicine needs to be available in both the inpatient and outpatient areas of medical care.

The Out-patient Clinic

Recognition of the need for out-patient treatment for teenagers has lead to establishment of adolescent clinics as well as so-called free clinics.

The type of problems treated vary from one hospital to another depending on sub-specialty services provided for adolescents. The interests and experience of the adolescent medicine staff also in part determine the emphasis of the clinics.

The Society of Adolescent Medicine's Committee of Out-patient Clinics states "the emphasis in a teenage clinic is on the whole patient rather than his effected or afflicted parts. The emphasis is on his phenomenal growth and his physical, emotional, intellectual, and social development. Children of this age need and want a physician to doctor them, not their symptoms. An adolescent clinic staffed with both generalists and specialists will create this setting for health care to the teenager."

The first visit of a new patient to an adolescent clinic usually includes a complete history of past illnesses as presented by a parent or guardian, as well as a history from the patient's perspective. A thorough physical examination is followed by an evaluation of specific problem areas and the development of a treatment plan. The total required time ranges from one to two hours.

It is not unusual for a patient to present with a complaint of asthma, but complete evaluation may show he is having difficulties in school, is a behavior problem at home, and may be experimenting fairly heavily with illicit drugs. A well trained adolescent medicine staff can effectively work with the youth in correcting all these areas of difficulty.

Specialists in various disciplines, such as psychiatry, dermatology, cardiology, and surgery and its subspecialties, should be available for consultations.

Table I shows the diagnosis of patients who were seen for the first time in the Adolescent Clinic at the Wilmington Medical Center, October through December, 1971. All the patients were seen as referrals from schools, parents, the community, local physicians, social agencies and other hospital clinics. The high number of patients referred with the diagnosis of obesity can be accounted for by the fact that the clinic has a special self improvement program with emphasis on weight reduction under medical supervision. Because the adolescent clinic is established on a referral basis, most patients have medical problems requiring long-term treatment and follow up.

The Inpatient Program

No adolescent program is completely effective without an inpatient program to which youngsters requiring admission to the hospital can be transferred. The hospitalized adolescent has many needs which cannot be met in the busy pediatric or medical-surgical areas. Body image concerns are evident even with relatively minor problems which require short term hospitalization. Here too, a team approach is necessary, and the informality of an adolescent hospital area allows the youngster to adjust more quickly to his hospitalization. Our twenty bed adolescent unit has school facilities, a recreation area with pool table and juke box, and snacks, except for those on special diets, readily available.

Nurses who work in the adolescent unit are particularly able to establish rapport with this age group. Other important personnel who work closely with the teenagers are the chaplain, the dietician (who is quite ingenius at making special diets palatable for teenagers), the social worker, the teacher, the recreation specialists, and the nursing specialist who works as a liaison between nursing staff and the patients and their parents. Conferences concerning specific patients are held regularly with all personnel to further delineate the problems and work toward overall treatment.

The teenagers also give each other moral support. Youngsters with chronic medical problems, such as diabetes or sickle cell disease, share medical tips and encouragement through the difficult episodes of their illnesses.

Training in Adolescent Medicine

Adolescent Medicine is a growing sub-specialty in the United States and Canada. However, there is controversy as to whether the specialty should be relegated to pediatrics, internal medicine, or incorporate parts of both specialties. At the present time most adolescent medicine specialists complete residency training in internal medicine or pediatrics, and then pursue a one or two year adolescent medicine fellowship at a hospital center with an established adolescent medicine curriculum.

The majority of those trained in adolescent medicine are now in university centers, but there is a growing need for these specialists in government services for adolescents such as drug programs and programs for unwed mothers, in university health services, and in school health. Many trained in the past few years are going into private practice.

Summary

Adolescent Medicine is a relatively new specialty designed to give comprehensive care to the teenager and young adult especially during the periods of vast physical, emotional and social changes which are necessary for the transition to adulthood.

A well designed adolescent medicine program should provide inpatient and out-patient medical care and a staff trained in the art of helping youngsters grow into well adjusted adults despite various medical, emotional or social deterrents.

TABLE I

Chief Complaint or Previous Diagnosis of Adolescent Patients seen in the Adolescent Clinic of the Wilmington Medical Center, October through December, 1971.

DIAGNOSIS:	*No. of Patients*
Psychologic problems (includes adjustment reaction of adolescence, drug abuse problems, and patients with history of suicide attempts)	14
Obesity	11
Diabetes Mellitus	6
Hypertension	5
Venereal Disease	4
Pregnancy	4
Sickle Cell Disease	3
Seizure Disorder	3
Cardiac Murmurs	3
Abdominal pain	3
Enuresis	2
Klinefelter's Syndrome	2
Infectious Mononucleosis	2
Hyperthyroidism	2
Functional Megacolon	2

One patient presented with each of the following diseases: Legg-Perthes Disease, Osteitus Dissicans, Cervical Disc Disease, Osgood Schlatter's Disease, Sarcoidosis, Urinary Tract Infection, Wolff—Parkinson—White Disease, Meniere's Syndrome, Bronchitis, Peritonsilar Abscess, Upper Respiratory Infection, Brain Tumor (astrocytoma II), Tenosynovitis, Follow-up of parathion poisoning, Adrenogenital Syndrome, Birth Control Information, Pneumonia, Rheumatoid Arthritis, S-C Disease.

AN INTERESTING CASE of a MARCH FRACTURE

by F. C. CHEN, F.R.C.S.

Introduction

Schulte (1897) first drew attention to a metatarsal fracture as a cause of swollen feet in soldiers. In the same year, Stechow reported his observations on metatarsal fractures in thirty six cases of swollen feet. His report is of historical interest as it was the first in which radiographs were used to confirm the diagnosis. He noted that when the second metatarsal was fractured, protrusion of the second metatarsal head beyond its fellows was a frequent radiological sign. He suggested that the prominent metatarsal head received abnormal stresses.

Before march fractures were recognised as a clinical entity, they were commonly mistaken for malignant growths (Dodd 1933). Now that they are well known, the pendulum may have swung the other way, and more sinister clinical conditions may be diagnosed as march fractures. Occasionally march fractures may co-exist with other more serious pathology (Meyerding 1944).

Case History

An eleven-year-old boy attended the accident and emergency department with a history of pain and swelling in his left foot of one month's duration. The pain was sometimes so severe that it disturbed his sleep. There was no history of trauma. He was diagnosed elsewhere as a case of healing march fractures of the second and third metatarsals of his left foot. Radiographs (figs. 1 and 2) showed periosteal reactions of the second and third metatarsal shafts, which were very suggestive of healing march fractures. On examination he walked on the outer edge of his left foot. A definite plantar swelling was palpable between the second and third metatarsals. His chest radiograph was normal, erythrocyte sedimentation rate was 7 mm./1st hour, white cell count was 7,700 per cu. mm. and haemoglobin was 12.5 gm.%.

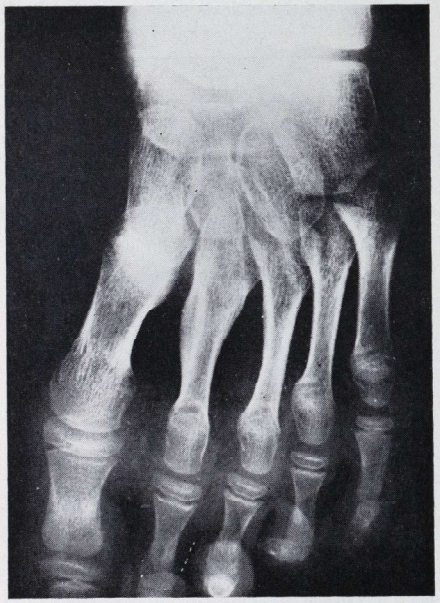


Figure 1.
Anteroposterior view of left foot to show periosteal reaction of the second metatarsal shaft. The third metatarsal shows only a mild periosteal reaction in this view.

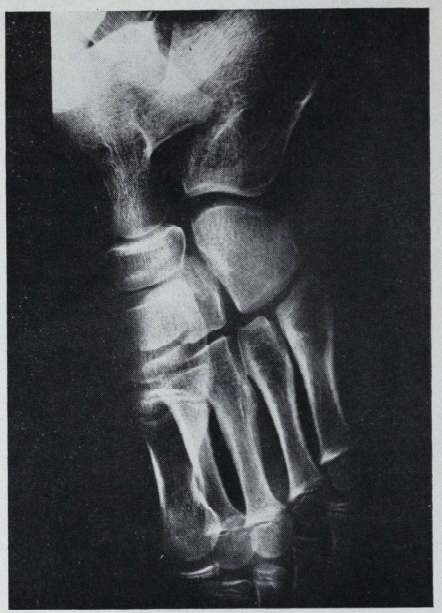


Figure 2.
Lateral view of left foot to show periosteal reaction of the third metatarsal.

Biopsy of the plantar swelling revealed a very large infiltrating cartilaginous tumour between the second and third metatarsals and appeared to arise from the second metatarsal shaft. The histology report confirmed the diagnosis of a chondrosarcoma. Sections showed pieces of abnormal cartilage, parts of which were dead and other parts of which showed abnormal growth, including spindle shaped cells, plump cells and multinucleate cells. The junction between cartilage and connective tissue was ill-defined with evidence of invasion. (figs. 3 & 4).

On the basis of these findings a below knee amputation was carried out.

At review two years following amputation, he remained well, had grown in height from 4 feet 11 inches at time of operation to 5 feet 7 inches at review, and in weight from 5 stones to 9 stones 12 pounds. There was no evidence of any metastases.

Discussion

The metatarsals are common sites for stress fractures. The second, third and sometimes the fourth metatarsals are commonly affected. Although the neck of the metatarsal is the commonest site, any part of the metatarsal shaft may be affected.

A hairline fracture may be seen in the initial radiograph, but sometimes the only radiological sign is the appearance of periosteal new bone formation.

The onset of pain is usually gradual and comes on during a period of activity.

Certain clinical features in the aforementioned patient cast doubt on the diagnosis of march fractures. They are:—

1. The age of the patient — march fractures are rare in children as the bones at this age are elastic.
2. Persistence of symptoms — in march fractures the pain rarely lasts for more than three weeks.

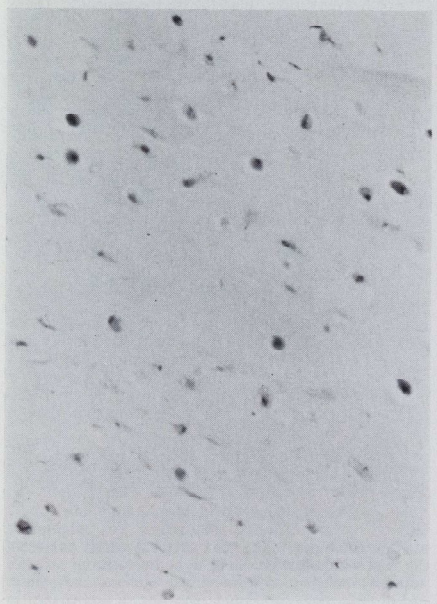


Figure 3.
To show abnormal cartilage cells, including spindle shaped cells, plump cells and multi-nucleate cells.

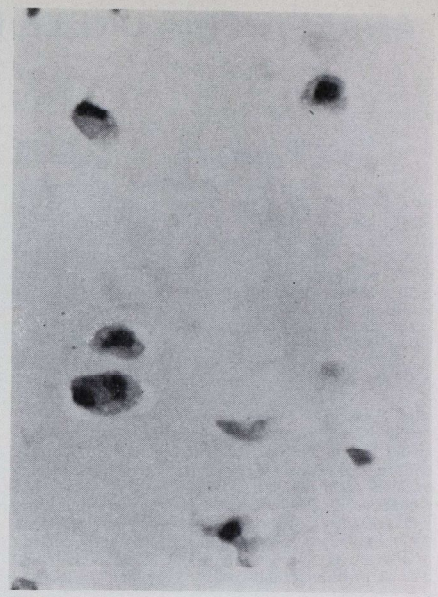


Figure 4.
High power photomicrograph to show multinucleate cell, plump cells and dead cells.

3. Presence of a discrete palpable tumour — this is unusual in march fractures. This report illustrates that clinical confusion between march fractures and other more serious pathology may easily arise. A diagnosis of march fracture can only be made with certainty after careful radiological and clinical examination.

Acknowledgements

I wish to thank Mr. J. Watson-Farrar, Consultant Orthopaedic Surgeon, Norfolk and Norwich Hospital, for his advice and permission to publish this case, Mr. R. C. Howard, Senior Consultant Orthopaedic Surgeon, for his advice, and Dr. J. H. Rack, Consultant Pathologist, for permission to reproduce figures 3 & 4.

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ANAESTHESIA UNDER DIFFICULT CONDITIONS

by T. B. BOULTON

All the world's a stage . . .
And one man in his time plays many parts.

"As You Like It": Shakespeare.

Fate, in the guise of the factors which have so far shaped his career, has caused the writer of this paper to take a continuing interest in medical practice in environments other than the sophisticated conditions in which we are normally privileged to work in National Health Service Hospitals in the United Kingdom. (See Bibliography.)

Difficult environments are, almost inevitably, associated with a shortage of trained personnel. This shortage may be actual due to isolation, as on a ship at sea, on an Antarctic expedition or in an underdeveloped country, or relative, because of an excessive work load, as in disaster or battle conditions.

There is one doctor to every 890 head of population in the United Kingdom but, in Nigeria, there is only one medical practitioner to every 60,000 persons and, in South Vietnam, one to every 29,000 of the civilian population. In such circumstances it is often difficult to find a medical practitioner to perform a surgical operation let alone one to devote himself solely to the conduct of anaesthesia. Specialisation is out of the question and a single practitioner must, of necessity, practice in many different fields.

It will become apparent later that the author's entry into the specialty of anaesthesia, influenced as it was by a conjunction of the Gemini, Venus and Mars, was almost fortuitous but an initial unfulfilled ambition to be a truly general practitioner, after the manner of the rural G.P. before the institution of the N.H.S., has undoubtedly influenced him, consciously or unconsciously, to remain in Anaesthesia. This discipline is more catholic in its practice than any other and overlaps the work and interests of almost every other speciality.

If practice is truly "general" it follows that techniques used in any particular branch of medicine in difficult environments must be simple and straightforward but this does not mean that they cannot embrace the principles of modern practice. The purpose of this paper is to recall some of the author's experiences in difficult environments, to review the hard lessons which have been learned and to suggest the principles upon which the practice of anaesthesia in difficult environments should be based.

DIFFICULT ENVIRONMENTS AT HOME AND ABROAD

"At first the infant mewling and puking in the nurse's arms"

The author's first experience with anaesthesia under difficult conditions was as a student in the immediate post World War II austerity era which preceded the inception of the N.H.S. in 1948.

The inpatient beds of the City of London Maternity Hospital were still situated in the old London Fever Hospital in Liverpool Road as a result of wartime enemy action. The unit was presided over by a single resident houseman-cum-registrar. There was no resident anaesthetist, and, if one were required, he or she was summoned from Bart's or the Royal Free. Often no anaesthetist could be called in time to deal with an emergency and one of the two Bart's students attached to the unit doing their midder, who had already completed his one month anaesthesia appointment, would be called upon to deputise.

It was a wet afternoon. The houseman was delivering the first of a pair of twins assisted by one student while the other (the author) was encouraging the mother and rather inefficiently administering gas and oxygen analgesia from a Boyles machine.

The first twin was a breach, the legs came down easily and the body hung out like a skinned rabbit. All seemed well but suddenly there was a cry of alarm from the houseman and the sweat stood out on his brow. The after-coming head was impacted and seemed immovable. The truth dawned; the rare complication of "locked twins", chin to chin had occurred.

"For heaven's sake, anaesthetise the patient!" There was no time to think about it even if it was one's first unsupervised anaesthetic. A stormy oxygen/nitrous oxide/trichloroethylene/ether induction followed accompanied by much coughing and spluttering. The houseman struggled at the lower end without avail for some time and then, by one of those coincidences which are surely providential, the Consultant Obstetrician just happened to call in at the Unit.

"Get the patient relaxed!" The plunger of the Boyle bottle was pushed down as far as it would go and the ether bubbled merrily while the pupils dilated and the respiration became quiet. A beautiful piece of obstetrical manipulation resulted in the safe delivery of the first child. The houseman holding the limp infant was wearing damp slippers. He stepped back onto the wet wires of sister's anglepoise desk-lamp, which had been pressed into service to give additional illumination; there was a sudden jerk and an expletive as he experienced an electric shock but the baby in his arms cried lustily and breathed well after this unique resuscitation. The second baby was delivered uneventfully; what did it matter if the mother took hours to recover from the ether and then vomited copiously? The whole team took part in an orgy of self-congratulation!

The lesson to be learned is that ether is a very safe anaesthetic even in the hands of the inexperienced and even if it has less pleasant side-effects than other agents.

"And then the . . . school-boy"

The school-boy stage of a medical career is surely the first house-job. In 1949 a house-surgeon was not normally called upon to administer general anaesthesia except for the occasional gas for a colleague in Casualty but, at times, this experience constituted a difficult and even dangerous situation both for patient and anaesthetist. One hot Bank Holiday afternoon a respectable looking mechanic, when recovering from a gas administered by the writer, thought he was "being chucked out of a pub in the Old Kent Road" and acted appropriately; in so doing he nearly terminated a promising career. On another occasion the last of the Walton No. 1 machines burst into flames and was extinguished with a bucket of water by the first patient in the septic queue; he then calmly submitted to gas and oxygen from a machine hastily fetched from the Dental Department.

The importance of preparation and particularly of fluid replacement prior to anaesthesia also began to be appreciated. One young severely traumatised patient, who had been rushed to theatre for immediate surgery before hypovolaemia had been adequately treated, died from hypotension during the intravenous induction of anaesthesia. The author learned and has never forgotten the importance of preparation before anaesthesia. There are few conditions in surgery, other than unrelievable respiratory obstruction, that require immediate dramatic life-saving intervention; the majority of surgical patients benefit from careful preoperative preparation, especially when they are suffering from hypovolaemia due to trauma or pathological fluid loss.

"And then the lover, sighing like furnace with a woeful ballad made to his mistress' eyebrow"

The cold fact is that the writer took up anaesthesia for love; love of a rather charming red-headed night nurse. Another house-job was required to give time to complete the courtship and anaesthesia seemed a better bet than E.N.T., which was the only other vacancy available.

The outstanding difficult environments for the Junior Resident anaesthetist at that time were the Dental Department, where two surgery porters were required to hold the patient down during the "black-gas" sessions, and domiciliary midwifery on the District.

The routine use of pudendal blocks for forceps delivery was still in the future in 1949 and the only acceptable technique of pain relief for instrumental intervention was general anaesthesia. One sometimes got the impression that the less experienced district midwife and her accompanying student regarded it as a confession of failure to send for the obstetric intern and the resident anaesthetist; be that as it may, the patients had often been in labour for some time and were considerably distressed by the time one arrived at the top of a tenement stairs humping a heavy bag and a portable oxygen/nitrous oxide/trichloroethylene machine. There was only one small cylinder of each gas on the apparatus and these were often quickly exhausted; an additional hazard was often the ubiquitous coal fire. Open drop chloroform had, therefore, frequently to be resorted to to complete the delivery. Better by luck than judgment and despite the conditions, the toxicity of the anaesthetic and the undoubted inexperience of both anaesthetist and obstetrician, it is fortunate to be able to report that, so far as the author remembers, there were no fatalities amongst either mothers or infants.

These experiences on the District demonstrated that cylinders can be a considerable disadvantage when mobility is required or supplies are limited. In difficult environments techniques, which rely only upon ambient air as a vaporising agent for volatile anaesthetics and which do not require nitrous oxide, have considerable advantages.

"Then the soldier . . ."

The position having been consolidated on the "Home Front" by an engagement the prospect of a "cooling off" period as a National Service medical officer in the Malayan Emergency was almost welcome. Whatever one felt about conscription at the time there is no doubt that it offered a period when one could grow up and take real responsibility. Our fathers and elder brothers, who had borne the brunt of World War II, had thankfully returned to civilian life and those in authority in the R.A.M.C. were, with a few notable exceptions, administrators rather than clinicians; it therefore fell to young, recently qualified national servicemen to take the major responsibility for clinical care in the army.

The author's experience was not exceptional. When he finished his Resident Anaesthetist appointment he had no particular intention of going on in anaesthesia but, within three months of joining the army and with only six months in the specialty, he found himself the only anaesthetist, civil or military, in northern Malaya with the additional responsibility for blood transfusion and skins and V.D. in that area. He was also, at times, pressed into service to perform p.m.'s and as a surgeon with a physician administering the anaesthetic.

During this period the importance for careful assessment and preparation and the restoration of blood volume before anaesthesia and the safety of ether as an

anaesthetic was confirmed. The need for apparatus independent of cylinders was also re-emphasised in a situation in which the supply position was tenuous, especially in times of heavy rainfall and flooding. The value of intravenous morphia, as analgesic cover short of general anaesthesia for the transport of patients and for freeing trapped casualties even by amputation, was effectively brought to one's attention and there were also opportunities for the assessment of the value of some local anaesthetic techniques. This especially applied to the use of spinal analgesia. The limitations of local analgesia were also learned; frightened unsophisticated people, with whom one cannot communicate because of the language barrier, are often very difficult to handle during operations under local.

Experience in Malaya during the Emergency also taught the need for careful organisation in handling casualties and men in difficult environments, the value of the rudimentary air-evacuation service, which was then available, and the importance of improvisation.

"And then the justice . . . Full of wise saws and modern instances"

The process of development to full responsibility in one's chosen profession is gradual and often as imperceptible as it is inexorable but early interests, almost accidentally acquired in the formative years, remain as one becomes older.

A decade of ruminating, theorising and writing about anaesthesia for difficult environments, including civil and military disaster conditions and in developing countries (including the U.S.A.!), culminated in the sudden and alarming discovery that one had indeed developed a fair round belly. The need to do something active, before becoming "a lean and slippered pantaloon with spectacles on nose" and finally progressing to "mere oblivion", became paramount. An opportunity to really work (and not just be a distinguished visitor), in South Vietnam for three months presented a unique chance to shake out the cobwebs and test one's theories in several very difficult environments.

A primary appointment in a children's international plastic and reconstructive surgical unit in Saigon presented the opportunity of proving the value of the draw-over techniques. These will be described below; volatile agents are vaporised in atmospheric air instead of nitrous oxide and oxygen from cylinders; ether, trichloroethylene and halothane were used in a consecutive trial lasting three months. The author was also introduced to the remarkable new agent ketamine which, when given by either intravenous or intramuscular injection, will produce a state of full unconsciousness while leaving the protective reflexes of the pharynx and larynx largely unimpaired. This was especially valuable in the treatment of cases, such as that illustrated in figure 1, where intubation was virtually impossible.

Participation in the training programme of Vietnamese nurse-anaesthetists was also undertaken in co-operation with South Vietnam's one and only trained physician anaesthetist, Dr. Nguyen Khac Minh. Nurses trained by Dr. Minh in Saigon have returned to their Province Hospitals and greatly improved standards. Prior to the start of the Training Programme in 1965 the mortality of patients undergoing surgery under general anaesthesia is reliably stated to have been over 20 per cent.

Exchange appointments with an Australian Civil team in Bien Hoa and the First Australian Field Hospital at Vung Tau brought one into contact with multiple casualty situations.

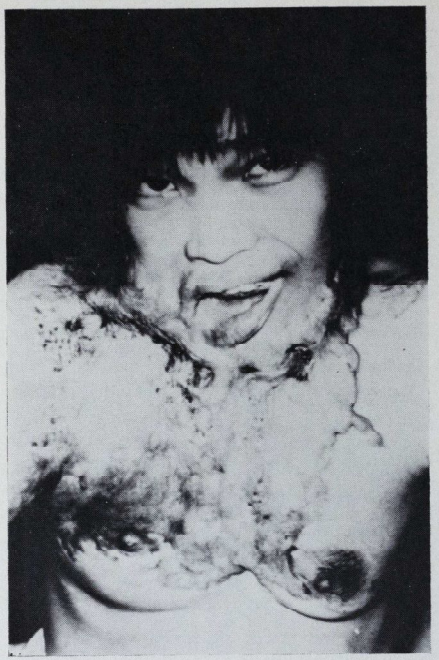

Figure 1.
Contracted scars following third degree burns as the result of filling one of the paraffin (kerosene) cooking stoves commonly used by the Vietnamese with high octane aviation petrol (gasoline) obtained on the black market.

At Bien Hoa traumatic, emergency and cold surgical cases were literally dumped at the operating room door throughout an 8 hour day in very primitive conditions. They were rapidly assessed, a transfusion was started and, after an intravenous barbiturate/relaxant "crash" induction, they were intubated and connected to an ether/air draw-over apparatus. Immediate intubation was mandatory, first because there was no knowledge of the state of filling of the stomach and the danger of regurgitation was therefore ever present, secondly, so that the patient could be rapidly settled on ether without the process being impaired by laryngeal spasm and coughing and, thirdly, in order to secure the airway so that the patient could be, if necessary, handed over to a nurse or orderly for monitoring and maintenance. One was also reminded of the lethal danger from infection of transfusing out-dated, inadequately screened and improperly refrigerated blood and the value and safety of electrolyte and artificial colloid solutions in the treatment of hypovolaemic shock.

The Australian Army's First Field Hospital was excellently equipped and well supplied with fresh properly screened and cross-matched blood. It also had an excellent resuscitation organisation but one physician anaesthetist had to serve up to three tables during a "Dust-off" helicopter evacuation. In this situation intubation again played a key role in ensuring the airway. After resuscitation all patients were induced and intubated by a standard technique and each was then handed over to a trained medical orderly who monitored vital signs. The physician anaesthetist then went from table to table making adjustments and reviewing the progress of all three patients.

The important deductions from the Vietnamese experience were, the confirmation of the efficiency of draw-over apparatus for both spontaneous respiratory and controlled ventilation techniques, the fundamental need for intubation as an essential part of any technique for a difficult environment and the practicability of employing trained non-medical personnel in difficult environments both on their own or under medical supervision.

CHOICE OF TECHNIQUES FOR PAIN RELIEF IN SURGERY

Many of the factors which influence the choice of analgesic or anaesthetic techniques under difficult conditions have already emerged. The author has discussed the details of the various procedures elsewhere (see the Bibliography); only a generalised outline is possible in this short paper.

Local analgesia

The use of local analgesia in the conscious patient will avoid the hazards of unconsciousness, notably respiratory obstruction and the danger of inhalation of vomit. On the other hand, as we have already stated, its usefulness is limited by the degree of patient acceptance. Local analgesic techniques are also, on the whole, less certain than general anaesthesia and more time consuming and, moreover, different techniques are required for different areas of the body, whereas a standard general anaesthetic technique can be devised to cover most surgical procedures (see below).

There are few situations more distressing and dangerous than that in which general anaesthesia has to be forced upon an unwilling, frightened patient after the failure of local analgesia. Techniques of local analgesia practised on conscious patients in difficult environments must be as near 100 per cent. reliable as is possible; in the author's opinion only spinal analgesia, regional intravenous injection confined to one limb by an arterial tourniquet and the limited continuous "inject and cut" technique come near to meeting this criterion.

General intravenous analgesia

The value of intravenous morphia has already been stressed. This is a most valuable technique for extracting trapped casualties from wrecked vehicles or buildings. The secret is to give the drug slowly and to give enough. Respiration becomes very slow but remains deep. There is a remarkable degree of amnesia; a colleague of the author amputated the foot of an airman trapped in a sinking flying-boat in Singapore harbour without subsequent recollection by the casualty.

Inhalational analgesia

The first (analgesic) stage of anaesthesia which is short of full unconsciousness and retains the protective pharangeal reflexes is also useful. Trichloroethylene and air is particularly valuable used in a fashion similar to that employed in midwifery. The apparatus required is portable, a little trichloroethylene lasts a long time and the agent is inexpensive.

Combined local and general analgesia

The value of the use of intravenous or inhalational analgesia to cover local analgesia should not be forgotten.

The induction of general anaesthesia and intubation

Sedation is desirable but, in fact, the only premedication that is absolutely necessary before a general anaesthetic is the injection of intravenous atropine to dry up secretions.

The arguments in support of intravenous induction, relaxation with a short acting muscle relaxant, such as suxamethonium, and immediate endotracheal intubation, in dangerous and difficult environments have already been developed. Intubation to secure and protect the airway should be considered as the primary

manoeuvre of anaesthesia, and the first skill which should be acquired by any person who may be called upon to administer anaesthesia. The more primitive the surroundings, the less experienced the anaesthetist and the less the quality and quantity of the available assistance, the more intubation should be practised both in the interest of safety and of rapid settlement to a state of steady general anaesthesia. This is particularly the case if draw-over apparatus is the method of choice as it obviates the essential need for maintaining a perfect fit with the anaesthetic mask so that ambient air can be effectively drawn over the liquid agent. Maintaining a good fit with a mask is by no means as easy as some might think especially in an edentulous patient. Rejection of the draw-over technique by anaesthetists who are only used to working with plenum apparatus, in which volatile anaesthetics are vaporised by gases escaping from cylinders rather than by air drawn over by the respiratory effort of the patient or by a bag or bellows, is usually due to failure to realise that it is absolutely vital to obtain a good fit with the mask or, preferably, to intubate early after an intravenous induction.

If no suitable veins are available anaesthesia can now be rapidly and effectively induced by the intramuscular injection of ketamine (see below).

Maintenance of anaesthesia with volatile agents

A typical draw-over system with which sophisticated modern anaesthesia can be administered without the need for compressed gases in cylinders is composed of three parts (figure 2); these are the vaporiser, a one-way valve and bellows or bag system and a dual purpose valve, through which air and anaesthetic mixture can be breathed spontaneously or delivered to the patient by means of intermittent positive pressure ventilation (I.P.P.V.) initiated by manual compression of the bag or bellows.

A modern anaesthetic for abdominal or thoracic (i.e. "cavitary") operations can be delivered by this apparatus; this would consist of intravenous induction with a relatively short acting agent (e.g. methohexitone or thiopentone), oral intubation after a short-acting relaxant (e.g. suxamethonium), maintenance by I.P.P.V. with minimal concentrations of any volatile agent in air (e.g. ether, trichloroethylene or halothane), and muscular paralysis with a long-acting intravenous muscle relaxant (e.g. curare or gallamine), and, finally, reversal of that relaxant by the administration of prostigmine and atropine.

In fact, this controlled ventilation technique can be used as a "universal" anaesthetic to cover any surgical operation whether "cavitary" or on the body wall or limbs ("non-cavitary"). It is, however, often more convenient to allow the patient to breathe spontaneously through the vaporiser for non-cavitary procedures. Ether is the agent of choice for spontaneously respired draw-over anaesthesia as it does not depress respiration except when given in excess and, if necessary, sufficient depth of anaesthesia can be obtained for abdominal surgery with the patient breathing ether/air alone. The vaporiser usually used for vaporising ether for the draw-over technique is the E.M.O. described in Dr. Bowen's article in this issue.

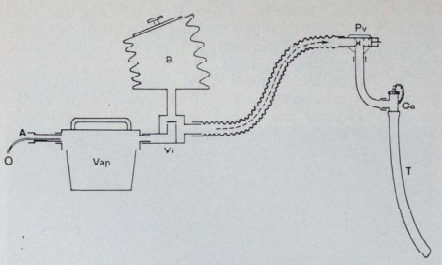

Figure 2.
A typical "draw-over" system. A=air-inlet; O=the position of the oxygen line when its use is indicated; Vap=vaporiser (for ether this would most frequently be the E.M.O.); Vi=one-way valve; B=bellows; Pv=dual purpose positive pressure/spontaneous respiration valve (e.g. a Ruben or AMBU-E valve); Ca=suction adaptor; T=endotracheal tube.

Halothane (Fluothane) alone is unsatisfactory because it depresses respiration and produces hypotension and is not a satisfactory "analgesic" agent (i.e. given without nitrous oxide it does not suppress reflex movement in response to surgical stimulus in low concentrations). Trichloroethylene (Trilene) is a good analgesic but a much weaker anaesthetic than halothane. A mixture of halothane and trichloroethylene delivered from separate vaporisers in series (figure 3) is, however, a satisfactory substitute for ether for spontaneous respiration and has the advantage of not being flammable.

The vaporisers required for vaporising halothane and trichloroethylene (e.g. Oxford Miniature Vaporiser—"O.M.V.") are much less bulky than the E.M.O. and this enables all the necessary equipment and drugs for sophisticated modern anaesthesia to be carried in an air-line flight bag.

A satisfactory vaporiser can be improvised from a Maxwell House Coffee Jar or similar container (figure 4).

Oxygen

If a limited supply of oxygen is available it should be used to supplement the air entrained into the draw-over system (figures 2, 3 and 4). Oxygen will always increase the margin of safety especially in the early part of the anaesthetic during induction and intubation. Supplementary oxygenation is also desirable in pregnancy and in anaemic, cardiac and pulmonary patients.

Draw-over techniques using air alone have been used successfully at altitudes as high as 3,000 metres (10,000 ft.) but above this height oxygen supplementation will certainly be required.

Logistically the flow of oxygen required to supplement air in draw-over techniques will not usually exceed 2 or 3 litres per minute; a small cylinder will last a considerable time at a flow rate of this order.

Maintenance of general anaesthesia with intravenous agents alone

Anaesthesia can be maintained with the patient breathing spontaneously by the carefully administered

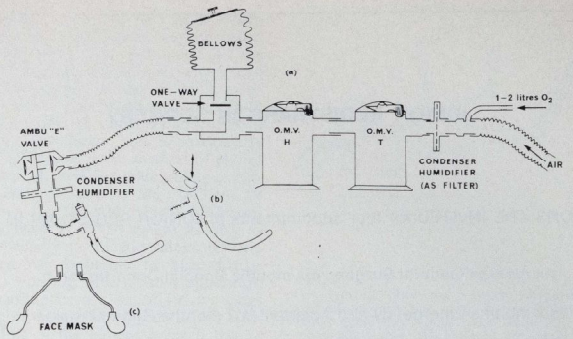

Figure 3.
(a) "Draw-over" system incorporating separate O.M.V. vaporisers for halothane and trichloroethylene in series. Note the dust filter.
(b) Method of reducing dead-space for children during intermittent positive pressure ventilation.
(c) Face mask.

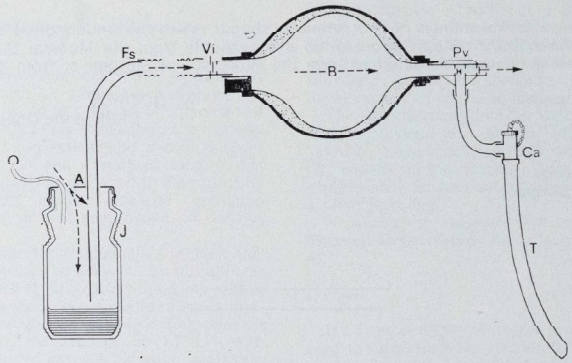

Figure 4.
Improvised system using a 4 ounce Maxwell House coffee-jar as a vaporiser. O=optional loosely fitting oxygen enrichment tube passing through the air-inlet hole (A) in the lid of the jar (J); vi=standard AMBU resuscitation bag. Other letters as in figure 2. A jar of this size will deliver about 10% ether, 1% trichloroethylene and 5% halothane. The concentration can be effectively doubled by gently agitating the liquid in the jar by shaking, and halved by drawing the side-hole in the tube (Fs) above the lid of the jar.

intermittent injection of short-acting drugs like thiopentone and methohexitone in a manner similar to the modern dental anaesthetic. Many thousands of soldiers were anaesthetised in this way in Allied Field Hospitals in World War II. It is also perfectly possible to intubate and paralyse the patient with curare and maintain the patient on controlled ventilation by a resuscitator bag or bellows alone and the intermittent injection of intravenous anaesthetics and analgesics such as pethidine or ketamine.

Improvised techniques for disaster conditions

Improvised to and fro techniques such as open drop methods (figure 5) or Flagg's can (figure 6) have little or no place in *planned* anaesthesia in a difficult environment under present-day conditions and, since, as we have already observed, all the necessaries for modern anaesthesia can be carried in a single flight-bag, no

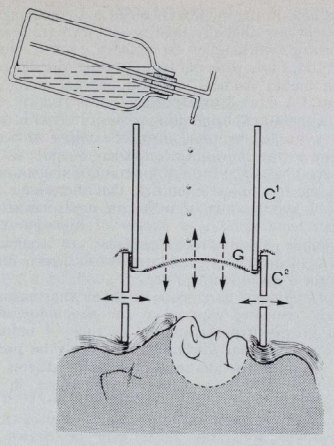

Figure 5.
Improvised "to and fro" open-drop ether apparatus with a "chimney" to increase the inspired concentration improvised from two food-tins (C1 and C2). There should be 12 layers of gauze at G.

practitioner knowingly going to an isolated area should be without them.

These improvised methods are, however, useful and practicable if draw-over apparatus and/or a bag or bellows for ventilation are not available.

Dissociative anaesthesia

The recent introduction of ketamine has provided a new dimension in anaesthesia for difficult environments. This drug can be administered intravenously or intramuscularly and induces an unconscious, trance-like "dissociative" state in the patient without producing undue respiratory depression and at the same time allows the protective reflexes of the larynx and pharynx to be largely maintained.

The particular value of ketamine in reconstructive surgery of patients with face and neck scars which prevent intubation and inhibit the use of local analgesia has already been mentioned (figure 1).

Dissociative anaesthesia is proving particularly useful to isolated practitioners working under primitive conditions. It is most satisfactory for non-cavitary procedures as the degree of muscular relaxation produced by the drug is not great but abdominal surgery has been performed under its influence alone.

Ketamine can be used as an intravenous induction and maintenance agent with a muscle relaxant and controlled ventilation technique, in an intubated patient but, under these circumstances, the advantages of spontaneous respiration and lack of respiratory and pharyngeal reflex depression are, of course, lost.

The chief disadvantage of ketamine is that adult patients may make occasional involuntary movements under its influence and may experience vivid dreams on recovery and the vomiting rate is fairly high, but these draw-backs are acceptable in the interest of safety under primitive conditions and can be reduced by suitable pre-medication. Children are rarely affected by these side-effects.

The ease of administration of dissociative anaesthesia is, of course, no substitute for adequate preparation for, or careful observation during, anaesthesia.

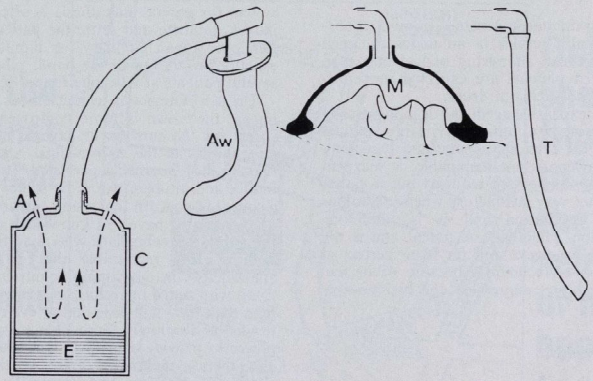

Figure 6.
"Flagg's can". A "to and fro" ether (E) apparatus improvised from a metal ether container, (C). A=air inlet holes drilled in the can. Alternative methods of use are shown; Aw=anaesthetic airway; M=anaesthetic mask; T=endotracheal tube. The apparatus is most efficient when used with an endotracheal tube.

OTHER DIFFICULTIES

Many other factors may influence the conduct and choice of analgesia or anaesthesia but these can only be considered here in general terms and illustrated by a few specific examples.

Race, disease and religion

A knowledge of the racial sensitivity or resistance to anaesthesia and of the indigenous diseases in a particular population is important. Asians are usually sensitive to anaesthesia, negro races, on the other hand, are often resistant. General conditions like malnutrition, anaemia or bronchitis may be endemic in a particular community, diseases such as sickle cell anaemia or porphyria, which are rare in other communities, may be common in individual towns or regions and the local drugs or addiction may influence response to other drugs; for example, the natives of Peru, who chew coca leaves, tend to be resistant to local analgesics.

Logistics and economics

The bulk and mass of particular agents or apparatus becomes important where the amount that can be transported is limited as may well be the case, for example, when light aircraft or helicopters are used or, at the other end of the scale, if the practitioner has to carry his own apparatus.

Cost can be of paramount importance in mission hospitals or when a health service in an underdeveloped country is operating on a shoestring budget and even more if impoverished patients are expected to contribute directly towards the cost of drugs.

Ether is a safe, inexpensive agent but it is logistically undesirable because of the comparatively large volumes which are required for each anaesthetic and it is flammable. Trichloroethylene is not flammable, is inexpensive and only small volumes are required but it causes tachypnoea and is not very satisfactory when used alone with spontaneous respiration and it is, therefore, limited in application. Halothane is potent and is not flammable but it is expensive and far from perfect as an agent for draw-over techniques because of its tendency to cause respiratory depression and hypotension.

Climate and topography

We have already discussed the need for oxygen supplementation at high altitudes. Resident populations such as those in the mountains of Peru are acclimatised and present less difficulty than people who are temporarily visiting, working or on military combat duty at high altitudes for, with the latter groups, the danger of acute mountain sickness and high altitude pulmonary oedema (H.A.P.E.) is ever present.

The temperature of operating rooms or areas is nearly always controlled by some form of cooling or heating according to the prevailing conditions outside; in fact, so universal has some form of air-conditioning and cooling become in tropical countries, that there have been reports of hypothermia occurring in small infants. On the other hand there is a danger of hyperpyrexia if thermo-labile anaesthetised patients are transferred from a cooled operating room to wards which remain at ambient tropical temperature.

In cold climates care must be taken that casualties who have remained exposed at sub-zero temperatures are not grossly hypothermic at the time of induction otherwise ventricular fibrillation can easily be precipitated. Vasoconstriction in hypothermic patients may also preclude the use of local anaesthesia in cold environments.

Dust in any situation is a particular source of trouble to draw-over apparatus as it may be drawn into vaporisers and jam moving parts; some form of dust filter is, therefore desirable at the air-intake (figure 3).

Personnel, politics and prejudice

In developing countries and other emergency situations where there is a shortage of doctors the need for nursing and other para-medical personnel to undertake technical procedures which, in more sophisticated surroundings, are the province of the medical practitioner, is well recognised by civil and military planners. It has been demonstrated earlier in the paper that the best system for general anaesthesia is often for the doctor to induce, intubate and settle the patient before he hands him over to an auxiliary for monitoring and for the practitioner to remain at hand, albeit responsible for several patients at the same time.

The use of nurses or technicians as anaesthetists working on their own is more controversial; the answer is surely for the surgeon to have as much knowledge of anaesthesia as the non-medical anaesthetist in order that he may provide supervision. If necessary he must induce and intubate before he scrubs-up. It is, however, a source of concern that many surgeons in isolated areas are content to have less knowledge of anaesthesia than the nurses or technicians who anaesthetise for them.

It is also regrettable that so many physician-anaesthetists in developing countries will have nothing to do with nurse or technician anaesthesia because they fear that they will lose status even in areas where it would be absolutely impossible to spare medical manpower to provide a medical anaesthetist for all general anaesthetics, assuredly these gentlemen would *gain* status by training and controlling nurse-technician anaesthetists rather than make themselves ridiculous by ignoring them and saying "they are all dangerous" when, manifestly, they are not.

SUMMARY

The primary duty of the anaesthetist is to keep the patient alive during surgery while at the same time providing pain relief and satisfactory operating conditions; whatever the circumstances the success with which this commitment is honoured depends on careful assessment of the patient, having open vein, ensuring a clear airway, maintaining adequate ventilation and choosing the correct technique.

This paper has endeavoured to show that primitive or isolated conditions are no excuse for the practice of primitive anaesthesia; careful planning can ensure that the principles of modern anaesthesia are applied whatever the conditions.

ACKNOWLEDGEMENTS

The author wishes to thank Children's Medical Relief International of New York for Figure 1, the Department of Medical Illustration for Figures 2 to 6 and the Editors of the journal *Anaesthesia* for permission to reprint them and Mrs. Richard Green for her patient secretarial assistance.

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BARGAIN STRAVINSKY (1882-1971)

One is so used to reading of Stravinsky as "the greatest living composer" that it comes hard to realise that he died last year. For those interested in modern history, he is buried in Venice. Who could forget those vivid television photographs of the Russian Orthodox funeral service and then the gondola draped overall in black carrying the coffin to the island cemetery with the strains of "The Symphony of Psalms" in the background. It seems hard to appreciate the violence and opposition that his music aroused in the early years of the century, but he was one of the foremost of the "enfants terribles". His opus 1 was a pleasant symphony in E♭ and this is more in the orthodox Tchaikovsky/Rimsky mould (rather close to Balakiriev), no true foretaste of what was to come. His liaison with the famous Diaghilev Ballet led to "Petrushka", "The Firebird" and last and most famous of all, "The Rite of Spring". The first concert performance of "The Rite" in Paris under Pierre Monteux in 1913 led to a riot and fight, such was the effect of the violent dissonances in which this remarkable score abounds. In some of the obituaries to Stravinsky one would have thought he only composed these ballet scores. Works like "Les Noces" or "Le Chanson de Rossingnol" are disregarded—beautiful and evocative music for limited resources. His ballet, "Appollo" must be the most warm twelve tone score ever written. The two symphonies of the '40s ("In 3 movements", and "In C") are both tuneful and the former extends back to the Baroque by its concertante writing for harp and piano. The "Symphony of Psalms" combines the austere beauty of sound of the classical psalmist with a modernity of scoring—one is seeing the work of two great masters. Two operas, one full scale ("The Rake's Progress") and one short ("Oedipus Rex") are frequently performed. Many small scale concertos were composed and there are many songs.

Recordings have been plentiful and, best of all, an almost complete range from CBS exists by the composer himself. Not all composers are great conductors but Stravinsky was of his own music. There is film of the diminutive figure rehearsing—his strength of personal communication, so apparent in his music, obviously inspired performers also. Alas, most of his recordings are at full price. A bargain set is available at £3.99 from *The Sunday Times* through the auspices of CBS. On three records you get a range of the orchestral output—"The Rite", "Petrushka", "Firebird" and "Pulcinella" suites, The "Symphonies in C" and "of Psalms". The sound is typically close with woodwinds spotlit, a little aggressive but somehow not out of keeping. The "Symphony of Psalms" is a lively and sharp performance and is, in particular, not to be missed.

My favourite cheap "Rite of Spring" is excellent value at 82p. It is a "Russian" performance, making much of the inherent folk element in this score—astonishing how poetic it can all sound (witness the recent live Berlin Philharmonic/Karajan performance). Markevitch is a conductor much missed from the English scene in the last five years and his direction of the Philharmonia Orchestra is very stylish: the 1961 recording is still a model of overall balance and tonal bloom—quite competitive with the best (Classics for Pleasure CFP 181).

It was Ernst Ansermet who conducted many of the early performances of the famous ballets, because of his post of principal conductor of the "Ballet Russe". His direct sympathy may be found in his many records of Stravinsky recorded for Decca. An excellent cheap record couples "Petrushka" and "The Firebird" suite. The mono sound has been enhanced to give a moderate recording which is satisfactory for small machines rather than sensational (Eclipse ECS 537 at 90p). Monteux's RCA record sounds better (authentic stereo) but the performance of the Boston Symphony is, to my ear, somewhat ragged (Victola VICS 1296 at 99p) My own preference for these ballets is to buy full price recordings because they rely on their vivid orchestration and that needs full modern stereo.

Two Supraphon records of the choral music must be mentioned—one is a fine Czech performance of "Oedipus Rex" under Ancerl. This is a warmer but less powerful reading that Stravinsky's own but at £1.30 is excellent value in resonant sound (SUAST 50678). The second couples the Mass with the cantata on 15th Century themes this work shows Stravinsky's extreme skill in utilising aged concepts to his own advantage. This record is excellent value (SUAST 50978).

Finally, a full price record of my favourite Stravinsky —"Appollo" and the "Pulcinella" suite (the latter based on themes from Pergolesi) in a wonderfully lithe and gentle performance from Neville Marriner's "Academy of St. Martins in the Fields" in superb sound on Argo (ZRG 575)—full price but still a bargain. What Stravinsky's final place will be in the history of music is still uncertain—I suspect there will always be a place for the ballets, but it may well be many years before the true worth of the rest of this incredible composer's output is fully appreciated.

ALLEGRO.

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MEDICAL BOOK REVIEWS

RADIOLOGY FOR GENERAL PRACTITIONERS AND MEDICAL STUDENTS
David Sutton. Second Edition. £1.25. Churchill Livingstone. 1972.

The first edition of 1965 consisted of twelve articles written for *The Practitioner* and published in book form. As well as revising the text for the present edition the author has added a chapter on "Para-radiological Imaging Methods" in which Isotope Scanning, Ultrasound and Thermography are briefly described. After being acquainted with the excellent large volume *A Textbook of Radiology* by David Sutton, this book is perhaps a little disappointing. Some of the illustrations are lacking in quality and some show particularly florid or late examples of a condition. Salient radiological features leading to the diagnosis are often omitted and difficulties in diagnosis rarely mentioned. In the section on the Chest the features of collapse and pulmonary embolism are not described. However some sections are good; within its limitations of size and price this book merits a place as a first introduction to the subject. The scope and place of Radiology is well demonstrated.

S. J. HINDS.

PATHOLOGY
J. R. Tighe. Third Edition. Pp. 319. £1.75. Bailliere Tindall. 1972.

This edition of *Pathology* is based on that written by the late Dr. J. L. Pinniger but is improved by the inclusion of new subjects both in general pathology and that of the systems. Each chapter has been brought up to date and the new subjects include allergy, autoimmunity and collagen diseases, gene and chromosome pathology. In the systems, diseases of the central nervous system and the skin are included.

The author does not claim to give the pathological minutiae but a basic understanding of the subject and welcomes the student to refer to other standard works. However this book is so well written that its content is easily remembered and those who purchase a copy will not regret their action and will also be very unlucky to fail "that exam".

The mental images of organic man bendath the skin which many doctors and even more medical ancilliaries carry through life are based on conveniently coloured pictures out of books. They are just maps, closer to the A.A. variety than the Ordnance Survey or a geological chart. Other images derived from the butcher impinge on this mental framework so that most people at least have an appreciation of the textures of bone and muscles and fibrous tissue in a freshly dead state; but of the living, nothing but their own interior sensations.

Dissecting preserved bodies was useful hand-training and gave one the essential time in which to imbibe into the subconscious some of the three dimensional relationships of things. A few of the names stick for life; but the bodies themselves had about as much resemblence to a living organism as a baked cake has to the substance and the mixing of its raw ingredients.

Radiologists' body-images tend to be of perspex and barium, the crystal skull and milk-white blood. Radiographs do, however, offer some three-dimensional help. They can be made to show movement in life and they undermine ingenous beliefs in the standardisation of biological form.

Thus, this excellent, clear book is a very good beginning for almost anyone who needs to study anatomy; but especially for medical students, radiologists and radiographers.

GEORGE DU BOULAY.

THE CLINICAL APPRENTICE
John Naish and Alan Read. Fourth Edition. 240 pages. £1.50. John Wright & Sons Ltd. 1971.

The particular combination of the literary and clinical talent of these two authors produces textbooks for the under graduate which whilst written with great style remain very informative. The fourth edition of this introduction to clinical medicine continues in this tradition and with the reduction or even abolition of the introductory course should appeal widely.

The main part of the book deals with history taking and examination of the systems with in addition examination of children and the acute case covered in later sections. The illustrations are copious and such is the clarity of the line drawings used that more could well be substituted for some of the now aged clinical photographs with considerable benefit to both future costs and display.

The low price of this primer combined with a stimulating presentation should ensure increasing future popularity with novitiate clinical students and prosperity for the department of medicine at Bristol

R. L. BOWN.

WHY A NATIONAL HEALTH SERVICE?
D. Stark Murray. 70p. Pemberton Books. 1972.
EFFECTIVENESS AND EFFICIENCY—RANDOM REFLECTIONS ON HEALTH SERVICES
A. L. Cochrane. £1.00 Nuffield Hospitals Trust. 1972.

I suppose there was never any serious expectation that a National Health Service in the U.K. could run smoothly. Neither before, during or after its inception has the N.H.S. been an easy animal to tame, and perhaps the present difficulties should best be viewed as a totally predictable phase in its history. Too many vested interests, too little money, and too many loopholes have always been its chief problems; yet despite all this, the U.K. can still boast of one of the most healthy populations in the world.

I hoped to find out why this is so by reading Dr. Stark Murray's *Why a National Health Service*, but came away none the wiser and not a little dismayed. Such information that he gives is sadly rather paltry, and the book totally lacks vigour—all the more surprising when one considers that Dr. Stark Murray was a great enthusiast early on, prominent in the Socialist Medical Association of the thirties. Not only it this book dull and badly written (full of trivial lists of who was present at such and such a meeting), but it also fails even to attempt an answer to the provocative title that he chooses. It is no more than a historical account, and readers who expect a logical argument as to the pros and cons of different health systems will be as disappointed as I was.

Dr. Cochrane's book *Effectiveness and Efficiency* is a great deal more stimulating. The author is Director of the M.R.C.'s Epidemiology Unit at Cardiff, and whilst the book fairly bristles with statistical tables, they are never unexplained or inappropriate. Cochrane makes a number of points about methodology in the N.H.S. and in particular makes strong and well-supported claims for the use of randomised controlled trials. He points out carefully the areas in which N.H.S. money has been shown to be well spent, and asks some embarrassing questions about public spending in other fields. The usefulness of coronary care units, the correct treatment of maturity-onset diabetes, the treatment of pulmonary tuberculosis, the value of psychotherapy—all of these topics are discussed with reference to their value to the patient and their cost to society. It may seem dull to have to talk about therapeutic medicine in terms of economics, when ideally there should be money for the luxuries too; but of course he is right—the N.H.S. could work if only its finances could be handled more realistically. It would be nice to have more money, but better use of what we have got is the correct and essential first step.

J. S. TOBIAS.

MATERIALS AND CLOTHING IN HEALTH AND DISEASE
History, Physiology and Hygiene: Medical and Psychological Aspects. E. I. Renbourn, with The Biophysics of Clothing Materials by W. H. Rees. 599 pp. £9.50. H. K. Lewis, 1972.

The author of this fascinating book qualified from Bart's in 1931, and has spent much time studying the historical, physiological and psychological aspects of clothing. He describes the book as "an attempt to deal with clothing and its constituent materials as an aspect of human biology and social behaviour". It is divided into seven parts: historical survey of the functions on materials and clothing; biophysics of clothing materials; the biology, anatomy and physiology of the body surface; the anatomy and physiology of clothing; clothes for health and purpose; medical aspects of materials and clothing; and the psychology of dress.

Containing numerous illustrations, this volume is most readable and illuminating. The technical information is presented scientifically, yet much of it is understandable by the layman. It is also leavened by fascinating facts both historical and modern relating to dress, undress and fashion in all parts of the world. It will be of interest to all concerned with applied physiology, hygiene, psychology and psychiatry, anthropology, sociology, costume and even dressings. In fact, anybody can dip into this book and benefit from the results of much research woven together in a well-documented study.

JOHN L. THORNTON.

SURFACE AND RADIOLOGICAL ANATOMY
W. J. Hamilton, G. Simon and S. G. I. Hamilton. Fifth Edition. £6.00. Heffer. 1971.

The fact that this book has gone into a fifth edition 33 years after its first publication is, of course, a guarantee of its worth; but the title is even more misleading than it was on earlier versions. Although much of the anatomy is referred to its surface markings, the real emphasis of the book is on the way in which interior structures seen on radiographs relate to the time-honoured diagrammatic anatomy of the traditional textbook.

IAN H. BAKER.

BAILEY & LOVE'S SHORT PRACTICE OF SURGERY
Revised by A. J. H. Rains and W. M. Capper. Fifteenth Edition. Pp. 1308. £6.50. H. K. Lewis & Co. Ltd. 1971.

The fifteenth edition of this well known volume indicates its continuing popularity. Over a quarter of a million copies have been sold since the first edition in 1932, including editions in three foreign languages. The layout of previous editions has been retained but much of the text has been rewritten and modernised. There is a greater integration of surgery with subjects such as physiology, pharmacology and bacteriology giving a better understanding of surgical conditions. The plates still illustrate the most severe example of a particular disease and I am sure are instrumental in the book's popularity. And for those worried about the Conjoint viva question "...and who was he?" the biographies of virtually all well known names in surgery are still to be found. A new orthopaedic and fracture section adds to this excellent book which at £6.50 is a bargain. Final year students and all active practitioners will benefit from owning it whether reading for examinations or solely for reference.

M. ROBINSON.

BEDSIDE DIAGNOSIS
Charles Seward. Ninth Edition. 537 pages. £3.00 Churchill Livingstone 1971

Each chapter of this book is designed to discuss the differential diagnosis of the more common symptoms with which patients present. Unfortunately this has produced a very fragmentary style which is both repititious and yet incomplete. There are few illustrations and no references to further monographs or review articles.

In its approach and price this book has little to offer the undergraduate and does not compare to other indices of differential diagnosis available to the postgraduate.

R. L. BOWN.

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

PENGUIN BOOK REVIEWS

JAPANESE COOKING
Peter and Joan Martin. Pp. 208, 40p. Penguin Books. 1972.

This Penguin edition of an already successful book will aid the spread of Japanese cuisine in this country: the Martins have produced a book which is more than a collection of recipes. They discuss the art of Japanese cooking and dining and, most important, give a list of basic ingredients and the shops at which they can be bought in London. These emporia are great fun, but be prepared to spend some time looking for your ingredients for the assistants may speak only a little English. The recipes themselves, which have been adjusted slightly to allow for the capacious British stomach, are easy to follow and should give little difficulty to the average cook. Numerous guests create little washing up if the same rice bowl is used for each course and you provide everyone with disposable chopsticks. If you have not eaten seaweed, chrysanthemum leaves or shavings of dried bonito which look as if they have been swept up from a carpenter's floor, now is the time to start; you will not be disappointed.

IAN H. BAKER.

GOD'S ENGLISHMAN—Oliver Cromwell and the English Revolution.
Christopher Hill. Pp. 318. 45p. Pelican. 1972.

If one were to choose one book which illuminated the obscurities of the Civil War one need look no further than this inexpensive paperback. Unlike most books relating to this period of our history, it has managed to attain a balance between the personal approach and the plain facts. The result is a series of fascinating interpretative essays about the creation of Cromwell and the forces with which he made history.

Most of the book describes Cromwell's life history and the political and social background which eventually led him to become Lord Protector, while the rest of the book considers in detail the changes and influences of the period.

There is an excellent index for those who only require this as a reference book, an extensive biblography for those wishing to investigate further and for those who, like me, thought that Roundheads were boring people who always stopped the fun of these rather dashing Cavaliers it makes good bed-time reading.

O. CLUTTERBUCK.

PAPA DOC. Haiti and its Dictator.
Bernard Diederich and Al. Burt. Pp. 424. 50p. Penguin 1972.

Written by two journalists who had lived in Haiti, this paperback is a fascinating account of the life on an island ruled by a Power mad Dictator.

Beginning in 1957, the story reveals the bloody, turbulent history of Haiti to the emergence of the Dictator from his origins as a quiet country Doctor—a story full of horrible murders, tortures and extortion.

Voodoo plays a small part in the proceedings, from the personification of the Haitian bogey-man, the Tonton Macoute, as the ruthless Secret Police, to the well authenticated tale of Papa Doc demanding the head of the rebel Philogenes in an ice bucket.

Although the book is serious reading, I liked one small story—Vice President Nixon is attempting to exchange pleasantries with a milkmaid. He asks the name of the peasant's donkey. The interpreter, anxious to impress "translates" the reply "He (Nixon) is crazy" as, "She says it hasn't got a name".

Well worth reading.

SHARON CARTER.

BARTS SPORT

TENNIS CLUB REPORT

The A.G.M. and Dinner were held on November 25th, 1971, at the Abernethian Room and the Barley Mow. At the meeting the following officers were elected for the 1972 season:—

Captain: N. M. Perry.
Secretary: P. S. Mortimer.
Vice-Captain: H. Simpson.
Social Secretary: J. Howell.

The season has started slowly due to bad weather and the resultant state of the grass courts. Two league matches have so far been played, a third, against Westminster, was postponed.

The match v. Guy's Hospital was played on May 3rd at their ground. Players had extreme difficulty in serving, and only after the match finished was it realised that the service lines had been marked out 3 feet too short from the net. The match was eventually won 6-3.

Team	*Singles*	*Doubles*
N. Perry	W	W
D. Stewart	W	
—		
C. Higgins	W	L
A. Klidjain	L	
—		
J. Howell	W	L
A. Colver	W	

On May 17th the team had a comfortable 7-2 victory against the London Hospital, at their ground.

Team	*Singles*	*Doubles*
N. Perry	W	W
B. Stewart	W	
—		
C. Higgins	W	W
S. Grainger	L	
—		
R. Bully	L	W
C. Wellingham	W	

ATHLETIC CLUB REPORT

Under the incredible fanaticism of Paul Taylor, the club has enjoyed(?) an early start to the season with vigorous training sessions taking place regularly over the last two months.

With this tremendous pre-season build-up and a 300% increase in the club's members, Bart's gleefully descended on the National Westminster Bank's ground at Norbury on May 2nd for their opening fixture (regretfully without Mike Page, who thought this an opportune time to take two weeks' rest).

Richard Moody won from Steve Mann in the 800m, but Steve went on to win the 1500m. N. Offonry (2nd 100m), Chris Noon (4th 100m), Paul Taylor (4th 400m), and Guy Routh also competed. Overall Bart's finished 2nd of the three teams.

Saturday, May 13th. Inter-Hospital Championships

There were some fine performances here, notably:—
Ian Weller, 1st 110m Hurdles.
John Jenkins, 1st Long and Triple Jump.
Mike Erith, 1st 800m.

Steve Mann was unlucky to be pipped in the 1500m, coming 2nd. Other results:
Richard Moody, 2nd 800m.
Steve Miller, 4th 200m.
Janus Kolendo, 7th Discus.
Paul Taylor, 2nd 400m.

Weller, Miller, Jenkins and Taylor came 3rd in the 4 x 100m Relay.

Guy's retained the Championship Shield, Bart's coming only 5th overall, mainly due to lack of field event competitors.

Wednesday, May 17th. U.H.A.C. Relays

These were held in conjunction with a match between London University and the R.A.F. The climax of the evening came when the phenomenal Bart's 4 x 400m relay team of Mann, Moody, Erith and Taylor recorded 3 mins. 38.8, overwhelming the University "B" and "C" teams.

Thursday, May 18th. Pearl Assurance Sports

This was another most enjoyable evening, and Bart's did well to finish 3rd out of five, despite our poor show in the field events. (Surely someone can throw the shot further than Paul Taylor?) Volunteers please.

Results:—
Alvin Corbin, 3rd 100m "A"; 2nd 200m "A".
Ian Weller, 2nd 100m "B"; 2nd 200m "B".
Steve Mann, 1st 800m "A"; 2nd 400m "A"; 2nd 1500m "B"; 4th H.J. "B".
Mike Page, 2nd 800m "B"; 4th H.J. "A".
Steve Miller, 5th Shot "A".
Paul Taylor, 5th Shot "B"; 2nd 400m "B".
Richard Moody, 2nd 1500m "A".
Corbin, Page, Weller and Taylor, 3rd 4 x 100m Relay.

Monday, May 22nd. Lloyds Bank Sports

Some high class athletes turned up for this. Richard Moody had an excellent time in the 600m (1 min. 27.7), and Steve Mann did well in coming 2nd in the 1000m. Also competed:—
Mike Page (2000m).
Alvin Corbin (60m, 150m).
Janus Kolendo (Discus).

Congratulations to John Jenkins (1st Triple Jump at Kent A.A.A.).

Finally rumours that Paul Taylor is at present in Majorca contemplating retirement due to the pressures of "fixture-cramming", his hectic social and business lives, and constant hounding by the press, are untrue.

SAINT BARTHOLOMEW'S HOSPITAL JOURNAL

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Editorial

The term "current affairs", to me, is one of those phrases with a subtle undertone, conjuring up a vivid picture of boring interviews by boring interviewers, at peak viewing time on the television. (The connotation in certain women's "gossip" magazines is totally different!)

The responsibility of the national press is to consider the phrase more literally, and present, what in the opinion of the editorial staff, are the more interesting or important current affairs of the day. This is an obvious responsibility, since the selection of news, and its presentation, will determine very largely the man in the street's knowledge of current affairs.

The only place in a newspaper where the editorial staff are relieved of this responsibility, is in the editorial itself, where the views expressed are understood to be one man's opinion, and not national policy. This is not true only of newspapers of course, but of all publications, including this one. Yet, in the last three months, extracts from the *Journal* editorial have appeared twice in the national press, written in such a way as to convey to the public that the views stated reflected official Hospital policy.

I refer to the editorials by my predecessors, on book stealing from the library, and, more recently, the shortage of married accommodation for students and junior doctors in hospitals. To my mind, this is a flagrant breach of editorial responsibility, and whilst we are very pleased to receive coverage in the national press, we feel that this should ALWAYS be accompanied by an acknowledgement of the source. (Fleet Street please note!)

SUMMER—A race against boredom

It's August again. How will the students of the hospital be spending their precious summer? If they are lucky enough to still be in, or have just finished, their preclinical course, they will be able to have a long holiday or be able to work, thus supplementing their inadequate grants. But what of the poor clinical student? If this summer is anything like the last few, half the students will just not bother to turn up to teaching sessions and the other half will turn up only to find that 30 per cent of it has been cancelled, because the teacher is away on his vacation. The summer then turns into a race against boredom, with the result that even fewer people come in to the hospital at all. With the lecture course finishing in late June, there must be a strong argument in favour of having a month or even a two month suspension of formal teaching in the summer, allowing those who want to come in to work on the wards and outpatients, the opportunity to do so. Those who do not, will be spared the boredom of arriving at the hospital for perhaps an hour's, or even no teaching, and the guilt of taking days off to avoid it.

LETTERS

Material will not be published unless the name of the author is known to the *Journal*. We will respect the confidence of persons preferring anonymity or a pen-name.

Dear Sir,

In answer to a "Situation Vacant".

Sorry Mac, We haven't got a situation vacant!

I live in a small town where *all* the Doctors know each other by Christian name; the population is of European descent, largely from the British Isles. Our place is not hot, but we can pride ourselves that we probably get more hours of sunshine than many other cities in Great Britain. We do not earn a lot of money either but then we do not count our happiness in our lives according to the number of coins jingling in our pockets!

My three children appear to have been satisfactorily educated at local State grammar and comprehensive schools, non-fee paying.

General practice is satisfactory in this country in spite of the N.H.S. We have pleasant surgery buildings, an E.C.G. machine, post graduate lectures only 15 miles away on many days of the week. We feel integrated with training as we also have students. We have access to our local hospital where we admit and treat our own patients. We do our own casualty work and minor ops. and Dental anaesthetics.

The harbour is about 12 miles away and the sailing is excellent. We are not un-cultured, with a very good live theatre at Exeter, and within easy distance of the Royal Ballet or Opera at Bristol.

We perhaps see a little more of Her Majesty than you do in Tasmania! Here. Bart's men are thick on the ground and this never prevents us from celebrating at any time of the year using an excellent menu.

We have fine moors only about an hour's drive away, and facilities for caving. (You will remember our last expedition no doubt!)

Come off it, Mac, you know as well as I do that General Practice is just as interesting in the U.K., pro vided you make the effort to interest yourself in it.

Yours,
MICK.
MICHAEL GLANVILL.
June 15th, 1972.

Dear Sir,

My canine friend greatly resents your editorial in the current issue and strongly advises you to mind your step!

GEORGE A. COWAN.
Jocelyn House Mews,
Chard,
Somerset.
June 8th, 1972.

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

Dear Sir,

This is my first letter to the *Journal* in my post as Chairman of the Students' Union. Firstly, my thanks to John Wellingham for his year of office, I only hope I can keep up his work. His report in the May *Journal* was very comprehensive and I feel I can add very little but my thanks.

Students' Union activity consists to a large extent to many items which are only of interest to an individual or one club. This fact means that Council meetings have often dragged out to several hours of somewhat forced discussions. In an attempt to counteract this I intend to hold more frequent Council meetings with a time limit of 1¼ hours. Some Council meetings will occasionally be devoted entirely to a particularly important subject. I think it is worth pointing out once again that any member of the student body may attend and speak at Council meetings although he does not have voting rights. Council meetings are advertised on Student Union notice boards at College Hall and the Hospital.

Clinical Curriculum

The three years of clinical work have now been re-arranged by the Curriculum Committee, and will affect the present first year clinical students. The first year now consists of six two-months terms in General Medicine and Surgery. The second year from October, 1972, will comprise three months' Paediatrics, three months' Psychiatry, two months' Obstetrics, two months' Gynaecology, and two months' Orthopaedics. A Chair of Paediatrics for Bart's/London has now been created with the teaching centred at Queen Elizabeth Hospital for Children, Hackney.

The Final Year will, from October, 1973, consist of five 8-week units in Medicine (St. Leonards), Anaesthetics and General Surgery, Specials, Neurology and Cardiology with Neurosurgery and Thoracic Surgery, and an 8-week elective. Holiday times will be fixed around M.B. Finals.

This new curriculum should serve to improve the teaching and perhaps make the course more interesting for students. We can only wait and see how well it works in practice.

Library Facilities

Following on from John Wellingham's suggestions, lockable shelves are now being fitted in the Charterhouse Library. A "books round" of College Hall rooms was performed, yielding £200 worth of books. I would like to issue a further plea for books to be returned to the Library, before the College decides to take firmer action.

Social Events

On a lighter note, Sports Day and the Barbecue Ball took place in the last few weeks. Fuller reports appear elsewhere, and I would just like to thank the organisers of both for their hard work. For Sports Day, Bruce Cambell, Mike Page and Paul Taylor produced an enjoyable day for all, marred once again by bad weather.

Ian Cracknell, for the second year, organised a tremendous Barbecue Ball assisted by other Wine Committee members, also I think special thanks are due to Dick Fowler for his work on the decorations which continue to improve yearly.

GUY ROUTH.
(Chairman, Students' Union).

ANNOUNCEMENTS

Marriage

WALSH—ANDREWS—On May 20th the marriage took place between Dr. Edward Michael Walsh and Dr. Heather Stephanie Andrews.

Engagements

LE QUESNE—HEYWOOD.—The engagement is announced between Mr. Robert Le Quesne and Miss Janet Heywood.

Deaths

BEVERIDGE—On May 9th, Dr. C. E. G. Beveridge, M.R.C.S., L.R.C.P. Qualified 1925.

KADLEIGH—On June 18th, Dr. Sergei William Kadleigh. Qualified 1970.

Appointments

Dr. D. E. Sibson has been appointed Consultant in General Surgery at Kettering General Hospital.

University of London

Dr. C. B. S. Wood has been appointed to the Chair of Child Health tenable at St. Bartholomew's Hospital Medical College and the London Hospital Medical College.

The title of Professor of Clinical Pharmacology has been conferred on Dr. Paul Turner in respect of his post at St. Bartholomew's Hospital Medical College.

Birthday Honours

K.B.E. (CIVIL DIVISION)—Prof. G. A. Ransome.
C.B.E. (CIVIL DIVISION)—Mr. W. T. C. Berry.

"Amateur Radio at Barts"

The idea is to set up an exhibition radio station (GB2SBH?) at the 850th anniversary celebrations. This station could make contact with others the world over. Could any radio amateurs or others interested please contact Gerard Bulger (G3WIP) c/o College Hall or at 111 Manor Road, N.16. 800 2063, and perhaps a more permanent radio station and society could be set up.

MUNICH OLYMPICS '72

John Albert has been selected to represent Great Britain in the canoe slalom at the Olympic Games this summer. The event takes place at Augsburg, near Munich, on August 28th.

John Albert in Training on Olympic Canoe Slalom Course, Augsburg.

BEYOND THOUGHT

By P. M. PEACOCK (a teacher of Transcendental Meditation)

Meditation is a simple technique for bringing the attention from the ordinary thinking level of the mind, to the source of thought. At that finest level, the level of the first impulse of a thought, the object of attention and the process of attending, cease, and the subject is left alone by itself. In other words, mind transcends thought, not by becoming blank on any of the thinking levels of the mind, but by following an object of attention to its source. At this level the mind is naturally drawn to become one with the inner stillness of pure awareness. The *activity* of thinking has ceased, there are no perceptions, images, no objects of consciousness, but just pure consciousness itself.

If the mind is still, then the activity of the physical nervous system must also be at rest, for the two run parallel; the activity of one being expressed through the other. But this restfulness of the nervous system is not of the same passivity as in sleep, but is a state of restful alertness, because the awareness is still, rather than being actually lost. So mind and body come to rest, a rest deeper than even in deep sleep. It is a rest that allows deep-seated stresses that have accumulated in the nervous system, to be released. This release takes place in process, without the present conscious mind being overshadowed by the miseries of the past. For in this process of passing to progressively earlier and earlier levels of the uprising of a thought, coming to the source of thought, becoming one with pure consciousness, and then coming back from there to the ordinary thinking level, the attention passes through all the layers of the mind, without being concerned with their content. The nervous system receives progressively more rest, alternating with more refined activity, and through this innocent alternation, deep-seated stresses are gradually dissolved, and the conscious capacity of the mind is gradually increased. Because, by daily travelling from the surface to the source, the mind becomes able to think at finer levels and capable of functioning consciously nearer to the source of thought. At these finer levels the energy of thought is more powerful, as energy at finer levels always is.

This process can truly be called scientific because it can be tested experimentally and reproduced over and over again. (The physiological tests already done on Meditators will be discussed later.) But it is a very delicate process and therefore it has to be properly taught and understood, or it can easily be lost again. For it is not new, it comes from a very ancient tradition; only, in the course of time, the clear understanding has been overlaid, and it is only now being revived, through the teaching of Maharishi Mahesh Yogi.

One of the advantages of T.M. over other methods is that it is meant for westerners, it demands no withdrawal from the world, or asceticism. One does not have to change one's way of life or suddenly adopt a new diet. One only has to sit down and meditate for two short periods a day and for the rest of the time be naturally active in the world.

For generations it was taught that it was very difficult to turn the attention inwards, because the mind is constantly wandering, brought out by desires, and so it has to be forced to concentrate. All this causes strain and so this path became one for only those who wanted to give their whole lives to it, by withdrawing from the world. But now this revival of understanding has come and cleared the way for any man to attain inner peace and security by giving him a firm foundation on which to base his life, at the level where unity prevails, where the unchanging underlies the changing. Because Maharishi has revived the understanding that it is the *nature* of the mind to go from a state of lesser happiness to a state of greater happiness. The level of pure awareness is the source of happiness, so given a way to go there and understanding of the path, the mind goes as naturally as water flowing down hill. So this meditation is easy, because it uses the natural desire of the mind. For basically desire is always for greater happiness and fulfilment.

But if strain and effort are made, then the physical nervous system becomes strained and this stops the natural flow of the mind. As the process becomes more difficult, men begin to say that it *is* difficult and that one must try harder. Suffering begins to be felt and men say that suffering is necessary for salvation. But man was meant to enjoy, not to suffer. So, using the natural driving force of life, desire, let us come to the source of happiness, which lies deep within us, and begin to express it on the surface of our lives, instead of accumulating stress and, in the process of earning a living, losing the very joy of living.

Dr. Hans Selye of Montreal, has done a great deal of work on stress. He has produced our most common diseases in rats by subjecting them to varying forms of stress. He has shown that an organism accumulates stress if it receives insufficient rest to clear itself.

In the natural way activity and rest alternate spontaneously, but, because our attention does not go right back to stillness, we do not use the full potential of our minds, or express in our lives the full light from the depth of our Being. Indeed, very much the opposite. There are innumerable people in our society who cannot even sleep properly, because they are so strained.

It has also been shown that in the first five years of life, a child can accumulate enough stress, through not being able to communicate properly with its environment, to ruin the rest of its life.

Carl Jung pointed out that we do not solve our problems, we have to outgrow them. Obviously, what was not given in the first five years of life when it was needed, cannot be given later, but the practice of T.M. has shown that a human being can outgrow these stresses; we are not slaves to our past. But the best way to outgrow them is not by analysis, by delving into the past and trying to dissolve each buried stress (a process both long and painful and often too haphazard), but by taking the attention beyond the level of the problem altogether and then coming back from there with some of the energy and bliss that lies at that deepest level of ourselves. It is like switching on a light to dispel the darkness, instead of trying to cope with the darkness.

"Meditation," Mararishi once said, "is like Mother at home." It brings all the security of the unchanging universal level of life to be the basis of our individual ever-changing surface existence. Just as Mother being at home when he gets there, gives a small child a feeling of utter security.

SOME CLINICAL EVIDENCE FOR THE TRANSCENTAL STATE

By A. PEACOCK, B.Sc.

Having given you an account of the philosophical basis of transcendental meditation (T.M.), I thought medical people would be particularly interested in some of the clinical research work that has been carried out on T.M. In the last few years a great deal of work has been done on the fourth state of consciousness, but this remains largely unpublished and so I shall incorporate only work that has been published.

On present evidence, psychologists recognise only three states of consciousness, those of waking, sleeping and dreaming. However, for many decades philosophers and mystics have claimed that other states of consciousness are available to man through meditation. The men capable of these higher states are unfortunately very few, and hence the physiological evidence available though widely publicised has been very scanty. Another difficulty was that the measurement techniques used, almost invariably interfered with the actual meditation process.

Dr. Keith Wallace of the University of California at Los Angeles therefore decided to investigate the meditation as thought by Maharishi Mahesh Yogi because (a) there are a great number of mediators practising this technique in the West, (b) the technique involves no particular concentration or sensory deprivation.

This technique of meditation is a process of turning the attention inwards through the subtler levels of thought until the thought itself is transcended, and the "source of thought" is arrived at. The technique involves no physical or mental concentration or suggestion and hence differs from both the ascetic types of meditation practised by the Hindus in the Himalayas and methods of hypnosis used therapeutically in the West.

Dr. Wallace used as subjects 15 University students who had been practising T.M. for between six months and three years. Each subject sat for five minutes with his eyes open, then for fifteen minutes with his eyes closed; meditated for thirty minutes, then sat for a further five minutes with his eyes closed.

Continuous measurements were made of oxygen consumption (using open and closed circuit systems connected to a Collins respirometer), E.C.G., E.E.G., G.S.R. and Blood Pressure.

Oxygen Consumption

Oxygen consumption, when measured by either the open or closed circuit methods, decreased by 20% after meditating for five minutes and remained low until the subject finished meditating when it rose back up to the resting level.

Dr. John Allison, of London, has ingeniously overcome the subjective difficulty of meditating when attached to a spironometer by measuring the cooling effect of the subjects' breath passing over heated thermisters. He has achieved results similar to, but even more marked than those of Dr. Wallace. However, one must remember that Dr. Allison was measuring respiratory changes which should be, but are not necessarily changes in the oxygen consumption proportional to the Skin Resistance.

Skin Resistance

Skin resistance increased from an average resting level of 90 kilohms to a steady level of 200 kilohms during meditation. It decreased to the resting level after meditation.

Blood Pressure and Heart Rate

Meditation produced a mean decrease in systolic pressure of 7 mms. Hg. and in diastolic pressure of 3 mms. Hg. Heart rate fell on average by 5 beats per minute.

E.E.G.

Before meditation but with the eyes closed, all subjects showed alpha wave activity. During meditation these waves invariably increased in regularity and amplitude. In two of the subjects, alpha activity stopped altogether and theta waves predominated.

All these tests distinguish T.M. from the states of wakefulness, sleep and dreaming and also hypnosis. In all cases the results obtained were more marked with meditation and the E.E.G. activity in meditation is different from that measured in any of these other states.

These results indicate that there exists within the reach of the psyche of man a fourth state of consciousness which I call the transcendental state.

The mere fact of the possibility of achieving this state, is sufficient reason for many people to meditate, but the marked physiological changes that occur during meditation suggest many therapeutic benefits. For example, T.M. seems to reduce "mental stress" and may be useful in treating anxiety states as well as other psychiatric disorders. Drug addiction has been successfully treated in Boston and many former drug takers (including those who used heroin) gave up taking the drugs because they found the subjective experience of meditation superior.

Dr. Benson has reported in the New England Journal of Medicine that in patients of his with essential hypertension, there was a significant and permanent drop in blood pressure in those who took up T.M.

There are many aspects to T.M. of both philosophical and medical interest and I feel that in years to come, established medical practice will be making more and more use of this simple technique from the East.

Further information on T.M. may be obtained from myself or Peter Smith at Barts or by contacting: Student's International Meditation Society, 11 Churton St., S.W.1, or Spiritual Regeneration Movement, Iddlesleigh House, Caxton St., S.W.1.

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JAI BANGLA?

By JACKIE HEATH and JAN SUMMERS

"Operation Bangladesh" began at the end of January, 1972. The International Red Cross had asked 20 countries to send small, mobile medical teams into the war-ravaged Bangladesh. Out of the blue five of us were contacted—"This is the British Red Cross Society. Can you go to Bangladesh next week?" Within a couple of days the team was formed—Dr. David Williams, a G.P. from Swansea; Janet Adams—a nurse administrator: Jan Summers—sister in S.O.P.s at Bart's; Jackie Heath, Bart's medical student; and Arnold Plummer, radio-operator and driver. All the team were widely travelled and had worked previously in under-developed countries. After a few days attempting to obtain sun-specs and sou'westers, galoshes, as the monsoon wasn't far off, anti-malarial pills, and cholera immunizations, the team flew out. We left Heathrow armed with a 10-seater landrover and 25 cwt. trailer, 2 million multivite tablets, sleeping bags, mosquito nets and two weeks army rations. On the same plane was the German Red Cross team, with whom we became great friends, and after a few hectic hours in Calcutta, both teams were air-lifted into Dacca, sitting amongst bags of powdered milk!

Political Turmoil

Bangladesh had been suffering from strife and disaster for a very long time, from both natural disasters and political troubles. East Pakistan was formed in 1947 when India was partitioned. The two wings of India which were predominately occupied by Muslims were cordoned off and named West and East Pakistan respectively, leaving the vast Hindu bloc as India. Thus, the enormous Indian sub-continent was divided up on religious grounds. At the time of partition, the people of Bihar state in India, who were Muslims, trekked across to East Pakistan, to settle in the new Muslim community. These Biharis continued to speak their language, Urdu, also spoken by their brother Muslims of West Pakistan, instead of Bengali as all the other East Pakistanis. India, on her part, never liked the partition, and trouble smouldered between her and West Pakistan over Kashmir. West Pakistan harboured the joint government of both Pakistans—geographically split by more than 1,000 miles, and successfully exploited East Pakistan. Most of the national purse, including foreign aid, was allocated to the industrialized West Pakistan, instead of her much poorer and far more populous twin, East Pakistan, under Ayub Khan. Resentment grew amongst the Bengalis, who formed the majority population of the total from both Pakistans. In 1969, General Yahya Khan took over and established Martial Law. He promised a national election on universal suffrage, which was held at the end of 1970. The Awami League of East Bengal under Sheikh Mujibur Rahman won with an overwhelming majority, who then demanded political autonomy for East Pakistan. On March 26th, 1971, the Pakistan (West) army moved in, and began the massacre of almost 3 million Bengali civilians, starting with the university students and lecturers at Dacca University, whom they machine-gunned down, unarmed, in their beds. On March 27th, Sheikh Mujibur was arrested and imprisoned in West Pakistan, and the Bengalis and Hindus fled over the border into India until 10 million reached Calcutta. A liberation army and a Government of Bangladesh in exile were set up. Meanwhile, in Bangladesh, the Biharis joined forces with the West Pakistan Army. While the massacre of the Bengalis continued resistance grew stronger while incidents occurred including the capture of 11 Indian soldiers in October by the Pak army. On December 3rd 1971 Pakistan bombed India, on December 4th War was declared and on December 6th India recognised Bangladesh as an Independent nation. On 21st December 1971, the Pakistan army signed the instrument of surrender to the Indian Army, after a total collapse of their military campaign.

So here was a newly independent country which had suffered centuries of poverty, starvation and cyclones, superimposed on which was 25 years of political and economical oppression, culminating in the brutal murder of approximately 3 million of her civilians, and then ravaged by a war which destroyed all her crops, her industries, her communication and transport systems, her forces of law and order, and most of her intellectuals. Here too were living 1½ million frightened Biharis, many of whom had been fighting with the enemy and betraying their fellow East Pakistanis only a few weeks before.

Concentration Camp

Within hours of arrival we were at our first mission briefing, and soon we were in the field. We were sent into one of the two Bihari concentration camps in Dacca. We went in with the German Red Cross and split into four teams. The camp was divided into several sections and one team adopted each section.

All food, the electricity supply and with it the mains water supply had been completely cut off for several weeks before the Red Cross was allowed into Mirpur. The camp was surrounded by soldiers armed with rifles and sub-machine guns who were "protecting" Mirpur, and no people were allowed in or out. The Red Cross had only gained admission for the first time three days before our team arrived in Bangladesh. Our first task in Mirpur was to conduct an accurate survey of conditions there—medical, nutritional, sanitation, housing and the treatment of the inhabitants etc. This proved to be easier said than done. In Section XI the people told us that there were 100,000 people crammed into that part. Short of performing a head count, it was impossible to prove or disprove. From experience there, the Biharis were unreliable witnesses—but there were thousands and thousands of people. We could not count the inhabitants because most of the men were marched off at intervals to be searched by the soldiers so the numbers were always completely different. A queue formed all round the section from about 6 a.m., of people waiting all day to obtain one pot of water from one of the handpumps. In the camp we saw real emaciation—particularly amongst the babies and small children. In many cases, the mother's milk dried up

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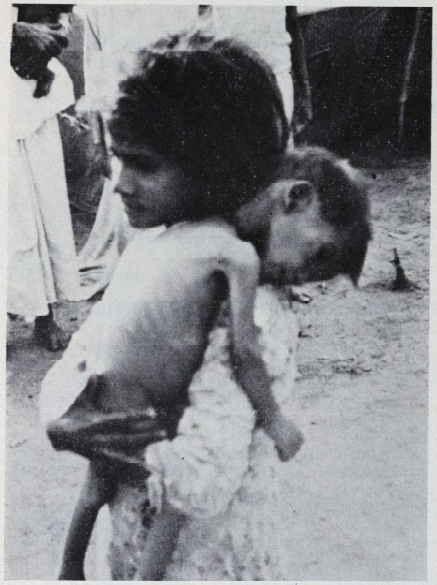
from malnutrition and the very young proved the most susceptible to the starvation.

Deep within Section XI was situated a tented section. One of the tents was a vast construction made of pieces of canvas, saris of different colours, and many areas without cover—not much protection against the impending monsoon—especially as these people slept on the ground, which was soon to become lakes of liquid mud. Over 2,000 people appeared to sleep in "The Tent". Most families possessed a small amount of bedding, a few cooking pots and only the clothes they stood up in —nothing else at all.



Emaciated baby

We spent some time in the futile occupation of food distribution. We had not been in Mirpur an hour before we realised that the food distribution system was corrupt. We decided that we would like to give it out ourselves to ensure that everyone received something, and to each an equal share. At first we had idealistic dreams of people forming orderly queues and we tried to put these into practice. We attempted to line people up, and then sit them down, so we would end up with one single file of people sitting quietly, and we could move down the line giving each his share of milk, rice and vitamin pills. Such illusions were promptly shattered! As we attempted to form the queue we asked the people to sit down, and moved down the row lining more people up. As we progressed the first people sitting down thought they were missing out and came chasing after us again. We had headmen yelling out in Urdu—"Line up. Single line; sit down or no milk!" but all to no avail. It was useless. At any second in time one was surrounded by thousands of people, begging for food, waving their sick baby under your nose, ripping your belt off, ramming the edges of their metal plates and mugs through your rib cage and occasionally rushing you and stealing the food supplies all together. Later we commandeered a small house which was surrounded by a wall 6 ft. high and had an iron gate, and a dozen strong men let people in one at a time to get the supplies. Some families had nothing in which to place their meagre rations—many women tied it up in the edge of their sari.

We had little time there for medical work. We treated asthma, dysentery, gastro-enteritis and chest infections. We were also busy at this time telexing London Red Cross H.Q. to airlift in for us a vast quantity of drugs from Singapore, for a new posting we had just received to proceed to the North West and establish a medical service there.

We had many preparations to make. One of our landrovers disappeared en route for Bangladesh, and it took some days to locate it and prepare it for its tough journey northwards. Such necessary items as hurricane lamps and camping stoves and kerosene (which was as rare as gold in post-war Dacca) had to be acquired together with mosquito spray, without which we would never have survived to tell this tale! By the time we had our marching orders we had two landrovers—one 10-seater and one lorry—plus two trailers and 3½ tons of drugs and equipment to embark on our hazardous journey into the unknown.

Journey to Saidpur

We left Dacca at 3 a.m. on February 24th. Our first destination was Bogra and we were unsure as to when we would arrive as missionaries passing through Dacca had informed us of 4-day long queues for the ferry across the Ganges. The journey was both terrifying and interesting. Most of the bridges had been either blown up or bombed, and we were subjected to hair-raising diversions down into the river bed, across pontoon bridges and rickety ferries. At most diversions we had to roar down a nearly vertical drop, weave at speed among lorries stranded in the quagmire at the bottom and accelerate up an equally steep bank before tons of weight could pull us backwards into the water. Often the only sign that a bridge was out of action was a twig in the middle of the road and perhaps an insignificant sign in Bengali which apparently said "Diversion".

However, eventually we all reached the Baptist mission in Bogra where we spent the night. The following day, after an equally exciting journey we reached Saidpur, making our base the Catholic convent, while looking for suitable accommodation of our own.

Minefield

We introduced ourselves to local government officials in the district, and received briefings about the situation in Saidpur, which was miserable indeed. Until three months previously, Saidpur had been a town of 70,000 people, predominantly Biharis. In the disturbances approximately half a million Biharis had fled into the town, where the Pakistan army had been stationed, for protection. These people were sleeping in the Post Office, the cinema, the schools (which were therefore closed),

Bridge blown up.

in railway carriages, in home-made huts of anything—sacks, matting, corrugated iron—and out in the open. They had no toilets. No sewage had been moved for four months and only five sewage workers, who were Hindus, were left. The water supply was intermittent, with the electricity supply. There was very little food in Saidpur, and people didn't have money to buy any. The major industry in the town was the Railway workshop, but none of the workers had been paid for four months, even though they still clocked in every day. All non-Bengali bank accounts were frozen, so even wealthy Biharis couldn't obtain money for food. All the authorities and police in Saidpur were Bengalis, despite the 98% Bihari population. The Biharis were terrified to set foot out of doors, even in daylight, in case they were arrested as "collaborators".

And as if Saidpur did not have enough problems, the whole district was mined. The Indian army coolly informed us after we had been living there a week that the Pak army had laid plastic mines all over the area, and they hadn't been able to locate them with mine detectors. We had to remember every day to be careful where we walked, only to drive down tracks that showed fresh bullock cart markings and even to watch where our helicopter landed. During our time there, several patients appeared at the hospital suffering from mine-blast injuries.

Shortly after our arrival, the Indian army withdrew from Bangladesh, leaving in their stead the Bangladesh regiments. The enemies of the Biharis now occupied every position of authority in the district. There were thus many enormous problems to tackle in this bleak corner of human existance.

Cholera

With mountains of sewage piling up around the town, and none being moved or treated, and the monsoon weeks away, to avert a cholera epidemic became top priority. It was not enough to immunise everyone against cholera, though that was no easy task with half a million people and five of us! We had to get to the root of the problem—the sewage itself. The day after we arrived we went round interviewing any public authority who could possibly have any connection with sanitation and ask him what he was doing about the situation. Answer—wringing the hands: "Nothing". Therefore we arranged an enormous meeting for all these authorities, and rounded up defaulters with our landrover! We finished up with a vast room full of people—the Chairman of the Municipal Council and his Sanitary Inspectors, the Railway authorities who administered the sanitation in their part of the town; the Awami League—the only significant political party; the M.O.H., Caritas Roman Catholic Relief organisation; an M.P. and of course the Red Cross. The meeting was a great success. The sewage problem was even more difficult than it sounded—it had religious undertones! Only Hindus of the cleaning caste would tackle the job. They had all fled and the Muslims wouldn't touch the work. After about two hours, a plan was decided upon. This consisted of a "Clean Drive Week" for the whole city. The Awami League was to mount a publicity campaign by posters and microphone. Volunteers were to be called forth to dig communal latrines in all areas with Bihari refugees, and keep them clean. For this they would be paid in milk powder—"food for work"—

which would also relieve the starvation problem. Inspectors would be appointed to ensure that everything ran smoothly, and the whole operation would be under the supervision of the Sanitary Inspectors of the Municipal Council, who would also choose the sites for the latrines. Caritas organisation offered to provide chlorine and potash to put down the latrines which would eventually be covered over with earth, and the Red Cross provided the equipment.

Several more meetings were necessary to chase up all the people who were actively involved in the programme. No one, except Caritas, did anything unless one stood over them. Eventually, over 700 people volunteered and each man was given a large quantity of food daily. "Clean Drive Week" was extended indefinitely to cover the whole emergency period. The latrines were dug, and by our third week in Saidpur the whole programme was fully operational.

Smallpox

Due to the gross over-population of Saidpur, and the total collapse of sanitation, it was decided that an immunisation programme was vital. Seventy local volunteers were recruited to vaccinate and to issue certificates. Smallpox vaccine and needles were transported by helicopter from Dacca. Supplies of cholera vaccine were not available initially, and cholera immunisation started later. After a teach-in for the volunteers, we set forth in the landrover to Union 1, where 80,000 Biharis lived. Using the vehicles as a base, where needles were sterilised and vaccine distributed, we each took an area of the Union.

Many of the people were extremely unwilling customers. Others, obviously starving, could not understand why we hadn't brought them food. We managed to vaccinate between 3,000 and 4,000 people each day. This will decrease the likelihood of a smallpox epidemic in Saidpur.

Hospital

The next problem to cope with was the inadequate medical service. With the lack of food, absence of accommodation, overcrowding, sanitation problems and very intermittent water supply, approaching monsoon, smallpox in a nearby area and cholera epidemic imminent, Saidpur must surely have been one of the world's unhealthiest places. Saidpur had had approximately twenty doctors—but fifteen of them had fled or been killed in the disturbances. Of those who were left, most saw patients and gave prescriptions—but the people had no money and could not afford the drugs. There had been two hospitals. The Civil Hospital was on the outskirts of the town, and the Biharis were afraid to walk up there. The other hospital, the Railway Hospital, provided free treatment for the Railway workers. One doctor worked at the Civil Hospital and three at the Railway Hospital. Both hospitals were almost completely empty, which was amazing, considering the vast numbers of really sick patients that we saw. At both hospitals the kitchens were closed (without even a flame with which to boil water) and the electricity and water supplies were out of action.

Operation "Clean Drive Week".

David and Jackie opened up two clinics in a disused ward inside the Railway Hospital. This was open to men, women and children of any nationality, religion or occupation. The consultation, treatment and drugs were entirely free to the patients. It started off as an out-patient dispensary, but soon it became impossible to refuse admission to certain dangerously ill patients, and so it began to operate as a small hospital as well. This was in the face of almost insuperable practical problems—particularly the *total* absence of cooking facilities, functioning toilets, water and electricity supplies! All drugs had actually to be dispensed at the consultation, and all treatments to be carried out at the same time. Most of the patients did not possess a bottle or jar, and could not obtain one, so tablets and liquid medicines were dispensed in plastic bags. Some emergency surgery was also performed—particularly when any victims had been shot, walked over mines or fallen under trains. But with our primitive facilities we avoided elective surgery altogether—apart from the fact that we didn't have a surgeon!

A few emergency home visits were necessary—rushing out in the landrover weaving past rickshaws until the countryside became virtually impassable. Somehow the landrover always made it—across innumerable rivers and hillock country, past picturesque agricultural villages, primitive ploughs, haystacks and holy cows to some little straw or mud hut.

Most of the patients walked to the hospital, but the worst ones came by rickshaw or bullock cart, or were carried in by their relatives. The hours were long at the hospital—we often left at 10 p.m. or even later and we still didn't get through more than half or two thirds of the patients. It was first come, first served. Eventually we came to know how many we could cope with in an average day (David seeing far more than the inexperienced student) and we used to skin stamp that number of patients. This system had the advantage to the patient that those who were unsuccessful in being stamped at 8.30 a.m. didn't have to queue all day and knew that they must arrive earlier the following day. Bad as it was not to be seen, it was worse still to queue until nightfall and still not be seen.

We had interesting clinics. Before a general clinic, Jackie held one for TB, followed by a pneumonia clinic (impossible to admit any but the worst cases), while David's general clinic opened at 8.30 a.m. We saw a lot of dysentery, gastroenteritis and worms; vast numbers of skin lesions, especially ulcers (tropical and non-tropical) and purulent sores, anaemias, malaria, hundreds of interesting eye disorders including iritis, which was quite common there, and a few trachomas. We saw a fair number of carcinomas and patients with ascites from unknown cause. Goitre was endemic in the area. There was scabies and malnutrition. The suspect children were weighed—one child of 4½ years weighed only 11 lbs. Night blindness was very common, as were the other vitamin deficiency diseases. In the first 3 weeks alone we saw cases of Nephistic syndrome, acute nephritis, P.U.Os., lymphadenopathy, shingles, mastoiditis, arthritis, ovarian cyst, congenital heart disease, rheumatic fever, meningitis, Talipes, gastric ulcers, respiratory infections, asthma and herniae. There was a case of Paget's disease of the nipple, Simmond's disease, parotid tumour, carcinoma of lip, branchial cyst, actinomycosis, TB hips, TB cervical glands, muscular dystrophy and thrush diarrhoea. We saw a lot of chickenpox and a few suspect cases of smallpox. Most of the TB cases we admitted were very advanced, some had massive haemoptyses daily and severe cachexia.

All in all, the clinic work was very varied. At the beginning we each employed a college student as an interpreter/medical assistant—and they were wonderful. Eventually we employed 2 each—but we could have used 6. Other problems we experienced were working for several hours after dark without any electricity—sometimes we didn't even have hurricane lamps and used to pass round a torch or a box of matches between four of us! Drug supplies were the worst problem. Initially, the British Red Cross air-lifted in from Singapore supplies of about 60 drugs we ordered. However, with the numbers of patients we saw (200 daily) these soon became exhausted. Most weeks a Red Cross helicopter flew up from Dacca with some of the drugs for which we had radioed. Occasionally we obtained some from a wandering charity van, e.g. Oxfam, or begged some particular drug we were desperate for from another team. With the drugs from all these sources, we were just about able to tick over at a minimal level, but continuation of our meagre supplies remained a large problem.

Jackie's Helicoptor Arrival.

Village Clinics

The Red Cross is obviously politically unbiased, but it is sometimes necessary to demonstrate this to the local people.

Although all the Biharis were living in Saidpur itself, the surrounding villages were inhabited by Bengalis. After a busy morning vaccinating, two of us drove the landrover and made a survey of these villages. Following this, we set up the "Summers Mobile Scabies Clinic" under haystacks, in barns and other sundry places. Most of our patients were babies and children and we treated malnutrition, discharging ears and eyes, respiratory infections, gastroenteritis, fungal infections and scabies.

The people were extremely hospitable and after each clinic we were offered afternoon tea, consisting of fried eggs with curry powder, fried sweet noodles, sweet paste and a cup of tea! We always arrived back at our base after dark, having once again negotiated the mud tracks.

Milk Distribution, Rehousing and Banking

Due to the increased level of starvation it became necessary to begin food distribution, established with the help of Caritas, using a system of ration cards.

Before the arrival of the monsoon, all those refugees who were living completely in the open were successfully rehoused in go-downs (warehouses).

On March 6th, 1972, the Bangladesh government decided to demonetize the 50 rupee note. It asked for Red Cross help in collecting old notes from the Biharis who would be too frightened to go to the banks themselves. Of 131 people who brought their money to us, only 65 returned a few days later to collect their new notes. While engaged in these activities, two of us were again staying at the mission in Bogra. We managed to pay a social call on the Bangladesh Army and were invited to inspect the troops.

International Effort

The days in Bangladesh were certainly exciting. Apart from the mines, we had a few days scare from a soldier's warning that one member of our small team might be shot to create an international incident. However, fortunately, the tensions settled. But these were also days of tragedy. At Khulna in the South a lot of Biharis bravely decided to return to their homes and jobs. Everyone was hoping that if this went smoothly it would set a pattern for the country. But virtually all of them, over 2,000, were slaughtered. A population exchange with the Bengalis of West Pakistan appears to be the only hope of a permanent solution for the Biharis.

The most satisfying side of our mission was to have been working as part of a very great international effort. There were Red Cross teams from as far apart as Japan and Canada, Finland and New Zealand, and most teams met about half the others. The international spirit of friendship, co-operation and effort in the struggle for peace and humanity was the greatest achievement, working as one for the sake of mankind.

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THE X BARBECUE BALL

PLAN

Imagine, if you will, a group of dedicated, determined men seated round a table. The lights are low, the group talks in hushed voices—no-one must hear of their plans. Suddenly their leader stands up. He is a tall, well built young man wearing the uniform of the Royal Air Force. The buzz of conversation dies as he prepares to speak. "Gentlemen," he says, wittily, "the operation will be called 'The Barbecue Ball'!"

"But we've called it that for nine years running, Ian," says a complaining voice.

"Ah, but this year it will be different," replies their leader, "this year there will be no cabaret!" The men gasp, unable to hide their astonishment.

"And what is more, Dave Jackson will be in charge of the food!" The men rock in their seats.

"And the ladies are going to decorate a room!"

By this stage the men can stand no more assaults on their standards of values and tradition, and rush from the room to pickle their disbelief in waves of ethanol.

PREPARATION

That is roughly how I choose to imagine the first meeting of the Barbecue Ball Committee. The next part of my story is concerned with the weeks between this meeting and the "great day". It is a story of a very great deal of hard work. Anyone who stuck his nose inside the gymnasium was liable to have it hit by a flying paint brush or a box of assorted nails. But through the airborne debris he might also have witnessed a miraculous metamorphosis—bales of chicken wire turning into outcrops of moonrock, scrap wood becoming Egyptian pyramids. I do not think enough people appreciate the amount of work that goes into this stage of the proceedings. At least four thousand men were employed in building the decorations this year (according to the free-drinks book).

PERFORMANCE

I would like to start this last part of my story by saying that the morning of June the ninth dawned bright and clear, a cheerful yellow sun brightened the buildings and sparkled on the windows and the birds chirped happily in the tree-tops of Charterhouse Square. Unfortunately, I would be lying, since the day was grey and miserable, a steady drizzle washed the buildings and marquees, and the occasional waterlogged bird was seen falling from the trees. Fortunately this did not seem to dampen the spirits of the willing workers and, when the gymnasium doors were fully dilated, the decorations burst forth from their uterine safety and were installed in College Hall.

Ten o'clock eventually arrived and the ball was started with the wonderfully surrealistic sight of the pyramids and the Sphinx being serenaded by Scots pipers. Journeying into the foyer, one came into the tomb of Tutankhamen. This was a typical piece of Fowler-Cracknell engineering, remarkable not only in its dimensions but also in its authenticity.

The entertainments were started at 10.15 by Pickerty-Witch who, if a trifle "teeny-bopper", nevertheless provided a good warming-up session. Food was then provided from eleven o'clock until two minutes past eleven. All credit to Dave Jackson for attempting to increase the length of time in which food would be available, but his plans were defeated by the gregarious instincts of the Barts animal.

The Harrison-Tweedie team wisely decided that if you can't beat the Refectory then you join it and had used its stark squareness very effectively as the main street of a Wild West shanty town. At 11.45 the stage was taken by Instant Sunshine. By not billing them as a cabaret, the usual crush was avoided and those who trusted Pat Walker to book good acts had their faith rewarded by seeing a very polished and funny musical act. Due to the medical origins of the group, their humour was particularly suited to their audience, a fact that was revealed by the number of encores demanded of them.

If you walked into the marquee at one o'clock, you might well have thought that the roast ox had died of an L.S.D. overdose. If you forced your way through the seething multitude to the front, the reason for this apparently irrational behaviour became evident. The Wild Angels, playing at 200 decibels, have an ability to drive the otherwise sedate and reserved Bartsman completely berserk. I hope they become a regular feature of the Barbecue Ball.

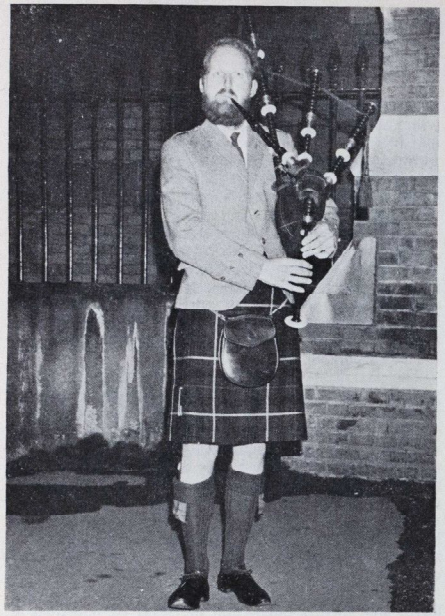
At 2.30 John Martyn took the stage in the Refectory. A progressive guitarist of high calibre, he did not appeal to everyone. I thought he was brilliant but many people obviously did not. However, there was, throughout the evening, a choice of entertainment.

Tim O'Donovan had converted the Bar Lounge into the deck of an old square-rigger and at various times in the evening this room played host to a modern jazz group, the inevitable steel band and the Nights Show Band. The Abernethian Room, beautifully decorated by Wiz Mansi and Jila Pezeshgi as a 200X magnification of a garden, housed the discotheque all night.

Kelley and Co. had disguised the Recreation Room as a moon landscape and at 3.30 the last big name group, Design, appeared there. I was very disappointed with them but they were without their lead singer. However, I was obviously in the minority since the room was packed solid.

So, after steak-and-eggs breakfast at five o'clock, the crowds moved off home. Those that came expecting the same as previous years enjoyed the ball. Those that came prepared to accept a slightly different format and entertainments loved it. In conclusion, a most successful ball and full credit to Ian Cracknell for organising it. I, for one, will be looking forward to next year.

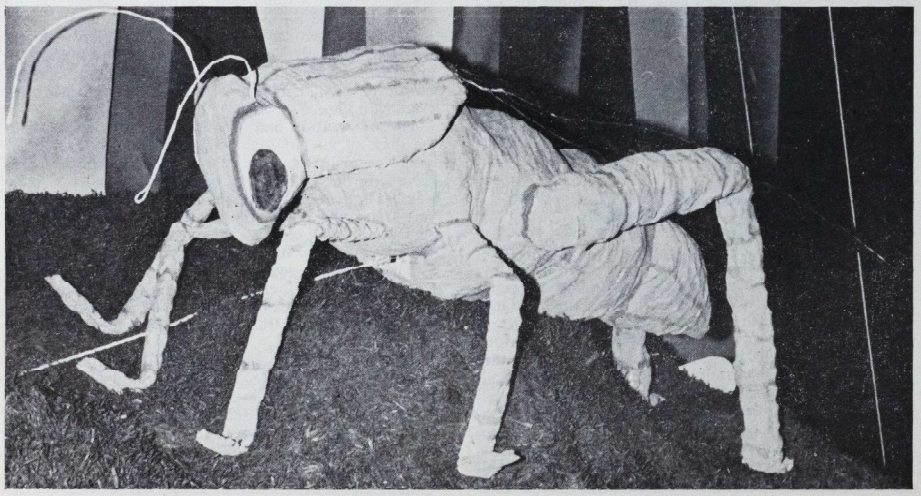
PETER BURNETT.



"It was not a warm night—note the tears in his eyes."

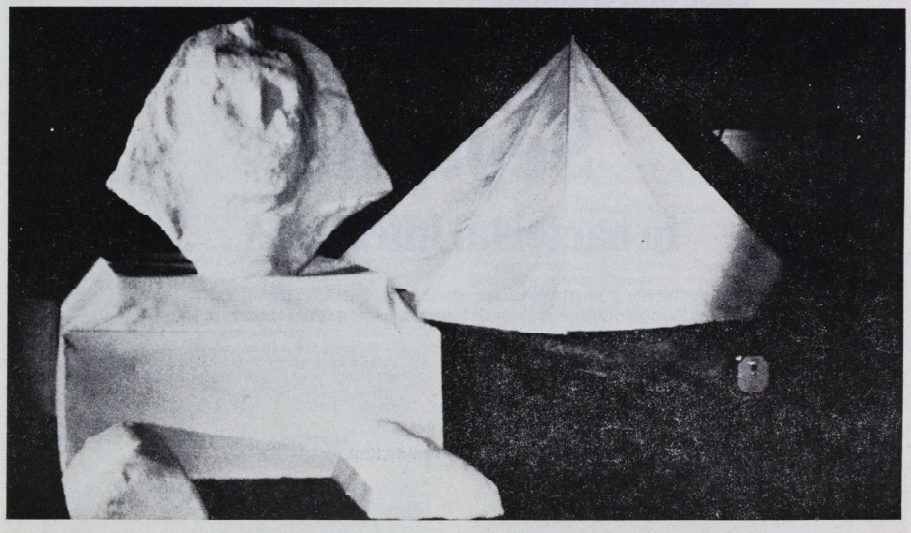
"You should see the Public Bar!"

— "Makes a change from beef, I suppose." —



BARBECUE BALL 1972

"Hello, Mummy."



"Sphinx ain't wot they used to be."

URIBAGGY

By FREDERICK SCOTT WILLS

—with apologies to Lewis Carroll
and indebtedness to his "Jabberwocky"

'Twas Bartslag, and the Bladdamen
Did squirge and squiggle in the bed;
All bungly was the Netherpen,
And the sloth-tubes out-bled.
"Beware the Uribag, my son!
The clots that clog, the coils that kink!
Beware the Catheturb, and shun
The bellowish Worterdrink!"
He took his sizza-sword in hand:
Long time the Antiflo he sought—
Then rested he by the Cistern tree
And fought the Uritaut.
And as in urithought he stood,
The Uribag, with tongue of flame,
Came whizzling through Pyjama wood
And peezled as it came.
One, two! One, two! and through and through
His sizza-sword went snipper-snack!
The Uribag he left a rag
And went expirting back.
"And hast thou slit the Uribag?
"Come rest in peeze, my pizzlish boy!
"O Peedom Day! Yooree, yooray!"
He spountained floods of joy.
'Twas Bartslag, and the Bladdamen
Did squirge and squiggle in the bed;
All bungly was the Netherpen,
And the sloth-tubes out-bled.

BOOK REVIEWS

PATHOLOGY
I. R. Tighe. Third Edition. Pp. 319. £1.75. Bailliere Tindall. 1972.

This edition of *Pathology* is based on that written by the late Dr. J. L. Pinniger but is improved by the inclusion of new subjects both in general pathology and that of the systems. Each chapter has been brought up to date and the new subjects include allergy, autoimmunity and collagen diseases, gene and chromosome pathology. In the systems, diseases of the central nervous system and the skin are included.

The author does not claim to give the pathological minutiae but a basic understanding of the subject and welcomes the student to refer to other standard works. However this book is so well written that its content is easily remembered and those who purchase a copy will not regret their action and will also be very unlucky to fail "that exam".

IAN H. BAKER.

SURFACE AND RADIOLOGICAL ANATOMY
W. J. Hamilton, G. Simon and S. G. I. Hamilton. Fifth Edition. £6.00. Heffer. 1971.

The fact that this book has gone into a fifth edition 33 years after its first publication is, of course, a guarantee of its worth; but the title is even more misleading than it was on earlier versions. Although much of the anatomy is referred to its surface markings, the real emphasis of the book is on the way in which interior structures seen on radiographs relate to the time-honoured diagrammatic anatomy of the traditional text-book.

The mental images of organic man beneath the skin which many doctors and even more medical ancilliaries carry through life are based on conveniently coloured pictures out of books. They are just maps, closer to the A.A. variety than the Ordnance Survey or a geological chart. Other images derived from the butcher impinge on this mental framework so that most people at least have an appreciation of the textures of bone and muscles and fibrous tissue in a freshly dead state: but of the living, nothing but their own interior sensations.

Dissecting preserved bodies was useful hand-training and gave one the essential time in which to imbibe into the sub-conscious some of the three dimensional relationships of things. A few of the names stick for life; but the bodies themselves had about as much resemblence to a living organism as a baked cake has to the substance and the mixing of its raw ingredients.

Radiologists' body-images tend to be of perspex and barium, the crystal skull and milk-white blood. Radiographs do, however, offer some three-dimensional help. They can be made to show movement in life and they undermine ingenious beliefs in the standardisation of biological form.

Thus, this excellent, clear book is a very good beginning for almost anyone who needs to study anatomy; but especially for medical students, radiologists and radiographers.

GEORGE DU BOULAY.

THE HOUSE PHYSICIAN'S HANDBOOK

C. Allan Birch. Third Edition. £1.50. Churchill Livingstone. 1972.

When choosing a small pocket-sized book, a kind of vade-mecum on any medical subject, one asks oneself what type of author should one choose. Should this sort of book be written by a middle grade Registrar or an experienced Consultant? This little book, intended for the newly-qualified Houseman, is written by an eminent Honorary Consultant Physician with much experience in Medicine but, one wonders, with perhaps limited memory of his Housemanship.

The first chapter sets out to deal with general information and is full of very useful information to the green houseman. This chapter, as is most of the book, is very well written and very clear, although slightly dictatorial in its advice on subjects like abbreviations. It also contains information for the "House Physician from Overseas" which consists of a list of references and, more useful, a list of phrases in English, French, German and Italian including that classic "couchez-vous sur le divan". On a more serious note there is very valuable information like broadcasting S.O.S. messages via the B.B.C., informing the Coroner, speaking to the press, police and relatives and other frequent but difficult duties.

My only serious criticisms of the book are connected with the second chapter, which is devoted to Clinical Procedures. My criticisms are that the Author is very detailed on, for instance, examination of the Urine, which nowadays seems to be left mainly to the Laboratory, and yet on a subject like Lumbar Puncture, which all Housemen need to know properly, the author devotes two rather thin pages. This whole chapter takes up less than three quarters that of the general information. Surely, in a book of this sort, clinical procedures are the most important feature of the book.

The third and fourth chapters are devoted to Clinical Pathology and Treatment and are admirably done, although I suspect, in my ignorance, that the section on laboratory tests may not be completely up to date. The treatment section is superb and really justifies buying the book. Everything one can think of is mentioned and plenty more besides. I can see that if every new Houseman read the final chapter (fourth) in this book there would be many less Registrars losing sleep at night. The book even mentions things like Methylated Spirits poisoning and a brilliant method for removing a fixed wedding ring with the aid of a piece of string and a matchstick.

In balance, whatever my reservations about lack of detail in some parts and too much in others, this book is a must for all new Housemen (and Women). With this little book in one's pocket I feel one could be killing a few less patients or at least causing the Medical Defence organisations a few less headaches. For £1.50 "The House Physician's Handbook" is a real bargain.

M. J. GOLDSMITH.

AN INTRODUCTION TO PHYSICAL METHODS OF TREATMENT IN PSYCHIATRY

William Sargant and Eliot Slater. 5th Edition. 318 pp. £3.00. Churchill Livingstone. 1972.

This book was first published in 1944 and its enormous popularity is shown by the present 5th Edition. This will be the last edition written by Sargant and Slater as both have now retired from clinical work in hospital, and it has always been their intention that the contents of this book should come from personal experience of busy hospital practice. This outlook shows itself in this book with a rather dogmatic approach but with an enthusiasm for the subject and their patients which is infectious. The book retains its main format and the sections on E.C.T., narcosis and leucotomy are excellent. The chapter on insulin coma is retained although it seems excessively long for a treatment which has almost been abandoned and Dr. Frommer has added a chapter on drug treatment in childhood and early adolescence. The authors have been determined to keep the book reasonably short and I am sure it will remain the standard reference book for physical treatments. However, I disagree with the authors' assertion that Chlorpromazine is the drug of choice for alcohol withdrawal.

C. M. B. PARE.

ALCOHOL AND DRUG DEPENDENCE—TREATMENT AND REHABILITATION.

M. M. Glatt, W. P. Jones, C. E. Salter, H. G. Thomas. £1.50. King Edward's Hospital Fund for London. 1972.

This book comes from the Alcoholic Unit at Warlingham Park Hospital which is well known and highly regarded for its work on this subject. It is not however a book on alcoholism but rather the administrative organisation necessary to deal with these patients. For the student it would be better recommended to read the Penguin by Walton and Kessel.

C. M. B. PARE.

A HOSPITAL LOOKS AT ITSELF—ESSAYS FROM CLAYBURY

Editor: Dr. Elisabeth Shoenberg. 278 pp. £2.50. Bruno Cassirer. 1972.

Since the War psychiatrists have become increasingly aware of the importance of the atmosphere of the mental hospital in promoting or retarding a patient's recovery. Thus "you tell me what to do—you're the doctor—you nurses are trained—I'm only the patient—it's up to you—find me a house, a job/get my wife back . . . " is held to be anti-therapeutic and lead to a safe dependency and in psychotic patients to the state of institutionalisation.

Claybury Hospital has developed the system of group discussions between patients, patients and staff, and between nurses and doctors to a high degree as one way of overcoming this and attempting to foster the healthy parts of the patient rather than focusing on the unhealthy aspects. This book describes these methods from the point of view of doctor, nurse, patient, social worker, etc., and includes the views of medical students who visit for periods of two weeks at a time. The book conveys the optimism and therapeutic enthusiasm of the hospital which must be beneficial in itself. But I am sceptical as to whether an "open" group run by the junior doctor or staff nurse for a period of six months can deal with more than superficial interpersonal difficulties in the severely neurotic.

C. M. B. PARE.

SOME ASPECTS IN THE PREVENTION OF MENDELSON'S SYNDROME, PRIOR TO THE INDUCTION OF GENERAL ANAESTHESIA

By G. B. GILLETT

Every three years the Department of Health and Social Security produces a Report on Confidential Enquiries into Maternal Deaths in England and Wales. The most recent report available covers the three-year period 1964-66.[1] (The 1966-69 report is due to be published later this year.) In this report, 2,630,150 births occurred and maternal deaths directly due to pregnancy and childbirth numbered 671. The number of deaths is less than half the number for the three years covered by the first report (1952-54) when only 2,079,275 births occurred. This reflects the greatly improved safety in pregnancy and childbirth that has been achieved. All the major causes of maternal death, i.e. haemorrhage, sepsis, pulmonary embolism and toxaemia have shown a steady decline over the years. Of the deaths due to the complications of anaesthesia in the period 1964-66 there were 50—over half of which (i.e. 26) were due to the inhalation of stomach contents. Of these 26 deaths, 22 had developed Mendelson's Syndrome, and 18 were deemed to have had avoidable factors. This unfortunately does not represent an improvement over the preceding 3-year period (1961-63) when there were only 16 deaths due to the inhalation of stomach contents. In fact, one has to go back to the 1952-54 period to find a three-year period with a greater number of deaths (32) due to the inhalation of stomach contents.

Although vomiting of solid food particles and their inhalation can give rise to areas of atelectasis in the lung or even possibly total obstruction of the airway—it is the insidious silent regurgitation of highly acid gastric juice (with a pH below 2.5) which on entering the lung can give rise to a profound reaction. The Syndrome defined by Mendelson[2] can come on rapidly or be delayed for a number of hours. It consists of increasing respiratory distress due to a combination of bronchospasm and a large outpouring of serous fluid from the respiratory epithelium. The patient becomes cyanosed and this is unrelieved by the administration of oxygen. On listening to the chest ronchi and numerous moist sounds will be heard over the affected areas. A tachycardia invariably develops and is associated with hypotension. The syndrome may well develop into one of a fulminant pneumonitis, pulmonary oedema and circulatory failure. Death may occur within a few hours of onset, in spite of vigorous treatment. Thus it is apparent that the regurgitation and inhalation of stomach contents remains a most grave and potentially lethal complication of obstetrical anaesthesia, and it is important to consider how it can be avoided. Obviously the skill of the anaesthetist concerned and the details of the technique he employs are of paramount importance. However, anaesthetic experience and technique alone are not a sufficient guarantee against this disaster and it is the main purpose of this short article to consider the ways in which those looking after patients in labour can help to protect the patients against Mendelson's Syndrome.

PREVENTION OF INHALATION OF GASTRIC CONTENTS

Local Anaesthesia

For a number of years it has been the practice to avoid the use of general anaesthesia where possible. Thus most outlet forceps deliveries are now performed with the aid of local infiltration and pudendal nerve block. More recently, epidural or caudal analgesia used during labour has enabled the more difficult forceps delivery to be performed without the aid of general anaesthesia. However, it should always be remembered that the aspiration of gastric contents is even possible during conduction anaesthesia.[3, 4]

Dietary Control

Ideally any obstetric patient requiring general anaesthesia should have an empty stomach. However, this is an impossibility for several reasons. Firstly one has little warning of which patients are going to require a general anaesthetic and it is undesirable and unpleasant to starve women as soon as they commence labour. Secondly gastric emptying is delayed by the presence of a large abdominal "tumour" and by the use of analgesic drugs. Also the presence of pain and apprehension will impede gastric emptying. Taylor and Pryse-Davis[5] showed that in patients, in active labour for over two hours, who came to general anaesthesia 55% had gastric contents of over 40 ml (as retrieved by a No. 8 (Fr) plastic tube passed into the stomach following established anaesthesia). The volume of gastric contents seemed to bear little relationship to the length of labour. In elective obstetric patients who had been prepared for anaesthesia by the restriction of oral fluids for 6

hours pre-operatively only 1 in 10 had gastric contents of more than 40 ml. As Crawford[6] has pointed out the aim of any diet given during labour is that it should be light and easily digested, whilst still being satisfying to the patient. Foods such as chunks of meat, unmashed potatoes, beans, peas and fruits or vegetables with a high fibre content should be avoided as they will remain in the stomach for many hours. This also applies to fried foods. Sieved foods provide the most satisfactory basis for each meal. Meals should be accompanied by fruit drinks which can contain a concentration of glucose not greater than 5%. Tea can be taken but milk drinks should be avoided as indigestible curds may be formed in the stomach. It is important that meals should be provided at roughly three hourly intervals, but that the quantity at any one meal should be kept small. Water or fruit juice can be allowed between meals.

Once labour has commenced patients should be divided into two groups—as far as diet is concerned. Those in whom a general anaesthetic is unlikely to be required—so called "low risk" patients—the above described diet can be continued throughout labour. In the "high risk" patients—i.e. breech presentation, multiple pregnancy, placenta praevia, severe toxaemia, trial of labour, previous Caesarean section, poor obstetric history or active labour prolonged beyond 18 hours in a primigravida and beyond 8 hours in a multigravida—a general anaesthetic may become necessary and these patients should receive the above described diet until labour is well established. From then on all fluids by mouth should cease and a drip of 5% Dextrose set up. In order to avoid an unpleasantly dry mouth the patient may have mouth washes and be allowed to suck ice. The fact that a patient may have an epidural established in early labour and is consequently pain free in no way means she may eat exactly what she likes; the above diet is to be adhered to. If a Caesarean section becomes a possibility then oral fluids should be stopped.

It is important to instruct patients during an antenatal visit regarding the sort of food they should take following the onset of labour and whilst awaiting admission to hospital. The practice—not unknown in the upper socioeconomic groups—of celebrating the onset of labour with the partaking of a large meal cannot be condemned too strongly.

GASTRIC EMPTYING

1. *Nasogastric Tube.*

It has been recommended by Edwards et al[7] and Morton and Wylie[8], and practised by many, that a wide bore oesophageal tube (e.g. number 12 English catheter gauge) should be passed into the stomach prior to the induction of anaesthesia in an obstetric emergency. Although this may well help to lower the slightly raised intra-gastric pressure, it in no way ensures the complete emptying of the stomach. (In a distended abdomen the intra gastric pressure may rise up to 18 cm. of water). As this is a highly unpleasant procedure to inflict on what may already be a distressed patient, and adds little to the safety of the subsequent anaesthetic, I do not advocate this procedure. (When anaesthetizing the patient, the administration of suxamethonium prior to intubation can cause a rise in intra-gastric pressure of up to 40 cm of water with the onset of fasciculation of the abdominal musculature[9]).

2. *Induced Vomiting*

The intravenous injection of apomorphine to induce vomiting in obstetric patients has been described by Holmes[10]. (Apomorphine is injected slowly, intravenously, until the patient feels nauseated—usually after 1 to 1.5 mg of apomorphine. 15-20 seconds later vomiting commences and rarely last for more than 1 minute.) This also is a highly unpleasant procedure for the patient and as it does not ensure an empty stomach I do not advocate this procedure either.

3. *Metoclopramide (Maxolon)*

Metoclopramide in the absence of anticholinergic drugs has been shown to effect an increase in gastric motility causing gastric emptying.[11 12] It has also been shown that metoclopramide, when given intravenously in a dose of 20 mg, is effective in emptying semisolid contents from the stomach in the emergency clinical situation.[13] When the ingested meal was "light" the stomach contents were emptied into the duodenum in 30 minutes. With heavier meals complete emptying took one and a quarter hours after metoclopramide.

It would seem that here is a method of promoting gastric emptying that is in no way unpleasant or harmful to the patient. Although as yet, there are no published results of the effectiveness of this method in obstetric patients, I do advocate the intravenous administration of 20 mg. metoclopramide 30-45 minutes prior to the induction of anaesthesia, where such a time interval is available. Following its administration the patient should lie on her right side to encourage the gastric contents to gravitate towards the duodenum. However, it must not be assumed that this technique will guarantee an empty stomach.

NEUTRALIZATION OF GASTRIC ACIDITY

Taylor and Pryse-Davis[5], as well as measuring the volume of gastric contents in obstetric patients in active labour for over 2 hours also measured the pH of the gastric contents. They found that in 42% of patients the pH of the gastric contents was below 2.5. Following the regurgitation and inhalation of gastrict contents, the "full blown" Mendelson's Syndrome is only likely to develop if the aspirated material has a pH less than 3.0-2.5. [5 14 15] Thus it is imperative that steps should be taken to maintain the pH of gastric contents above the level of 3.0 during active labour. This was suggested as long ago as 1957 by Dinnick[16] and restated by Taylor and Pryse-Davis[5] in 1966. More recently in 1971 Williams and Crawford[17] have shown that by giving 15 ml of Mist. Magnesium Trisilicate B.P.C. 2-hourly throughout active labour the intra gastric contents will be maintained above the critical pH level of 3.0 (except in the circumstances of an unusually high and prolonged acid secretion).

It is also vitally important to administer 15 ml of Mist. Magnesium Trisilicate to all obstetric patients beyond 30 weeks pregnancy who are to undergo general anaesthesia for any operative procedure. (e.g. external cephalic version, elective Caesarean section, etc.) In these patients, although suitably starved and having a lower volume of gastric contents, a higher percentage will have a pH

below 2.5.[5] A single dose of Mist. Magnesium Trisilicate will effectively raise the pH for a period of 140 minutes, and so can suitably be given at the same time as the atropine pre-medication, i.e. 45 minutes to 1 hour pre-operatively.

Atropine

Atropine, as well as drying secretions, will block the vagus nerve—an important factor as vagal reflexes can tend to open the cardia[18] and make regurgitation more likely. With patients in active labour who require general anaesthesia it is best to give 0.6 mg of atropine intravenously a few minutes before induction. It is particularly important to give the atropine intravenously if metoclopramide has been given with a view to decreasing the gastric contents.

Equipment

It is extremely important that the anaesthetic equipment in the labour wards is up-to-date and well maintained. To this end it is a good idea to enlist the help of an operating theatre technician who can pay regular visits to the labour wards to ensure the good working order of the anaesthetic equipment. A list of both equipment and drugs to be kept should be displayed on the wall so that all equipment and drugs can be made available at all times.

Cricoid pressure

All personnel working in the obstetric department should become familiar with the position of the cricoid cartilage in the neck. The thyroid cartilage is readily palpable and the cricoid cartilage lies immediately below it. Thus, when the anaesthetist is inducing anaesthesia the person helping him will be able to apply cricoid pressure—i.e. push the cricoid cartilage backwards—as the patient loses consciousness. The pressure is maintained until the cuff of the endotracheal tube is inflated. This is known as Sellick's manoeuvre[19] and as the cricoid cartilage is a solid ring, when pushed backwards it will prevent the regurgitation of fluid into the pharynx. Pressures as high as 100 cm of water can be withstood and this is far higher than those likely to be encountered. However, should the patient actively attempt to vomit the cricoid pressure must be released, otherwise there is a danger of oesophageal rupture.

SUMMARY

Various points have been looked at which can help in the prevention of Mendelson's Syndrome (and as with all things prevention is better than cure). Of these, the provision of the suitable diet to patients in labour and the 2-hourly administration of 15 ml of Mist. Magnesium Trisilicate to all patients in active labour are probably the most important.

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

Book Review

FUNDAMENTAL PHYSICS OF RADIOLOGY

W. J. Meredith and J. B. Massey. Second Edition. 674 pp. £6.25. John Wright & Sons Ltd. 1972.

This large and comprehensive textbook has been considerably revised, the first edition having appeared in 1968. It was the first major book to try and answer the question of how much physics a radiographer or radiologist should know—and it did the job well. Its chief fault is that it tries to reach too many audiences, and therefore includes more information than many of its readers require. The text is divided into four main sections: the production, properties and measurement of radiation; diagnostic radiology; radiotherapy; and radiation protection. The physics of electricity and magnetism is sadly not dealt with at all—it is a shame for a book of this size to have to refer students still further for such central information. However, the fine presentation and excellent use of diagrams more than compensate for the small omissions, and this is a sound book at a reasonable price which can be highly recommended.

J. S. TOBIAS.
Flowerhill,
Enniskerry.
Co. Wicklow.

BARTS MUSIC FESTIVAL 1972

By ALLEGRO

This article is a composite of reviews of the 3 musical events of recent months involving the Royal and Ancient institution. Everywhere from Camden upwards appears to have its music festival (even Bromsgrove!) and it is pleasant to see Bart's joining this national trend.

It was our great privilege to welcome Lady Barbirolli and Valda Aveling as oboist and harpsichordist to the Great Hall on May 4th. Lady Barbirolli appears under her maiden name of Evelyn Rothwell. She had a justly famous past as 1st oboe in the Scottish National Orchestra, Glyndebourne Festival Orchestra and the London Symphony Orchestra. She is a true scholar—she has searched out interesting music of the past which she performs with tremendous skill and enthusiasm. Her technique is still immaculate and her warmth of personality is so readily obvious from almost every note she plays. It must be a great joy to her to have an artist of such consummate skill and modesty as Valda Aveling as harpsichordist. She is an excellent soloist in her own right and her gentle accompanist role was beautifully judged. Mr. Tom Goff's harpsichord makes a lovely (if 20th Century!) sound and it was fascinating to listen to the great man after the concert talking about the instrument.

My favourite work in this recital was a delightful bitter-sweet piece by Arthur Jacob written especially for the two ladies. It makes incredible demands on both oboe and harpsichord alike and this performance was especially exciting. We heard other duos by Kirnberger, Besozzi and Dandrieu. Valda Aveling played 3 Scarlatti sonatas—L 164 in D will be long remembered for its almost Tarantella rhythms. She played Haydn's Sonata No. 35 in C in Part 1. Evelyn Rothwell has rearranged works for harpsichord for oboe and we heard such a piece by Rameau (Les Tendres Plaintes).

The large audience that appeared for this concert makes the idea of a Bart's Great Hall Celebrity Series not too far-fetched. The idea would be to have four such concerts a year, arranged well in advance and to sell a subscription ticket to guarantee admission. These could well be self-supporting and could cover the smaller range—imagine "The Amadeus" in the Great Hall!

The second instalment of the summer music festival (May 18th-20th) consisted of the first production of the newly revamped Gilbert and Sullivan Society. For 3 nights they offered "Iolanthe" in the Golden Lane Theatre. For those unwise enough to miss this production, I can only say that next year they may be presenting "Pirates", so buy your tickets now.

Iolanthe is ideal for the amateur group with its naive but charming story of the fairy who married the Lord Chancellor leading to the birth of her son, half fairy, half mortal, and the story of how he (Stephon) eventually wins his girl, Phyllis, who is a ward in chancery and marries her.

The curtain rose on the most beautiful Arcadian set I've seen, a real tribute here to Mrs. Feroze Din, who designed it. The central panel consisted of floral decor with a distant arch which led to green fields—in the lateral part of the stage were almost Don Giovanni pillars with such topical comments inscribed on them as "Bart's for the cup". The fairies "lightly tripped" and sang lustily with obvious enjoyment of their task. Maggie Budd gave a highly authoritative performance as the Queen of the Fairies and Pam Benison's Iolanthe made up for what it may have lacked vocally by being well acted. (I do not think Sullivan helps by setting the ballad to an extremely arduous vocal line and many professionals fare far less well than Miss Benison did.) Cathy Taylor has a beautiful and powerful voice—she can hit her high notes clearly and I was surprised to hear that she has never had vocal training. Her Phyllis was moving indeed. The bucolic and beery trio of Gamble, Cooper and Griffith made a superbly entertaining Lord Chancellor and two Earls respectively—I was glad to see the freedom they took—some of the ad libs were even funnier than Mr. Gilbert's lines. Half the fun of amateur "G&S" is when things go wrong and one can watch the attempt to improvise, so when the chorus of Dukes and Marquises half muffed an entry, the double entendre was skilfully managed. The sets to Act 2 (Westminster, Big Ben, The Houses of Parliament) were even more impressive than Act 1. I can only say that these sets were preferable to either the D'Oyly Carte sets or even those used by the excellent Coliseum/Sadler's Wells production of 1961. Pat Thrower's direction was simple and yet highly effective—Private Willis can easily be overdone but here George Blackledge was extremely well disciplined and his singing humour was ideal—he well deserved the encores he received.

My one regret at this performance was that it could not have been entirely Bart's completed. Unfortunately, at the eleventh hour a professional conductor had to be obtained—much credit should be given to Richard Carver for having taken the performance on, so far, musically. Robert Anderson, when he appeared on the scene, would admit, I'm sure, that all the spade work had been done for him. Mr. Anderson conducted the score with a high degree of commitment and confidence, in what may well have been his first professional engagement. I left the Golden Theatre with a feeling of having had a tremendous evening in the theatre—I do hope next year that this society gets the support from the hospital it fully deserves—Golden Lane Theatre should be packed out.

The third instalment of the music festival (June 8th) consisted of nothing less than a concert performance of Beethoven's only opera, "Fidelio". For the price charged (50p) one can see the opera in a reasonable seat at the Coliseum and I think on that basis one can be fairly critical. Whatever translation Mr. Anderson used was, to put it mildly, horrid. (He is not alone in using a ghastly translation because even that haven of English performing opera, the Coliseum, also uses a horrid translation.) If we are to have opera in English and I accept that some people prefer it done that way, then let's get some modern translations. My next criticism, and this is a much more fundamental one, is a question of Mr. Anderson cutting all the dialogue. This makes complete nonsense of the work. The musical numbers of Fidelio do not move sweetly from one to the next without linking dialogue: I can only say that, to me, this represented a complete lack of sensitivity by Mr. Anderson to Beethoven's intentions. Yet again, the bleak Westminster Hall with its vast cold wastes cannot begin to rival any concert hall or even less a theatre (the right place for such an undertaking). The audience too was sparse (a few more than appeared for Vaughan Williams) —perhaps they preferred to see the real thing with a full cast of international singers for the same price.

From Mr. Anderson's note in the scanty programme, he does not see this as an opera of blazing radicalism, of freedom from oppression. From his interpretation, too, he feels the opera not as a great dramatic entity. His style with the opera was very much dainty and "Dresden China" in sum, small scale. It was never earthy or rugged. He was hampered by a Leonore whose voice betrayed the strain of the big occasion. The actual quality was excessively unpleasant: she slid into her notes and had a woolly tremor on the top of her stave. Her diction was such that she could have been singing in Serbo-Croatian and I would have understood just as much! I doubt she really felt the opera because she was emotionally flat as well as vocally.

The general dyspeptic nature of this review can be toned by the excellence of the Marcellina. A small voice, but so much better disciplined and so much more enjoyable. She vocally acted with her lines, too. I just wish she had been asked to sing Leonore. Pizzaro was suitably vocally dramatic. Rocco had a dull voice and spent most of the evening singing into his chest—I wonder how many actually heard his lines?

Orchestral playing was adequate—in fact the horns in the Abscheulider were more steady than the soprano! The small choral contribution was clearly delivered but I felt sorry that such an enthusiastic body should be so wasted. Come, Mr. Anderson, if you wish to use our choir, give us choral works. You've so many to choose from. As a suggestion, Haydn wrote 6 late masses and the Nelson Mass is such fun to sing. You don't like Haydn? What about the Mozart Requiem K626 or the Coronation Mass K317? No to Mozart? Then there's always Elgar's "The Music Makers" or "The Kingdom". I do feel it's high time the choir were given their head in a work of their choice, however much one enjoys listening to great opera.

BARTS SPORT

BOAT CLUB REPORT

It has repeatedly amazed me how gifted my predecessors have been in making the most of mediocre efforts of Bart's rowing sound like a year of unparalleled successes! It would make a pleasant change to be in a position to "tone down" the achievements of the Club, but that must be the happy lot of next year's Secretary.

The underlying cause for the rather limited achievements of the Club this year has been simply a shortage of oarsmen. This is partly a result of the diminishing achievements of recent years and partly due to a lack of emphasis on the encouragement of freshers and novices to row. It is also true to say that there have been virtually no experienced oarsmen joining the College in the past few years, either from school or from Oxbridge. The situation is such that at the height of this summer, normally the peak of the Boat Club's activity, we have been left with a maximum of three available oarsmen at any one time.

However, every club's fortunes go up and down over the years, and Bart's rowing will again get on its feet. To enable this to happen quickly help must come from inside the Club and outside. From within, there must be the setting of realistic goals for the year, and a determination to organise clinical appointments, etc., to fit in with these aims. More experienced oarsmen must concentrate on teaching and training freshers and novices, enabling them to compete in the U.H. Winter Regatta and Allom Cup events, and hopefully forming a junior crew to race in the summer. As for themselves, the senior oarsmen must set their sights from the outset on doing well next summer, and the Visitors Cup at Henley! By so doing, they will automatically attract new oarsmen into the Club the following year.

In the meantime, help from outside the Club in the form of a strong nucleus of oarsmen amongst the new intake, particularly from the Oxbridge students, would be much appreciated!

As far as this year's rowing is concerned, our first competition was in the United Hospitals' Winter Regatta last November. Apart from a fine effort by Dave Swithenbank in the junior sculling event, it was a disappointing start to the year's racing.

In the New Year, things looked brighter when, in March, we found a composite crew with Broaborne R.C. and entered an eight in the Head of the River Race. Despite the fact that we had not rowed together as a crew before the event, it "clicked", and we improved our position by 50 places, finishing 108th.

In preparation for the Bumps in May, the 1st VIII spent a few days in training at Henley, and prospects looked good. However, on the day, they failed to fulfil the promise they had shown earlier, and went down ignominiously to St. Thomas's 2nd VIII, finishing 5th on the river. The 2nd VIII did better, maintaining their position over the three days. A 3rd VIII, and an "Invitation VIII" inspired by Jim Foster, made a noticeable, if not altogether successful, contribution to the event!

Our thanks go to Mr. Chris Hudson, Mr. John Currie and Dr. Brian Ayers for all their encouragement and coaching throughout the past year; and our best wishes to John Holmes and the other new officers for a successful season ahead.

BART'S LADIES' VICTORY

Although it will be news to most of you we did in fact win the United Hospitals' Ladies' Tennis Cup last year. And we've won it again this year! A simply scintillating 7-2 success easily swept Royal Free aside!

This triumph rounded off a rewarding season which included our Cambridge Tour where we beat Homerton 6-3, Girton 7-2 and Newnham 8-1.

Our thanks to our cup team:
Sue Parish (Capt.),
Viv Bromwell,
Pam Benison,
Wiz Mansi,
Su Boddy (Sec.),
Mary Brown.

SU BODDY.

SAILING CLUB

In an effort to gather novices and experienced sailors it was decided that a weekend spent at Burnham-on-Crouch might prove popular. Indeed, come 1200 hrs. on Saturday, June 17th, 25 folk met outside the "Anchor" pub ready to brace themselves for the murky waters of the River Crouch. We had access to plenty of boats, including the Commodore's Folkboat, two Squibbs (fibreglass keel boats) and four Enterprise dinghies. By 1430 everyone was squeezed in somewhere afloat. The weather was ideal for exciting sailing with the wind blowing around Force 4-5 and the sun being exceptionally generous.

The keel boats fared easily and everyone kept dry, but the dinghy sailors were not so lucky. Two of the Enterprises capsized on an exposed bend in the river and were kindly helped by passing yachts. One crew was invited on to a yacht for tea! During the course of tea, all eyes fell on the other Enterprise rapidly approaching the bend and sure enough they were all smartly tipped into the water. Everyone returned eventually and regained any lost spirits back at the pub before supper.

The evening was spent propping up the bars around town, and after paying their respects to the "Snake Pit Disco" at the R.C.Y.C., people crawled home in the early hours of the morning to sleep on a bunk or even the floor. The wind unfortunately blew up in the night and come early morning it was blowing near gale force and all sailing had to be called off for the Sunday.

The weekend was a success even considering the disappointment of no sailing on Sunday. I should like to thank everyone for coming along, and especially the Commodore and Vice-Commodore for their support. It has become easy now to arrange sailing at Burnham with the introduction of a "pool" system of boats, meaning that there are many boats available. It should be realised that there are five sailing dinghies belonging to the Bart's club based on the Welsh Harp reservoir in North London and at Burnham. I shall be only too pleased to help people interested in using these boats. I may be contacted at College Hall, Charterhouse Square.

RICHARD WELLS.

BOXING

Congratulations to Michael Beeney on winning his weight in this year's British Universities Boxing Championships.

In an extremely exciting fight, he beat Andy McGrow of Edinburgh in the semi-finals. McGrow was floored three times in a contest that had the spectators standing, and afterwards was awarded the Best Loser Trophy. In the final Michael was matched against J. Howells of Aberystwyth, and outpointed him in a more skilled and controlled fight.

Michael boxes with the Guy's Boxing Club, and any Bart's men are welcomed by the trainer, Charles Pocknell, who says that they do not have to box or spar, but merely to learn self-defence and keep fit.

O.G.W.B.

RIFLE CLUB REPORT

This year has seen the introduction of more lady members and we have also encouraged nurses to join us. There have been a few changes down at the rifle range, the principal one being the building of a fire door from Medical Records straight on to the firing point. Anyone lucky enough to escape from a fire could well have been shot instead. This necessitated the building of a wall in front of the door, and the installation of a new lighting system. By a marathon effort the range was also cleaned, the new lights showing how bad it had really become.

The Annual General Meeting was held in October. Club Officers were elected for the year. Finances were reviewed, with thoughts about buying a new rifle for our left-handed members. Cups were awarded to Tony Knight, Mike Pembrey and Martin Sweatman. It was decided not to enter so many postal matches this year, but to have more shoulder-to-shoulder matches.

Autumn Term saw the U.H. match against Cambridge University with four members of our Club representing U.H. The match against Watneys was as popular as ever. A team of seven was entered against the Bank of England. That evening had its lighter side. Seven scruffy individuals, walking into the foyer, were met with rather suspicious looks when a voice asked in an Irish accent: "Would this be the Bank of England at all?" A match against the Metropolitan Police was cancelled.

A Social Evening was held in January. This was mainly "fun shooting" open to allcomers, with handicaps for the more experienced marksmen. As an induce-

ment to attend, free beer and food was offered. Silver Spoons were awarded to winners of the knock-out competitions. The evening ended as usual in the bar and it was decided to make this a yearly event. The Rifle Club Dinner was held at the "Cheshire Cheese", Fleet Street, in February. Guests were Mr. Gordon L. Bourne and Mr. Morris. The "Bar and Disco" in March was a great financial success, with the proceeds going towards the rifle fund.

Full Bore

There has not been much opportunity to get to Bisley so far this year, but shooting will continue into the Autumn Term.

The Staff v. Students match was again won by the students this year, but by a narrow margin. The staff were represented by:—Mr. Gordon L. Bourne. Dr. Aumonier. Dr. J. Angell-James. Dr. J. Riddle. Dr. Ian Franklin. Dr. John Johnson.

Students:—Mike Pembrey. Tony Knight. John Lawn. Charles Russell-Smith. Phil Morrison. Lesley Mansfield.

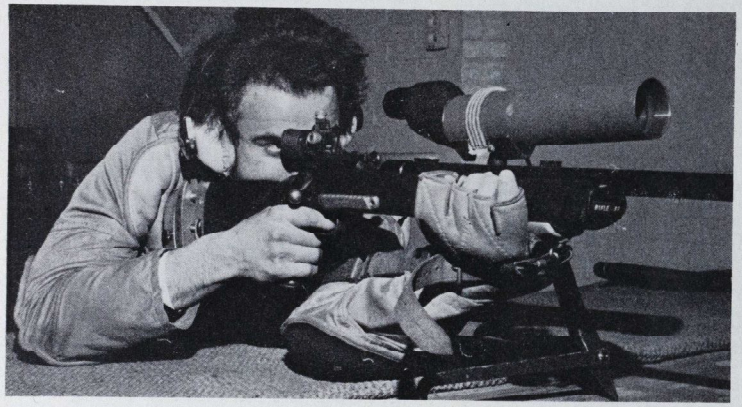
The individual championship cup for the highest score was awarded to John Lawn. Also notable was Ian Franklin's score at 500 yds. In poor visibility he only dropped one point, totalling 34 pts.

The London University Pafford Cup in May was shot in appalling conditions. The Hospital was represented by:—Tony Knight, Chris Seedergreen, Phil Morrison, Charles Russell-Smith.

Every time one of the team shot the heavens opened, so they finished hastily and retired to the relative comfort of the club house bar.

The final position was 4th out of 8. Better luck next year!

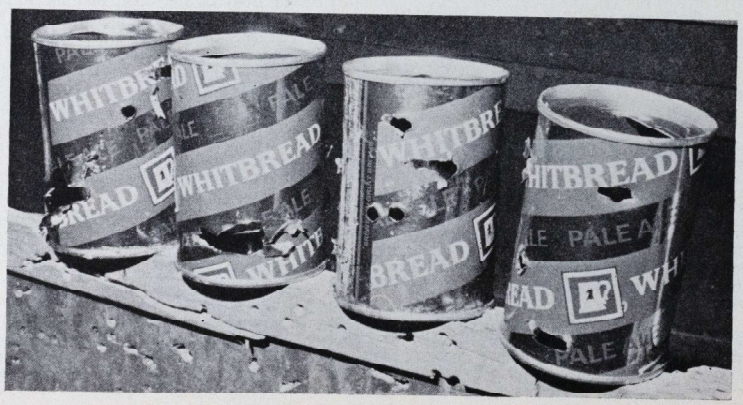
Congratulations to Tony Knight who won the Century Prize at Bisley last summer with a possible 50 pts., nine of which were V bulls.



TONY KNIGHT

AIM ! !

I ONLY SHOOT FOR THE BEER



Journal Christmas Card 1972

The cover of this year's Christmas Card is a colour reproduction of a print of St. Bartholomew's Fair (below). The Fair is to be revived in 1973 to commemorate the 850th anniversary of the Hospital's foundation.

Priced at 6p, the card will be available throughout the Hospital. Overprinting of names and addresses can be arranged at £2.55 per order; these orders should be placed before the end of September.

All enquiries and orders should be addressed to the Art Editor, St. Bartholomew's Hospital Journal, St. Bartholomew's Hospital, West Smithfield, London, E.C.1, and should be clearly marked "CHRISTMAS CARD"

SAINT BARTHOLOMEW'S HOSPITAL JOURNAL

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Editorial

"Doctor" is derived from the Latin verb "docere", to teach. Of course, this function falls on only a very small percentage of medical graduates; but very few, if any, of those who do teach, get any formal training in teaching methods.

This is, now, apparently a situation almost unique to medical education. It used to be true of all University courses, the rationale presumably being that a man who has already devoted a good many years of his life to a specialised subject, will get some of it to rub off onto his students, one way or another.

But in the last decade, other Faculties have seen the need to have trained teaching staff, as the concepts that have to be put across, get more numerous and more complex. It enables them to utilise the means at their disposal to their best effect.

In medicine, however, this has not been the case. This may be because, in medical schools, the role of all clinical teachers is supplementary to their main functions as physicians and surgeons—in contrast to their opposite numbers in other science Faculties. It may also be that the intensity of postgraduate education does not permit the time for even a short course in teaching.

Even so, the fact remains that Barts' and all its counterparts are Teaching Hospitals. Whilst no one denies that the first duty of any hospital is towards its patients, the teaching component in such hospitals must come a close second.

I am not suggesting that, because of this lack of training, all the academic staff are bad at teaching. Indeed, some are excellent; most are very good, and only a very few seem totally unsuited to teaching.

But these few come into contact with comparatively large numbers of students, and, over the course of the clinical training period, can considerably influence the knowledge and attitudes of these students. What, then, is the answer? It would seem that the likelihood of incorporating a teaching course in the medical postgraduate system, is remote.

But surely, one immediate step which could be taken, is to employ "teaching ability" as a criterion in the selection of all grades of staff in Teaching Hospitals (with the obvious exception of Junior House staff). This could be assessed when the applicant comes for interview, by an educationalist, with experience in such matters. It would have the additional effect of redirecting otherwise first class medical staff, whose interests and abilities do not lie in teaching, to fill posts in non-teaching Units, thereby relieving the force of competition for Teaching Hospital places, and upgrading the standard of hospitals elsewhere.