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Editorial

I had resolved that in 1973, my editorials would be about matters other than medical education in Barts. And yet, here we are in January and already I have succumbed to the temptation.

Yet I make no apology for this early lapse, because my 'grievance for the month' is one which I know has inflamed many students in the past.

I refer to the preferential teaching given to visiting students attached to Bart's firms. Let me clarify this seemingly racialist point of view immediately, by saying that I wholeheartedly approve of the concept of exchange students and foreign student attachments, but not if it detracts from the teaching given to the rest of the firm.

The all too common situation, now, is that a final year firm is given only two or three ward rounds, and perhaps one O.P. session a week; whereas the visiting student attends *all* the firm's rounds and clinics, is taught on a one to one basis, works with a registrar throughout the day, and consequently ends up vastly better informed than his or her Bart's contemporaries.

The usual reply, when this delicate subject is raised, is that it is impossible to have some fourteen students at a business round or a special clinic, without disrupting the firm. But if only one or two students can comfortably be accommodated on all these other occasions, I fail to see why they might not equally well be *Bart's* students!

Two or three days full time attachment to a registrar on each firm would ensure that *every* student—Bart's or otherwise—would have seen all the common practical procedures and be conversant with all the common managerial problems peculiar to that specialty.

It is hard enough to remain enthusiastic about *any* course that is already grossly oversubscribed to, but when Bart's students are being turned away from some of the very sessions to which visiting students are admitted, they may well fail to see clinical material which will later confront them in practice . . . or across a green baize table at Queen Square.

ANNOUNCEMENTS

Births

MILES—On November 11, 1972, to Dr. David and Jennifer, a daughter.

Marriage

MCGRIGOR—EMERY—The marriage took place between Mr. R. B. McGrigor and Mrs. E. Emery.

Deaths

ASHBY—On November 15, 1972, William Ross Ashby, M.A., M.D., M.B., B.Chir., M.R.C.S., L.R.C.P., F.R.C.Psych. Qualified 1935.

ASHTON—On October 10, 1972, Fred Ashton, M.D., M.B., B.Chir. Qualified 1944.

ATTWOOD—On November 16, 1972, John Horace Attwood, M.B., B.S., M.R.C.S., L.R.C.P., D.A., F.F.A.R.C.S.

HUSBAND—On November 23, 1972, Anthony Dearden Husband, F.R.C.S., M.R.C.S., L.R.C.P. Qualified 1940.

Appointments

Dr. J. T. Hayward Butt has been appointed Professor of Anaesthesiology of the University of Chicago, Illinois, U.S.A.

Dr. N. F. Kember, B.Sc., Ph.D., has been appointed Reader in Physics as from 1st January, 1973.

Prizes

The Kirkes Scholarship and Gold Medal, 1972, has been awarded to J. C. Dawe.

Changes of Address

Dr. J. T. HAYWARD BUTT, M.D., F.F.A.R.C.S., has moved to; 317, West Montabello, Rancho Solano, Phoenix, Arizona 85013, U.S.A.

Dr. THOMAS ARTHUR WATKIN EDWARDS, has moved to "Wharfdale," 8, Densley Close, Welwyn Garden City, Herts.

East Anglian Rahere Society

Former Bart's students living, or working, in East Anglia are invited to the Annual Dinner which is held in the autumn of each year and to which a member of the Consultant staff of St. Bartholomew's Hospital, is invited as the Guest of Honour.

This year Dr. Tom Boulton joined us at Mildenhall, Suffolk, under the Chairmanship of Dr. Clive Parsons.

The next Annual Dinner will be held in 1973, under the Chairmanship of Mr. A. P. Bentall, Senior Consultant Obstetrician and Gynaecologist to the United Norwich Hospitals.

The origins of this Society are recorded in the St. Bartholomew's Hospital Journal of March 1949, when Dr. Walter Radcliffe reported the foundation of the Ipswich and Colchester Rahere Club. On this occasion some nine Bart's students met for a Dinner at the George Hotel, Colchester, under the Chairmanship of Dr. Perry Rowland. Since 1949 the Club has expanded to include Doctors in East Anglia. For the last few years meetings have been held in different parts of the region and an attempt is made to notify all known Bart's men of these meetings.

Clearly, Bart's graduates moving into East Anglia may be unaware of the existence of the Society but will be placed on the mailing list if an application is made to me.

Up to the present members have resisted the presence of their wives, (or husbands) at the Annual Dinner but an occasional meeting is also held in the spring or summer, to which wives are invited.

In 1973 it is hoped to link such a joint meeting with attendance at the 850th Anniversary Celebrations of the Hospital and the publication of my letter in the Hospital Journal will give a wider publication to the existence of the Rahere Society in East Anglia.

N. ALAN GREEN, M.S., F.R.C.S.

MACCABAEAN PRIZE AND MEDAL

Entries for the 1973 Maccabaean Prize of £30 and a bronze medal are now invited for an essay of 4,000 to 6,000 words on some aspect of the history of medicine or pharmacy. Intending candidates, who must be under 30 years of age on 15 March, 1973, may apply for further particulars to the Honorary Secretary of the Faculty of the History of Medicine and Pharmacy, Dr. J. K. Crellin, The Wellcome Institute of the History of Medicine, 183, Euston Road, London, N.W.1.

STUDENTS UNION CHAIRMAN'S REPORT
May-November 1972

I took over as Chairman of the Union from John Wellingham on May 1st. His report for the months preceding (November, 1971—April, 1972) appeared in the May Journal. Since that time, I increased the frequency of Council meetings to once a fortnight and put a time limit of 1¼ hours on each meeting. This is because there has been an increasing load going through Council over the past year.

The main reason for this, is the lack of activity in the sub-committees of the Union. The Wine Committee and Teaching committee work well, although increased activity of a pre-clinical teaching committee would be welcome. The Finance, Clubs' Union and Floors Committees have been little more than nominal bodies. Other committees must also take on their duties to reduce the large number of minor matters that are of interest only to their particular field. This is my main intention for the coming months, so that the S.U. Council can spend more time on its primary function of representation to the College, on matters coming through these committees, and liaison with other medical colleges and student bodies.

I do not propose to give detailed reports of all the matters passing through the Council over the past few months. If anyone has any particular queries, I suggest that they contact me. There are a few matters, however, that I think are more worthy of mention.

Teaching:—

The new clinical curriculum is now under way. First impressions appear to be that although it is an improvement on the old, changes are not really radical enough to improve the education obtained at Barts on any more than a very temporary basis. Discussions with the staff suggest that there is widely felt discontent with the centralisation of teaching at Barts, particularly in the first clinical year. Any changes in the first year curriculum will necessitate a long overdue change in the lecture programme. Future discussion will press for changes in Pathology teaching—perhaps the most critical course of all.

Social Events:—

This section could easily be headed Wine Committee as they have now increased the number of social events they run to include pre-clinical end-of-term parties, discotheques at any excuse, the annual Boat Trip, and of course the ever improving Barbeque Ball. The members of this committee work harder than most students realise, as they also have to run the bar—which involves far more than just standing behind it, for an hour or two every night. My thanks to John Carroll and his committee for their work over the past year and good luck to Ollie Else for the next.

One final matter I would like to mention. It has become increasingly difficult to work within the present confines of the constitution of the Union, which has been in use, almost unaltered, for very many years. I propose after the AGM to ask Council to completely revise the present document and to present a draft copy to an Extraordinary General Meeting in the coming year.

My thanks for their help in running the Union go to the whole Council but particularly Paul Taylor and Roger Peppiatt. The Union is becoming increasingly important at Barts and there is every sign that the Council have realised and are responding to this so that I think we can now look forward to a highly eventful year.

GUY ROUTH,
Chairman.

THE 850th ANNIVERSARY

Dear Sir,
Bart's is 850 years old this year. There are few people who have entered its precincts and failed to be aware of its historic and traditional background: there are few places which can boast such a proud and dedicated life. It has passed through many turbulent times, but throughout has never ceased to render service to the sick and the poor.

This century, perhaps, has brought more change to the world than any which has gone before and its effects must inevitably alter the old Bart's. We can no longer afford to linger on memories of past greatness but we can, and should, pause for a moment to honour a unique past with a celebration worthy of the name. A celebration which must be not only a joyous recollection of the past, but a stimulus to look forward with enthusiasm and inspiration to formulating the pattern of medicine in the society of today.

A great deal has already been planned with the help and hard work of people from all parts of the Hospital. There is still much to do, and those of us already heavily involved have no doubt that support will continue to increase and all our united efforts will make 1973 a landmark in our history.

An outline of some of the festivities accompany this letter, and details will be made available as plans are finalized. new ideas will be brought to your attention as they evolve in the coming months.

While we celebrate, we will also grasp the opportunity to raise funds to build a Research Institute at Charterhouse, replacing the ugly void left when our preclinical students move eastward to Queen Mary College. Such an Institute, if it were possible to join it with those from St. Mark's Hospital and from Moorfields, could produce a massive complex with possibilities for postgraduate activity which can fire the imagination and inspire with new enthusiasm.

The old image of Bart's is changing, but we have an opportunity to enter the new era with strength and determination, and to make the future as exciting and purposeful as the past. There is bound to be sadness in looking back, but there is also satisfaction in creating the future.

JAMES O. ROBINSON, M.D., M.Chir., F.R.C.S.,
Chairman of Co-ordinating Committee for
Anniversary Celebrations and Appeal.

DIARY OF EVENTS 1973

Wednesday March 28th
CELEBRATION BALL IN GUILDHALL—tickets available nearer the time from the Anniversary Office.

Monday April 30th and Tuesday May 1st
MEDIEVAL FEAST IN THE GREAT HALL. The menu will be based on the Coronation Feast of Henry VIII. Starting about 7.30 p.m with musical and theatrical entertainment between the courses, it will last about three hours. Tickets nearer the time from the Anniversary Office.

Saturday May 5th
BARTHOLOMEW BALL in Smithfield Market—dancing in Grand Avenue to London's top bands—the market transformed. Champagne and wine imported specially for the occasion. Cabaret. Costume 1123-1973. Tombola. Tickets include supper. Foodstalls selling snacks open from 9 p.m. to 3 a.m. Tickets from the Anniversary Office.

Tuesday May 8th to Saturday May 12th
"WILLIAM HARVEY REVOLUTIONARY CIRCUS"—a celebration of the 850 years that Bart's has been a hospital but concentrating on one period of history and on one man who was perhaps the greatest ever to have worked at Bart's. William Harvey who discovered the fact that blood circulates in the body and shattered the theories of thousands of years.

The play is not a scientific treatise but a collection of scenes telling the story of William Harvey and his life in the Hospital. The old theatres which entertained the fair-goers of Bartholomew Fair are used to join the scenes together and the whole is commentated on by Hieronymus Cowper, a little known 18th Century Biographer of William Harvey.

The combination of these units is a witty, entertaining play, dealing with the period of history from the Reformation to the execution of Charles I but sidetracking to look at life as it was for the ordinary people who went to fairs for their entertainment in those days.

The play will be performed before the Henry VIII Gate of the Hospital starting each evening at about 8.30. A spectators stand will be erected in West Smithfield and tickets will be available through Ticket Agents and the Anniversary Office.

Wednesday May 9th
VIEWDAY. This will be held as usual but with several stalls in the Square selling commemorative articles.

Saturday May 12th
BARTHOLOMEW FAIR—in West Smithfield, Grand Avenue and the grounds of the Medical College, Charterhouse Square.

In Grand Avenue—the Fair from its inception to the 17th Century with merceries, pewter pottery and gingerbread among the wares for sale—puppets, punch and judy and theatrical entertainments and a recreation of the stalls owned by craftsmen who later joined together to form the City Guilds and Livery Companies.

In West Smithfield—the Fair as it was at its decline in the 19th Century and as it might have been today, with roundabout, helterskelter and all the sideshows that go to make a Fair.

In Charterhouse—Entertainments, among them Falconry, Wrestling, Morris Dancing and Handbell ringing.

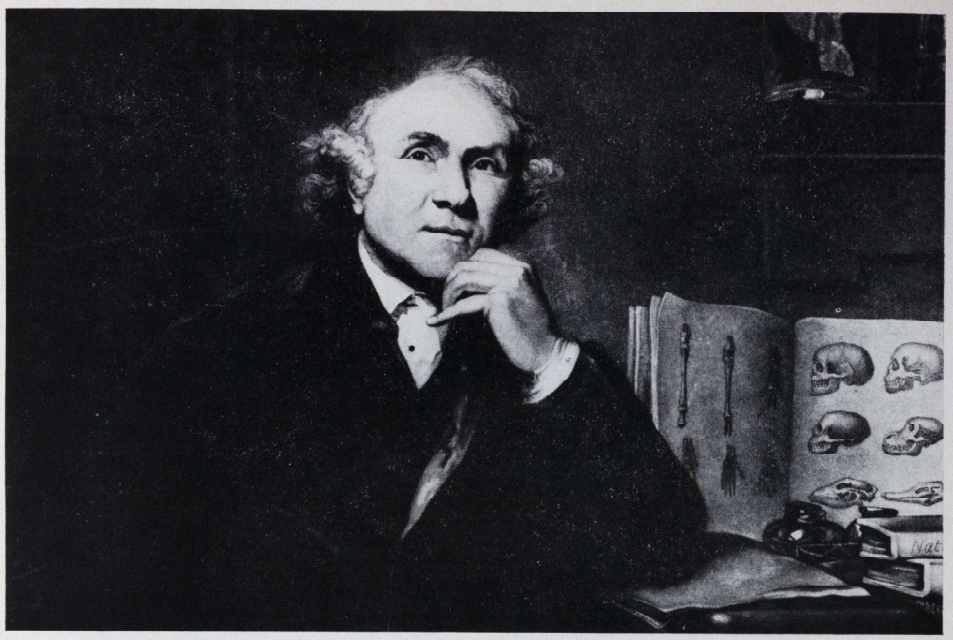
A HISTORY OF THE ROYAL COLLEGE OF SURGEONS

By W. R. LeFanu, Librarian of the College 1930-68.

The Royal College of Surgeons of England has been incorporated under this title since 1843, when its Fellowship was founded, but it has a pedigree of six hundred years and direct continuity with the Guilds and Companies which preceded the grant of a Royal Charter to the Royal College of Surgeons of London in 1800. The Lord Mayor instituted a Guild of Surgeons before 1369; this Guild was united with the Barbers Company by Henry VIII in 1540, but after a further two centuries the Surgeons left the United company in 1745 and established a separate Company of Surgeons under Act of Parliament. The new Company started with bright auspices. John Ranby, Sergeant-Surgeon to the King, was the first Master, and the famous William Cheselden was the moving spirit of the reform. A fine new Hall was built in the Old Bailey, a short walk from the Royal College of Physicians which was then in Warwick Lane, and very near St. Bartholomew's. But in the easy-going eighteenth-century way the Court of Assistants, as the governing board was called, neglected the Company's business. Its only activity was the somewhat perfunctory examination of surgeons for its Membership, which permitted practice in the London area, and the qualifying of young men as Navy and Army surgeons. The great surgeon John Hunter, as a member of the Court in 1786, and John Gunning, as Master in 1790, encouraged their colleagues to reform, but nothing was done. When the Court in 1796 conducted its proceedings without legal formality, a move was made to begin again. A house was bought in Lincoln's Inn Fields, to which the Company moved in 1797; the Surgeons have been there ever since, though the buildings have been frequently enlarged and three times rebuilt. A new constitution was sought from Parliament, but the Bill failed to pass. Since the illegality of 1796 had officially dissolved the Company, the surgeons now obtained a Royal Charter, which founded the Royal College in 1800.

An event of almost equal importance had just taken place. The old Company at its last meeting accepted from Parliament the charge of John Hunter's Museum, with the conditions that it should be opened to medical men, that "a proper person" should be employed to keep it "in as perfect state as possible at the expense of the Surgeons", and, most importantly, that a course of twelve lectures based on the Museum should be given each year. This commitment to the active maintenance of what is in fact the National Museum of Medicine gave the new College a purpose and function which were of wide influence beyond its duty as the representative body for the surgeons of London. Henceforward the history of the College has two equally interesting facets: public work as the guardian of the interests and standards of the profession of surgery, and a domestic story of educational work developing round the Hunterian Museum. All this is admirably recorded in Sir Zachary Cope's *History of the R.C.S.* published in 1959.

As a public professional body the College was handicapped for a long time by the constitution which it inherited from the old mismanaged Company: the Court of Assistants was a self-perpetuating body, choosing its members for life from the staffs of the great London hospitals alone, and appointing its Examiners also for life from its own members by seniority. How senior they were will be realised when we read that Sir William Blizard was still an examiner at the age of 92 and Sir William Lawrence suffered his fatal stroke when arriving at the College to examine at the age of 84. This state of affairs led to much unrest among the ordinary Members, mainly general practitioners who thought their interests were ignored, but including the young hospital surgeons who saw no prospect of election to office in the College before they were old. The Court of Examiners required evidence only of anatomical and surgical training, with no wider medical knowledge, and restricted even that to men from the London hospitals or the Schools of Surgery in Dublin, Edinburgh, Glasgow or Aberdeen. Improvement of education for general practitioners was undertaken by the Society of Apothecaries by the terms of their Act of 1815, and strong pressure was put on the College to come into line and liberalise their requirements. Thomas Wakley, editor of *The Lancet*, organised mass meetings of Members of the College which were coldly rebuffed by the Court of Assistants. The Court obtained a new Charter in 1822, changing its title to "Council" and its Master's title to "President", but not altering the life-tenure of the Councillors. William Lawrence, assistant surgeon to St. Bartholomew's had supported Wakley's protest, and now a group of assistant surgeons led by Benjamin Brodie of St. George's sent in a petition for reform; this was ignored. John Abernethy, the famous Bart's surgeon, became President of the College in 1826 and rebuked the Council for their apathy, calling the petitioners "a very respectable and amicable association of Members", but it was three years before the Court of Examiners agreed to recognise the provincial medical schools. Abernethy greatly improved the educational work in the College by securing the appointment of two able young doctors: Richard Owen, a Bart's man, to develop the Museum under the "conservator" William



John Hunter 1728-1793

Clift, F.R.S., and Robert Willis, M.D.Edinburgh, to organise the Library.

Between 1828 and 1835 Lawrence, Brodie and other eager reformers were elected to the Council and were supported by their senior colleague Sir Astley Cooper, the greatest English surgeon of his time. Meanwhile the House of Commons appointed a Committee of Enquiry into Medical Education, which issued an informative Report in 1834, encouraging reform of the medical corporations. Reform of the College took effect in 1843 through a new Charter. Its great innovation was the institution of a new higher degree of Fellow of the College. Before the end of 1844 several hundred Members were nominated as Fellows; thereafter the Fellowship would be obtainable only by examination. At the same time the life-tenure of Council members was ended; in future they would be elected by the whole body of Fellows for a fixed term.

During the 1850s the Council was active in promoting joint consultation among the medical corporations in England, Scotland and Ireland and with the young British Medical Association to formulate a satisfactory Medical Act, when it was known that Government intended to take control of the registration of practitioners. This was the first time such general consultations had been held, and their satisfactory outcome was largely due to the efforts of Sir Benjamin Brodie. The College showed interest in education for obstetrics and dentistry. It instituted a Licence in Dental Surgery in 1860 which proved most successful, leading in the far future (1946) to the Faculty and Fellowship in Dental Surgery within the College. The Licence in Midwifery had been introduced in 1853, but was suspended in 1876, because women medical students applied to be examined for it though not otherwise medically qualified. The College only admitted women to its examinations by grudging steps. Women first qualified in England in the 1860s with the L.S.A. degree, but it was not till 1909 that they were admitted to the College and even then without any right to share in its government. This final restriction was removed only in 1926.

Sir James Paget, the great Bart's surgeon, was active in the College throughout his career. As a young man he prepared the Catalogue of the Pathology Collection in the Hunterian Museum, and later served successive offices till he became President in 1875. In the late 1860s and through the 1870s he steered to success a scheme for a joint qualification in medicine and surgery, securing agreement not only from the Royal College of Physicians and the Society of Apothecaries but from the English Universities as well. This large scheme was however not implemented, but thanks to Paget's work the Conjoint Examination for the M.R.C.S. and L.R.C.P. was instituted in 1884, and the specialist Diplomas were placed under the jurisdiction of the Conjoint Examining Board of the two Royal Colleges.

Above: Royal College of Surgeons 1814
Below: Royal College of Surgeons 1972

In the early years of this century the Council of the College, more liberal than its Victorian predecessors, was active in negotiating with other medical bodies on such controversial topics as the introduction of National Health Insurance, and about medical education and research. During the first World War (1914-18) the Council was often consulted by the authorities, many of its members were on active service; among others who attained high rank was Sir Anthony Bowlby, surgeon to St. Bartholomew's, who became Consulting Surgeon to all the British Forces in France, and was President of the College in 1920-23. But the domestic departments of the College, its Museum, Laboratories and Library passed through a period of stagnation.

Berkeley Moynihan, Lord Moynihan of Leeds, breathed new vigour into the affairs of the College after the war. He had been elected to the Council in 1912 and was President 1926-32. He had already taken a leading part in founding the Association of Surgeons and the *British Journal of Surgery*, and was widely known, not least in America, as a brilliant surgeon and a persuasive medical statesman. With the munificent help of Sir Buckston Browne, F.R.C.S., he was instrumental in founding a Surgical Research Institute at Downe in Kent under the direction of the College. As a result a group of pioneering young surgeons was attracted to work at the College and at Downe between 1932 and 1939, when advanced research facilities were not readily available elsewhere.

In the middle of the nineteenth century the College was chiefly known to the outside world by the work of Richard Owen in the Hunterian Museum. Owen was an ambitious man of untiring energy, and made the Museum a centre for research in comparative anatomy and pathology. His five-volume Catalogue of the Physiological Collection, published in the 1840s, made the College known all over the scientific world; visiting scientists made it their first point of call in London. The Hunterian Lectures were originally given by leading surgeons such as Astley Cooper, John Abernethy and Charles Bell; then Richard Owen gave twelve lectures each year from 1837 to 1855 without repeating his subjects. Subsequently the lectures have been allotted to various surgeons, often young men, to report new advances.

Under Owen's successors, of whom Sir Arthur Keith, conservator 1908-33, was the most widely known, the Museum continued to grow and became a vast storehouse of anatomical, physiological and pathological specimens, of interest chiefly to specialists. Its destruction by bombing in 1941 was a great historical disaster, but the central collection was restored much nearer to John Hunter's original intention by Frederic Wood Jones, curator 1945-54, and his successor Miss Jessie Dobson who has only just now retired. Benjamin Brodie told in his Autobiography how he was introduced to research by working in the Hunterian Museum as a young man, and James Paget followed him thirty years later. After Owen's time research was largely restricted to the maintenance of the Museum. When the Conjoint Examination Hall was opened in 1886, joint laboratories of the two Royal Colleges were opened there and attracted some prominent research workers, Charles Sherrington among the rest. A little later the two Colleges inaugurated the Imperial Cancer Research Fund, now an independent foundation with great laboratories adjoining the College of Surgeons in Lincoln's Inn Fields.

The Library was built up by its first librarian, Dr. Robert Willis, to form what G. J. Guthrie, President in 1833, called "the finest anatomical library in Europe", and during the later part of the last century was the only large medical library in London freely available to doctors and scientists; its collection of periodicals was particularly notable. In the redevelopment of the College after World War II the current collections were reorganised as a research library for surgery, the surgical sciences and the related specialties. At the same time, through the active encouragement of Sir Geoffrey Keynes, Consulting Surgeon and a Governor of St. Bartholomew's, who was appointed Honorary Librarian of the College when he completed his term on the Council, the great collection of historic surgical and anatomical books has been restored and developed. The Library also possesses important memorabilia of famous surgeons of the past, including students' copies of Abernethy's lectures and the papers of Sir James Paget besides those of Hunter and Lister.

The College houses a splendid collection of portraits of famous surgeons by the great English artists, and other fine paintings, silver and furniture. Catalogues of these possessions have been published in recent years through the energy and enthusiasm of Sir Victor Negus, who also as chairman of the Hunterian Trustees promoted publication of new Catalogues of the Hunterian Museum.

During the second World War, 1939-45, the College was severely damaged in the last large-scale air-raid of May 11th, 1941; the Museum was almost completely wrecked. This disaster, however, led to a complete revitalising of the College's activities under the masterful guidance of Lord Webb-Johnson, President 1941-49. Faculties of Dental Surgery and of Anaesthetists were formed within the College, and permanent departments for research and graduate teaching were established. These were grouped together as the Institute of Basic Medical Sciences affiliated to London University's Postgraduate Medical Federation, and a residential college for graduate students was built, in close integration with the College, by Lord Nuffield. Fellows and Members were offered opportunities of sharing in the professional and social activities, and as already mentioned Museum and Library were modernised. Generous donations to help this development came from friends of the College all over the world, and great benefactions were contributed by charitable Trusts such as the Wellcome and those of Lord Nuffield and Lord Marks among many others. The completed restoration was celebrated in 1962 by a gracious visit from H.M. the Queen.

This new active life of the College has been made widely known through the monthly journal, the *Annals*, which Sir Cecil Wakeley, President 1949-54, launched with success in 1947; Sir Cecil also promotes the production of the roll of Lives of former Fellows, which have been published up to 1964. The latest notable advance in the College's work has been the inauguration of the Department of Surgical Sciences, under the direction of the eminent past President, Lord Brock; a logical completion of the group of research departments which have developed in the College in the last quarter of a century.

DVORAK-BARGAIN RECOMMENDATIONS (1841-1904)

Dvorak's music is mostly warm, romantic and tuneful—a real tonic in the long winter evenings. He was born in Czechoslovakia, and much of the Czech folk melodies may be heard in the music. More especially, the dance rhythms abound such as the "Furiant". It wasn't to music that the young Dvorak turned—he trained as a Doctor but got bored with this. He wrote and discarded many early works before allowing a symphony to be published as his opus 1—the "Bells of Zlonice". He continued to compose a flood of operas, religious music, symphonic and chamber works of all types as well as songs. He came to England in 1888 and dedicated his Symphony No. 8 (op 88) to Cambridge who gave him a doctorate. He went to the United States in the 1890s and began to assimilate many of the tunes of the slave populations—the "New World" Symphony, op. 95 and the "American" or "Nigger" quarter, op. 96. His last orchestral work was the magnificent 'cello concerto op. 104 by which time he had returned to Czechoslovakia where he was to die, a national hero.

Recordings of Dvorak's music are almost as plentiful as concert or radio performances of his works. Complete cycles of the symphonies have already appeared from Decca (LSO/Kertesz) and Philips (LSO/Rowicki) and DGG have announced plans for a complete cycle from Kubelik. As usual it pays to shop around. The Czechoslovakian recording company, Supraphon, have put out no fewer than three recordings of the New World Symphony with the Czech Philharmonic, none recommended despite authenticity. The Seventh Symphony, op. 70, was written after a visit Dvorak had paid to Vienna and Brahms, and there are hints of a style and form that didn't worry the Czech composer normally—it has the abundance of tunes of the other works also. It is full of glorious woodwind detail in the slow movement and a furious dancing finale. A marvellous record is available from Decca (SDD 260) of the LSO and Monteux—still as fresh as ever in sound and beautiful in performance. If a performance of the "New World" is required, I would recommend either Ormandy's with the LSO (CBS 61053), a fine performance, if a bit overblown, or the old Toscanini record, a truly wonderful performance that immediately grips one, but I find the 7th much more rewarding as a symphony. Do not miss hearing the earlier symphonies—No. 5 op. 60 and No. 6 op. 76 offer riches indeed (no cheap recordings though).

Time and time again one hears the Slavonic Dances used as encores or TV sound tract music or even travellogues. They never fail to charm by their tunes and rhythms—just Dvorak at his best. In many ways the Cleveland Orchestra performances under Szell are ideal—bright and breezy if just a little hard-driven and unyielding but a good bargain to get all the works (op 46 and op. 72) onto one disc (CBS 61089). The recording is slightly less than fully rounded—somewhat harsh but still quite recommendable. Much of the chamber music is enjoyable. I particularly enjoy the piano quintet—an ideal work to introduce anyone to the delights of chamber music. Curzon's recording with Vienna Philharmonic Quartet is ideal in its Lyricism and rhythmic verve and the Decca recording is suitably mellow (SDD 270). Another Decca record of the string sextet op. 48 and quintet op. 97 is equally a gem and not to be missed (SDD 315).

The operas and religious music have received less than their due on record—I have heard the Requiem and find much of it rather dull. "Rusalka" was popularised by Joan Hammond—"O Silver Moon". I cannot remember a performance of any Dvorak opera in this country since 1960.

I must finish with a full price recommendation. My favourite Dvorak work is the 'cello concerto. The brilliant Russian 'cellist Rostropovitch has recorded it twice, at least, once for HMV and once for DGG. Tortelier too has recorded it. Magnificent as these are, my personal choice for a reading of unaffected beauty with superb support for the Berlin Philharmonic and Szell is given by Pierre Fournier. No pulling about occurs here, it is all straight and the music simply speaks for itself. Marvellous sound too (DGG 138755).

ALLEGRO.

THE WIX PRIZE ESSAY

The Life and Works of Sir James Young Simpson (1811-1870)

By N. STOY

part 2 : OBSTETRICS and GYNAECOLOGY

"His name was writ in chloroform, but he was first and last an obstetrician" (R. W. Johnston, 1947). Simpson was elected to the Chair of Midwifery at Edinburgh University in 1840 at the age of 28 and held it for thirty fruitful years until his death. He was a gifted teacher and despite a wealth of professorial talent in Edinburgh at the time his lectures on Midwifery reputedly attracted the largest attendances. Only on looking through his 'Obstetric Memoirs and Contributions,' the 'Selected Obstetrical and Gynaecological Works' and the 'Lecture Notes' which contain the substance of the practical part of his Midwifery Course, does one begin to realise the full extent of his impact on the subject. He contributed more to it in his lifetime than any man before, he rationalised and systematised it, and inculcated it upon a new generation of students.

A highly feared complication of pregnancy in the nineteenth century was eclampsia and it was responsible for much maternal mortality and morbidity. Simpson shares with Lever of Guys the credit for their independent discovery in 1843 of albumin in the urine of patients suffering from this condition. Simpson's distilled teaching on the symptoms and management of eclampsia are to be found in the 'Lecture Notes'. He knew that the premonitory symptoms associated with the albuminuria were:

"1. Dropsy of the hands and face.
2. Headache and other pains.
3. Lesions of the senses and paralysis.
4. Nausea, vomiting, diarrhoea, cramps, etc."

His principles of management, which included advice to "keep the circulation depressed", to "bleed largely, and again if necessary" and to depress the circulation on the first attack threatening in subsequent pregnancies, indicate that, had the sphygmomanometer been introduced some half a century earlier than it was, Simpson might well have specifically enunciated the diagnostic triad of pre-eclampsia! In treating the condition he suggested that the excitability of the nervous system be subdued by chloroform and delivery be expedited with forceps if possible. The pathology underlying eclampsia and pre-eclampsia is still very much a mystery today. Among the "supposed causes" entertained by Simpson were the "plethoric condition of pregnancy"; toxins in the blood such as urea, carbonate of ammonia, kreatine and alkaloid poisons; "hydreamia, leading to oedema of the brain under increased blood pressure in the arteries"; and underlying "granular disease of the kidney". Just to be on the safe side he also included "state of the atmosphere". A number of interesting cases of eclampsia, some attended by amaurosis, were published by Simpson in 1852; in the second of these, in which eclampsia was supposed to have supervened after about eight weeks of the puerperium, there seems to be some understandable confusion between convulsions complicating uraemia and true eclamptic fits.

Another common condition which came under Simpson's scrutiny was cephalopelvic disproportion and he was quick to advocate the use of long forceps in contracted pelvic brim as an alternative to the practice still popular in his day of sacrificing the child by craniotomy. This was sound teaching both because the operation of craniotomy itself carried a maternal mortality of about 20% and because in good hands the long forceps could avert many foetal deaths. In the early 1840s Simpson introduced a new design of long forceps. This instrument received such recognition that for about a century it was employed for the vast majority of assisted deliveries, and a slightly modified version is still widely used today.

As shown in the illustration, Simpson's forceps were a synthesis of the best features of earlier designs. The choice of handles, for instance, was in keeping with Simpson's belief that forceps were "only properly used as an instrument of traction, not compression". The joints were kept loose to facilitate introduction and application, and the lock, an improved version of Smellie's, stayed fixed between contractions. Outlet injury was alleviated by incorporating parallel shanks beyond the lock. The cephalic curve and length of the blades was sufficiently generous to give adequate protection for the head, and a feature of great practicability was the marking of the anterior surfaces of the handles. Simpson's mode of application of the long forceps was in some respects unorthodox and at variance with the widely accepted views of Smellie put forward a century earlier. If the indication for forceps was uterine inertia or haemorrhage with no disproportion and the head engaged, Simpson (like Smellie) favoured application of the blades symetrically to the sides of the foetal head. However, the most common indication for the long forceps was transverse or asynclitic arrest from a reduction in the conjugate (antero-posterior diameter of the brim) due to forward projection of the promontary of the sacrum. Here, Simpson (unlike Smellie) thought asymetric or oblique application of the blades to the head was a better procedure. Thus the posterior blade passed over the side of the occiput and the anterior blade passed over the brow or temple, so that they came to be "somewhat in the oblique diameter of the brim". The advantages claimed for this approach was that it

spared the urethra from damage and placed "the blades of the instrument in exactly those parts of the pelvic circle where there is least pressure, and consequently most room for them". One suspects that when coping with the more severe rickety flat pelvis that he must have come across in his large practice Simpson had learned by bitter experience that his way of applying the blades was sometimes the only way of getting them on at all!

Simpson was well acquainted with the disadvantages of the long forceps when compared with the short forceps: "from the direction of compression in the long forceps operation—viz., in the antero-posterior or oblique diameter of the foetal head—the danger and mortality to the child is generally far greater than when the short instruments only are used, the direction of the compression with them being transverse". Simpson in fact was never a man to rush for forceps of any type where patience or an alternative mode of delivery would be safer. For example, he taught that "posterior positions would deliver themselves without forceps, and at any rate it was perfectly proper to use the vectis if so desired. It was a matter of flexing the head, and then assisting in the rotation, by hand or with the vectis, and then allowing the patient to deliver herself". (The vectis was a single, uncurved blade).

The problem posed by disproportion, however, was more intractable. Occasionally early artificial induction of labour could forestall the need for craniotomy or the long forceps. Another technique which Simpson first tried in 1847 (on the same occasion that he first administered ether) was internal version and breech extraction. This manoeuvre was performed in the belief that the foetal head stood compression better from below upwards as it afforded a wedge shape instead of a dome to the narrowed pelvic inlet. Furthermore, it substituted the lateral compression of the child's head by the contracted sides of the pelvis for the more dangerous oblique or longitudinal compression by the long forceps. In this day and age it is recognised that in a breech delivery the rapid passage of the foetal head through the pelvis, preventing adequate moulding, and the tendency to tentorial tears from the character of the compression, are adverse factors which raise the foetal mortality as much as 5% to 10% above that for cephalic presentations, even with no disproportion. Nevertheless, Simpson's own experience and investigations indicated that in minor degrees of disproportion there was more chance of securing a live birth by version and breech extraction than by delivery with the long forceps, and he strongly advocated that turning should replace craniotomy.

In the context of cephalopelvic disproportion some statistics collected by Simpson are informative as they illustrate the importance of foetal head size as a cause of problems in labour. In a closely reasoned paper published in 1844 he adduced evidence to show that in a large proportion of complicated labours the child was more likely to be male than female and reached the staggering conclusion that, "Upwards of 7,000 deaths in all—namely, above 6,500 of the deaths of infants during and after birth, and 500 of the deaths of mothers in childbed occurring annually in Great Britain—are referable to the direct or indirect agency of the . . . larger size of the head of the male child." These figures are a pointer to the catastrophic wastage of human life accountable to cephalopelvic disproportion in the mid-nineteenth century, but their import is even greater when it is remembered that the results express only the differential of male as against female infant mortality; to the above figures would have to be added an unknown number of deaths of female infants due to disproportion, together with a balancing pool of male infants who died from the same cause and the associated maternal mortality, for some idea of the total loss to be obtained.

Nowadays cephalopelvic disproportion represents a minor hazard of pregnancy in this country. Pelvic assessment at antenatal clinic gives early warning of likely problems in labour, and with improved standards of nutrition and general health pathological causes of disproportion are becoming increasingly rare. In the management of disproportion craniotomy, the long forceps operation, and internal version have of course all been supplanted by Caesarean section—either elective or after unsuccessful trial of labour. In Simpson's day Caesarean section meant almost certain death to the mother, and he advised it only as a last resort in grossly contracted pelvis (conjugate $<1\frac{3}{4}$ inch with transverse diameter <3 inch); in 1865 he was one of the first to use uterine sutures in this operation. Simpson's long forceps survive with De Lee's modifications (longer shanks to keep the handle away from the anus, broader flatter blades to give more protection to the foetal head, and simplification of the handle in favour of lightness and ease of cleaning) and are still very much in vogue for mid-cavity deliveries where rotation is not required.

Not content with the existing aids to delivery in his armoury Simpson invented a piece of apparatus which is the direct forerunner of the modern Malmström vacuum extractor (or "Ventouse") introduced in 1955.

(see facing page.)

Simpson's design was described in 1849 in a paper entitled "On a suction tractor; or new mechanical power as a substitute for forceps in tedious labours", and to Simpson goes the honour of first applying the suction principle successfully to terminate labour. He made several variations of the tractor. One of the earliest consisted simply of a common metallic vaginal speculum fitted with a piston, its broader trumpet-shaped end covered with leather and greased with lard! Despite the primitive design he managed to exhaust sufficient air from the system to achieve a hold on the foetal head and pull the baby into the world. After seeing a tractor demonstrated one visiting Russian physician exclaimed, "C'est superbe, superbe; c'est immortalité à vous!" Later tractors employed more sophisticated cups and an improved syringe based on the breast pump then in use. The one illustrated is in the care of the Department of Obstetrics and Gynaecology of Edinburgh University.

How the idea for the tractor occurred to Simpson is not entirely certain. He was reminded by a friend that he had conceived it as long ago as 1836 when watching a group of schoolboys lifting up large stones by 'suckers' made of pieces of wetted leather with cords attached at their centres. However, he also knew of the work of Neil Arnott who in 1829 had published a design for a pneumatic tractor based on a circular leather suction pad which could be extended by solid rings or radii.

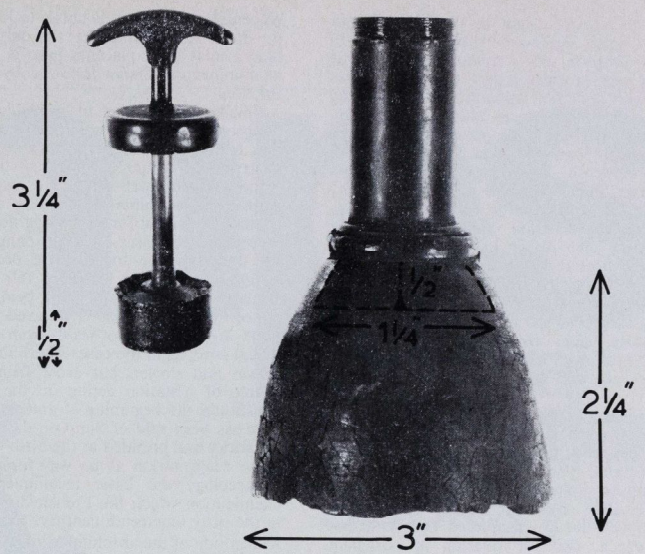


Fig. i. Vacuum Extractor

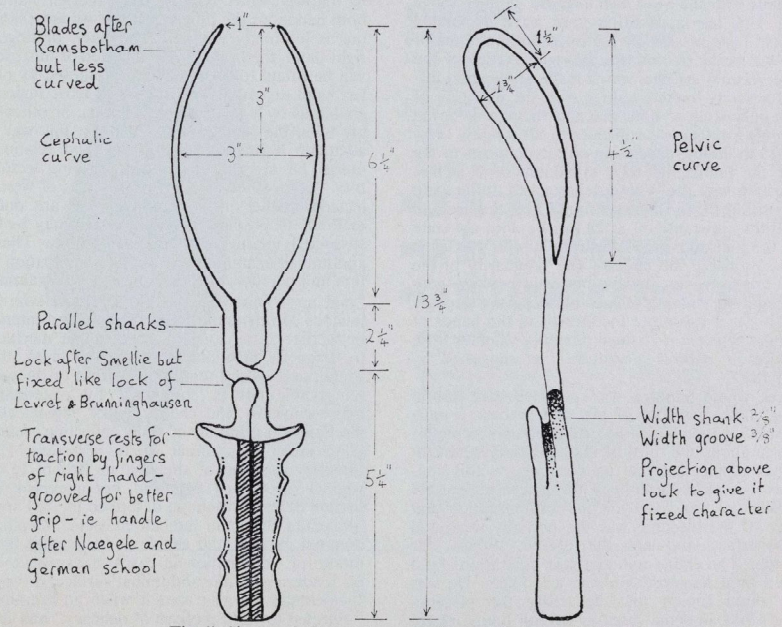


Fig. ii. Simpson's Long Forceps (after original woodcut)

Arnott thought this device might be used both in obstetrics and to raise depressed skull fractures. In December 1848 Simpson saw a demonstration of the artificial French leech in which a dart to pierce the skin was combined with a suction apparatus, and this may have given him the design for an exhausting cylinder. In his writings on the tractor he points out how suction was employed in Nature to great effect in the discs of limpets and cuttlefish. Soon after the tractor first appeared a certain James Mitchell achieved notoriety by claiming to be the true inventor. In a letter to Simpson, published in the London Medical Gazette, he stated, "I made my own design known to you in the answer to question three at the end of term examination, in speaking of the rotation from occipito - posterior position to occipito-anterior position. On another sheet, I made a rough sketch of the instrument." Going further back in history, James Yonge in 1706 or 1707 described a case of prolonged labour in which "a cupping glass fixt to the scalp with an air pump failed to draw out the head".

The more evident advantages of the suction tractor over the forceps were that there was less danger in application and traction, no compression of the skull in its most vulnerable planes, and less chance of pelvic damage. Simpson thought that the tractor would be simpler and safer than any other method proposed in cases of long labour due to disordered uterine action and arrested breech, and for rotation in persistent occipito-posterior position. He clearly envisaged its application in pelvic presentations, as well as in cephalic presentations with the head well engaged or high above the brim. This last application must have demanded considerable feats of skill by the operator as the major disadvantage of the tractor was the rigid fixation of the cup to the vacuum syringe, which made application difficult and severely limited control over the direction of pull. It is interesting to note that the vacuum achieved by Simpson's tractors was sufficient to lift weights varying from 25 to 80 lbs, depending on the diameter of the mouth of the funnel, up to a maximum of 3 inches. Experimenting with the 'Ventouse' attached to the scalp of a fresh stillbirth, Ian Donald found that the vacuum broke and the cup came off at 23 lbs; he does not state which of the four sizes of Malmström cup he was using but it was probably the largest. The popularity of the Ventouse apparatus in modern obstetric practice goes from strength to strength. Many obstetricians strongly advocate it "as a substitute for forceps in the hands of men who are deficient in manual dexterity whether from inexperience or natural ineptitude", as suggested by Arnott in 1829.

One area where Simpson was less successful was in the management in labour of placenta praevia, a most dreaded complication which he estimated caused maternal death in about one third of the cases. His treatment of the unavoidable maternal haemorrhage in this condition was manual separation of the placenta from the uterine wall and was based on the misconception that the source of the bleeding was the partially separated placental surface and not the uterine vessels. He believed that if an entire and complete separation could be effected fatal haemorrhage was less likely. He was therefore often forced into delivering the placenta before the child, in some cases by several hours; rarely the child survived if it was born immediately following placental expulsion. It is unfair to judge him too harshly for these shortcomings for the only heroic alternatives then available for placenta praevia were rupture of the membranes or version followed by forcible breech extraction.

Finally, and worthy of particular mention amongst Simpson's contributions to obstetrics, is his introduction in 1855 of the practice of monitoring the foetal heart during labour by means of the stethoscope, as a guide to foetal well-being. He recognised that bradycardia was an ominous warning of impending foetal death and a signal for expediting delivery. "There were, however, rarer cases in which danger was indicated to the child, by the foetal pulse becoming much more rapid than ordinary, reaching 150 or 160 beats in the minute, and at the same time being often very irregular or intermittent. Dr. S believed the danger in these latter instances did not result from pressure on the umbilical cord, as in the cases where the pulsations became slower and slower, but arose from pressure or some source of irritation acting on the brain." Surely this constitutes the beginning of antenatal paediatrics!

It has been said of Simpson that he gave new life to obstetrics and presided at the birth of gynaecology. This is no exaggeration as he was foremost in applying to gynaecology the basic techniques of diagnosis and examination which the French did so much to pioneer in the early nineteenth century. Most important was his recognition of the absolute necessity for bimanual examination in reaching an accurate diagnosis. In 1850 he wrote that in examining the uterus "a rule requires to be followed which is too often forgotten, namely to use both hands for the purpose. For if we are examining the uterus internally with the forefinger, or fingers of the right hand, the facility and precision of this examination will be found to be immensely promoted by placing the left hand externally over the hypogastric region, so as to enable us by it to steady, or depress, or otherwise operate upon the fundus uteri." Only in this way could an adequate impression of the size and relations of the uterus be ascertained. In the opening lecture of his fifty "Clinical lectures on the diseases of women" (collected together in a single volume) are outlined the methods of physical diagnosis which may be helpful in suspected uterine or ovarian pathology. These are an abdominal examination—by sight, palpation auscultation and percussion, a vaginal or rectal examination and "that most important mode of diagnosis viz. the simultaneous combination of the external and internal modes of tactile examination". Amongst the mechanical aids to diagnosis mentioned are the speculum, the uterine sound, and sponge tent for dilatation of the cervix. This remarkable list is completed by examination both microscopically and chemically of vaginal and uterine discharges, aspiration of fluid collections, and examination under anaesthesia where necessary. Historically Simpson was one of the first in Britain to adopt the vaginal speculum (1841) and, not unexpectedly, examination under anaesthesia described in 1851 was his own brainchild. Its main indications were "to relax the abdominal parietes and enable us to practise the different modes of examination in cases of excessive or neuralgic tenderness of the abdominal surface, or vagina, etc." Incidentally, he also used it when an examination was "objected to from motives of delicacy" and during parturition to obtain accurate information in cases of sus-

pected malpresentation. The Simpson uterine sound, or bougie began to be employed in the early 1840s and extended the information obtainable from the bimanual examination. In doubtful instances it could be used to determine whether a tumour involved the uterus or one of its appendages, and it gave a more precise estimate of the size of the uterine cavity.

In operative gynaecology Simpson once more led the field by being the earliest to gain useful access to the non-labouring uterus. His expanding sponge tents for dilating the cervix preceded the Hegar dilators, introduced in the year of Simpson's death, by upwards of 20-30 years. The construction of the tent was simple and he gave details for the enthusiast to make his own. The finished item was the shape of a slender cone and had a tape attached at the base for removal. When inserted it became swollen by imbibing fluid from the surrounding tissues.

Although a somewhat 'Heath Robinson' device, it must have been effective in dilating the cervix as it enabled Simpson, with a certain amount of ingenuity and an assortment of instruments—including silver wire, blunt-pointed scissors and the 'polyptome'—to remove endometrial polyps and some of the more accessible intrauterine fibroids. Tents of sea-tangle could be used as an alternative to sponge tents but in cases of intrauterine growth, where there was increased risk of infection, Simpson preferred the more rapidly expanding sponge tent. Even the sponge tent took 20 to 30 hours to dilate the neck of the womb to four or five times its normal diameter. Occasionally it was necessary to widen the neck of the womb even more and then a succession of tents of increasing size were employed; in this way even a sessile fundal polyp might be reached. In the treatment of sterility and obstructive dysmenorrhoea incision of the cervix was sometimes called for and Simpson designed the first hysterotome for this purpose.

An operation with which he was much concerned was the relatively new one of ovariotomy, originally performed for the excision of an ovarian cyst by Ephraim McDowell of Kentucky in 1809. Indeed it was Simpson who coined the word 'ovariotomy', later referred to by the eminent American gynaecologist, E. R. Peaslee, as "a barbarous compound of Latin and Greek, and besides does not express the meaning intended". Simpson in one of his lectures characteristically regales us with some fascinating history of the operation. It was identical with the spaying of animals, performed to prevent breeding or to encourage fattening. Adramyttes, the King of the Lydians, was the first man to castrate women as he apparently preferred female to male eunuchs, and Boerhaave recorded that a certain swine-spayer castrated his daughter as being the most effective means of putting an end to her licentious practices! Simpson makes the interesting observation that the famed Percival Pott had once "cut down upon a small tumour in either groin of a young female and remover from both sides a body which had all the appearances of an ovary and was apparently—as proved by the physiological results, as well as by the anatomy—nothing else than this organ contained in a hernial sac, and liable to pain on compression in its new position".

The proponents of ovariotomy hoped that it would eventually replace the practice of repeated tapping of ovarian cysts through the abdominal wall. The latter approach had a wide following amongst surgeons because the risk of peritonitis was slight, although sometimes a spreading and fatal sepsis did originate in the cyst lining. Its major disadvantage was that it was rarely curative and in the long term the patient often became cachexic. Simpson reports one record case of 80 tappings over 25 years which yielded 729 gallons of fluid! He realised that if only the fear of opening the abdomen could be surmounted the removal of a large mobile ovarian cyst on its long pedicle would not be technically difficult. Although he did not often operate himself he championed other workers who were trying the procedure, and set out to dispel the deeply ingrained prejudice of the majority of surgeons. By 1856 Charles Clay of Manchester had achieved 49 recoveries in 71 patients and by 1870 Thomas Keith, a former student of Simpson's, had completed a series of 100 ovariotomies with only 17 deaths. The bugbear of the operation was post-operative abdominal sepsis, and Spencer Wells developed an ingenious clamp to bring the pedicle stump outside the wound during healing and so prevent dead tissue remaining in the abdomen. Simpson must have been very gratified to see that by about 1865 ovariotomy was considered to be a safe operation.

The differential diagnosis and pathology of ovarian swellings and the medical and surgical aspects of ovarian cysts comprise eight absorbing lectures of the fifty 'Clinical Lectures of the Diseases of Women', and ovariotomy has two lectures to itself. This book is a mine of information on all the common gynaecological maladies, and many of the lectures include representative case histories of patients who happened to be in the wards at the time of writing. Other subjects treated at length include uterine cancer, amenorrhoea and dysmenorrhoea fibroids, surgical fever, pelvic cellulitis, phlegmasia dolens, vesico-vaginal fistula and uterine subinvolution. 'Uterine subinvolution' and 'pelvic cellulitis' are both terms we owe to Simpson and he first gave coherence to the concept of pelvic inflammatory disease.

There is one fascinating lecture on coccygodynia and malformations of the coccyx. 'Coccygodynia' was Simpson's term to describe pain in the coccyx and neighbouring region. In some instances he took the bold step of removing the entire coccyx but the condition could usually be cured by dividing the muscular and tendinous fibres attached to the coccyx. On one occasion when he performed this operation on a woman from India the knife broke and the blade was left embedded in the coccygeal fascia. The patient was alarmed at first, but when she realised on sitting up that her pain was gone she said she did not mind if the blade remained. Simpson continues, " And there, for aught I know, it remains to this day—an illustration of a pathological law . . . that pieces of iron and other metals may remain in contact with the living tissues, and may lie embedded in their midst for any length of time, without giving rise to any marked degree of inflammatory action." Elsewhere in the lecture details are given of a rare coccygeal tumour which he considered was made up of remnants of a second foetus from a blighted ovum which had arrested early in development and become attached to the caudal region of the normal co-twin. Sometimes these tumours, when inoperable, were of little inconvenience to the victim; Simpson mentions that one "young man, who is now a clerk in a public office, works all day at his desk, sitting upon, and in one sense at least supported by, this undeveloped brother."

FASHION 1972

A Guide to Current Trends at Bart's.

By THE JOURNAL FASHION CORRESPONDENT

It appears that the conventions of fashion apply just as rigorously in a community like Bart's as in the rest of society. The following is intended therefore as a guide for those who are faced each morning with the terrible problem of what to wear.

Nurses are obviously restricted by the starch of their uniforms, and apart from hair-style and depth of make-up, are happily exempt from the vagaries of fashion. Not so the doctors and students! Incorrect dress at a place such as Bart's can be as much a social stigma as a regional accent or a dislike of alcohol. However, anyone who follows the rules set out below will be immediately accepted as a man of substance.

CONSULTANTS

Consultants may be permitted a little eccentricity in view of their age and position but certain conventions still apply. Baldness is a useful attribute since people still seem to equate a dearth of hair without with a plethora of neurones within. Half-moon, gold-rimmed spectacles add to the illusion of wisdom and, even if his vision is excellent, a consultant is well advised to obtain a pair with non-refracting lenses. For surgeons, three-piece suits, preferably pin-striped, are de rigeur, and the white coat, if used, should look as though it is only worn for two hours per week, which, indeed, it is. For consultant physicians, similar principles apply, although they may be permitted a stethoscope. This, however, is best concealed and its use kept to a minimum, 'though it should have an ancient and battered appearance. The pockets of the white coat should, of course, be kept empty so as not to spoil the lines of the figure. Moreover, full pockets suggest an improper dependance on dairies and notebooks.

REGISTRARS

The distinction between physician and surgeon is more marked at the registrar level. Surgical registrars are generally younger versions of their bosses, and as such are expected to mirror their appearance. Therefore, coloured shirts with stiff white collars, old school or club ties, and three-piece suits preferably with a watch-chain are favoured. Their counterparts on the medical side, however, may be permitted a degree of flamboyance which they hope may be mistaken for the eccentricity of a great, if disorganised, brain. Therefore, they should wear coloured shirts and flowery ties, and may even be permitted a degree of facial hirsutes. Obviously, a more unusual appearance is expected of psychiatrists, and bow ties, wild hair and other excesses are commonplace in this specialty.

HOUSEMEN

For housemen, it is likely that they may have little time to plan their wardrobe carefully. Nonetheless, certain essentials must be purchased before starting on "the house".

A selection of colourful shirts and ties, at least one pair of bell-bottoms, and some suede and ancient shoes should suffice, although it is advisable to have more formal wear should your consultant invite you to a clinical or social function in Harley Street or elsewhere. A rather gorgeous strawberry purée and white tie is popular currently with the houseman. Clean white coats may imply that the houseman is neglecting his duties, so new coats should be rolled up and crumpled before wearing. The pockets should also be filled with old diaries, cigarette packets, copies of Cancer Ward and so on to suggest that the houseman's time is both precious and well-occupied.

STUDENTS

The conventions for students are no less strict than for their seniors. Preclinical students must have long, unkempt hair, a dirty pullover, faded jeans and gym-shoes. Anyone so rash as to appear smart, or have a haircut, is inviting instant and sustained derision. The same social pressures apply in the hospital but, in the patients' interest, it is fair to insist that the appearance is not likely to terrify the old dear in bed 18 who has never been in hospital before and who thinks all doctors are soft-spoken Scotsmen from Tannochbrae. For this reason alone, I think students (and doctors), should have reasonably short hair, clean hands, and wear a collar and tie. However, once out of the wards, no restrictions other than those of fashion are needed, and typical après rugger wear might be a baggy sweater with jeans plus of course the usual accessories of a pint of beer and a multi-decibel voice.

FASHION 1937

This extract is from the Bart's Journal of 1937:

. . . The young surgeon's apparel is of the greatest importance; he should be dressed in the neatest and darkest of suits; immaculate shirts and Bond Street ties are to be recommended. Only the most eminent can afford to be seen in brown tweeds baggy about the knees, pullovers, or cerise ties. If black coats are worn, a certain latitude is allowed in the stripes of trousers, and unexpected originality will often be discerned about the legs of the otherwise entirely soberly clad.

From the sartorial angle consider the following concerning a young surgeon who went to see a case when not in 'uniform'. One Sunday morning this newly appointed Chief Assistant went to the Hospital wearing an ancient tweed suit. While in the wards a call came from an important G.P. in the country. A fat fee was mentioned. The young man had no time to return home to change, and borrowed sufficient instruments from the theatre (he had none of his own anyway), dashed off to the train. The G.P. driving a Rolls, met him at the station. His expression of disgust so unnerved the consultant that he nearly leaped on the train again. The result of this visit was that the G.P. never sent him another case, and next day the young surgeon interviewed his tailor. As a cheering fact the operation proved a success and the patient was satisfied. But that was not the point.

BARTS SPORT

(1) HOCKEY CLUB REPORT

The University of London 'Six-a-side' Hockey Competition

This competition is held yearly at the beginning of November. Teams are entered from most of the hospitals and colleges of the university, the larger ones putting in two. It has been won for the last three years by St. Thomas', but having lost their nucleus of United Hospital players this year, they are not such a force. Last year the Barts six reached the semi-finals being beaten by St. Thomas'.

This year Barts entered two teams, listed below. The competition is run on the principle of dividing the teams into four divisions, and each division consists of a league of six sides, which play out to find the league leader; thus providing four semi-finalists. Barts 1 was in the first group, Barts 2 in the fourth.

The first team's matches produced a mixture of results. Those against Q.M.C. 1 and Guys 2 were disappointing draws, where chances were made but the finishing was missing. However against City and Guilds, and Wye five goals were scored and some effective play was displayed. Bedford failed to field a side, a walk over giving Barts the lead in division 1 and a place in the semi-finals without conceding a goal.

The second team had a more difficult task, in that on paper there were better teams in their group. With less talent, the side called for hard running and good tactics. The first two opponents, Q.M.C. 2 and Royal Free, didn't offer much resistance and enabled some valuable practice for the later matches. Imperial 1, last year's U.L. cup holders, were next, fielding two London University players. Barts, by hard and close marking, managed to win by a single goal, having had more scoring chances than Imperial. After this the team tended to relax and allowed Westfield to draw in the closing second of the next match. Since Imperial had won all their other matches, Barts had to win their last match to avoid a replay to decide the league leader. U.C.H. 1 were the opponents. A fast move down the left wing by Ashton with a quick centre inside the first minute gave a scoring chance which Morgan put in.

After that U.C.H. were never in the game and two more goals were added.

Semi-finals

Guys 1 won Group 3 and gave the first six their strongest opposition. Barts, using their wings laid on chances, but strong defensive cover by Guys prevented any scoring. Two goals were disallowed, and then Guys had a short corner. A hard chest high shot was deflected by Martin Gillings for a long corner. However at the end of the game Barts was ahead on long corners. In retrospect Barts had more of the play and deserved to win.

Kings was the other semi-finalist, and were probably the weakest. Again the seconds had an attack on the left which ended in a goal in the first minute, after which the result was not in doubt. A quick clearance from the defence to Morgan on the half-way line produced a fine solo goal, thus leaving an all Barts final.

The Final

To have both sides in the final is probably a record. Unfortunately it was played in near darkness. The second side played with more gusto and had the better of the first half, gaining a short corner. But the first six started to tighten their grip in the second half and had more of the attack, forcing more corners. In the end the first side won by a long corner. The achievement of having two sides in the final must underline Bart's strength this year, and bode well for the Cup matches later in the season.

First Six	Second Six
Colin Reid, U.H. Captain	John Linsell
Jim Tweedie, U.H. Sec.	Peter Donaldson
Martin Gillings, U.H. Player	Adam Scott
Jim Smallwood, U.H. Player	Richard Ashton, Barts Captain
Andy Young	Richard Morgan
Roddy Barclay	Mike Ashby

R. E. ASHTON.

RESULTS

FIRST ROUND

GROUP I

Barts I v Q.M.C.I.	0—0
Barts I v Bedford	w/o
Barts I v City & Guilds	2—0
Barts I v Guys	0—0
Barts I v Wye	3—0

W 3 D 2 F 5 A 0

GROUP IV

Barts v Q.M.C. II	2—1
Barts v Royal Free	1—0
Barts v Imperial	1—0
Barts v Westfield	1—1
Barts v U.C.H.I.	3—0

W—4 D—1 F—8 A—2

SEMI-FINALS

Barts I v Guys I	0—0
Barts II v Kings	2—0

FINAL

Barts I v Barts II	0—0

Barts I Winners on Corners

(2) RUGBY CLUB REPORT

Despite quite reasonable attendances at pre-season training the first two months of the Rugby season must go down as the worst Barts rugby has experienced for a considerable time. Although various reasons have been proposed, the lack of success must be related to the fact that of last season's Cup Final Side, only one player—Rog Brookstein, this season's skipper, played regularly for the 1st XV, which by and large has not been a settled unit.

SEPTEMBER

The season began with a game against Beckenham, (29/9/72) who were by no means the weakest side played this season. This game provided our only success of the season so far with a win by 18pts—13. As usual September games rely on the experience of the older members of the Club and the side included John Laidlow, who gave an outstanding individual performance, Jerry Sowden, safe as ever, and Clive Grafton at scrum-half. The team played well under the circumstances but as the score suggests the game was close.

The 2nd game envolved a visit to Southend where Barts were soundly beaten by vastly better organised team. The score of 36pts—0 flatters Southend to a certain extent, but underlined the weakness of the whole team to tackle a man and hold the ball. Result Barts 0, Southend 36.

OCTOBER

The Freshers Trials took place on October 4th and it immediately became obvious that the Barts problem positions in the ¾'s would still remain. It seemed that we were blessed with duplications in various positions:

Tony Taylor and Hugh Maurice at full-back

Murray Porter and Jim Frame at scrum-half

but also a good O/H in John Powell and a fast wing with plenty of guts in John Goddard.

In the forwards we had our usual share of good back and front row players but 2nd Rows again were thin on the ground.

The first match in October proved to be fairly disastrous, when we took on an Oxford side which contained 11 county players. For the first 15 mins it would be fair to say that Barts were on top and winning by 6pts—3, but some weak tackling in the centre destroyed the confidence of an inexperienced Barts XV and inspired a very competent Oxford back division into running in 52pts in a one-sided game. Result Barts 6—Oxford 52.

CAMB LX CLUB

For this match the Barts pack was strengthened by the inclusion of 2 Oxford players — Dave Badenoch and Dave Elliot — both of whom play regularly for London Scottish. However the match again was not lost in the pack but by a lack of attack in the centre of the field. Barts led for a short time in the first half but eventually succumbed to the LX Club. Result Barts 7 — C.U. LX Club 19.

For the next two Saturdays we played two sides that were weak but the Barts team failed to make any headway.

Against Old Blues, the Barts pack won 90 per cent of the Ball from all positions, but the backs failed to create any impression on a polish set of Old Blues backs. Old Blues did however possess one strong running wing who showed that the whole team were still unwilling to tackle. Result Barts 10, Blues 16.

Canterbury provided a sterner test than Old Blues, but were again fairly weak. The team put on probably the worse performance of the season and lost, though John Laidlow again managed to score our solitary try towards the end of the match when the Barts pack really got on top. Result Barts 4, Canterbury 18.

The following week our fixture against London University was cancelled because they were unable to field a side.

NOVEMBER

November is the month of Barts visit to Devon and Cornwall to play 3 matches against Cambourne, Falmouth and Newton Abbot. In the past this tour has been one of the high-lights of the season, as far as players were concerned, but again the changing attitude at Barts showed through by the difficulties occurring in trying to obtain sufficient numbers for the tour party. Eventually the following players left for Cornwall on Friday, 3rd November:—

R. Brookstein; J. Capper; J. Frame; K. Harrison; N. Markham; J. Goddard; T. Whitehouse; G. Jenkins; D. Court; D. Rowlands; R. Coleman; G. Aiken; J. Kaye; P. Cooper; A. Hawley and Billy the driver. They were joined on Saturday by J. Mann and R. Adley, on Sunday by D. Jefferson; J. Sowden; O. Else; J. Carroll and D. Badenoch, and on Monday by J. Powell.

The match against Cambourne was played in typical Cornish wet weather. Barts fielded an inexperienced side even by this season's standards and in the first 20 mins were surprised by the ease with which they could dominate the Cambourne pack and backs. Unfortunately we were again unable to convert the supply of good ball and running by the backs into points and eventually the home-side scored a breakaway try which was converted. The game continued in much the same fashion with the Barts side having the territorial advantage, but the Cornishmen again scored 2 breakaway tries with one being converted. Although it's difficult to pick out individuals, the back-row of Kaye, Coleman and Hawley stood out well for the Hospital.

Result Barts 0, Cambourne 16.

Due to the effects of fire and water the Barts touring party became separated early on the Sunday morning (just after breakfast), so the numbers in the Hotel became decreased, however this didn't dampen the team spirit and several members took full advantage of the seas of the Cornish Riviera, either clothed or unclothed.

By Monday the Tour Party was at full strength but again due to accommodation difficulties the starting time of training was delayed by the odd 90 minutes (not unusual for the side). After a fairly brisk training session, the team was confident of putting up a good show against Falmouth, however the home team were a very much improved side and easily beat a Barts side which on paper was the strongest on tour. We did however score our first points when John Powell made a neat inside break to feed John Carroll who crashed over for a try.

Result Barts 4, Falmouth 33.

Tuesday envolved the trip to Torquay for Wednesday's match against Newton Abbot. The Barts side

again seemed a strong one on paper and indeed it looked as if we might record our first victory of the Tour. During the first half the Barts pack was in control but we again could not convert chances into points. Newton Abbot came more into the match during the second half and scored a few tries. Jeremy Kaye kicked a consolation penalty for Barts.
Result Barts 3, Newton Abbot 16.

Barts v O. Haberdashers

The game was played at Chislehurst in typically November weather, with a hail shower at the start of the match. Unfortunately the Barts XV took slightly longer to settle down than Haberdashers with the result that they soon found themselves behind by 4pts, after an overlap was created by the Old Boys. Barts fought back strongly but conceeded another try before John Mann took a scoring pass from Paul Cooper. Although the Hospital tried very hard after the score, the good ball won by the pack was not put to good use and the score remained the same.
Result Barts 4, Old Haberdashers 8.

Barts v D. division Met. Police

The game was again played at Chislehurst, but the conditions were ideal for a good game of open rugby, and this was the way that the Barts XV played it. The reappearance of Mick Martin in the centre added much more bite to the Barts attack and it was not long before the tries started coming. In the first half, Rog Brookstein, Keith Harrison and John Goddard crossed for tries: Mick Martin converting two. The police replied with a converted try. In the second half Rog Brookstein added two more tries, and Geoff Lane scored one. Two of the tries were converted by Mick Martin.

Although the score seemed quite convincing, much good ball was wasted by shoddy handling, so that the score might have been nearer the 50pts mark.
Result Barts 32, D. division Met. Police 6.

The prospects for the rest of the season aren't as bad as the results suggest. The team as emphasized, is on the young side, but during the past few matches have begun to play together as a unit. The forwards, as in many Barts teams of recent years, have shown that they are equal to most of the packs they have come up against, while some cohesion behind the scrum is now beginning to appear. Injuries during the early part of the season have robbed us of the services of several players, most of whom are now playing again. However, we have lost Rog Bulley for some time, and Dick Fowler for the season due to a bad leg injury. We'd like to wish both these players a speedy recovery and anyone else who's still injured.

With our fair share of luck regarding injuries and the ball running a little more with the Barts side, the next Journal should provide totally different reading and results for the Rugby Club.
Record so far:—

Games				Points	
P	W	D	L	F	A
11	2	—	9	87	233

DAI ROWLANDS
Secretary, Rugby Club.

(3) BARTS FOOTBALL

U.H. 6 a side competition

A trophy is now awarded for this competition, and Bart's were able to field two sides despite the fact that it is held before the start of the Preclinical term. The 'A' team beat some strong opposition to reach the final but were unable to defeat a strong U.C.H. side.

'A' team v King's B 1—1 (won on corners)
'A' team v King's A 2—0
'A' team v Westminster 1—0
'B' team v St. Mary's 2—0
'B' team v R.D.H. A 0—2
FINAL 'A' team v U.C.H. 0—2

U.H. LEAGUE

With several useful players in the new intake, the club looks forward to a successful season. Both sides started well, and the 2nd team particularly has put in some very good early performances. After a short bad spell the 1st team has picked up somewhat and we hope to see both sides well placed in their respective leagues at the end of the season.

1st XI League

v Charing X (W) 7—5
v R.D.H. (W) 4—1
v Middlesex (D) 4—4
v London (L) 4—6
v Kings (L) 0—3
v Guys (L) 0—3
v St. Marys (L) 3—4
v St. Thomas's (W) 4—0
v Westminster (W) 4—1

2nd XI League

v Charing X (W) 7—1
v Middlesex (W) 2—0
v London (W) 3—1
v Kings (W) 2—0
v Guys (D) 2—2
v Georges (W) 4—1
v St. Marys (W) 5—0
v U.C.H. (L) 2—5
v Westminster (L) 1—2

U.H. CUP 1ST ROUND

BART'S 1ST XI v KINGS 1ST XI

After losing their earlier league game to the strong King's team, Barts were hoping to turn the tables. With their new President Mr. Lettin supporting, the team opened brightly, and after a couple of close misses Barts went deservedly into the lead, Ian Weller scoring direct from a corner.

This spurred Kings to action and they soon equalised with an unstoppable shot. The Barts' defence now showed uncertainty and two soft goals were conceded before half-time.

H.T. Barts 1 Kings 3

Hopes of a recovery by Barts were dashed by a penalty awarded early in the second half. Although three goals down the Barts team played with spirit throughout the second half and in fact made several scoring chances, but they lacked finishing power.

RESULT Barts 1 Kings 4

E. NOREN (Secretary)

(4) CROSS COUNTRY CLUB REPORT

The season's first event was the University College 6 x 1.6 mile Invitation Relay around the notorious dirt tracks of hilly Hampstead. The stupendous Barts SEXtet included guest-star Tim Hunt—fresh from the fracture clinic—and a smattering of other athletes whose peak fitness was a thing of the future. Nevertheless, several rivals were overhauled at speed in almost every lap, to heave Barts into 30th. place out of 43 University teams from all corners of the kingdom. The following were responsible:—

1st lap	R. Miller	9 mins. 33 secs.	33rd
2nd lap	T. Hunt	9 mins. 57 secs.	35th
3rd lap	M. Page	9 mins. 23 secs.	32nd
4th lap	P. Acres	10 mins. 35 secs.	34th
5th lap	B. Campbell	9 mins. 03 secs.	31st
6th lap	S. Mann	9 mins. 13 secs.	30th

Fortunately, the sun was shining (birds singing, puffy little clouds, etc., etc.) at Parliament Hill the following Saturday, when the Bart's supersquad arrived to find nobody else from London University present. It soon materialised that the first U.L. Leagues and U.L. versus Cambridge race had been mysteriously postponed for one hour. . . . This discovery was greeted by mumblings of discontent and dissension from those eager to return to their Saturday afternoon studies, and consequently the start found only the essential five still sunbathing. However, bursting no doubt with solar energy, these five leviathans of the cross country world completed the 5½-mile course, to boost St. B.H. to a dizzy 5th in Division I of the University League:—

36th	S. Mann	32 mins. 44 secs.	
48th	B. Campbell	33 mins. 50 secs.	
59th	R. Miller	34 mins. 31 secs.	
69th	M. Page	35 mins. 23 secs.	
105th	P. Taylor	39 mins. 04 secs.	(134 ran)

David Bedford—athlete extraordinary—once again pitted himself against the might of the Bart's Cross Country Squad at Bushy Park on November 8th. The event was a giant meeting of Divisions I and II of the University League, over a three-lap course totalling nearly six miles. S. Mann and B. Campbell both allowed Bedford past after the first mile, counting on his rumoured weakness in a sprint finish: due to a series of small oversights, however, contact was lost with the incredible D.B. before the final stages of the race. Bart's plunged back to 8th in Div. I, but still remain the top Hospital team. . . . The struggle for supremacy continues in the St. Mary's Hospital Porritt Cup race on November 29th: read our next gripping instalment. Results of the Bushy Park encounter:—

21st	S. Mann	30 mins. 46 secs.
35th	B. Campbell	32 mins. 01 secs.
87th	T. Hunt	35 mins. 25 secs.
108th	P. Taylor	37 mins. 09 secs.
123rd	G. O'Byrne	38 mins. 26 secs. (149 ran)

In conclusion, the Freshers deserve a mention for their extraordinary apathy towards Cross Country: the only requirements are two legs and a sense of humour. If this lack of support continues, we may eventually see Bart's lapse into the oblivion which has swallowed so many other hospital Cross Country Clubs.

BRUCE CAMPBELL.

(5) SUSSEX CRICKET TOUR 1972

Memories of a poor season were partially dimmed by the tour to Sussex in August. Perfect weather, rustic surroundings and village pubs made for six very enjoyable days; and we won three matches!

Based in Brighton, games were played in the surrounding Sussex countryside; games against Burgess Hill, Cousley Wood and Seaford Seagulls were won whilst we were less fortunate against Ferring, Rottingdean and Brook House.

Highlight of the week was the annual "pond race" against Rottingdean. A good crowd, swelled by publicity on Radio Brighton, had assembled outside the Plough Inn when, at 11 p.m. precisely, the local Constabulary arrived to stop the traffic for the duration of the race.

Having not won in living memory, Rottingdean had apparently put in some serious training. This was evident as Rottingdean opened up a seemingly unbeatable lead over the first three legs of the relay race. Graham Purcell took over for the final lap but despite his efforts, the position seemed hopeless. Receiving the acclaim of his ecstatic supporters, the Rottingdean runner was striding arrogantly towards the finish when he suddenly slipped on the dark and treacherous path bordering the pond. The home crowd watched in stunned silence as Graham leapt triumphantly over their fallen hero who was now bleeding profusely and grovelling in the mud. Bart's had won yet again. In a desperate attempt to salvage some of their lost pride, Rottingdean challenged us to a race across the pond.

Paul Cooper, playing the Captain's part (or was his judgment by the evening's festivities?) stripped to underpants and shoes and waded magnificently through the slime, scattering startled ducks in all directions. Losers once more, Rottingdean seemed resigned to the fact that they will never beat Bart's—except at cricket!

1973 SEASON

Prospects for next season received a boost when Professor Lawther agreed to become our new President; we look forward to a long and happy association—both on and off the field.

One of Professor Lawther's first duties will be to preside over the AGM in February. We will be very pleased to see freshers at both this event and at the indoor nets at Alf Gover's cricket school in Wandsworth. All standards are catered for so do not be afraid to join in. Details of these forthcoming events will be posted soon.

Members of the Bart's Touring Team (with scorers Sue and Cathy) relaxing outside the "Gardener's Arms" after the last match of the tour at Brook House.

RECENT PAPERS BY BART'S MEN

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

BENTALL, H. H. (with others). Long term follow up of atrial myxoma. *Brit. Heart J.*, 34, 1972, pp. 1018-1023.

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———, (and others). Alzheimer's disease in one monozygotic twin. *J. Neurol. Neurosurg. Psychiat.*, 35, 1972, pp. 707-710.

JOPLING, W. H., (and H. D. Mehta). A case of leprous nodular interstitial myositis. *Lepr. Rev.*, 43, 1972, pp. 39-43.

*KERLING, N. J. M. The foundation of St. Bartholomew's Hospital in West Smithfield, London. *Guildhall Miscellany*, 4, 1972, pp. 137-148.

LANDON, J., *see* NIVEN, P. A. R., and others.

MCCOLL, I. The value of upper gastrointestinal fibroscopy. *Brit. J. Surg.*, 59, 1972, pp. 793-794.

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STANSFELD, A. G., *see* DAVIES, J. D., and ———.

WALLER, R. E., *see* BROOKS, A. G. F., and ———.

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

BOOK REVIEWS

BANDITS

E. J. Hobsbaum. Pelican. 40p. 160 pp.

Originally I thought that this book would be useful to have as a television reference book to find out whether Jesse James really rode off into the sunset, once more on the run, and whether Robin Hood really did get the King's pardon, but while it does mention these well-known bandits it says much more about banditry. It delves into the social history and the psychology of bandits identifying three main types, the noble robber, the avenger and the guerilla, with plenty of examples and a good index and bibliography for reference. This classification and the reasons for banditry are particularly relevant for many of the disturbances in the world today.

The book is very liberally and diversely illustrated, concise, and easy to read so that no reader could fail but to be entertained by it.

A. J. SEARLE.

VICTORIAN UNDERWORLD

Kellow Chesney. Pelican. 75p. 456 pp.

This book describes the criminal world beneath the apparent respectability of Victorian Society. With intriguing detail the activities of "gonophs" (pick-pockets), footpads, fences, prostitutes and the like are described.

We learn that "gegors" (professional beggars) faked purulent sores by hiding slices of rotting meat under coils of filthy bandages; and that at the workhouse, "in Andover paupers given 'green' (that is still putrefying) bones to grind, struggled for the pieces of meat sticking to them".

The list is endless, and one plods through the book with morbid curiosity occasionally delighted by the ingenious crimes but often revolted by the corruption. The ink drawings are very good but I think this is really a book for those with a "special interest".

S. M. CARTER.

AN INTRODUCTION TO CLINICAL RHEUMATOLOGY

William Carson Dick. Pp. 192. £1.25. Churchill Livingstone, 1972.

There is no doubting the need for books about the rheumatic diseases. Library shelves and medical bookshops are crammed with volumes on cardiology and gastro-enterology while rheumatology is neglected; since this disproportion does not extend to the number of patients attending either general practitioner surgeries or hospital clinics, it deserves correction. The chapters on rheumatology in many current text books of medicine are pathetically inadequate and I can only welcome Carson Dick's "Introduction to Clinical Rheumatology".

The author is a young rheumatologist, recently appointed to the thriving centre for rheumatic diseases in Glasgow, where he has spent most of his medical life. I don't agree with everything he says, for example, the opinion that 10% of patients with rheumatoid arthritis need steroid or A.C.T.H. therapy; and I would have preferred more detailed description and explanation in an introduction to the subject rather than comprehensive cover. The rarest arthropathies are mentioned to the detriment of the common and more important conditions; the mucopolysaccharidoses receive as much space as Polymyalgia Rheumatica. The book is full of facts, sometimes somewhat indigestible. I was disappointed that there was no description of the methods of examination of synovial fluid for crystals and the Murexide test is nowadays superfluous.

There is much to admire in this book, which is available in paperback at a very reasonable price. No undergraduate will have wasted his money on it. The omission of references will surely exclude it from the reading list of membership candidates and limit its usefulness for postgraduates, but to many practising doctors, it will provide a useful account of the subject.

E. C. HUSKISSON.

BARTS CLUBS

(1) Drama Society Report

Asked to write a short passage on 'The Successes of Barts Drama in the Past Year', the temptation to eulogise, in typically amateur fashion, with a load of banal, mealy-mouthed clap-trap is enormous and I shall probably fall foul of it, exhibiting my lack of experience at such onerous duties.

Among the significant advances of the year was the increasing usage of 'Liquid Theatre'. Conceived by the Wine Committee and crystallized by three weeks of rehearsal in the bar over the previous summer; this did little to enhance the standard of acting other than removing a few teeny inhibitions, darling, but it did engender a corporate spirit which carried us happily through a year without many of the previous 'mainstays' of the society.

George Blackledge assumed control of the proceedings, reluctantly at first, but with increasing energy and enthusiasm as the year progressed, exhibiting such skill both as director and administrator that it is hard to describe 1972 as anything else but 'George's year'.

The Christmas term productions had a mixed reception from cast and audience alike. 'Inuit' by David Mowat was produced in the old, heirarchical style of imposing an unknown and unloved play on some unfortunate would be actor or actress and rounding off the issue by terming them 'director'. In this case Olivia Hudis, although accepting and doing wonders with a tragically sparse script, maintained to the last that the play was not 'her cup of tea'. The reason that the play did not strike home was the lack of structure and incomprehensibility of David Mowat's writing—I mean no slight to him, he is a nice man and tries hard. 'Syracuse Myth' on the other hand, conceived by George Blackledge and improvised by a very strong cast, enjoyed much praise both here and at the NUS festival in Bradford, where it was beyond a doubt, the most telling amateur production.

The Easter term again brought two productions. One was produced for and seen by few, but for all that Peter Bacon's improvisation on the difficult subject of 'Pollution' for the ULU Festival made an enjoyable evening for all those interested enough to attend.

The other play 'The Merchant of Venice' was, from the cast's point of view, the most enjoyable production in a long time, and the enthusiasm generated by them certainly seemed to spark off feeling the Barts audience. Again George's directional skill encapsulated the whole proceedings and made all the effort expended worthwhile.

Finally, though he'll probably mock me for doing so, I must pay tribute to James Griffiths. His acting talent, both on and off stage must now be known throughout the hospital, from consultants to kitchen staff. Over the last five years he has set a standard of acting far above that expected from such an apparently inhibited sector of society. Many of his performances will be well remembered, but the high-spot of his career to date was only experienced by a few; when as Njinsky in 'The Mirror and the Star', which broke into the spheres of 'high drama', at the finals of the NUS festival in Southampton—Barts being the first ever medical school to achieve this—James received a standing ovation from a critical and discerning audience of nine hundred. His voluble involvement in all productions has generated much interest from all quarters and his example has encouraged many less confident performers to have a bash. No doubt you'll hear from the source about any developments in a possible acting career.

Despite these losses; both George and James now have other, varied pastimes, the society is still strong and filled out by a large influx of newcomers. I hope the productions this year; 'Next Time I'll Sing to You' and 'If Walls Had Ears. . .' this term and 'Hassan' in February, will reflect the continued good feeling in the group.

ROBERT ROBERTSON
Secretary, Drama Society

(2) Folk Club Report

It was decided in late September to re-start the Folk Club on a more permanent and regular basis. Up to the time of writing three sessions have been held. Increased publicity and a change of venue (College Hall Bar Lounge) have increased their popularity and we have been fortunate in having several stalwart outside supporters who have loaned both their equipment and their talents.

To have more audience participation would be nice—one evening an impromptu Morris Dancing Band appeared and it was sad that so few people "Morrised" (or attempted to!). Two classical guitarists have provided some culture, although whether classical guitar has a place in a folk club is arguable.

We still need more performers and I feel sure that there are many musical nurses whom we never hear—perhaps they can be persuaded to turn up more often.

Later next year we hope to have some guest singers. Folk club dates for January are 17th and 31st.

PETER GLANVILL,

(3) CAVING CLUB REPORT

The 1972-73 season started encouragingly when 12 people arrived at Fairy Cave Quarry at the end of October. We overcame the heating problem by sheer numbers; 14 people slept in one room.

The next day the party split three ways, one group visiting Swildons Hole under Hugh Rogers' leadership, another visiting East Water Cavern and the girls were "hived off" into another party to do something a bit easier. On Sunday most people relaxed and looked at the marvellously decorated Shatter cave.

The second trip to Wales was a combined one with U.C. As usual, South Wales was wet and windy; only three Bart's people got there although Dr. Glanvill joined us on Saturday. We visited Tunnel Cave, a large high winding rift, where Hugh was to be occasionally seen back and footing along 20 feet above the rest of us!

The climax of the trip was the passage of a nasty 15 foot climb which we later learned "required" a ladder and life line.

On Sunday 11 of us visited the long (20 miles) and complex (we got lost) system of Ogof Ffynnon Ddu. We had intended to reach the underground river there which can now be followed for 3 miles. Five people came on our last Mendip trip—the threat of exams to pre-clinicals had reduced our numbers. We again stayed at Fairy Cave Quarry and spent Saturday exploring the caves there. On Sunday Peter Glanvill led a party of 8 on a round trip in Swildon's Hole (see a previous *Journal* article entitled Double Trouble). Jerry Hollands learned something of the problems of route finding in the same cave. We all emerged with clean clothes but soaked.

PETER GLANVILL,
Secretary, Caving Club.

(4) PHOTOGRAPHIC SOCIETY REPORT

This has now reformed and we have a grant of £20 available. The old lock to the dark room has been removed and a Yale lock fitted. Anybody requiring a key should contact Peter Smith (M.C.R.) or Charles Wellingham (College Hall). We are making a charge of 50 pence each for these keys. The excess will go into the photographic society funds.

We hope between us to try to provide photographic facilities for the various activities in and around the Hospital, i.e., Balls, Sports Events, etc.

PETER GLANVILL,
Photographic Society.

SAINT BARTHOLOMEW'S HOSPITAL JOURNAL

Founded 1893. Vol. LXXVII No. 2

Editorial

In this month's *Journal* are a number of articles by Medical Students which are related to a greater or lesser degree to their education and the world which immediately surrounds them. This desire for involvement is not a common finding at Bart's, where a vicious circle of non-participation promotes lack of interest, making the case for participation weaker and actual reforms more difficult to institute.

A positive response to these articles from students and staff may make possible the many real and important changes that are needed here. It is not our aim to make just another vaguely good-natured plea to people to shake themselves out of their apathy. Read these articles, form an opinion, and ACT.

Now that it appears that at last the nature and functions of the GMC are to be re-examined, it might be appropriate to suggest clarification of the rôle of the medical insurance companies in the dealings on the medical profession with the GMC and with the public. The premiums of these agencies have gone up again and it would be a shame if fees and legislation reached the levels that are prevalent in the United States. Are these companies purely defence organisations, or are they going to become part of the general set-up, acting either as prosecutor or defender?

A more specific point that merits discussion is the position of the full-time NHS hospital doctor who although he is working as part of a team with nursing and other staff stands alone when he has to defend his actions in court.

ANNOUNCEMENTS

Births

LLOYD—To David and Carol (née Fox) a daughter, Megan Ruth.

GARNER—On November 8th, to Graham and Adrienne (née Huskisson) a daughter, Tanya Jean.

Deaths

BARLOW—On November 4th, Dr. L. W. Barlow, M.R.C.S.Eng., L.R.C.P.Lond., D.P.H. Qualified 1914.

TAYLOR—On December 20th, 1972, Mr. A. Taylor. Former clinical assistant to the Dental Department.

Changes of Address

Mr. D. GARFIELD DAVIES has moved to 29, Morelands Drive, Gerrards Cross, Bucks. Tel. Gerrards Cross 87120.

Surgeon Lieutenant D. J. BAKER has moved to the Medical Mess, Harold Wood Hospital, Harold Wood, Essex. Tel 45 45533.

Dr. G. S. R. LITTLE has moved to Cadwgan Gwbert on Sea, Cardigan, West Wales.

Miss J. M. SOUTTER has moved to 3 Dawell Drive, Biggin Hill, Kent. Tel. Biggin Hill 5543.

Engagement

ACRES—ROBERTSON—The engagement is announced between Mr. Peter Acres and Miss Elizabeth Robertson.

Marriages

ROSSER—COURTENAY—The wedding took place on December 30th between Dr. E. M. Rosser and Miss H. A. Courtenay.

Apology

In the last issue we mis-spelt Mr. W. R. Le Fanu's name on the cover.

Purification

HANCOCK—CUDLIPP—Trev and Fran announce that they have finally made it legal.

CHRISTMAS FOOD PARCELS

THE OCCUPATIONAL THERAPISTS WOULD REALLY LIKE TO THANK EVERYONE FOR THEIR GENEROSITY IN GIVING SO MUCH FOOD TO HELP THE OLD PEOPLE AT ST. MATTHEW'S HOSPITAL, N.1. LAST YEAR THE DAY CLUB WAS ABLE TO DISTRIBUTE 82 FOOD PARCELS TO PATIENTS WHO WERE ON THEIR OWN OVER THE HOLIDAY PERIOD. THIS YEAR THEY HOPE TO MAKE UP EVEN MORE PARCELS.

'BLEEPS'

The control equipment for the new "bleep" system has been installed and the new bleeps will gradually be brought into use in three phases. The new bleeps will replace the existing ones in circulation which in turn will be used to maintain the system rather than increase it to cover people who do not at present carry bleeps. Once the new system has been phased in completely, new requests for bleeps will be considered.

Members of staff who at present carry bleeps will be contacted and the receivers will be exchanged, they will also receive instructions on their use.

Phase I commenced on January 1st, 1973 and the bleep system as a whole is now run on a day-to-day basis from the Telephone Exchange. It will no longer be possible to obtain a bleep from Windmill Court for emergencies but instead the Telephone Supervisor must be contacted on extension 7272. At night this will be answered by the switchboard.

May I remind all staff that to request a person to be bleeped, telephone extension 211 should be rung, and to answer a bleep, telephone extension 7373.

WESSEX RAHERE SOCIETY

This is open to all Bart's men and women and normally meets in Bristol, Bath, Taunton or Exeter about twice a year for dinner, followed by a talk from someone from Bart's. The next meeting is planned for the spring, in Bath.

If resident in the West Country and wishing to be placed on the mailing list write to: Dr. George Lloyd, "Glenhurst", Higher Downs Road, Babbacombe.

WIX PRIZE ESSAY

For technical reasons Pt. III will appear in the March edition.

DISEASE AND ILLNESS - A NECESSAY DISTINCTION TO MAKE

All ethnic groups, including our own Western society, regard illness as a state or condition in which those afflicted find themselves from time to time. Health and illness for us are essentially polar ends on a continuum, illness being a wide embracing term that covers the numerous diverse diseases that are today classified in medical practice. A disease for medical practitioners has objective biological significance, and is recognised by such criteria as disorders of cellular metabolism, deficits of certain enzymes, genetic abnormalities, etc. These biological disorders alter the physiological and maybe even the psychological functions of the individual, and it is through the assessment of these functional upsets that the clinician learns to make his diagnosis. Medicine, thus, using this approach seems to be based on a classification of disease by clinical inference, and can be regarded as the study, treatment and prevention of disease.

Medicine, though, is also concerned traditionally with the act of healing, and this concept is directed towards sick people with the aim of curing their illness and restoring them to good health. A sick person in our society is one who is unable, through physiological or psychological dysfunction, to conduct a normal life such as go to work, eat three meals a day, enjoy a family life, sleep well, fit in and conform with the views held by the majority, etc. This normality is therefore based upon our own social and cultural ideals, and so illness in its turn must have social and cultural features. Since different societies have different cultures and different conceptions of what is normal, it would not be surprising to find that a disease causing illness in one society does not necessarily cause illness in another society.

This is a difficult idea to grasp because the conceptions of what is disease and what is illness are inextricably interwoven in our type of society. This is probably due to our notions of health that incorporate both the biological and the social. Taking the biological standpoint, health could be defined as the absence of disease, i.e. a healthy person is one who is asymptomatic. But this definition is incomplete in itself because health is also associated with some ideal of social integration and balance and in our society that seems geared to ever increasing scales of productivity, adequate social function is also a necessary requisite. In this sense, we often regard health as an ideal, something that can be approached but is rarely attained. A disorder of physiological function then is always associated with a disorder of social function, i.e. we always see disease associated with illness. Moreover this association has very durable bonds because an individual who does not conform to our social norms is labelled a misfit and regarded as mentally ill, such a condition being regarded by many doctors as having organic origin, i.e. associated with disease.

Enough of the wottle and let us now briefly extend our ethnographic horizons to New Guinea and look at a group of people there called the GNAU.

The Gnau's view of health is rather different from ours, for they hold to a sort of elastic notion which sees illness as a part or as a risk of living. The Gnau's term for illness (WOLA which means Bad or Ruined) is the same as their term for old age, and as such they recognise a normal course of life in which the strength to resist illness waxes and wanes; this view, then, making the deaths of the elderly, and also of infants for that matter, rather more ordinary than those of people in their prime. An old man gradually succumbing to some long term debilitating disease, such as Syphilis for example, would not be regarded as ill, he would be regarded as simply fulfilling the normal course of his life.

In order to appreciate this, we must look at the Gnau's practice of food taboos, i.e. foods that are forbidden to individuals at different stages of life and are also rather confusingly called WOLA. The food taboos are most complicated and extensive at birth and up until puberty, after which they are gradually lessened until, in old age, virtually all that was classed WOLA becomes permissible. These taboos form part of the Gnau's conception of the association of illness with social and biological status. At puberty, the young person is regarded as fully entire and complete and as such is very vulnerable to the malicious spirits that wantonly attempt to inflict illness upon him; the spirits, though, being hindered in their task by the vigorous food taboos that protect the person. If such a protected person then becomes ill, the relatives and those near him anxiously try and seek out the cause of this unlikely event and may conclude that illness befell him or her because of a breach of food taboos or because of an unduly ferocious spirit. As the young person matures and proves himself in the activities of life, the restrictions protecting him are gradually lifted and he is allowed more of the food which before would have endangered him with illness. In this way a person moves towards that ruined state of old age, with at each stage any afflicting illness causing less alarm and less enthusiasm to discover a cause.

When a Gnau becomes ill, his behaviour is markedly different from ours. He possesses a very reasonable vocabulary for describing a general illness or an illness of a part of himself, yet verbal description is unknown, and illness is communicated to relatives by silent conventional display. The decision to be ill is taken wholly by the patient himself, and the person goes into complete withdrawal, shutting himself up in a small hut, lying wretchedly amidst his own excrement and refusing food or the contact of people who might bring with them dangerous influences either from their sexual or ritual condition. All this is not exactly conducive to hygiene, but for the Gnau there is an important element of prudence in this behaviour. The sick person is regarded as being in a state of vulnerability; he must avoid drawing attention to himself and must appear wretched in order to try and deceive the evil spirits into thinking that they have completed their work and can therefore leave. The end of the illness again is determined by the patient who makes his return to normal status by destroying the "sick-hut" and by taking a ritual bath.

The Gnau's convention for sick behaviour makes it very difficult to assess the severity of any illness because the silent withdrawal display is a stereotype and is simulated by every sick person. In this way it tends to mask the differences in the objective effects of various diseases.

In Western medicine, illness tends to be defined by inference from signs and symptoms, this procedure not being solely restricted to our society for that matter but also to many others, of which the Azande or the Lunda in the Congo can be mentioned. Symptoms for us are significant because they indicate a biological cause and hence have a bearing on the treatment to be used. The Gnau, however, classify illness at the level of its causes—there being spirits, destructive magic, witchcraft or sorcery. These causes, though, are not discernible from symptoms but rather from oracles and other divining procedures, and hence the description of symptoms becomes irrelevant to the situation. This explains the lack of verbal description of the illness.

In treatment then, the Gnau have no specific herbs in the sense of plants whose medicinal use depends on the observation of clinical signs, but they do have many plants that are utilised in ritual treatment, their use being dependent on identification of cause and on a knowledge of the complex relationships that exist between plants and evil spirits.

The Gnau are one among many ethnic groups who have their own conceptions of health and illness, conceptions that to us with our vastly superior medical knowledge can only seem irrational and primitive. But if these conceptions are not looked at in isolation, but rather in the total social context, then their logicality cannot be denied. And it is here that we need to make this distinction between disease and illness, if Western medicine is going to extend its frontiers successfully into areas where magic and ritual play a far more important rôle than science. If we accept the external biological criteria of disease and divorce these from our notions of health and illness, then at least we have some sort of yardstick by which to compare the different concepts of illness that prevail in different societies. And in this way we can even turn in on ourselves, and perhaps begin to learn that illness need not always be associated with organic disease, that there might be social illness which could in its turn reflect injustices or iniquities in the society in question. Medicine then, without detracting at all from its immense and very beneficial scientific progress, might turn more towards a greater understanding and appreciation of the patient as a social being and a person.

A. D. HARRIES.

THE ROYAL COLLEGE OF OBSTETRICIANS AND GYNAECOLOGISTS

By JOHN L. THORNTON and PATRICIA C. WANT

The College of Physicians of London was founded in 1518, and in 1540 the Guild of Surgeons and the Barbers' Company were united to form the Barber Surgeons Company. An offshoot of this was the Company of Surgeons of London, founded in 1745, which in turn became the Royal College of Surgeons of England, founded in 1800. The Society of Apothecaries was formed as an independent body in 1617, when the apothecaries were separated from the grocers. These organizations were concerned with the education, examination, and licensing of physicians and surgeons to practice in London.

Obstetrics was sadly neglected, remaining largely in the hands of ignorant women, despite the introduction of men-midwives. Surprisingly enough, this took place in the seventeenth century, and Percival Willughby (1596-1685), who described himself as 'Gentleman', and should probably be recognised as the first British specialist obstetrician, wrote 'Observations in midwifery', and the abbreviated 'The country midwifes opusculum or vade mecum' for the instruction of midwives. He quoted William Harvey (1578-1657) extensively, and obviously regarded him as widely experienced in the subject. This suggests that the man-midwife was not uncommon in this country in the seventeenth century, but was frowned upon not only by the public, but was not officially recognised by the medical profession. Willughby's book was circulated in manuscript, and was not printed in English until 1863. Had it been published when written it might well have deeply influenced the development of obstetrics, and would certainly have caused historians to form a different opinion of English obstetrics in the seventeenth century. Harvey's section 'De partu' in *De generatione*, 1651 is regarded as the first original work on midwifery by an English author, and Harvey has been called the Father of British Obstetrics.

Even with the advent of such eminent men-midwives as William Smellie (1697-1763) and William Hunter (1718-1783), there remained great opposition to men attending women in childbirth, and this attitude persisted for a considerable period. Both the Royal College of Physicians and the Royal College of Surgeons declined to give adequate recognition to obstetrics as a specialty, and during the greater part of the last century the London medical schools had visiting lecturers on the subject, there being no beds for midwifery cases, and no obstetricians on the staff.

In 1783 William Hunter was admitted as the first Licentiate in Midwifery of the College of Physicians of London, but no obstetrician was eligible for election to the Fellowship. Although several general surgeons made considerable contributions to gynaecology, it was not recognised as a specialty. Sir Henry Halford (1766-1844), when President of the Royal College of Physicians, stated: "Obstetrics is no calling for a gentleman", and the Royal College of Surgeons excluded from its Council and Court of Examiners anyone practising obstetrics. The General Medical Council also was biased against obstetricians.

The Society of Apothecaries first included midwifery in its examination for Licentiateship in 1845, and after 1884 the two Royal Colleges founded the Conjoint Board, midwifery being included as one of the subjects for examination. However, obstetrics and gynaecology were considered as far inferior to medicine and surgery, and it appeared obvious that due recognition could only come with the establishment of a separate College. In the general hospitals the formation of adequate departments of obstetrics and gynaecology was opposed by the physicians and surgeons, so that separate hospitals were formed. Eventually, chairs of obstetrics and gynaecology were established in the medical schools, and the need for these subjects to receive recognition by the formation of a separate College was recognised by a few individuals, although many others refused to accept it as a practical possibility. Victor Bonney was opposed to the formation of a College, but was not involved in hindering its development, and in 1947 he was elected to the Honorary Fellowship.

The leading figure in the early history of the College was undoubtedly William Fletcher Shaw. He met Blair Bell who had founded the Gynaecological Visiting Society in 1911 with a membership of thirty, and in 1925 when the Society met in Cardiff, the formation of a College was further discussed. Blair Bell, Comyns Berkeley, Ewen Maclean and Fletcher Shaw formed a committee to explore the possibilities, and the first meeting was held on 22 April 1925. Sir Francis Champneys, Sir George Blacker, Herbert Spencer, Watts Eden and Fairbairn were invited to meet the committee, to which Russell Andrews had been added. Champneys and Eden objected to the title 'College', and there were other difficulties. The five committee members each subscribed £20 to cover current expenses. Blair Bell was elected Chairman, Fletcher Shaw Honorary Secretary, and Comyns Berkeley Honorary Treasurer. A Memorandum and Articles were drawn up and sent to members of the Gynaecological Visiting Society and a few others, who met in February, 1927, the last appearance of the Society in relation to the founding of the College. This was to have Fellows and Members, the former to be selected from the latter. The Council was to consist of representatives from London, the Provinces, Scotland and Ireland, and one-third of the seats on the Council were to be allocated to Members, who, with Fellows, were to pay annual subscriptions.

The draft Memorandum and Articles of Association were submitted to the Board of Trade, and an advertisement was inserted in *The Times* stating that objections should be lodged by 11 July, 1928. Both the Royal Colleges objected to the proposed issue of certificates for proficiency in obstetrics and gynaecology, and the Board of Trade set up a Court of Enquiry. The declining birth rate after the first World War drew the attention of the public to maternal mortality, and the

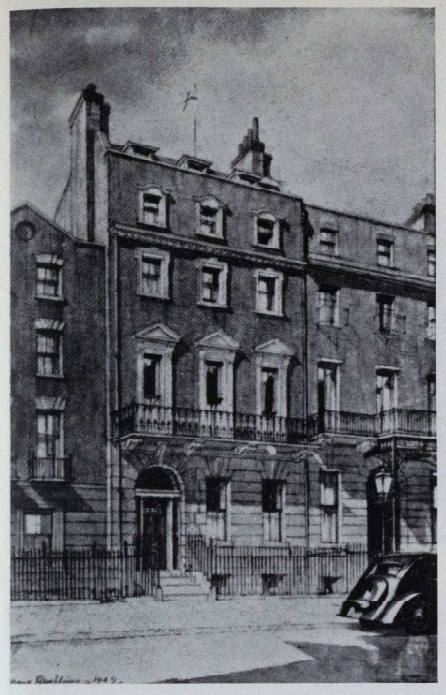

Fig. 1. First Headquarters of the College.

improvement of teaching obstetrics was an important reason for the formation of the College. Maternal mortality had become a political issue, and many efforts were made to procure agreement between the parties concerned. The Royal College of Physicians was won round, but the Royal College of Surgeons proved more obdurate. Finally the Board of Trade accepted registration on 26 August, 1929, and formalities were completed on 9 September. The College was registered as a Limited Company, with permission to delete the word 'Limited', and the formal certificate was received on 13 September, 1929. The British College of Obstetricians and Gynaecologists was born. Lord Riddell, the newspaper proprietor, gave much needed financial aid, and continued to support the College in its initial years, during which many difficulties were overcome, and the basis for future development was established.

Important dates in the chronology of the College began with 25 September, 1929 on which the first meeting of the Council was held. Blair Bell was elected as the first President, Comyns Berkeley as Treasurer, and Russell Andrews and Fletcher Shaw as Joint Honorary Secretaries. Miss Winifrede Mallon, who had been private secretary to Fletcher Shaw, was appointed Secretary to the College in December, 1930, and on 5 December 1932 the College House was opened by HRH the Duchess of York (now the Queen Mother) at 58 Queen Anne Street, the first headquarters of the College. In 1938 the title 'Royal' was granted, and after delays caused by the war, the Royal Charter was obtained in 1946. During the following year it became apparent that the headquarters bequeathed by Blair Bell were not large enough to accommodate the expansion of College activities. An appeal was launched, and eventually the present headquarters on Crown land in Sussex Place, Regents Park were opened by Her Majesty the Queen on 13 July, 1960. This houses the Nuffield Hall, which seats 400; the Council Chamber; Committee Rooms; the Wellcome Research Museum; the Library, which was greatly extended during 1970-71, and had a small lecture theatre built above it; accommodation for the staff of the *Journal*, the secretarial staff, caretaker, and a lodge for the head porter. The President has a suite, and there are rooms for overseas visitors, in addition to catering facilities. An audio-visual room has recently been equipped. Many generous benefactors made possible this fine headquarters of the College, including Lord Nuffield, Lord Marks, and the Wellcome Foundation, with strong support from its own Fellows and Members.

At an early stage in its history the College set up Regional Councils (originally Reference Committees) in Australia, Canada, New Zealand, and South Africa, with Reference Committees in Malaysia and Singapore, All-India (divided into four zones), Pakistan, and Ceylon. Committees of the College are devoted to Examinations; Hospital Recognition; Postgraduate Education; Scientific Programme and Central Congress Committee, which organizes scientific meetings at the College and elsewhere; Scientific Advisory and Pathology Committee; and Maternity Hospital records and reports committee. There are executive committees for Scottish and Welsh affairs, and there is a joint obstetric-paediatric link with the British Paediatric Association. The College gives assistance to committees of enquiry, Royal Commissions and government departments. A representative of the Royal College of Surgeons serves on the Council.

Examinations are conducted for the Diploma in Obstetrics, which is taken by over 1000 candidates per annum, including many general practitioners, and there are over 800 candidates sitting for the MRCOG examination every year. Three years after the foundation of the College there were 228 Members and Fellows, and by 1971 this number had grown to 4228. There were also over 300 recognised training posts abroad.

The *Journal of Obstetrics and Gynaecology of the British Commonwealth* (formerly *Empire*) is owned by, and edited from the College. Under the capable editorship of successive editors it has achieved a foremost position among specialist journals devoted to the twin subjects. The high scientific quality of its contents is maintained by the careful selection and editing of material submitted.

A scheme for the establishment of a Museum was outlined in 1938, and from small beginnings this has developed into an extensive teaching collection of specimens and slides, and a register of rare gynaecological tumours. It also has on display the Chamberlen instruments, and many other obstetric forceps and instruments.

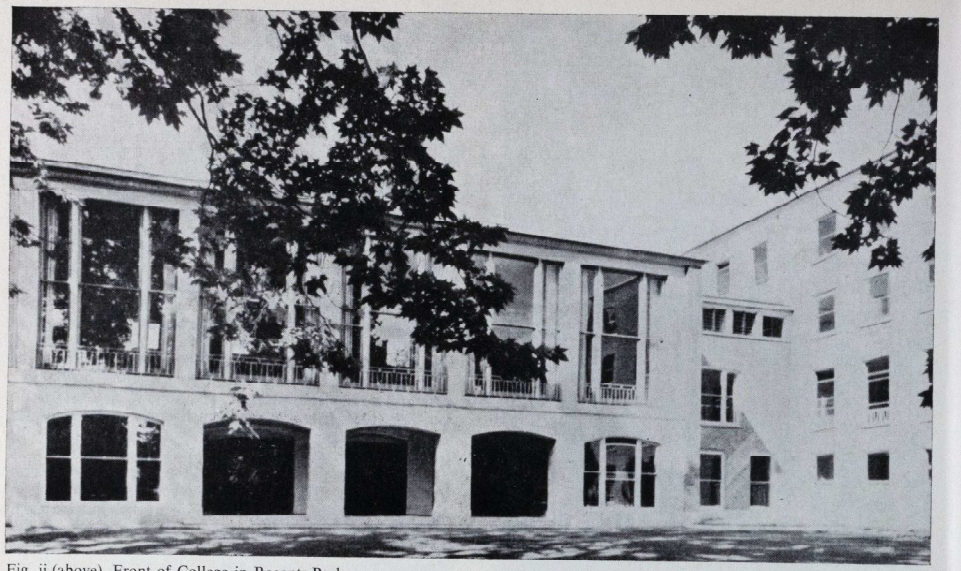

Fig. ii (above). Front of College in Regents Park
Fig. iii (below). The Nuffield Hall.

The Library was founded in 1932 when William Blair Bell gave books from his own library, and persuaded other members to make similar donations. He later bequeathed some 450 volumes, ancient and modern, but his original idea of a Resident Librarian was not continued after the war. A large working library was deemed unnecessary owing to the then close proximity of the Royal Society of Medicine. The majority of the older books came from the library of Roy Samuel Dobbin (1873-1939) of Cairo, whose collection was acquired by the College in 1938 with money given by patients of Sir Henry Simson, the sum of £500 being but a fraction of their true value. Dobbin made many other donations of books during his life, and also bequeathed further items at his death. A catalogue of books published up to 1851 was published in 1956, with a second edition in 1968. The collection was almost entirely historical, but in 1961 a grant was received from the Wellcome Trustees to bring the collection up to date, to equip the library bibliographically, and to make it a working library. A full-time trained librarian was appointed in April 1961, and plans were initiated to make the collection comprehensive within its subject limits. This resulted in rapid growth, and the library premises were extended during 1970-71, mainly due to the generosity of Mr. and Mrs. T. H. Markland. The room housing the main part of the collection is now known as the Markland Library.

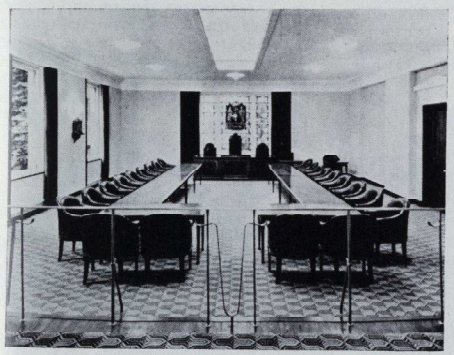

Fig. iv. The Council Chamber.

Although intended as a reference library, the collection is widely exploited for the benefit of Fellows and Members throughout the world. Bibliographies are compiled, photocopies of articles are made, and information is supplied on request. Examination candidates also use both the Library and Museum extensively, and others may consult the collection upon introduction by a Fellow or Member.

The College has published several important reports on topical subjects, including the following: *Memorandum on the training of medical students in midwifery and gynaecology*, 1932; *Report on a National Maternity Service*, 1944; *Report of an investigation into the use of trichlorethylene as an analgesic in labour*, 1948; *Maternity in Great Britain. A survey of social and economic aspects of pregnancy and childbirth undertaken by a Joint Committee of the Royal College of Obstetricians and Gynaecologists and the Population Investigation Committee* (OUP), 1948; *Report on the obstetric service under the National Health Service*, 1954, revised 1956; *Methods for monitoring the fetus in pregnancy and labour*, edited by Stanley Clayton and Richard Beard, 1971; and *Unplanned pregnancy: report of a working party*, under the chairmanship of Sir John Peel, 1972.

On the occasion of the Silver Jubilee celebrations in 1954 Sir William Fletcher Shaw wrote *Twenty-five years. The story of the Royal College of Obstetricians and Gynaecologists, 1929-1954* (Churchill) 1954; and J. M. Munro-Kerr, R. W. Johnstone and Miles H. Philips edited *An historical review of British obstetrics and gynaecology, 1800-1950*, (Livingstone) 1954.

This is but an outline of the events leading to the foundation of the College, of its rapid development during a comparatively short period, and of its current activities. Under successive Presidents, officers and members of Council it has continued the policies envisaged by its founders, widened these in the light of modern conditions, and successfully advanced the interests of obstetricians and gynaecologists, particularly stressing the educational view-point. By means of international co-operation, links have been forged with overseas specialists, and the College is recognised as the focal point for these when visiting this country. Possibly the success of the Royal College of Obstetricians and Gynaecologists, the third Royal medical college to be formed, has stimulated other specialist groups to follow suit. Their prosperity will depend upon the courage, pertinacity and enthusiasm of their leaders combining for the benefit of the particular interests of their membership.

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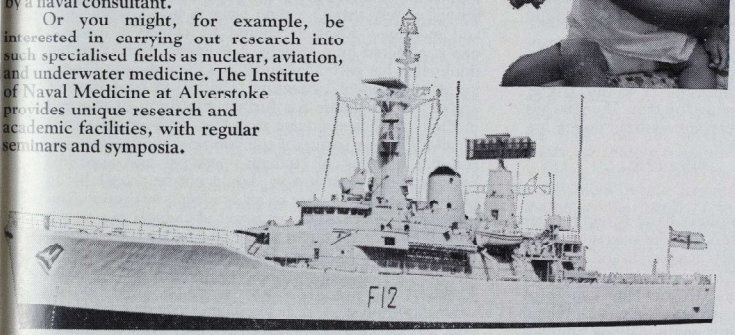

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RN
ROYAL NAVY

BARTHOLOMEW UNFAIR

By ALLAN HOUSE and MICHAEL JOHNSON

"Education is what is left when we have forgotten what we learnt."

A recently published book, "Medical Education—A Critical Approach" by Michael Simpson, a doctor at Guy's,* provides a comprehensive review of research into medical education in recent times. It voices criticisms that are familiar to any medical student who takes a serious interest in his education, it's distinguishing feature being that it supports every point with evidence from research, rather than ill-founded impressions and pre-conceived opinions. To this extent it is a heartening book for those less than satisfied with the status quo, but the inevitable final feeling is one of depression and frustration. Many of the criticisms are valid to the point of being facile, and yet the prospect of changing the system accordingly remains bleak, as anyone who has battled with the apathy of both students and staff, and with their incredible suspicion of any innovation will confirm. One wonders for how long a profession with its ideas so firmly set in the past can maintain itself in a position of respect, or whether it will slip back into its rôle of so many centuries past; a poor cousin of science, a contradiction of the humanitarianism it so forcefully professes.

This article expounds some of the criticisms in Dr. Simpson's book as they apply particularly to Bart's. They are not all original to his book or to our article, but are none the less worthwhile for that. If there has been any analysis at Bart's relevant to these points, we apologise for our ignorance of it.

*published by Butterworth's . . . price £2.90.

SELECTION

Bart's, with other teaching hospitals, has a strong reputation for applying certain criteria to the selection of its students which are not entirely academic, and whether this is deserved or not, it acts as a powerful pre-application selection technique. A random sample of U.C.C.A. reports from a proposed new entry would lead one to the opinion that every rugby-playing, public-school educated, doctor's son in the country had applied to the Royal and Ancient. And this is not a quaint tradition which is rapidly being eliminated. In Britain, as the Todd report showed, the number and percentage of selected medical students with medical fathers had increased from 17% in 1956 to nearly 21% in 1961 and over 21% in 1966. This produces an intriguing state of affairs; firstly, the intake at Bart's is from an extremely narrow and homogeneous social group, and its atmosphere suffers as a result, and secondly, the criteria employed seem to have an inverse correlation with subsequent performance; women, non sports players and those from non-medical families doing considerably better at all stages of their education. The Todd report found that 23.1% of the children of medically-qualified parents and 18.5% of the children of others had to repeat some of the course. This negative correlation does not hold true, incidentally for post-graduate success, where, for reasons that are not immediately obvious, there is again a disproportionate representation of ex-public school pupils and ex sportsmen.

Interview candidates are always asked about hobbies, but there is an extraordinary narrowness in the concept of accepted non-medical activities in medical school. None is actively incorporated into the course, and only sport and musical interests are generally accepted as valid pastimes. When Ian McColl as Sub-Dean at Bart's said, "I do not care whether they play rugby or the trombone as long as they have a good outside interest" he unwittingly defined almost the full gamut of activity at Bart's.

A little discussed and almost indefensible means of selection, used to an alarming degree at Bart's is elimination of students on the basis of pre-clinical performance. A whole article could be devoted to the failings of the pre-clinical course. Even the principle of teaching the so-called basic sciences, Anatomy, Physiology and Biochemistry, in one indigestable block before having any contact with medicine in practice can be, and has been, questioned. These two years form the most intellectually bleak period of the course, and yet they come immediately after the tedium of A-levels at school. Surely this is a time when a man's intellectual and emotional horizons should be extended. Instead, one is battered by a variety of teachers, each of whom thinks that his particular subject is the only one deserving of the students' attention. That 10-15% of freshers are found unsuitable for further education by the end of their preclinical course may say much about means of selection, the nature of the course and examinations, and the handling of students' personal and academic problems, but what it says should not be acceptable to any responsible member of an academic institution. Unfortunately, there is little prospect of change, at least not until the merger with the London Hospital pre-clinical school as part of Queen Mary College.

TEACHING

Dr. Simpson's book includes an intriguing classification of educational objectives with which various learning techniques can be analysed. We reproduce an abbreviated summary of this as Table 1. This covers the 'cognitive domain'. A classification of educational objectives in other domains, i.e. the 'affective domain'; receiving, responding, valuing, and the 'psychomotor domain': perception, motor skills, communication, is less helpful, but that is not to say that these objectives can be ignored by the teaching program. Education at Bart's, as at most other teaching hospitals, is aimed at the lowest levels in this classification, principally at simple recall. Higher intellectual skills and methods of handling, sorting and expressing new ideas are largely ignored. With the increasing use of multiple choice question assessments, one is not even required to be able to write!

The result is a teaching machine churning out learning machines, and despite the plethora of internal prizes at Bart's it is mediocrity of thought and action that is encouraged by such a system.

Methods of teaching at Bart's are traditional; lectures, seminars/tutorials and ward rounds for the clinical students. Charterhouse Library is open to all, but clinical students will find it difficult to study in a library stocked for their needs after the medical college library closes at 6.00 p.m. The audio-visual department, lauded as the great teaching innovation at Bart's, is dragging its feet somewhat, but will eventually become a source of reasonable 'canned' lectures rather than a new teaching method.

Lectures are by nature a poor means of teaching. The current trend at Bart's seems to be more and more to turn them into dictation sessions where interruption and discussion is discouraged by the tone and size of the gathering. Their content is largely dogmatic and its source not quoted, leaving the student who is challenged about the knowledge acquired there with the weak response, "We were told it in a lecture, sir." Attempts to involve students in choosing the content and nature of lectures, and in picking their own lectures, have been largely abortive.

Seminars and small-group teaching provide an invaluable method if properly applied. The teacher and students should be equally involved, discussing problems of learning and teaching. Each student should have a personal tutor, who he would keep for the whole course. The method is defeated by the setting of old exam questions as essays which are written without thought and later discussed without interest. All too often these sessions degenerate into mini-lectures or attempts to display ignorance as an amusing or shameful state. The system is poorly organised and often not employed at all in clinical teaching.

The ward round is a time-honoured institution, born out of the age when a prospective practitioner attached himself to a great man and learnt his art over years of close association. Its chief value in modern times should be to introduce students to the art and science of talking to and examining patients, at which it fails almost universally. Large groups stand for hours in discussion that is hindered rather than helped by the patient's presence, often only referring to him to confirm a point in the notes. As a result, the only teaching students ever get about how to form a relationship with a patient may be by watching a doctor or colleague questioning a collection of signs and symptoms, with about fifteen onlookers. If they are even less lucky they will merely stand while a colleague is grilled for an afternoon on his non-examination of one of 'his' patients. Indeed, what makes a patient 'his' seems to be only that this may happen, and that he has to test the patient's urine once a week. Unless his patient is 'picked on' during a ward round he will never be taught about the case, and unless he is given a pre-operative surgical case he will never participate in the patient's treatment. It seems odd that those subjected to the horrors of this system are such active supporters of it only a few years later.

Practical involvement of students in their course is most strongly criticised as being absent in the clinical course, laboratory work being considered the pre-clinical equivalent, although it has about as much relevance to the course as urine testing has to patient care. A student in pre-clinical studies or Medical Science should be involved in, and introduced to the principles of, research work every bit as much as a clinical student should be directly involved in patient care. The only step in either field in recent years has been the negative one of abolition of attachments at non-teaching hospitals.

EXAMINATIONS

Examinations form a major part of a medical man's life. They may make him suicidal, alcoholic, or psychopathic, they may ruin his career or his marriage—all these in an entirely literal sense. The importance attached to them by the system, and therefore by the student, is out of all proportion to their value. Medical education revolves entirely round the examination system, and as this tests only the lowest levels of ability, education inevitably suffers. Certainly, Bart's must to some extent aim its teaching at satisfying the requirements of this unfortunate system at finals, but it is the apparent acceptance and active promotion of its tenets at all levels of the course that is depressing.

The examination does have a place in education. It may help highlight weaknesses in a student's knowledge which, with rapid analysis and early feedback, can help in his education and in teaching standards. It may also be used to help decide if he has achieved sufficient mastery of a subject to proceed to the next part of his course. The first of these functions is neglected almost completely at Bart's, and the system becomes one imposed on students who find it of no value, and have no sympathy with its aims. Nothing is as likely to cause rapid disillusionment as an exam which is set and marked in secret—the only feedback being some mark or even just a letter of the alphabet.

If we are to analyse the examination system at Bart's, we must therefore do so solely with regard to its efficacy as a means of assessment of ability. The types of exam used for this purpose are the essay paper, the oral exam, (or viva), and the multiple choice question (M.C.Q.) paper, or objective exam.

Many studies have shown that essay papers give inconsistent results. Results are affected by handwriting, grammar, the mood of the marker, question spotting, knowledge of the examiners requirements rather than of the subject and chance on having revised on the narrow selection from a large field. As a result marks fluctuate wildly from paper to paper, and it has been suggested that a candidate must be in the top third of his year to be reasonably certain of being in the top half in a given essay exam. These papers still form the majority of the 2nd M.B. examination.

Oral exams are particularly highly valued by medical examiners. They may form up to 50% of total marks, and often determine whether a candidate passes or fails. Results depend upon the candidate's age, sex, appearance, accent, personal relationship with the examiner, the time of day and the candidate's viva technique, usually quite apart from his knowledge. Not surprisingly, correlation between examiners is poor.

Objective papers are designed to overcome many of these criticisms, and in addition have the advantage that rapid marking should allow early feedback and analysis of the results for the students' benefit. Unfortunately, these advantages are dissipated at Bart's by the fact that they are set by 'amateurs', i.e. those not taught specifically how to set them, the result all too often being a paper that confuses and irritates rather than educates. The central point of the question should be stated as clearly and unambiguously as possible. Faults in wording, such as the use of a double negative, words such as

'always' and 'never', (seldom characteristic of anything in medicine), and woolly terminology such as 'common'. (how common is 'common'?), should be strictly avoided. Alternative answers should be plausible and, wherever possible, should represent common mistakes and misconceptions. There should be no doubt amongst people who know the subject as to which are the best answers. Consistency in performance seems to indicate a consistency in ability to handle the medium and the fact that they all test merely isolated recall of facts.

There is a general feeling among students at Bart's that success during the course depends as much on an ill-defined system of continuous assessment as it does on examination results. This feeling is supported by the existence of dossiers on all students which record their progress at Bart's and the impressions they made at other hospitals. A system of assessment, the nature of which is not made clear to the student, and the results of which are not made available to him, could hardly be described as being in his best interests, and, indeed, would be disapproved of by many universities in England.

An important criticism of exams at Bart's is not of their nature, but of the fact that they are used as the instrument of a high-failure system. A course that selects its raw material to such a degree as is true of medicine should not accept the drop-out rates that are prevalent at this hospital. To say that, by this means, standards are improved is patently untrue; as Dr. Simpson says, if we were to set criteria of health such that 95% of the population were pronounced unfit, we would in no way have improved public health. The failure of Bart's students to succeed in such exams at University and National level might be argued as showing that other aspects of education are stressed at Bart's, but this is an unconvincing piece of double think. Perhaps the final word on this topic should go to Sir James Mountford; "As a general proposition I would suggest that when more than 10% of a class fails, something is seriously wrong with the selection of students, or the teaching they have received, or the examining to which they have been subjected; and that when the failure rate reaches 25%, it is time for what may be euphemistically called a staff reorganisation."

Dr. Simpson's review of medical education also deals with effects of the medical course on students' personalities. The medical course is potentially the most interesting, varied, and stimulating undergraduate pursuit available at a University. After all, it is the study of man, and of his interactions with his environment, and at the same time, it provides an important and assured position in society, and an opportunity to improve the existence of fellow human beings. It is little wonder, then, that medical students generally are idealistic and altruistic at the beginning of their studies. They have mostly competed hard for a place in a new, exciting world, supposedly far removed from the dry cramming of the schoolroom. What do they find? They meet bad lecturers, badly organised repetitive material, and yet more fact cramming and examinations.

The effect of the course on the students is, ultimately, the only true indication of its worth. As we have seen, pass rates in examinations are artificial and even artifactual estimates. Students are initially faced with a vast body of information which they presume has to be learnt, and they attempt to absorb it. In this obviously vain attempt they may resort to uncritical memorising at the expense of their education. They commonly use crammer-type books which present medical information as cut and dried fact, whereas it is, of course far from this. In any event, they very soon realise that not everything can be learned in the time available, so that some kind of selection must be made. A conflict arises here between selecting what the student feels he may need to function as a doctor, and selecting what the examiners, and usually his teachers will require. There is very little guidance at any stage about what should be learned and what passed over, and students tend to feel cheated if they learn unimportant data. However, as examinations approach, the great majority of students conform, and attempt only to memorise factual knowledge for the exam. Indeed, a favoured expression of teachers is, "for the purposes of the exam you will need to know . . ." No other purpose seems to be recognised! Teachers are regarded as suppliers of facts, and those who do not give useful clues as to what the students should study in order to pass are regarded with great disfavour and even bitterness. Registrars who arrange small group tutorials find themselves beseiged by the whole final year, looking for simple factual knowledge, and first year lectures are crowded with panic-stricken students. Hours are spent analysing old exam papers and 'spotting' questions. The irrelevance of all this to practising as a doctor need hardly be pointed out, and it is exemplified by the experiences of housemen, who find themselves totally unprepared for the job for which they have trained for at least five years.

It is hardly surprising, then, that in an analysis of similar groups of medical and law students, the medical students were initially less cynical and more humanitarian, but that these differences disappeared as they proceeded through the course, which is designed to act as a toughening-up, dehumanising, assault course. As soon as he starts, the keen, fresh-faced student is asked to dismember a fellow human-being's body, and a defensive reaction of frivolity and callousness rapidly prevails. When he comes to the clinical course he is given a compulsory series of lectures on Forensic Medicine, which, far from encouraging concern for the victims and perhaps the sick perpetrators of horrible crimes, deals with sexual offences and murders with such music-hall comedy that it appears to confirm Lord Longford's belief that prolonged exposure to such material tends to deprave and corrupt. After five or so years of this emotional toughening-up, the finished product manages to combine ultra-conservatism with sociopathic, amoral behaviour.

When the student realises, as most do, that his initial idealism and concern for humanity is a hindrance to his progress, and that all that is asked of him is that he can recite factual knowledge, he is faced with three alternatives. He can attempt to fight the system as an activist, or he can show passive resistance, that is emotionally 'copping out', becoming apathetic and avoiding classes where possible, or he can join the system. As anyone in the second half of his first clinical year will know, the majority of students take the second alternative. They then take part in some of the games that students play in hospital. They realise that they can get by with an impression of knowledge. They show great confidence, and an appearance of concern. They become adept at circumlocution; rephrasing the question or answering a

different question. Many are quite happy to fade into the woodwork, where the teachers are often only too pleased to leave them. They become afraid to ask obvious questions which may seem stupid, and they only ask questions to which they already know the answer, thereby giving an appearance of knowledge. The influence of their fellow students is obviously very important in enhancing this effect. In the inverted culture of medical students, athletic prowess or apparently non-medical activities are more highly prized than intellectual achievement. To be seen to be studying constitutes a gross 'faux pas'—indeed, work must not only be done, it must *not* be seen to be done. Eventually, as has been pointed out, the pressure from the students is to be taught facts suitable for their exams, and other experience or education is disregarded.

In spite of the cardiac atherosclerosis that increases rapidly with seniority, the people teaching the new students who come to the hospital each October must be touched by their enthusiasm and interest. They hang around for hours in their first few weeks hoping for an opportunity to be able to do something for their patients. They are not easily convinced that testing their urine and taking their blood-pressures every four hours fulfills their ambitions and they soon learn to evade these 'responsibilities.' They are never truly involved in the decision making or management of their patients. As a result they tend to bother only with 'interesting' patients, that is those with rare diseases or obvious clinical signs. They have little time for more mundane patients, or for those who cannot give a clear-cut history or easy diagnosis. The patient becomes simply the instrument with which the student can demonstrate his knowledge to the consultant. After the round he can be forgotten.

Another area in which students are often keen to participate is research. Yet in the five or more years which he spends in what is effectively a research institute he may hardly be aware that research is going on, apart from being told that Bart's was the first to do this or that so many years ago. Few students come to learn even of the problems of research, let alone trying any, and are therefore unable to critically examine new methods and treatments that they will be using as doctors. It is often pointed out to students that certain discoveries were made by students, but one wonders if those students were in medical schools today whether they would have the time, opportunity or encouragement to make their discoveries.

We may conclude then, that the keen, idealistic, student entering medical school soon 'learns' to be cynical, and self-confident, and realises that his future as a doctor depends on spotting the right questions and regurgitating facts as required for the exams. Furthermore those who succeed according to the criteria of the system are those who accept those criteria. Since those who reject this are by definition the failures, they can successfully be discounted from further consideration. The majority between the extremes, who never come to any definite conclusion, are normally left with such a feeling of relief and self-congratulation at having satisfied such an unreasonable task master that they rarely pause to wonder if they have been dealt with kindly by a stystem that has monopolised their intellectual development for five of its potentially most fertile years.

This article, like the book that inspired it, concentrates on the criticism of medical education at Bart's. We do not apologise for this; we were not attempting to write a review of that education, but a review of some of the criticisms of it. Our aim is to provoke argument, to promote active participation by all undergraduates and post-graduates in their education, and by doing so, to promote change.

We hope many people will read this book, and at least think about its arguments even if they object to them. Bart's has gone on for 850 years, but it is by no means immortal.

TAXONOMY OF EDUCATIONAL OBJECTIVES

COGNITIVE DOMAIN

(1) Knowledge
Recalling previously learned material
e.g. Recognition of common terminology, specific facts, principles, etc.

(2) Comprehension
The lowest level of understanding
e.g. Explain, give examples of, summarise X. Interpret graphs, signs, etc.

(3) Application
Ability to use learned material in new and definite situations and problems
e.g. How might we . . .? Solve, relate, demonstrate, etc.

(4) Analysis
Ability to break down material into its component parts
e.g. Differentiate, infer, distinguish. Evaluate the relevancy of data.

(5) Synthesis
Ability to combine parts to form a new whole
e.g. Plan an experiment, categorise, compile; creative behaviour

(6) Evaluation
Judgement of material, combines elements of (1)-(5), together with value judgements
e.g. Research reports, interpretations and criticisms of the literature

Modified from "Medical Education—a critical approach" by Michael Simpson.

The views expressed here are personal and in no way reflect official "Journal" opinion.

JOURNAL MATTER

ALL CONTRIBUTIONS TO THE **APRIL EDITION** SHOULD REACH THE *JOURNAL* OFFICE (TYPED) NOT LATER THAN **THURSDAY 22nd FEBRUARY.**

THANK YOU.

TEACHING AT BARTS: A Students Opinion

By ROGER PEPPIATT, M.Sc., A.K.C.

(Chairman of the Students' Union Teaching Committee)

Recently, Professor Elton has suggested that universities must catch up with primary schools, and change to a system in which the student is actively involved in the learning process instead of being a passive recipient:—

"What is required is a radical change in the educational environment from one in which the student in general is the passive recipient to one in which he is the active participant, and in which the teacher is one who facilitates learning."

When one makes this remark in front of an audience of primary school teachers, one receives some rather pitying smiles, for what is still revolutionary in higher and much of secondary education, is by now the orthodoxy of primary education.(1)

This is one aspect of the important concept of education being a process in which the students and staff are both active participants, rather than the outdated view which is typified by Cardinal Newman's description of the task of a University being to prepare man "to fill any post with credit by exposing him to masterpieces of human thought and knowledge".(2)

I would like to apply this premise to four facets of our situation at Bart's.

1) *Representation:* For many years the National Union of Students has quietly but persistently campaigned to give student representatives the right to sit on many university committees. It has achieved some success.

Some academics say the students will be bored and waste valuable time. To set against this is the forceful argument that the disappointment of the boring committee and lack of results "would be an incomparable educational experience—one which would leave quite standing many a more formal course in civics or in history".(3)

I look forward to the day when there is adequate student representation at Bart's.

2) *Curriculum.* I believe that the opinions of students about the content of their course, especially after 4-5 years' study, deserves considerable attention. Students have a right to express their view that X is given too much emphasis and that Y should be given more.

For instance, about half of us will become GPs and yet out of three years' study, we spend only eight mornings with GPs (and one lecture on the subject each year). It is fair comment, whether it comes from a student or a consultant, that our course is too heavily biased in favour of Hospital Medicine.

3) *Evaluation:* Just as the staff have the right to criticise or praise the students, so we have the right to express our opinions on the staff's performance whether it be in lectures tutorials or ward rounds. The efficiency and quality of the educational process can only be enhanced by such dialogue if it occurs in an atmosphere of mutual respect. For instance, students grouse that the staff do not care about teaching when ward rounds are cancelled, and the staff grumble about the apathetic and lazy students when the reverse occurs. Frank discussion and willingness to accept responsibility must lead to greater understanding and less ill-feeling.

4) *Objectives:* What are we studying at Bart's for? Is it just for the privilege of putting M.B., B.S. after our names? Is there a difference between training and education? Let me quote Professor Elvin: "The meaning of the word liberal in the phrase 'a liberal education' is liberating or freeing. From what? From the tyranny of the routine, the limited, the immediate. In spite of the social changes that have made the phrase out of date, if we think only of its former contexts, there is this important and fundamental meaning and relevance in it. Without this 'value' there cannot be education. There can only be training."(4)

References

(1) "Failing Lectures" by L. R. B. Elton (Head of the Institute for Educational Technology, University of Surrey) in the *Guardian*, Tues., Nov. 7th, 1972, p. 15.

(2) "On the scope and nature of University Education" by Cardinal J. H. Newman (1852).

(3) Authority in higher education" by Dr. N. Spurway, pub. by SCM Press 1968.

(4) "Education and Contemporary Society" by H. L. Elvin (Director of the Institute of Education London), pub. by Watts 1965, p. 192.

ARTS & CRAFTS EXHIBITION

"Tomorrow's World" celebrity, Raymond Baxter opening the Exhibition in the Great Hall

1st YEAR QUESTIONNAIRE 1971-1972

By JANE PRICE

The object of this questionnaire was to test opinion of the first year clinical students (for 1971/1972) towards various aspects of the teaching they had received.

A duplicated list of 14 questions was sent to each member of the year, 118 in all, during the first week in September. Forty-three were returned by the end of October, and the results below are based on these.

Most questions required only a simple yes or no answer although some, particularly H, had several possible combinations of answers. The results are given as numbers and percentages.

Questions	*Results*	
A. Do you think that a short introductory course of lectures and practicals, lasting two months would be useful, at the beginning of the year?	YES 22 52½%	NO 20 47½%

Probably more would have agreed with the idea if the time stated had been shorter than two months and on several questionnaires four or six weeks has been suggested as more suitable lengths of time.

B. Is 12.00 noon a good time for lectures?	YES 34 85%	NO 6 15%

If not suggest a better time.

The suggestions given were: 9.00, 9.30, 10.00 and 4.30 p.m.

C. Would you prefer separate pathology lectures rather than seminars?	YES 26 63½%	NO 15 36½%
D. Would you like pathology tutorials throughout the year?	YES 34 84%	NO 8 16%
E. Would you like to see more firms adopt the tutorial system of teaching?	YES 34 84%	NO 8 16%
F. Would you prefer to have one month fixed holiday in the summer rather than the present system?	YES 18 45%	NO 23 55%
G. Do you thing that attachments to other hospitals are of value?		
a) in the first six months	YES 17 44½%	NO 21 55½%
b) in the second six months	YES 43 100 %	NO 0 0%

H. Which form of evaluation do you prefer in the firm's grading of students?

multichoice	22	31%
other written paper	5	7%
viva	27	38%
personal opinion	14	19½%
none	3	4½%

I Do you think that two month firms are the right length?	YES 39 87½%	NO 3 12½%

If not, which length would you prefer?

Answers given were: i) 3 months ii) 6 weeks.

J. One year is too long, about right, or too short a time to spend doing medicine and surgery *continually*?		
too long	16	33½%
right	29	60½%
too short	3	6%
K. Would you like to see more scope for student involvement in the practical work at Bart's?	YES 37 89%	NO 5 11%
L. Would you like to see students having more responsibility for patients nominally under their care?	YES 33 76%	NO 10 24%

DISCUSSION

Except for questions A, F, and G(a), the year gave some definite answers.

A large majority agreed that the new time for lectures at 12.00 noon was a great improvement on the old time of 9.00 a.m. Sixty-three per cent of the year felt that separate pathology lectures would be more informative than seminars that we receive, at present and 84 per cent thought that pathology tutorials throughout the year were desirable. Eighty-four per cent also felt that it would be helpful if more firms were to adopt the tutorial form of teaching. This demand for more small group teaching seems likely to grow within the college, as the firms become larger.

Hundred per cent of the year were in favour of attachments to other hospitals during the second six clinical months of the first year. A majority of students are against this during the first six months, which would suggest that it is a topic that they have given thought to, rather than immediately agreed on any escape from the hospital for a while. At present, official opinion seems very against the idea of attachments but I think that it should be noted that this 100 per cent result comes from a year where many did take the opportunity of going to other hospitals, and is a direct reflection of the practical gain which they experienced in this way. While firms at Bart's remain at the 15 + student level that they have now reached, attachments are the only opportunity of personalised teaching and scope for much practical work which is not available in the Bart's scheme of things at present.

Vivas and multichoice papers are the most favoured form of evaluation with personal opinion coming a poor third.

Most of the year think that two month firms are an improvement on the old three month period, although there are a few dissenters wanting to return to the old. Although a small majority wish to study only medicine and surgery continually throughout the first year, 33 per cent felt that this time could be better spent if divided, over all three clinical years. Last, but not least, it is important to note that a majority of students would welcome a chance to be more involved in patient care and the practical side of hospital life.

ETHICS AND MEDICAL EDUCATION

The British Journal of Medical Education has said: "There is no formal teaching on the moral problems in medical schools and discussions on ward rounds are necessarily limited." This is surprising because we are constantly faced with moral issues, not as an object of discussion, but as practical problems; for example, when should we tell a patient he is dying? how much effort do we put into preserving the life of an appallingly deformed new-born baby? how do we balance the quality against the quantity of life?

Most of us, by the time we have qualified, will have encountered these problems, but how many of us will have recognised the ethical issues involved? Moreover have we received any preparation to make moral evaluations? Do we "play it by ear" or assume that the Hippocratic Oath still binds us all to a common code of behaviour? Or do we even realise that the Hippocratic Oath is in at least one respect contradicted by parliamentary legislation?

PRESSURE GROUPS

What steps could be taken to remedy this lack of training? A simple answer would be to appoint a teacher of medical ethics in each of the London medical schools. However, as an eminent surgeon said: "One can imagine what it would be like if a particular consultant on the academic staff were detailed to give a series of lectures on the ethical aspects of medicine. He would either sound so sanctimonious that the students would detest him, or he would sit on the fence so heavily that the iron would enter into his perineum." No one would wish the teaching of medical ethics to be in the hands of a representative of a religious, medical or political lobby or pressure group such as Moral Rearmament or The Voluntary Euthanasia Society. Equally, no one man can have the detailed knowledge of the specific moral problems of different specialties to give a series of lectures on the whole of medical ethics. Although Moral Philosophy is taught throughout British universities there has been no study of ethics within medicine and the philosophy of medicine as a subject does not exist. Thus there is no agreed philosophical basis on which someone teaching medical ethics could base his lectures.

THE ALTERNATIVE

A far better alternative is to ask specialists who teach medicine and are familiar with the medical situations to discuss together in front of an audience of medical students, ethical problems raised through the practice of medicine. When information to clarify issues is required from other disciplines, lawyers, theologians, philosophers and sociologists, for example, should be readily available, but the problem is to maintain a high academic standard for their discussions. The nearest lawyer or theologian, like the nearest G.P. is probably the wrong one.

A CONSENSUS

The London Medical Group has tried to answer these needs. It has brought together experts in various fields to try to clarify some ethical issues and if possible find a moral consensus. It has introduced an element of reflection into a particularly unreflective professional training. During each academic year the LMG holds twice weekly lectures and symposia in the London medical schools and organises study seminars, clinical ward rounds and an annual conference.

An interdisciplinary consultative council exists to guarantee a high academic standard and every topic discussed is subject to a student critique. Indeed, unlike any medical school course, unsatisfactory lectures are not repeated. There is an annually elected president who is always a medical student, assisted by an 80-strong team of medical students, nurses and MSWs, who undertake the local organisation. However, the LMG is more than a student society and is increasingly being recognised as an effective cooperative effort between students and consultants to ensure that the study of medical ethics in medical schools is no longer ignored. Most medical schools, either through their Deans or their student unions have given grants towards the expenditure involved. A new postgraduate association which has grown out of the LMG is the Society for the Study of Medical Ethics and this has received favourable comment from the British Medical Journal and the Lancet. SSME is run by junior hospital doctors, some of whom were associated with the LMG or similar groups in Edinburgh, Newcastle and Sheffield.

Last year's conference, on the Problem of Euthanasia, was attended by 310 people and was heavily oversubscribed. The subject to be discussed at this year's annual conference, to be held on the weekend of February 9th, is "Survival of the Weakest", and will discuss the clinical and moral aspects of advances in perinatal care; it will be held at the Royal College of Obstetricians and Gynaecologists, and one of the Chairmen will be Mr. Donald Fraser.

The popularity of these lectures and symposia is shown by the fact that this year they have been attended by an average of 150 people, half of whom have travelled in the rush hour to attend. Lecture lists with details of these open lectures and symposia may be obtained from the LMG representatives in this Hospital, who are:

First year Clinical	Joseph Pang
	Hugh Shepherd
Second year Clinical	Pamela Soppett
	Martin Gillings
	Colin Lewis
Third year Clinical	Miranda Whitehead
	Ian Jack
	Andrew McNinch

Alternatively information may be obtained from the Secretary, London Medical Group, 103 Gower Street, London, WC1.

PAEDIATRICS IN WILMINGTON, DELAWARE

By C. B. LYNCH

Introduction:

Many Bart's students get into an unbelievable panic when it comes to the time for them to choose a hospital abroad in which to do their paediatrics course; this is certainly not an easy choice to make because they often find it demands academic, social and economic considerations.

So I take this opportunity to bring to the awareness of all Bart's students details of an "incredible" paediatrics undergraduate course at the Wilmington Medical Center, Wilmington, Delaware, U.S.A.

I must emphasise that this article is not in any way meant to dissuade students from the Bart's-based course, or make any comparisons, but to impart information and to stimulate the thoughts of those intending to do paediatrics abroad.

The Hospital:

The Wilmington Medical Center represents the federation of the three largest hospitals in Wilmington, namely the Delaware Division, the Memorial Division, and the General Division. It is the fifth largest voluntary non-profit-making general hospital in the U.S.A.

The Delaware Division deals with almost all the paediatrics cases and here is where Bart's students spend most of their three months.

Dr. Herman Rosenblum is the Director of Paediatrics Services. He is actively involved in the organisation of the departmental activities and the teaching of the house staff and medical students.

The Department has three parts: the wards, the Out-Patient and the Newborn and Premature Nurseries.

The Wards:

Ward patients are housed at the Delaware Division as private, non-private, medical and surgical patients. The Paediatric Wards, the Intensive Care Unit and the Adolescent Wards are sited together in the main building. Ward patients are admitted either from the clinics, the emergency room or referred by private paediatricians outside the hospital.

The Out-Patient and Emergency Room:

Dr. Elizabeth Craven is Director of this Department. She conducts teaching sessions on ambulatory medicine to the house staff and medical students, and directly supervises the daily activities.

The Out-Patient Department is a composition of the Paediatrics, Rheumatic Fever and Special Cardiac, Adolescent, Allergy, Neurology, Well Baby, Speech and Hearing, and Cystic Fibrosis Clinics.

The annual turnover of Paediatric visits to the clinics and the emergency room is 10.5 thousand and 21.3 thousand respectively. The Paediatrics Clinic constitutes a large proportion of the Out-Patient Department and is largely used by the poorer section of the community who, presumably, cannot afford private consultation fees.

At the end of each day the director reviews the records of patients seen in the general clinic and emergency room and holds informal conferences with the house staff and medical students.

A full-time social worker is available to the Out-Patient Department and she works with a Public Health nurse, the Home Care Programmes and community agencies to co-ordinate the care of problem patients.

The Newborn and Premature Nurseries:

The major part of this department is at the General Division of the Wilmington Medical Center; dealing with 90 per cent of the total deliveries (4,500 per year) in the greater Wilmington area. There are only twenty bassinets at the Delaware Division and these act as an overflow area for the Nursery at the General Division.

There are 84 bassinets at the General Division divided into 16 Family-Centre-Plan nurseries and a 20 bassinet of premature or intensive care babies. There is also a Cytogenetic Laboratory for genetic evaluation, demonstrations, teaching with slides and studies.

Associated Department (Alfred I. Du Pont Institute):

This Institute runs very good clinics for the handicapped child, musculo-skeletal disorders, cerebral palsy, rheumatoid arthritis and birth defects.

The Paediatrics Course:

Although Bart's students are accepted as Junior Interns at the Wilmington Medical Center (locum housemen), they are also exposed to the same teaching course that students from Jefferson Medical College (Philadelphia) take.

All students and junior interns are expected to take detailed histories and do complete physical examinations on all patients they see, and work them up for ward rounds and conferences.

Morning ward rounds are held daily by an attending paediatrician for the month; very often the chief residents and the director make rounds.

In the nursery, students are allowed to examine newborns under the supervision of a resident house staff. The premature unit offers excellent opportunities for students to learn about the outcome of high-risk pregnancies, acutely traumatised, cardiopulmonary problems and congenital malformations.

Also students may be asked to present cases of interesting pathology at the intradepartmental conferences.

(Stipend:

Each Bart's student receives a net average income of $140 fortnightly. Claims for tax refunds must be submitted before departure from the U.S. $40 a month is deducted from the gross income for accommodation.)

Thanks to all the staff at the Wilmington Medical Center for their help in the preparation of this article.

JUNIOR REGISTRARS IN GENERAL SURGERY

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

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

1 post: six months Emergency and Accident/six months General Surgery

1 post: six months Neurological Surgery/six months General Surgery

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

The posts are tenable from 1 June, 1973, and the Salary Scale is that of a Senior House Officer in the National Health Service.

Applications, with the names of two referees, should reach the undersigned by Monday, 12 March, 1973. (Application forms are available from the Medical Staff Office).

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

**Urology
Orthopaedics
Thoracic Surgery

J. W. GOODDY,
Clerk to the Governors.

SENIOR HOUSE OFFICER
EMERGENCY AND ACCIDENT DEPARTMENT

APPLICATIONS ARE ALSO INVITED for the post of SENIOR HOUSE OFFICER in the Emergency and Accident Department. The post is *for six months only* and dates from 1 July, 1973.

Applications should reach the Clerk to the Governors by Monday, 12 March, 1973, and forms are available from the Medical Staff Office.

JUNIOR REGISTRAR IN GENERAL MEDICINE

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

The post is tenable for one year from 1 July, 1973, and the salary scale will be that of a Senior House Officer in the National Health Service.

Applications, with the names of two referees, should reach the undersigned by Friday, 16 March, 1973. (Application forms are available from the Medical Staff Office).

J. W. GOODDY,
Clerk to the Governors.

RECENT PAPERS BY BART'S MEN

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

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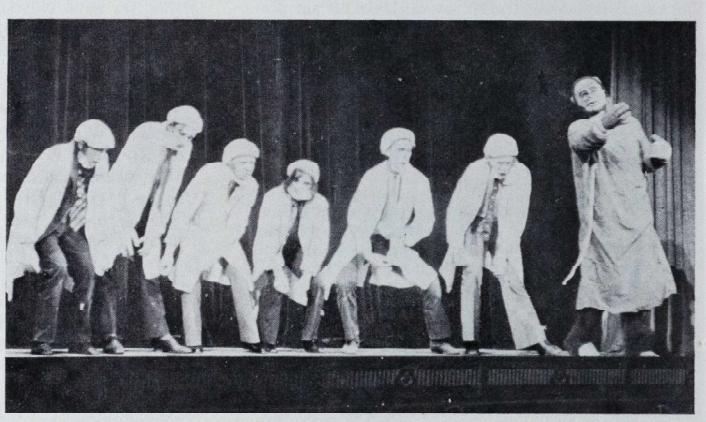
*Reprints received and herewith gratefully acknowledged. Please address this material to the Librarian.

POT POURRI 1972



Having spent Christmas in distant climes (in Manchester), your correspondent is unable to comment on the Ward Shows this year, except that all reports received are favourable. To compensate for this omission, I went twice to the Pot Pourri! The two performances were incomparably different! It is obviously very difficult to fashion a very mixed collection of Ward Shows into a polished evening's entertainment, but the sloppiness of Thursday's performance, and the behaviour of some of the players backstage, who nearly disrupted part of the show, will not be easily forgotten by those who had sat in a half-full, unheated theatre to watch what appeared to be a dress rehearsal.

All this was, fortunately, different by Saturday, and great credit is due to Tim Finnegan who assembled this year's Pot Pourri. First on the bill was a combined show from the Clerks and Dressers. It's a pity that the whole of one year could only produce one show with a small group of actors. Their selection of sketches was varied and amusing, however, the highlight being the Jungle-Book song, I'm the King of the Surgeons. Hopefully, the talents of this year will be more abundantly displayed next Christmas.

The Midder and Gynae Show was very good considering the small number of people involved in it. They included four excellent songs—demonstrating that songs come across much better in this kind of atmosphere than sketches or one-liners. The show had good visual impact also, and maintained its impetus right through. I particularly remember Pam Ouyang and Paul Cooper singing the Contraceptive song, and the Pee, Po, Belly, Bum, Drawers song.

Once again, the D.Q.C. produced a show, and predictably it was mostly about queers and Y-fronts and things. The show took a while to warm up but then took off with a polished sketch by an anonymous pair of arms and Martin Gore's face, a hilarious General Amin, and some good songs which were sustained largely by the voice of Chris Gillespie.

After the interval, the kids show gave us an episode of Winnie-the-Pooh in a hospital setting. The authentic costumes and distinct characterisation made this very popular with the children at Christmas, and with the insertion of a few "double-entendres" and willing audience participation this show went equally well at the Pot Pourri.

There was, unfortunately, no offering from the Finalists, so the evening finished with the House Show, traditionally the biggest and best. Well, the tradition was maintained, though rather as a display of big-business organised talent which lacked the charm and personal appeal of the smaller shows. Once again the songs were a big success, particularly the Services (Anti-) Recruitment Song and the final song. Especially charming were the conjuring act with the lovely Miss Grimaldi as the assistant, and Tim Fenton's Smithfield Climber breed of canine houseman.

The interludes between the shows were ably filled by the various talents of George Blackledge and James Griffiths assisted by Jila "Alma Cogan" Pezeshgi. Their offerings included a cautionary tale, a pair of duets, notably the stirring Ex-Chelsea-Or, and a contest—the prize this time being leadership of a Christian Union weekend.

Mr. Blackledge seemed, indeed, to be quite ubiquitous—for when he was not either introducing a show or taking part in one, he was to be found at the back of the audience cheering, applauding or sobbing as appropriate to the drama.

Statistical Analysis of the Pot Pourri 1972

Total number of shows	5
Men dressed as women	8
Women dressed as men	0
Homosexuals	4
Dixons of Dock Green	3
Television Contest Sketches	3

The Traditional arrangement of Ward Shows and the Pot Pourri provides an opportunity for many people who would otherwise have nothing to do with acting or the Drama Society to stand up and make an exhibition of themselves and those who make the effort find it enjoyable. However, the shows seem increasingly to be covering the same or similar ground, and using the same songs and material. There are those who would say that this is an argument for putting on a tailor-made Christmas Show, which avoids repetition and can be sufficiently rehearsed to appear as a polished performance. If this happened just before Christmas, there would be an opportunity for pre-clinical students to be involved, and with suitable arrangements, nurses could also take part. And since the audience would consist of people who work in, and know, the Hospital, there would be more opportunity to relate the show to hospital life and characters. This kind of arrangement works well at other hospitals in London and elsewhere, playing to full houses, and in several places actually getting members of the Consultant Staff on stage, singing at one of the performances! The patients need not suffer because the most suitable parts of this show could then be used to entertain the patients and staff working at Christmas, thus preventing the present difficulties of trying to write shows for two completely different audiences.

I hope that those likely to be involved in next year's entertainment may perhaps give this a thought.

Although your Bacchanalian correspondent was mostly preoccupied during the Pot Pourri Party with trying to obtain a bottle of wine (Wine Committee please note) and with avoiding the beer-charged syringes of certain less-than-couth members of the D.Q.C., he did manage to see the Theatre Belles Cabaret. These fearless lasses sang and danced their way through a great selection of songs undeterred by an artillery of water that left them looking like the girl in the Manikin advertisement (well, almost!). Unfortunately, many of the heroes of their songs were unable to be there, but perhaps a repeat performance could be arranged in James Gibb House! Congratulations to the various authors, to the yelling theatre belles who surmounted the audience, and to Mary Barnet who got it together.

ANDANTE.

BEGGARS BANQUET REVIEW

It is unusual for controversy to surround a Ball, but this year's Clubs Union Ball managed to arouse plenty.

It was conceived as a Beggars' Banquet with entertainment based on this theme—"dress as tramps" being the order of the day.

This innovation aroused great resentment, for it seems Bart's students hate breaking with tradition—especially that of wearing dinner jackets to a Ball. It wasn't just apathy, it was antipathy!

There were mutterings that the freshers weren't coming because they wouldn't be able to try out the D.J.'s they'd bought.

To turn to the actual event, the groups were good and for this we can thank Graham Aiken. "Guilty Secret", a Bart's group, were well received and no doubt will soon be planning a National Tour. The only thing that marred the entertainment was that the Drag Act failed to appear.

Foodwise, gone were the elaborate hampers of Yesteryear, to be replaced by hotdogs and (of which there was naturally a choice).

Decorations were "representations" of well known London sites (Bomb and otherwise), including a rather unusual Eros in the middle of the Hall (courtesy of Jim House and Co.).

The number of people who came was disappointingly small, but most had made a real effort to dress up and there were some most extraordinary outfits to be seen among them a dress made entirely of newspapers.

A few people turned up, looking comparatively foolish, in dinner jackets. In summary this was a success despite opposition, and could only have been improved by a better attendance.

WATER POLO

In October the team came second in the University knockout competition. This was an excellent performance and the second time in three years we have been runners-up.

The result was due to a superb team effort—the team being C. Fenn (Capt.), A. Frame, P. Bullock, R. Adley, D. Cooke, B. Johnston and newcomers Pete Knight and Rick Holtby.

In the first round we beat Mary's II 5—2, despite giving them two handicap points and went on to crush I.C. II 5—1 in the short game of two periods.

In the semi-final we unexpectedly beat University College, who some had tipped to win the tournament, in a close game (4—3).

The final of four periods was against I.C. I, an experienced team with six University players and a Yugoslav goalkeeper. Our fitness let us down, but it was no disgrace to lose 9—5 to such a team and we beat them at drinking the free beer afterwards anyway!

In the Hospitals League this term we did quite well until the last couple of matches when 'flu hit. We beat the London, drew once with Mary's and narrowly lost to R.D.H. We will probably end up third in the first division.

The second team did superbly and are almost certain to win the third division—a very good performance, thanks largely to Pete Knight, Rick Holtby and Pete Ravenscroft's organisation.

In November, Chris Fenn had a trial in Liverpool for the British Universities team which is preparing for the 1973 Moscow World Student Games: and later that month played for British Universities in a series of matches against Great Britain at Crystal Palace.

XIth DECENNIAL CLUB

The annual dinner of the club, now joined by the Xth decennial club, will be held on Friday, May 4th 1973 in the Great Hall under the Chairmanship of Dr. E. Rosser. Cards will be sent to members in due course.

Enquiries to M. L. Maley,
3 Rutland Lodge,
1 Clifton Road, London, S.W.19.

BARGAIN RECORDS J. S. BACH 1685-1750

This column has made most of its selections from romantics and it has been a pleasant change to turn to J.S.B. It has always been a great mystery that this great composer's music remained unperformed in the 75 years following his death in 1750 until Mendelssohn "rediscovered" it (perhaps the latter's most important musical achievement). One can imagine the surprise of those Leipzig audiences in the 1830s hearing such masterpieces for the first time. Styles in Bach vary. Pre-war, the orchestral works were performed with large orchestras, solid sturdy rhythms and plenty of base, the choral works with massed chorus. In the early '60s there was a tendency to revert to study of the original scores (often ambiguous anyway) and to turn to small orchestras even with original period instruments such as might have delighted Bach. Often these performances are rhythmically lighter and more buoyant. The harpsichord replaced the piano in the continuo part. Thus many works are available on record in different styles of playing—of course most are valid and the final choice is a matter of personal taste.

A striking example of this may be found in records of the orchestral suites. Pablo Casal's recording with the Marlborough Festival Orchestra even has a few conductorial grunts and in its late '30s way, these 2 records are wildly exciting, showing that enthusiasm in music making is so vital—his orchestra was composed of students—these records are available in a cheap box set (CBS 72517-8: £2.50). Equally exciting in its authentic way is Neville Marriner's full price set but despite its academic accomplishment, it is not the set I return to often, unlike the Casals.

The violin concertos, whether transcription or authentic are works of great beauty—the compositions that have made many who claim Bach's music to be too "highbrow" revise their opinions. The slow movements, in particular, are deeply emotional music. The concerto for oboe, violin and orchestra is also a ravishing work. A useful record couples David and Igor Oistrakh in the two violin concerto and Buchner and Schann in the violin and oboe concerto. The readings have given me lasting pleasure, on (DGG 135082: £1-60).

The Brandenberg Concertos may be heard played by orchestras of all sizes. The vastest is the massed strings Sir Henry Wood used in No. 3 (a sensational performance in all ways!). The smallest is Neville Marriner's. Two bargain sets give great pleasure. If you can still get it, Marcel Couraud's with the Stuttgart soloists is magnificent—beautifully recorded and rhythmically satisfying (on Fontana 6720001: £1-50 for 2 records). Not far behind is the two record set played by the Wurtemberg chamber orchestra conducted by Jorg Faeber. This conductor is an excellent Bach interpreter, whose style is authentic and always musical—not quite so exciting as Couraud (TV 34044-5S: £1-98). A new set has recently appeared played by the Virtuosi of England conductor Arthur Davison and although good is not preferred to either of the older two.

Bach wrote for many solo instruments the 'cello and violin works are justly famous and both available in excellent cheap complete 3 record sets at about £1 a record played by Paul Tortelier and Josef Suk respectively (SLS 798, SLS 818). The organ music is well represented on cheap label—All Lionel Rogg's excellent first set of Preludes, Toccatas and Fugues are available on the Oryx label at £1-25 a record—but beware some dodgy surfaces. The playing is wonderfully rich on the Suisse instrument he used. Helmut Walcha's records mainly appear at full price. It is quite incredible to watch this organist play by "feel"—he is blind and has been since infancy. A bargain record couples the famous Toccata and Fugue in D minor with the Prelude and Fugue in C and two trio sonatas—wide stereo sound makes this an ideal introductory record to Bach's organ music (DGG 135046: £1-60).

Bach's choral music is less well represented on cheap label. For my final choice, a full price recommendation of the Magnificat in D, a vibrantly stirring piece with full orchestra, chorus and soloists, at once martial with trumpets proclaiming, and yet beautifully lyrical at other times—The Munchinger version on Decca is the one to get—the coupling is the Cantata No. 10 (Decca SXL 6400).

Bach wrote so much—one can but hope those who have perhaps dismissed his work as academic and dull might listen to some of the above records and begin to realise his full worth.

Allegro.

NURSES PRIZE GIVING

The Presentation of Certificates and Awards to Nurses was held in the Great Hall on October 30th, 1972. Miss Jones, Chief Nursing Officer, said it was a particular pleasure to welcome Sir Edward Howard, Bart., D.Sc., to the hospital both as Lord Mayor of London and a member of the Board of Governors. In welcoming the Master of the Clothworkers Company Miss Jones spoke of their increased generosity this year thus enabling two Sisters to enter for Part A of the Diploma of Nursing, as well as their customary provision of medals and first year proficiency awards.

Miss Jones outlined some of the activities that had taken place in the hospital during the past year, and then spoke of the changes in staff due to retirements, promotions and marriage. Miss T. Noel Smith was welcomed as Principal Nursing Officer, replacing Miss Harper who had recently retired. The nursing staff were grateful for all the voluntary help given by the Women's Guild and W.R.V.S. A brief reference was then made to the recently published Briggs Report of the Committee on Nursing, Miss Jones commenting that this would be studied with interest. The nurses were reminded that great job satisfaction was to be found in nursing, and Miss Jones hoped that those who were not continuing with their career at present due to home and family commitments might consider returning later, perhaps on a part time basis.

A report of the past year in the Department of Nurse Education was then given by Miss Collyer, Principal Nursing Officer—a busy year which had also seen a start made on the building of the new school. Examination results had been good; the first group of Degree Course nurses had obtained their degree and hoped to become State Registered Nurses by Christmas; the nurses taking the three year State Registration course had achieved an eighty five per cent pass rate in the recent examination—a less gloomy picture than that reported in the national and nursing press of the large number who failed in this examination. Miss Collyer expressed her gratitude for the help given to the student and pupil nurses seconded to other hospitals for obstetric, psychiatric and geriatric experience, and to those responsible for supervising the nurses community experience. Inevitably staff changes had occurred, and it was encouraging to see an end to a period of shortage as three people were at present taking the Tutor's Course. To the prizewinners Miss Collyer offered her congratulations, and thanked their parents and friends for the support they had given throughout a period of training which one knew was often stressful—her hopes were that these newly qualified nurses would maintain a high standard of patient care wherever they worked.

Sir Edward Howard then spoke of his delight in being invited to take part on this occasion, in his position as Lord Mayor he had few opportunities of speaking to young ladies—he always regarded the City as the 'last bastion of Mens Lib.'—although this pattern had changed latterly when a take-over by the miniskirts had occurred. He reminded the nurses that the School of Nursing was nearly a hundred years old, he asked them to look back with pride and pleasure on their time here, for time spent in training was valuable. The Lord Mayor then presented the certificates and prizes, this being followed by a short address by Sir Henry Jones, Master of the Clothworkers Company. He said that it was ninety years since the then Master started collecting money for this hospital, at first prizes were given to the best probationary nurses, but later the awards were extended to include the medals as well. Then followed the presentation of this year's Gold, Silver and Bronze Medals and the first year proficiency awards. Votes of thanks were given by Miss P. K. Evans (Gold Medal) and Miss J. A. C. Boyle (Silver Medal), and following the conclusion of the ceremonies prizewinners and guests were entertained to tea in Gloucester Hall.

HELEN GRIBBLE.

SAINT BARTHOLOMEW'S HOSPITAL JOURNAL

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Editorial

It may come as a surprise to older Bart's men to note that for the first time in many years a number of pre-registration house jobs have not been applied for (at the first time of asking) by any Bart's graduates. It will be less of a surprise to those who have had a close association with the hospital in the last year or two, for it is a sign of a trend that has been underway for some time.

There are several reasons for this trend, most of which are well known to those still associated with Bart's. Accommodation is not all it might be, especially for married housemen, and the likelihood of improvement in the near future appears remote. It is now widely realised that there is much useful clinical experience to be gained outside the Teaching Hospitals, and it is significant in this respect that the unfilled jobs are all surgical. With this new "broadmindedness" is the acceptance of the view that it is no longer a *sine qua non* for those seeking postgraduate advancement to hold a pre-registration appointment in their own Teaching Hospital first. At least in theory, pre-registration jobs should be combined with an opportunity for instruction and self-education; unfortunately with long duty hours and large numbers of students in competition for teaching time, this theory is rarely realised.

This reasoning seems to extend to post-registration house jobs, several of which have been lowered in status in an attempt to fill them with Bart's men.

The future is uncertain. Fusion with the London and the turning of Bart's into a post-graduate teaching centre will alter the requirements for staff and also the availability of suitable candidates. It remains true that the prestige of a Teaching establishment is well measured by the desire of its graduates to work there subsequently.

The lesson is not clear to see, but it obviously requires further study. One wonders if other London hospitals have suffered the same problems. The conclusion must be that students no longer see themselves as the product of a single hospital to which they consequently owe allegiance. Bart's Man is dying out.

STUDENTS UNION LETTER

January 24th, 1973.

Dear Sir,

May I, in my first letter to the *Journal* as Chairman of the Students' Union, first take the chance to thank Guy Routh for all his work in this capacity. My thanks are personal and on behalf of Bart's students in general. I have been elected Chairman until the end of April, and Doug Russell now has the job of Secretary.

Few students realise the extent of the Student Union commitment in the organisation of the academic life of the College. In this field we are responsible, obviously, for representing the views of students on the course, and we can do this at several levels. We are now represented on the College Committee and on the Curriculum Committee, which may shortly be meeting to discuss a revised clinical curriculum. A Student/Staff Committee also meets regularly and—if that's enough Committees for now—we are fortunate in having in Professor Shooter a Dean who is prepared to meet any student to discuss grievances.

However, we are still faced with the problem of communicating decisions thus reached to the main body of students and we seem to be in danger of restricting this information to those interested enough to attend Council meetings or read the S.U. noticeboards. I hope that Year Representatives will actively inform their "constituents" and encourage a feedback to the Students' Union Council. Any response is better than none, and I would like to stress again that any student is welcome at Council meetings.

Involvement is a recurring theme—any viewpoint is listened to and any active help appreciated. I would also like to see some participation in local social work organised through us, more involvement with the people for whom our Hospital is responsible. And on a lighter note, active help with the 850th Anniversary celebrations is urgently needed. This is our affair, and no one else will be organising it for us.

Finally, may I mention the Students' Union involvement on a wider front, where we represent Bart's at BMSA, London University and London Medical Schools Meetings. Though decisions reached there rarely seem to affect us, it is important not to divorce ourselves from the mainstream of medical student thinking, and to use these meetings for the gathering and exchange of information. I hope that an increasing number of Bart's students will come to share our interests.

Yours sincerely,
PAUL TAYLOR,
Chairman, Students' Union.

ST. BARTHOLOMEW'S HOSPITAL STUDENTS UNION
WINE COMMITTEE

present the X Annual

SMOKER

to be held on the

19th, 20th and 21st MARCH

Price of tickets to be announced

NO STAG NIGHT — BLACK TIE on the 21st — ALL WELCOME

ANNOUNCEMENTS

Births

CARRUTHERS—On January 16th, 1973, to Dr. Richard and Victoria (née Medvie), a daughter: Alexandra Elise.

Deaths

FOX—On January 16th, 1973, Dr. George Noel Fox, B.A., L.M.S.S.A. Qualified 1928.

HARVEY—On January 17th, 1973, Percival George Francis Harvey, M.B.B.S., M.R.C.S., L.R.C.P. Qualified 1935.

MACKENZIE—On December 1st, 1972, Melville Douglas Mackenzie, C.M.G., M.D., M.B.B.S., D.T.M. Qualified 1911.

ORPWOOD—On August 13th, 1972, Robert M. M. C. Orpwood, M.R.C.S., L.R.C.P., D.P.H.Lond. Qualified 1933.

TWIGG—On January 10th, 1973, Garnet Wolseley Twigg, B.A., M.A., M.B.B.Ch., M.D., M.R.C.S. Qualified 1913.

WAKS—On August 6th, 1972, William Waks, M.R.C.S., L.R.C.P. Qualified 1934.

WARE—On September 23rd, 1972, Hubert Austin (John) Ware, M.A., M.B.B.Ch., M.R.C.S., L.R.C.P. Qualified 1924.

Engagements

BAUGH—HILL—The engagement is announced between Dr. J. W. David Baugh and Miss Nicola H. C. Hill.

DR. C. FROGGATT—MISS P. K. SMITH—The engagement is announced between Dr. Clive Froggatt and Miss Paula Smith.

Changes of Address

W. M. CASTLEDEN, M.B., F.R.A.C.S., has moved to 39, Pyrland Road, Islington, N.1. 01-226 0570.

Dr. and Mrs. J. STEVENS, after March 21st, c/o Dept. of Cardiology, Groote Schuur Hospital, Capetown, S. Africa.

A. J. WALKER has moved to The Medical Clinic, 3009, 31st Avenue, Vernon, B.C., Canada.

Dr. A. PADFIELD has moved to 48, Riverdale Road, Sheffield S10 3FB. Tel.: 0742 64532.

Mr. D. GARFIED DAVIES. Consulting Rooms—149, Harley Street, London W1N 1HG. Home address—29, Morelands Drive, Gerrards Cross, Bucks. Tel.: Gerrards Cross 87120.

Appointments

Mr. W. F. HENDRY, Ch.M., F.R.C.S., has been appointed Consultant Urologist from February 1st, 1973.

Dr. MONICA CRONIN, M.B., Ch.B., F.F.A.R.C.S., has been appointed Consultant Anaesthetist from March 10th, 1973.

Dr. A. PADFIELD has been appointed as Consultant Anaesthetist to the United Sheffield Hospitals.

COMING EVENTS

HER MAJESTY THE QUEEN WILL VISIT THE HOSPITAL ON MARCH 21st FROM 3.00 - 4.30 p.m.

GILBERT AND SULLIVAN SOCIETY

The annual production of the Bart's Gilbert and Sullivan Society will be staged at the end of March. Their choice this year is The Gondoliers, and performances will be at the Golden Lane Theatre on the 29th, 30th and 31st March; curtain up at 7.30.

LITERARY SOCIETY

EDNA O'BRIEN IS COMING TO TALK TO THE LITERARY SOCIETY ON MARCH 20th at 8.00 p.m. IN CHARTERHOUSE.

BARTHOLOMEW BALL

One of the principal events of the 850th celebrations will be the Bartholomew Ball on Saturday May 5th. The Grand Central Avenue of Smithfield Market will be decorated and there will be refreshments and dancing to Ray Ellington and others. Tickets will cost £1.50 each, and it is hoped that from three to four thousand people will attend, wearing costumes of any period since 1123.

We are grateful to Mr. ELLISON NASH for informing us of a Guide to Study Leave in the Metropolitan Hospital Regions, produced by the British Postgraduate Medical Federation. This booklet gives details of courses in London and at regional medical centres. Copies are, we understand, sent free to Registrars, Senior House Officers and Post-registration House Officers, but Pre-registration House Officers should be able to obtain copies from the Dean's Office.

THE ROYAL COLLEGE OF PATHOLOGISTS

By Miss P. L. CHATER

In this brief account of the young Royal College of Pathologists it would seem appropriate to preserve a considerable degree of anonymity and to avoid naming most of those who were active in the foundation of the College. Many of them still play important roles in the College's affairs.

It was in the years immediately following the Second World War, when the arrangements for introducing the National Health Service were under discussion, that pathologists began to feel the need for representation in these discussions on an equal footing with their clinical colleagues. At the same time many pathologists believed that an organized system of training and examinations was needed for admission to their specialty, comparable to what was provided by the Royal Colleges of Physicians, Surgeons, and Obstetricians and Gynaecologists for those entering the clinical specialties. The National Health Service Act, which came into force in 1948, designated the Royal College of Physicians of London as the appropriate body to represent pathology in England and Wales, but in fact only a minority of pathologists were members of that College and the College made little effort to represent pathologists' interests. With the increasing complexity of pathology itself many pathologists considered it wasteful for trainees to burden themselves with the task of passing the chancy examinations for the M.R.C.P. but at the same time it was clear that an M.D. or Ph.D., though more relevant for a laboratory doctor, did not in any way ensure that the holder was properly trained even in one branch of pathology.

It was considerations such as these that led the Association of Clinical Pathologists to set up a committee under the chairmanship of the late Professor Geoffrey Hadfield to consider what action should be taken. The main possibilities they considered were first, that the Association of Clinical Pathologists itself should become an examining body; second, that an independent College of Pathologists should be established; and third, that the Royal College of Physicians of London should be asked to set up a Faculty of Pathologists within the Royal College. In the event, opinion seemed to be divided between the latter two courses of action and discussions dragged on for almost a decade until finally the Association persuaded the rather reluctant Pathological Society of Great Britain and Ireland to join them in a plebiscite of their members. This showed a definite majority of those voting to favour an independent College and a further approach to the members of the two organizations revealed a substantial number of pathologists as willing to back the formation of a College by putting down hard cash. It was at a meeting of these "subscribers" held on June 21st, 1962, in the London School of Hygiene and Tropical Medicine that the motion setting up the College of Pathologists was carried unanimously: and the following day Sir Roy Cameron, F.R.S., Professor of Morbid Anatomy at University College Hospital Medical School, accepted an invitation to become the College's first President.

The first year of the College's existence was occupied by the provisionally appointed Council drawing up a constitution for approval by the subscribers, admitting the Foundation Members, and holding the first Council election. Minimal office accommodation was leased from the Red Cross Society at 12 Grosvenor Crescent, and here the College Secretary set up the administration of the College's affairs.

The original constitution of the College recognized four main specialties within pathology: morbid anatomy and histopathology; medical microbiology; haematology (including blood transfusion); and chemical pathology (including toxicology): and, a few years later a fifth specialty—immunology—was added. Once the constitution had been agreed by the subscribers, incorporation of the College by the Board of Trade was soon achieved followed by the granting of a Section 19 licence permitting the College many administrative privileges. Registration as a Charity was also granted in 1963. With these formalities behind them the first elected Council got down to the important task of drawing up training and examination regulations and getting the examinations under way. The training scheme was divided into a two-year period of general training, during which experience was to be gained over a wide range of laboratory medicine, followed by a period of specialist training lasting at least three years, during which the trainee concentrated on a single special subject. In 1970 the College modified its regulations to permit trainees to specialise in their chosen branch of pathology at an earlier stage. Now, although the College recommends that trainees obtain experience over a wide range of laboratory work, they are required to choose a single subject for the Primary Examination. A wide-ranging multiple-choice question paper is, however, retained for all medical candidates, but essay questions, practical tests, and oral examinations cover only the chosen specialty.

The College soon came to be recognised as the appropriate body to represent pathology at the national and international level. Since 1966 it has had the privilege of nominating representatives to Advisory Committees for National Health Service Consultant appointments in pathology in England and Wales and since 1968 the President has been a member of the Joint Consultants' Committee.

The College soon outgrew its first office in Grosvenor Crescent and moved to progressively larger premises first at Chandos House (as a tenant of the Royal Society of Medicine) and then to 16 Park Crescent, near Regent's Park. Finally, as a result of a generous donation from Mr. (now Sir) Michael Sobell, the College was able to obtain, jointly with the Cancer Research Campaign, a long lease of premises at 2 Carlton House Terrace, overlooking the Mall. This house had been severely damaged during the air raids on London, but after extensive repairs and alterations financed by the Sobell donation it now provides first class office and committee accommodation for the College. The largest room combines the functions of Council room, scientific meeting room and dining room. It can take up to 90 for a lecture and up to 65 for a dinner, so for its main meetings the College still has to hire accommodation in other premises—usually at the Royal College of Physicians or at the nearby house of The Royal Society.

In 1968 the Queen agreed to become the College's Royal Patron and in 1969 permission was given for the adoption of the Royal title by the College. This was quickly followed in 1970 by the granting of a Royal Charter, and finally on December 10th, 1970, Her Majesty honoured the College by visiting the completed premises at Carlton House Terrace to perform the opening ceremony.

From its earliest days the College had decided not to run courses for trainee pathologists but to leave this activity to the Association of Clinical Pathologists, which already had considerable experience in the field. Since 1967, however, the College has staged a series of highly successful two-day symposia on broadly based subjects such as transplantation pathology, automation and data processing, acute respiratory diseases, pathology of trauma, intestinal absorption and host-virus reactions. These symposia, attracting audiences in excess of two hundred, have been held in the premises of the Royal College of Physicians of London, but since moving to Carlton House Terrace, the College has embarked on a series of half-day scientific meetings on more specialised subjects, with an audience limited to about 90 participants and held in the College's own premises. It is planned to hold these meetings at roughly monthly intervals and to have occasional similar meetings outside London.

The College is of course still evolving and is likely to continue to modify its structure and attitudes to meet the changing pattern and role of laboratory work in contemporary medicine. It had been agreed by the original subscribers that the foundation membership would be limited to medical graduates but that subsequently the Council would make arrangements to admit suitably qualified non-medical scientists working in pathology. At first this important group were admitted only on the basis of the submission of published works, but later Top Grade hospital biochemists and their equivalents were for a period offered direct admission to membership. Now there is a full examination system for non-medical scientists closely comparable with the examinations for medical graduates, but with appropriate differences in emphasis. Medical graduates can register the M.R.C.Path. or F.R.C.Path. as additional qualifications with the General Medical Council. In addition to its Membership and Fellowship, the College also grants a Diploma (D.R.C.Path.) to medical graduates passing the Primary Examination in four subjects.

An important development occurred in 1971 with the establishment of five specialty committees, representing the five main branches of pathology. These committees consider matters from the point of view of each specialty and report back to the Council whose task it is to co-ordinate their recommendations into the general policy of the College as a whole. In addition a Scottish Affairs Committee has been set up to advise Council on matters concerning the organization and practice of pathology in Scotland. With the help of all these committees and of special working parties appointed for the purpose the College has in the past year published important papers on the training programmes for the different branches of pathology and on the consultant staffing of pathology departments in district general hospitals.

It is to be noted that under its Royal Charter the College is run by its Council. Every Member and Fellow is eligible, if duly proposed, to stand for election to Council and all have a vote in the postal ballot which determines the Council's membership; and all have the right, under the relevant regulations, to question the Council on its stewardship at the Annual General Meetings. No doubt the structure of the College will continue to evolve to meet changing conditions: but in the meantime the College is well equipped to play its part under its fourth President, Professor J. V. Dacie, F.R.S., in safeguarding the standard of practice of pathology in the reorganized health service and in promoting the advancement of pathology as a scientific discipline.

Miss Chater is the College Secretary.

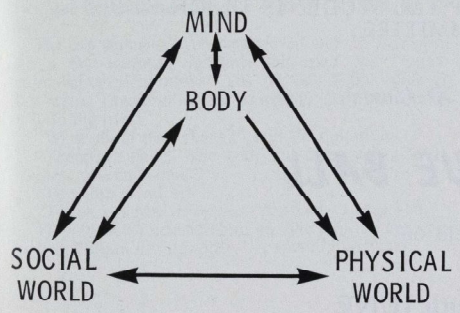
MORAL RESPONSIBILITY IN A TECHNOLOGICAL AGE

By NICHOLAS HUTT

Before the era of modern science the physical world was a mysterious and hostile place. Every family lived in the shadow of famine and dreadful disease. In those circumstances the physician could do no more than try to relieve the resultant suffering by individual treatment. As a practitioner of a mystical but noble are, the doctor was above practical politics; he could not hope to change a world that he did not understand.

Today the position is very different. In many cases we understand the origins of disease in our physical environment. Very often we discover that the suffering once attributed to the work of an angry god, now lies within our own control. It will be argued here that this fundamental change in our relationship with the environment, demands a level of moral or political consciousness amongst the medical profession which has not yet been achieved.

All ill-health can be described in terms of man's adaptational relationship with his environment. We know that the symptoms of infectious disease are often



the result of a breakdown in a possibly balanced symbiotic relationship. The incidence of T.B. is related to the quality of living conditions. We know that mental "disorder" is strongly associated with post-industrial societies. We are suspicious that predisposition to cancer can be caused by various common hydrocarbons. In fact, it would now be considered irrational to accept any form of ill-health as being spontaneous; a cause is always sought in our environment.

Furthermore, we live in a technological age, where this environment is subject to unprecedented control. Every facet of the western world now owes something of its character to the "marvels" of modern science. Consequently, contemporary man has greater responsibility than any previous generation, for the quality of his environment, and therefore, his life.

Unfortunately, the predominant philosophy amongst today's medical profession is much the same as that of its nineteenth century forefathers. Practical politics are an anathema, and "outspoken" colleagues are shunned as trouble makers. The almost exclusive focus of modern medicine still remains the individual patient. Ill-health is eliminated by readjusting the individual to the environment, so that a harmonious relationship is restored. Although this is usually a humane and worthwhile exercise, it leads to a dangerous and invalid assumption. By ignoring the part played by the environment in the production of disease, the medical profession uncritically endorses a view which accepts the world as being beyond our control. Consequently, in the popular consciousness, ill-health is still pictured as a mysterious affliction which has no apparent logic in its choice of victim. As patients rush to hospital where lives and sanity are "saved", they do not know that there is a grim logic which we often understand. They do not know that as members of the working class they are more likely to develop "schizophrenia", or that their babies are more likely to die an early death. They do not realise that as members of an affluent self-indulgent nation, they have a greater chance of atherosclerosis. Because they do not know, they do not ask for change.

The problem is a difficult one because we live in an uncritical society. Our lives become more and more depersonalised as we are housed in high-rise flats and work in huge characterless industrial combines. As we soak up the immediate gratification offered by prepacked plastic entertainment, and watch our resources dwindle to their expected end, it all seems quietly inevitable. However, this is where we are wrong; almost every change and development in the modern world is the result of a controllable human action. If we are to maintain a tolerable existence, for ourselves and for future generations, we must question the work of modern science and ensure that it embodies the values and aspirations of the whole community. Although this critical awareness is the responsibility of every member of our society, health workers are in a particularly important position. Every "patient" who presents himself, represents an expression of dissatisfaction with the world. In every case we must question "Why?" and ask ourselves whether it is necessary. If Chemie Grünenthal had worked with a different set of priorities could the tragedy of Thalidomide have been avoided? Grünenthal's first concern had not been for profit, could not the tragedy of Thalidomide have been avoided?

When old age pensioners die of hypothermia this winter, we must wonder why. We must make it known that they died of cold, that they died because our society chooses to ignore their financial needs. We must attempt to get things changed.

If there is still any doubt about the political nature of health care, consider the experience of the Cuban people. Since Castro's triumph, the incidence of T.B. and tetanus has been halved, while Polio, Diphtheria and Malaria, previously prevalent, have been virtually eradicated. Guevara achieved more for the welfare of the Cuban people as a guerrilla, than he would have in a lifetime of medical practice.

It would be naïve to expect any radical change in outlook amongst the senior members of a well paid profession. However, it is possible that a new critical outlook can develop among today's students, if we change the format of our education. It is a depressing fact that in the first three months of a clinical course for one hundred and fifty of tomorrow's doctors, we have yet to formally question whether the work of the Health Service is consistent with our own aims and ideals. Instead our time is devoted to the transference of objective truth and the physiological tricks of the trade. Our education must lead us beyond the protective confines of the hospital wards to consider the kind of existence that most of the community leads. We must question the inequities of life visible to all but the narrowest mind. Even as we walk through the hospital we might reflect on the incongruity of expensive cars within the buildings where four-fifths of the ancillary workers receive a wage of less than £20 a week, and patients in the wards after a lifetime machining asbestos, now die of lung disease. To put even this in a wider perspective, it is said that "a peasant in the tropics has to work a third of his life just to feed his tapeworm".

If we are to move towards any semblance of democracy and justice, we must openly discuss the values that are employed in the organisation of our society. We must learn where the provision of Rolls-Royces comes in the list of Health Service priorities. We must discuss the allocation of resources for foreign aid, defence, education, psychiatric care and specialised surgery. The relative support we give to each represents a moral judgment in which the whole community must participate.

Unfortunately, the burden of moral and political responsibility falls particularly heavily on the doctor in our society. Entrusted with the protection of the community's health, the doctor is afforded enormous prestige and influence. If the Health Service is to remain faithful to its humanitarian ideals, we can no longer stand aloof. Rather than playing the part of heroes, struggling with leukaemia after the bomb has dropped, we must stop and ask ourselves "Why ill-health?" For if the cause lies within our control we are obliged to justify its continued existence.

If we are to rescue our fate from the hands of unreflective scientists and businessmen, we must develop a critical democracy. Health workers, continually faced with the tragedies of our society and environment, have a particularly important part to play.

A SPOONFUL OF SUGAR HELPS THE MEDICINE GO DOWN

By TIM PACKER

The real Mary Poppins was a witch who lived all her life in a dark cave. She held the secret of life and death. A young altruist called Fiz was one of her admirers and he used to call on her for favours.

"Mary Poppins," he declared on one visit, "That last secret potion you gave me was disastrous! It was a good sleep potion, but you didn't tell me that it was a baby poison too!"

"That was because you didn't ask me," replied the old witch, "and anyway, I don't care."

The young man shook his head in wonder.

"Look," he said, remembering why he had come, "last year in Britain we lost £190 million of production due to Rheumatic Disease. Can you do anything for us?"

The old woman's eyes went glazed and she was silent for a few minutes. Suddenly she cried out, "Supercapitalisticexpialidotious! Yes, try this stuff I made up last week. I made it up for something else, but I think it'll do the trick."

"What about side effects?" said Fiz doubtfully.

"There are none," she said, and then, with a smile, "unless you find some."

The youth stood up.

"Thank you Mary Poppins. You know I trust you."

The old witch watched him go. She took up her knitting and began to sing softly, "A spoonful of sugar. . . ."

The article in this issue by Nick Hutt concludes with a plea to health workers to see their work in an ecological context, and to develop a personal responsibility for the state of the society they live in. It is the intention here to present a simplistic view of the development of our social organisation, to show how economic forces have come to direct human decisions away from the responsibility that each man owes to other men.

Karl Marx believed that in his day the economy structured society by dividing the people up into classes: the money possessing classes (the bourgeoisie), and the working classes (the proletariat). It was his view that those who had money (capital) could use it to make more money, by employing men to work at profitable enterprises. The profit was thought of as "surplus value", that is, for part of the day a worker worked for himself (his wages), and the rest of the day he worked for his employer (in producing profit). This indeed was a form of slavery, but it was justified, because after all, was not the employer providing the man's livelihood? And how else was an economy to expand, except by profit? For, as we shall see, the economy must expand. A basic aspect of this type of economy was a belief in free enterprise; that prices should find their own level according to the laws of supply and demand. This creates fierce competition between the producers, for those who fall short on efficiency will go under. These pressures were to help in the development of technology, and to keep the workers wage at a minimum. Expansion is the key to efficiency; and coupled with this capital intensive trend, unemployment becomes inevitable. Indeed, we know that a level of unemployment is a prerequisite of a stable capitalist economy. Marx knew this and he believed that its days were numbered. The time would come when there was such a disparity between the two styles of life, that the working class would rise up and claim the benefits of their own work. There would be a proletarian revolution, with the formation of a socialist society where all men are equal.

The capitalist structure of society anticipated this outcome. Two developments changed the bleak outlook for capitalism: one was the creation of the welfare state (including health services and unemployment benefits), and the other was the development of Trades Unions. This latter creation meant that the working class had really joined the collective bargaining of the system; it accepted the status quo and was negotiating with it.

With the development of the media, a very powerful tool for expansion became available. By advertising, the people could be persuaded to buy products, and thus provide the very profit that was to exploit them at work. By virtue of the inherent inequality of reward in this

type of set-up, the advertisers were able to create needs in the public consciousness. Status became inextricably associated with money and possessions; luxuries that previously only the wealthy had been able to afford, were offered to the masses. The provision was that they had to work and save in order to buy the products of their labour (with a cut to the owners of the companies).

This state of affairs seems quite just at first glance; everyone is getting what they want, most people are working and production is continually being increased. But, to put it in terms that we can all relate to, can we afford the price? Today value has become synonymous with price. Health, art and entertainment are all commodities to be bought and sold. Everybody spends his life working in order to buy more goods (ironic word), and it becomes inevitable that people justify this effort by elevating materialism to a religion. Of course, it is no coincidence that materialism is *the* religion of capitalism.

This self-reinforcing system, which has created artificial needs in men, then justifies itself to them by fulfilling these very needs—what a formula for success. The "wonderful" advances in science have made this success possible. Technology has been developing hand in hand with capitalism ever since the industrial revolution; they are mutually complementary. Technology affects us in such a variety of ways. It provides us with what capitalism always promised us, it is the embodiment of the power that resides in money, and it is the means by which money can fulfil all those good things that god was supposed to do: to feed us when hungry, to warm us when cold and to comfort us when we feel lonely. God, we are self-sufficient! We don't need anybody, we know what makes the world go round—and it isn't love!

But we do need each other. Not only has capitalism brought us to the materialist ethic, but it has separated man from his fellow man and from his work. Expansion and the obsession for efficiency require men to stand in production lines and perform simple repetitive operations all day. The production line stops for no man—he must get a replacement before emptying his bladder. The stress is high and the exercise apparently pointless, for the worker never sees the product of his labour and someone else is getting the benefit. If he could see the end result, could he be proud of it? A surplus of material goods and a contribution to the hierarchy that keeps him in such a soul-destroying job.

There is no way of escaping this total commitment to economism—no area of human existence is sacred; social prestige, sex, security. They all sell. It would be easier to appreciate this morbid state of affairs if, as in the nineteenth century, there were the oppressed and the oppressors to be seen. But this is no longer so; expansion has resulted in a bewildering complexity. Capitalism has been imbibed by us all, and we have become our own oppressors. Companies are no longer owned by entrepreneurs but by shareholders. All humanity is extracted from the financial operations, and responsibility is mystified in beaurocracy and allegiance to the rules of competition. Now more than ever, capital functions as a force over and above the people who actually work within it. Individual responsibility is lost so that terrible acts of inhumanity can be performed in the name of competition.

A good example of the way economic forces have lost touch with human beings is the "Thalidomide" case. There is probably no one concerned with the Distillers Company who would deny the crippled children adequate (financial) compensation. But people are powerless; mere people are not able to transgress the laws of the economic gods that rule us. Even the shareholders who are supposed to own the company have no say, and the company directors are bound to follow the path of least financial resistance. But what of moral responsibility in a world where decisions are apparently out of the grasp of human sensibility? The legal system has shown itself to be strikingly ineffective in providing any kind of justice; a large company can afford to await the outcome of a 15-year court case—the crippled children cannot.

The Thalidomide case has certainly unmasked some unpleasant aspects of our social structure. Distillers have demonstrated the incompatibility of compassion and economic interests, and Chemie Grunenthal, the German company which first introduced the drug, have shown us something even more sinister than the beaurocratic paralysis that we have inflicted on ourselves. The fact that many knowledgable doctors and pharmacologists believe that the drug was inadequately tested, may possibly be put down to the ignorance of the times, but Chemie Grünenthal have been accused of far worse. If the legal proceedings had not ended in confusion, the prosecution were confident of proving that the company had actually ignored warnings of the suspected correlation between the drug and the deformities. They were also accused, not only of failing to withdraw the drug immediately, but also of simultaneously advertising its complete safety. If this kind of behaviour is the result of the pressures of competition in a company that is supposed to be benefiting mankind, what can we expect from the rest of industry which has no such pretensions? Their pollution has been shown to be increasing exponentially, and if human beings can only learn from disasters like "thalidomide", the first ecological disaster to impress us as urgent will be the destruction of life on this planet.

Society today is characterised by inequality of financial reward and thus of social prestige, it has become so estranged from its own economic forces that it ignores human needs, and treats humans as commodities. Consequently they feel isolated, and powerless to control their own lives. What implications does this type of social structure have for the organisation of a health service?

We are very familiar with the casualties of physical violence, for it is a part of our society, and we see evidence of society's wish to appoint blame and punish the violent among us. However, it is less familiar for us to consider other illnesses and disabilities as the result of political violence; that is, violence perpetrated on an individual by virtue of his position in society. There are many examples to choose from, where the way we live in a highly organised and competitive society, has a direct effect on people's health. Industrial diseases, the diseases of the poor and the results of stress ("atherosclerosis" and "mental illness") are the most obvious.

As mentioned in the last issue, health is a value-laden concept. It presupposes the question, "Health, for what?" In our culture it appears that health is that which fits in with society best, especially with society's requirement for work. The allocation of money for medical care in this country bears a striking correlation to the working status of the patient: consider the amounts that are spent on mental defectives, the crippled and the old. When allocation of money for research is being considered, one often hears what effect the disease has on the national economy. The aim of research does not appear to be directed to the alleviation of human suffering, but to the Gross National Product!

With respect to our concepts of health, the medical approach to "mental illness" is interesting. Immense efforts have been made to find an organic basis to mentally troubled people. If it could be established, it would immediately relieve society of any soul searching as to the cause. It would be scientifically explainable and, presumably, the symptoms could be treated in the same way. This bears a striking resemblance to the medical attitude to physical disease—physical aetiology and physical treatment only. Society is cleared of any possible blame. In psychiatry the issue is more obvious because the "diseases" are those of affect and rationality which are areas in which science has no jurisdiction. The aetiology is very puzzling unless we consider the social context. Then, perhaps, "mental illness" becomes understandable as proto-language, a last ditch attempt at expressing the terrors of an impossible conflict with social rules. This kind of approach demands a reappraisal of what we take to be "normal" human morality and rationality. It presents alternatives, and demonstrates how intolerant we can be of those who deviate from the norm.

Charcot was the first to make "malingering" respectable by defining it as an illness, and thus alleviating the personal responsibility. Although Freud related the intra-psychic conflict of the mentally ill to the efforts of the individual to come to terms with the demands of society, his interest was finally in the individual psyche. The "anti-psychiatrists" such as Laing and Szasz see the problem as society inflicting intolerable demands on an individual. The illness is in the society that makes such demands. Can we say that a society that permits wars to be waged, pollutes the world and ignores the interests of its people, is sane?

Our social structure is in every one of us; as much in the submissive attitude of the patient as in the charismatic image of the consultant. Each one of us, then, has a personal responsibility for that structure, and the question of what to do about it is a personal one. Only when we have decided that things could be improved, and that we are going to try, will we get a glimpse of the scale of the obstacles to improvement created by self-interest and complacency.

THE FUTURE OF THE CHARTERHOUSE SITE

Preparations for the union of Bart's Medical College with the London Hospital Medical College and Queen Mary College are now going forward steadily. After an initial period of hesitation, it has been realised that Bart's will be best served by early and confident planning for the future, rather than by hopeless opposition. We are grateful to the Dean for preliminary details of progress to date.

Formal relations between the Colleges are through the Joint Policy Committee, set up on the recommendation of the Todd Steering Committee in July 1969. The terms of reference of this Joint Policy Committee are broad, covering the organisation of teaching, examinations, and proposed new developments and the finance thereof.

Land adjacent to Queen Mary College is in the process of being purchased, and by 1979 it is hoped that the new joint pre-clinical school will be built. The University Grants Committee has given an assurance that Charterhouse will be retained within the Bart's/London/Q.M.C. complex when the pre-clinical departments move to Queen Mary College. Plans for its future use are still tentative, but there is every hope of developing it as an outstanding academic complex serving the research and postgraduate needs of the twinned schools. The following departments are under consideration as important parts of this development.

Departments for which support already exists:
- M.R.C. Air Pollution Unit
- Department of Experimental Pathology
- Clinical Biochemistry Complex
- Department of Clinical Pharmacology
- Department of Neurophysiology with Experimental Neurology
- Laboratories of the Department of Oncology
- W.H.O. Cholera Reference Centre
- Department of Medical Physics with Electronics
- Experimental Laboratory of the Department of Anaesthesia

Departments for which negotiations are in progress:
- Research Institute, St. Mark's
- Academic Department of Enterology
- Institute of Ophthalmology
- Laboratories of the Department of the Environment, and Toxicology
- National Radio-Immunoassay Centre for Peptide Hormones
- Department of Reproductive Physiology

Conjectural Departments:
- (i) Units which might be established:
  - Department of Human Genetics
  - Academic Unit of Endocrinology
  - Academic Unit of Diabetes and Metabolism
  - Unit for Investigatory Paedoaudiology
- (ii) Units which may be needed for the support of clinical departments, when the existing pre-clinical departments move to Queen Mary College.

It is hoped that in addition it will be possible to build residential flatlets for Hospital and College staff and visitors, and facilities for conferences.

We hope in the coming months to provide further details of developments and also describe the facilities now being built on the Queen Mary College Site.

JOINT PUNCTURE – INDICATIONS, ADVANTAGES, TECHNIQUES AND HAZARDS

By E. C. HUSKISSON and H. W. BALME

In some forms of arthritis the examination of joint fluid is essential for accurate diagnosis, whilst in many it is relatively unhelpful as the changes are somewhat non-specific. We have even known them to be positively misleading. Similarly, joint injection with steroids can be strikingly beneficial in some circumstances yet actually harmful in others. As even puncturing a joint has its risks, especially of sepsis, it is as well to know when to do it and when not.

Indications for Diagnostic Puncture

The sure diagnosis both of septic arthritis and of the crystal deposition diseases depends upon the characteristics of synovial fluid. In septic arthritis the fluid is purulent, containing about 100,000 white cells per cu. mm., predominantly polymorphs; culture should yield the causative organism. The need for immediate and appropriate antibiotic therapy to prevent joint destruction makes joint puncture urgent in every case where infection is suspected. This applies particularly when acute arthritis affects only a single joint. In addition, patients with rheumatoid arthritis have an especial tendency to sepsis in affected joints; it is therefore essential to aspirate a single joint which suddenly becomes increasingly painful and inflamed during the course of the disease. A major snag is that the joint fluid in rheumatoid arthritis is often purulent, with up to 40,000 white cells per cu. mm., and its appearance may be indistinguishable from that of septic arthritis, so that a positive culture is required to establish the presence of infection. Sometimes, unfortunately, so dangerous is infection within a joint that one has to start treatment without a positive culture, especially if antibiotics have recently been given. Staph. aureus is the commonest organism but a number of others may cause an identical clinical picture. There are other infections which cause arthritis and slightly different clinical manifestations, notably gonorrhoea, meningococcal infection, salmonelloses, tuberculosis and brucellosis; again the diagnosis must rest upon the finding of the causative organism in synovial fluid.

In gout and pyrophosphate arthropathy (sometimes known as "pseudogout" though it bears little resemblance to gout in most cases), a rapid and certain diagnosis is made by the identification of crystals in joint fluid. In gout they are needle-shaped and strongly negatively birefringent; in pyrophosphate arthropathy they are smaller with square ends, and weakly positively birefringent. The diagnosis of gout is often incorrectly made on the basis of hyperuricaemia, a common finding in non-gouty individuals, not uncommonly absent in the gouty who may have normal serum uric acid levels especially in their first few attacks. Huskisson and Balme (1972) pointed out that many other conditions may cause the syndrome of acute pain in the big toe (pseudopodagra) and at least two, sarcoidosis and psoriatic arthropathy, are sometimes associated with hyperuricaemia. There is much to be said for aspirating the affected joint in all cases; a rapid and certain diagnosis is a considerable advantage to the physician in managing the case. In pyrophosphate arthropathy, the diagnosis may be suggested by the presence of radiological articular calcification, chondrocalcinosis articularis, but this is also seen in old age, after trauma, in chronic infections such as tuberculosis, tophaceous gout, haemochromatosis and acromegaly. Crystals are as specific for gout and pyrophosphate arthropathy as tubercle bacilli for tuberculosis and upon their identification the diagnosis should be based.

In conditions other than infective arthritis and crystal deposition diseases, synovial fluid is less helpful. Ropes and Bauer (1953) made the important distinction between synovial fluid in inflammatory and non-inflammatory conditions. Normal fluid is clear and viscous, fails to clot on standing and contains less than 1,000 cells per cu. mm. of which most are mononuclear. In inflammatory conditions such as rheumatoid arthritis, synovial fluid loses its normal viscosity and may clot; there is a large increase in polymorphs which may cause turbidity. In non-inflammatory conditions such as osteoarthrosis the fluid resembles normal fluid. Inflammatory fluid is found in conditions such as the

Fig. (i) A needle-shaped urate crystal (polarised light microscopy)

arthritis of ulcerative colitis, ankylosing spondylitis, sarcoidosis and Reiter's disease. Non-inflammatory fluid is found in traumatic arthritis, and degenerative arthropathies such as osteoarthrosis. There is a continuous spectrum of findings, rather than a clear-cut distinction and there are exceptions, notably the arthritis of systemic lupus erythematosus in which the synovial fluid has the characteristics of non-inflammatory fluid (Pekin and Zvaifler, 1970). In rubella arthritis, the fluid has the characteristics of inflammatory fluid but there is a predominance of mononuclear cells (Chambers and Bywaters, 1963). Blood stained xanthochromic fluid is found in haemophilia, other bleeding disorders and sometimes after severe trauma.

The findings of positive tests for rheumatoid factor in cases of seronegative rheumatoid arthritis suggested that this might be a useful diagnostic test but there is an almost equal incidence in other conditions (Huskisson, Hart and Lacey, 1971). In rheumatoid arthritis, complements levels are lower than in other inflammatory conditions (Pekin and Zvaifler, 1964) and in Reiter's disease, they are higher (Pekin, Malinin and Zvaifler, 1967). At the time of aspiration, a synovial biopsy can be taken and is occasionally useful in the diagnosis of rheumatoid or tuberculous arthritis.

Indications for Therapeutic Puncture

Aspiration of fluid is required in septic arthritis and in most cases it is desirable to aspirate daily; if recovery is delayed or aspiration impossible, surgical drainage will be required. Relief of symptoms is sometimes obtained by aspiration of very large tense effusions, for example in rheumatoid arthritis, though the effusion usually returns rapidly. Aspiration in haemophilic arthritis has been shown to speed recovery but is unnecessary and probably best avoided since ultimate recovery is unaffected.

Injection of steroids into joints produces a local anti-inflammatory effect which is particularly useful in chronic conditions such as rheumatoid arthritis for a single joint which remains painful and swollen when disease activity is otherwise controlled. It is also a useful aid to the mobilisation of a stiff joint and to speed recovery in acute pyrophosphate arthropathy when the response to oral anti-inflammatory drugs may be disappointing. There is no indication for injection of steroids into joints affected by osteoarthrosis or other non inflammatory conditions. Injection of antibiotics is usually unnecessary since satisfactory levels of drugs in synovial fluid can be obtained by the oral or intramuscular route. An exception is the need for antibiotics such as Polymyxin which are too toxic for systemic use.

Hazards and Precautions

In good hands, about 1 in 10,000 joint punctures are complicated by septic arthritis, a disaster which must be avoided as far as possible. A strict aseptic technique must be used and the patient must be warned to report at once if exacerbation of symptoms follows joint puncture. Repeated intra-articular steroid injections may lead to destructive changes resembling avascular necrosis, especially in patients who respond well and increase their activities. Rest for 24 hours after puncture and care thereafter should be advised. It is usually unwise to give more than three steroid injections in any one joint. Repeated intra-articular antibiotics cause "post-infectious synovitis", an inflammatory condition which may delay recovery from septic arthritis. Some steroid preparations are crystalline and will cause crystal synovitis resembling gout.

Site and Technique

Any joint can be aspirated and the position and technique have been described by Hollander (1966). Painful inflamed joints for example in gout present no particular problem and the procedure often relieves pain.

What to do with the Fluid

It is unfortunate that in many cases, a correct diagnosis is not made because the correct tests are not carried out on the fluid. After aspiration, the colour, clarity or turbidity, and viscosity of the fluid should be noted. A 2 ml. sample, anticoagulated in a sequestrene tube, is required for a white blood count and differential. Another sample, preferably at least 1 ml. in a sterile container is required for culture; a preliminary gram stain may be very useful in a suspicious case. A wet preparation should be examined by polarised light microscopy for the presence of crystals, using a first order red compensator to determine the positive or negative birefringence of any crystals identified. These three investigations should be routinely requested in all cases. The remaining fluid can be conveniently kept to observe the presence or absence of clot formation. In some cases, it is possible to obtain only a drop or two of fluid which should be left in the syringe and needle; it is possible to culture such a sample and to make a wet preparation for microscopy.

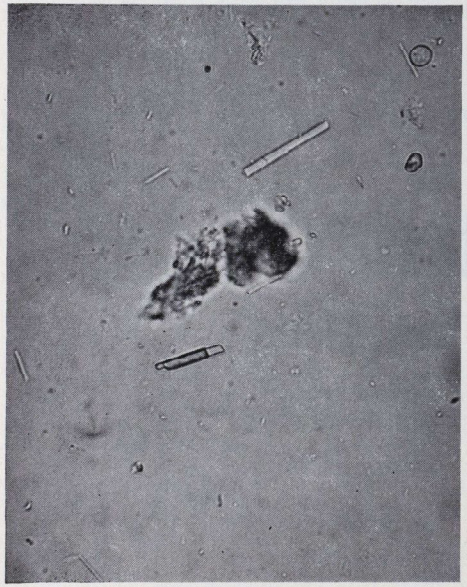


Fig. (ii) Brick-shaped crystals of Calcium pyrophosphate dihydrate (polarised light microscopy)

Summary

Aspiration of fluid is required for the diagnosis of septic arthritis and crystal deposition disease and in the treatment of septic arthritis. A sterile technique is essential. Injection of prednisolone is useful in some conditions.

Aspirated fluid should be divided and dispatched as follows:—

2 ml. in a sequestrene tube to Haematology for W.B.C. and differential.

1 ml. or more in a sterile container to Bacteriology for culture.

1 ml. or more in a sterile container to Rheumatology for crystals.

After aspiration the patient should be advised to rest and to report at once if symptoms increase.

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A RATIONAL APPROACH TO THE TREATMENT OF VASOMOTOR RHINITIS

By D. MACMILLAN, F.R.C.S.

The diagnosis of Vasomotor Rhinitis is at the best a precise label to affix to certain cases of rhinitis whose symptoms are caused by an imbalance (often iatrogenic) of the autonomic nerve supply to the nose. At the worst, it is a diagnosis of the destitute, a rhinological rag-bag into which all patients with inexplicable nasal symptoms are thrown.

Vasomotor rhinitis is a type of perennial rhinitis which is not allergic in origin, and which is not due to sepsis. In this sense it is essentially a diagnosis of exclusion, but from time to time certain aetiological agents may be pin-pointed. The symptoms may mimic allergic rhinitis, with paroxysms of sneezing and watery rhinorrhoea, or may consist of nasal obstruction or a chronic post-nasal drip. Examination of the nose may reveal either a pale, oedematous mucosa or a red congested appearance: nasal polypi are not uncommon. The appearance of the mucosa is identical with that found in allergic rhinitis. In a few cases serum eosinophilia may be found, but this investigation is seldom of diagnostic value in rhinitis.

The term "Vasomotor" suggests that the condition is due to an abnormality of the autonomic system, and in some patients this hypothesis may be substantiated. In all cases the drug treatment is based on the use of substances which act on the autonomic nervous system. The nasal cavity is supplied by both parasympathetic and sympathetic nerves, the former being cholinergic and secretomotor, the latter being adrenergic vasoconstrictor fibres. The parasympathetic fibres are in the majority (Nomura and Matsumra 1972). They originate in the superior salivary nucleus, and travel via the facial nerve and its greater superficial petrosal branch to reach the pterygoid canal. Here they join with the fibres of the deep petrosal nerve (sympathetic from the superior cervical ganglion) to form the nerve of the pterygoid canal, or Vidian nerve*. This nerve passes to the nasal cavity by way of the sphenopalatine ganglion (where the parasympathetic fibres synapse) in the pterygopalatine fossa. Stimulation of the parasympathetic division causes swelling of the nasal mucosa, with sneezing and watery rhinorrhoea (Malcolmson 1959). Cervical sympathectomy leads to nasal congestion (Krajina, Harvey and Ogura 1972) whereas Vidian neurectomy causes a decrease in the nasal secretion and shrinkage of the mucosa.

* after Vidus Vidius, a sixteenth century physician.

Those patients whose symptoms may be attributed to autonomic imbalance are usually receiving drugs for the control of hypertension. Bethanidine and guanethidine are both adrenergic blocking agents, while methyl dopa acts by interfering with the synthesis of noradrenaline. All these drugs may produce nasal obstruction because of unopposed parasympathetic activity. This symptom is occasionally found in patients suffering from myasthenia gravis, who ingest substantial quantities of neostigmine. This drug is an anticholinesterase and therefore potentiates the action of acetyl choline not only on the neuromuscular junction but also on the nasal mucosa. Endocrine imbalance is a frequent cause of vasomotor rhinitis, and many pregnant women suffer from nasal symptoms; conversely, some women are only free of their vasomotor rhinitis when pregnant! The stuffy nose is also common at both puberty and the climacteric, and more recently has been seen in patients taking the contraceptive pill (Alberti & Black 1968); Rees (1964) showed that vasomotor rhinitis is frequently a psychosomatic disorder and many clinicians would confirm this view! Some people appear to have hypersensitive noses, and experience nasal symptoms on exposure to bright lights or sudden changes of temperature and humidity. A few cases of vasomotor rhinitis result from misuse of nasal vasoconstrictor drops and sprays. These agents are extremely valuable in the treatment of acute rhinitis and sinusitis, but their long-term use can result in gross thickening of the nasal mucosa. This condition is termed "vasomotor rhinitis medicamentosa".

The treatment of vasomotor rhinitis has in the past ranged from taking a cold bath, garlic tablets and zinc ionisation of the nose to various forms of allergic mumbo-jumbo. Today, treatment is based on control of the patient's symptoms by:

1. The removal of any causative factor, when this is possible.
2. The prescription of drugs which act on the autonomic system.
3. Corticosteroids (rarely).
4. Surgical operation.

It is usual to begin treatment with antihistamine, regardless of whether the symptoms consist of sneezing, nasal obstruction, or post-nasal drip. The use of antihistamines in a non-allergic condition dates from the days when all evils in ENT which were not due to sepsis, neoplasm, or trauma were attributed to an underlying "allergic diathesis". In allergic rhinitis, antihistamines act by competitively preventing histamine reaching its site of action, but in vasomotor rhinitis they act by virtue of their anticholinergic (atropine-like) side effects.

Antihistamines diminish the nasal secretion and tend to shrink the mucosa: their principal side effects are drowsiness and dry mouth. Most patients respond to one or other of these drugs (there are about forty currently listed in MIMS), and some of the most useful preparations combine an antihistamine with a sympathomimetic substance (e.g. Dimotapp, Actifed). These drugs are very popular with both patients and doctors (they have even been taken to the moon) but one suspects that their composition is something of a pharmacologist's nightmare.

Those patients whose symptoms do not respond to antihistamines require some thought and not a little patience. One's choice of treatment is dictated by the symptoms, rather than by a random selection of another (and then another!) antihistamine. In my experience patients whose main complaint is of nasal obstruction often respond to a sympathomimetic agent such as ephedrine or pseudoephedrine by mouth. Failure to relieve nasal blockage with these preparations is an indication for surgery. For reasons already given, vasoconstrictor drops or sprays should not be prescribed. Patients whose complaint is of post-nasal drip (with little or no sneezing) form the most difficult group. In these cases a "pure" anticholinergic such as propantheline ("probanthine") or deptropine may be prescribed if an antihistamine does not help. These drugs tend to cause a very dry mouth and care must be taken not to prescribe them in patients suffering from glaucoma. Many of these patients find the use of an alkaline nasal douch more helpful than drug treatment. It is better to spend a few minutes explaining to the patient that little can be done for his post-nasal drip than to expect him to attend the clinic at monthly intervals for the prescription of yet another useless antihistamine. Patients are not stupid and most realize when their symptoms are incurable!

More recently some rhinologists have used imipramine in the treatment of resistant cases of vasomotor rhinitis. This tricyclic antidepressant drug has anticholinergic properties and is given in small doses (10 mgm. t.d.s.). This dose is insufficient to have any effect on an underlying depressive illness, and its effect on the nose is usually apparent within twenty-four hours. Imipramine is a valuable addition to our armamentarium.

Corticosteroids are very effective drugs for the treatment of "sneezers", but on the whole the use of steroids in vasomotor rhinitis is like using a sledgehammer to crack a nut. They should be reserved for very resistant cases, and for patients who are about to be subjected to severe stress (such as examinations) when frequent sneezing would be a serious problem. Steroids may be given as nasal drops or as snuff. Dexamethasone snuff is a useful preparation and is said not to cause suprarenal suppression (McAllen 1969).

Disodium cromoglycate (as Rynacrom) has been used in the treatment of allergic rhinitis with favourable results, but it is of little value in vasomotor instability. In a recent series Hopper and Dawson (1972) suggested that patients who respond to this drug are in fact victims of allergic disease.

Surgical treatment is often required for the relief of nasal obstruction. Indeed, there are few patients whose nasal blockage cannot be relieved by a carefully selected operation. Nasal polyps must be removed, and any severe deformity of the septum should be treated by a submucous resection ("S.M.R.") but the most common problem is that of oedematous inferior turbinates. These may be trimmed surgically, or the diathermy may be applied beneath the mucosa to produce scarring and eventual shrinkage ("S.M.D."). In mild cases surface cautery of the turbinates may be performed in the out-patient department using local analgesia. A few cases of severe sneezing and rhinorrhoea are suitable for the operation of Vidian Neurectomy. The patients selected for this form of treatment should be psychiatrically stable and have very severe symptoms uncontrolled by simpler means: few in fact come into this category! The Vidian nerve may be approached via the nasal septum (Minnis and Morrison 1971) or through the posterior wall of the maxillary antrum after a Caldwell-Luc approach (Golding Wood 1970), and good results are claimed (Gregson 1970).

Summary

Vasomotor rhinitis is a common complaint in both the G.P.'s surgery and the ENT department. Careful investigation and treatment planned on a logical basis will relieve most patients of their symptoms, but surgery may be required in some cases. It is a condition to be approached with a little science, considerable enthusiasm, and much patience.

Acknowledgment

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THE WIX PRIZE ESSAY

The Life and Works of Sir James Young Simpson (1811-1870)

By N. STOY

part 3 : THE MAN

James Simpson was born on June 7th, 1811, at Bathgate, a village of handloom weavers and farmers in Linlithgowshire only 18 miles from Edinburgh. A country doctor left us the following laconic description of his birth: "8th child, son. Natus 8 o'clock. Uti veniebam natus. Paid 10s. 6d." From his father, who was the local baker and descendant of a line of farming stock, he was said to have acquired his "self reliance and habits of persevering industry", while from his mother of Huguenot extraction came his mental alertness, sympathetic nature and stubbornness in the cause of right. Probably just as important was the amount of grey matter he inherited from both parents. The size of his head was always noteworthy, prompting the comment of William Makepeace Thackeray that he had "the body of Bacchus and the head of Jove"; at his post-mortem it was revealed that his cerebral convolutions were unusually numerous and, according to a BMJ correspondent, "twisting and turning round on each other, as if they could not find room within the head. The island of Reil was very wonderful."

His early education was favoured by the custom then prevalent among poorer Scottish families of selecting one child for a more complete education with a view to his entering one of the professions. It may have been because of his early promise or because he was the youngest that James Simpson was chosen to represent his family in this way. The privileges that ensued were willing financial support by his older brothers and exemption from working in his father's shop. He probably realised his good fortune for he studied hard at the village school where he soon became the star pupil.

When only fourteen years old Simpson was sent to Edinburgh University to study for the Master of Arts degree. He lodged with two hard-working medical students, John Reid and a Mr. MacArthur, and it is likely that their close proximity was responsible for a change in the direction of his life, for after less than three years extending his knowledge of Latin and Greek, and dabbling in mathematics and moral philosophy, he enrolled for the medical curriculum.

He qualified to practise in 1830, one month short of his nineteenth birthday, but had to be content with a Licentiate of the Edinburgh Royal College of Surgeons as he was too young to gain his M.D. The death of his father in 1830 decided him to apply for a practice in order to contribute to the family resources, but he was disappointed at not being elected to the post which he had chosen; so, still relying on financial assistance from his ever-helpful brother Alexander, he returned to Edinburgh to continue his studies. In 1832 he presented his M.D. thesis "De causa mortis in quibusdam inflammationibus proxima" and took his M.D. degree after a rigorous examination conducted entirely in Latin.

His thesis and inaugural dissertation so impressed the Professor of Pathology, John Thomson, that he gave Simpson an assistant's post in his department; and Thomson it was who soon strongly advised and persuaded Simpson to take up obstetrics as his particular speciality. Once committed to this course Simpson displayed an almost ruthless determination to succeed, and, indeed, the next phase in his life is best considered as a time of preparation and endurance, waiting for the Chair of Midwifery to fall vacant. As he later said himself: "I came to settle down a citizen of Edinburgh, and fight amongst you a hard and uphill battle of life for bread and name and fame!" Obviously at 22 he was far too unknown and inexperienced to apply for the professorship (even by Edinburgh standards!) and it was a fortunate turn of fate that the aging occupant of the Chair of Midwifery, James Hamilton, continued in office for another seven years.

Simpson crammed a lot into this formative period, becoming thoroughly conversant with pathology and midwifery, and a respected teacher of both disciplines. A three-month tour of London and Continental hospitals was undertaken in critical mood. By the end of 1837 he had become "extra-academical" lecturer in midwifery and the coveted Chair was at last in sight. By this time his patience was probably wearing thin, for in pointing out Professor Hamilton to some friends he once commented, "Do you see that old gentleman? Well, that's my gown!" In 1839 Hamilton resigned and Simpson put in his application for the professorship to the Town Council.

Simpson had much in his favour to back up this application—a detailed knowledge of pathology, four or five years practical experience in obstetrics, the publication of a good number of well received papers, and a spell in general practice (in 1832). He now boasted a library and museum worth at least £200 and threw about £500 into his canvassing, preparing seventy testimonials which stressed his academic accomplishments. A hundred and fifty page catalogue of his museum was printed. His attitude to the campaign was straightforward: "Did I not feel that I was the best man for the Chair I would not go in for it."

He expressed his biggest doubts to his brother Alexander in a letter thus: "I have been told by a number of the Council that they have no objection to me but my youth and my celibacy." Although he could do nothing about the former he swiftly countered the latter by announcing his engagement to his second cousin, Jessie Grindlay, whom he had met at the end of his continental tour and with whom he had since been corresponding. Marriage followed on December 26th, 1839, but there was no time just then for the honeymoon! When the day of the election finally arrived amidst mounting excitement on February 4th, 1840, Simpson gained seventeen votes and his final opponent, Dr. Evory Kennedy, of Dublin, sixteen. Jubilant, he began his honeymoon the following day.

To the professorship Simpson brought dedication and perseverance—qualities which he had instilled into himself during his climb to fame. It is probable too that he cherished loftly professional ideals but these were always tempered by a strong sense of realism. The result was a successful practical philosophy. In trying to understand Simpson's character, his addresses to the new graduates of Edinburgh University are worthy of some attention as they give an insight into what he considered should be the aims of all doctors.

The key to success was to build up good habits of work early in professional life. "Let your time be a property of which you are truly avaricious," he said, "and of every item of it be able to render to yourself a proper reckoning." He also warned against entrusting advancement to the "patronage of power and wealth". In his own life Simpson assiduously avoided this pitfall as he knew the consequences: "Young physicians often dream that by extending the circle of their private acquaintances they thus afford themselves the best chance of extending the circle of their private patients. In following out this chimerical view, much invaluable time is frequently lost, and what is worse—habits of indolence and pleasure are often, with fatal effect, substituted for those habits of study and exertion that are above all price."

In spite of or perhaps because of his strong principles, Simpson's thirty years in the Chair of Midwifery were not without their stormy periods. Indeed controversy and clashes of personality were prominent features of medical circles in the nineteenth century. Much of this was bound up with the rapid advance of medicine, for many workers had strong convictions about the direction in which events should be moving; argument also centred on who deserved credit for specific important discoveries. Scotland was particularly prone to such disruptions and they became an integral though not particularly welcome part of Simpson's life. His obituary writer (BMJ. 1870) put it this way: "Born in the land of thistles, and nurtured in a city where controversy and partisanship attain most portentious developments, where elections are always fierce battles, and their intervals times not so much of peace as of preparation, it is not surprising that Sir James had enemies as well as friends." Most of Simpson's serious differences of opinion were with the Professor of Surgery, James Syme.

Syme, the "Napoleon of Surgery", had turned from anatomy to surgery during Simpson's student days and, on being unceremoniously barred from the wards of the Royal Infirmary, had founded a hospital of his own, Minto House. It was soon flourishing and earned him a reputation which placed him in the vanguard of rising surgeons; it seems that his colleagues at the Royal Infirmary now had good cause to worry. By 1833 the Chair of Surgery was his.

Simpson and Syme first crossed swords when the Pathology Chair came up for re-election in 1837. Syme iterated that general pathology was "not only useless but injurious" and mounted a campaign against the continued teaching of pathology as a subject in its own right. He believed that it was best assimilated in the clinical situation alongside the symptoms, signs and treatment of disease processes. Simpson, who had recently been deputy Professor of Pathology, was naturally fundamentally opposed to Syme's point of view. Pathology after all was just beginning to make unprecedented strides (especially at the microscopic level) and the need for its continued existence was almost self-evident. Simpson produced a pamphlet which completely demolished Syme's case and a new Professor of Pathology, William Henderson, was duly instated.

Towards the end of Simpson's life a more serious feud broke out between the rival professors when Simpson was attempting to popularise acupressure. Syme intimated that in promoting this clumsy technique where other methods of haemostasis (such as "torsion" of vessels) were equally effective Simpson was doing a great disservice to surgery. At the heart of the matter was Syme's resentment of a gynaecologist's intrusion into the realms of general surgery and he wrote indignantly to The Lancet (1865). "I have scrupulously avoided any interference with projects relating to other departments of teaching. Thus when it was proposed to accelerate the progress of babies entering the world by applying sucking pumps to their tender scalps, however much commiserating the helpless victim of an inventive genius, I left the matter to my obstetric colleague." When Simpson produced a pamphlet early in 1865 answering the various objections to acupressure, Syme disdainfully tore it up in front of one of his clinical classes and disposed of it in a sawdust box containing surgical remains.

The antagonism between the rival camps was perpetuated even after Simpson's death by his pupil Lawson Tait; his target was Joseph Lister, a protege of Syme's and his successor as Professor of Surgery. Tait (like Simpson) refused to recognise Listerism and, creating rather an artificial distinction between antisepsis which

he opposed and asepsis which he practised, stated on one occasion, " . . . the evil of Lister's teaching has been over and over again instanced by many of his disciples trying to cover faults that could be avoided, by attributing the disaster arising from them to the suppositious germ." Simpson himself was said to have been the author of a bitter letter signed "Chirurgicus" which appeared in the *Edinburgh Daily Review*; it attacked Lister and claimed that carbolic acid was introduced by the Parisian, Lemaire.

Although these clashes could be violent while they lasted, good sense usually prevailed in the end. Thus, despite the fact that Syme was on record as saying that he did not "attach much importance to the extinction of pain during operations", he later became very enthusiastic about anaesthesia and an expert in the administration of chloroform. Similarly when Simpson had a serious abscess of the finger in 1850 he took his wife's advice and asked Syme to perform the necessary surgery. When both Simpson and Syme were united in their aims they were a formidable team, as when they both opposed Hahnemann's system of homeopathy in 1851.

Their immediate object was to oust Professor Henderson who was a recent convert. Ironically Henderson was the man whom Simpson had earlier fought so hard to instate as Professor of Pathology! In the general drive against homeopathy Syme, who believed that rhubarb and soda were the only efficacious drugs, was a useful ally, but Simpson was the chief spokesman. In slating the homeopathic practice of prescribing drugs in doses so minute as to be insignificant he wrote scathingly, " . . . a grain of a drug divided into quintillionths or decillionths might in truth serve an entire race during an entire geological epoch", and he wondered how Edinburgh could support three thriving homeopathic drug establishments! A recent article in the *British Journal of Hospital Medicine* (Oct. 1971) in support of homeopathy reveals that the notions of "vital force", the "potentised remedy" and the "constitutional remedy" still have their adherents today. It mentions that much harm was done to the movement in 1851 when many of the "professional brethren in Edinburgh denounced the entire system as 'quackery, delusion and imposture' and excluded those doctors who practised it from their societies, and treated them as outcasts." It is true that this article has some appealing aspects; equally persuasive however is Simpson's book "Homeopathy: its tenets and tendencies, theoretical, theological and therapeutical" published in 1853. Nearly 300 pages long, it is the result of exhaustive investigations and performs a great service to medicine in advocating a rational approach to therapeutics.

Simpson found respite from his exacting professional undertakings in the company of his family and friends and in the pursuit of antiquarian and archaeological research. If he possessed the art of relaxation it did not take the form of inactivity or laziness for a restless energy and drive pervaded nearly all his waking life. Only the incapacitating pains of angina could slow him down and even then he would embark on exhausting train journeys to visit patients or to look at archaeological sites.

As a young man some of his digressions into poetry show that he was appreciative of women and the diary of his continental tour contained the enthusiastic note that Liege was "full of good-natured gash old wives, and sonsy, laughing-faced, good looking, nay, some of them very good-looking girls", and that he had "not seen one positively ugly face". The claim has been advanced by some that his pupil Lawson Tait may have been his illegitimate son. Certainly there was a strong physical likeness between the two men, and there is no record of Tait's birth having been registered. During the 1830s Simpson was deeply involved in working towards the professorship, but this was apparently not to the detriment of his social life. In 1838 he wrote to Jessie Grindlay, "Last winter was a strange blend of working and romping—of study and idleness—of pleasure and pathology—of lecturing and laughing—of investigating the phenomena of diseases and inner parties—of agues and quadrilles—of insanity and coquetry." Clearly, for Simpson a change was infinitely better than a rest, and it is not surprising that these excesses somewhat undermined his health. Perhaps what he needed was the stability of marriage.

Statue of Simpson in Prince's Street, Edinburgh.

By all accounts Simpson approached wedlock in rather a calculating way but the result was evidently a happy one. Jessie bore Simpson nine children in all, but the death of two in infancy and three as young adults was a grievous loss. As Simpson's fame grew Jessie found an outlet for her talents as hostess to their many guests. In this role she "poured out more tea than any woman in Scotland", and the luncheons at 52 Queen Street became almost legendary. Here there was no class distinction; the "salt of the earth" would sit down with the "savourless" and the rich with the poor, sometimes with some embarrassment until the arrival of Simpson set the wheels of friendship in motion. After thirty-one years of happy, if hectic, married life Jessie died in 1870 within months of her husband.

The products of Simpson's archaeological researches are a most significant part of his total achievements. His magnum opus of 1841 on leprosy and leper hospitals in Scotland and England constitutes a valuable historical record of the disease and is a model of antiquarian research method. It shows too how seriously he took his pleasure as it traces the history of 119 leper houses and lists nearly five hundred references!

His investigations revealed that leprosy was once unknown in Europe but became endemic between the tenth and sixteenth centuries as attested by laws and papal bulls of that period. In Scotland place names containing "lazar" or the prefix "spital" or "spetel" suggested that leper hospitals existed before the time of Robert the Bruce. Robert the Bruce was himself a sufferer and tradition has it that he was the founder of a leper hospital near Prestwick. The Town Records of Edinburgh disclosed that in 1584, on the orders of magistrates, accommodation was found for five lepers in the suburb of Greenside; at the same time two devoted wives volunteered to be shut away with their leprous husbands. Items of legislation of the Scottish Parliament provided further evidence of the disease.

The segregation of affected victims was the avowed object of these earliest hospitals and they were charitable rather than medical institutions. When the Church was the benefactor, lepers often had to regulate their lives according to strict religious formulae. The rules of one establishment contained the following, "Since by the access of women scandal and evils of no slight nature arise, we above all things forbid that any woman enter the hospital of the brothers, with the exception of the common laundress of the house, who must be of mature age and discreet manner of life so that no suspicion can attach to her." Often the inmates had to take vows and for any who stepped out of line, starvation, eviction, birching or the gallows were all employed as methods of punishment. It is interesting that lepers were regarded as dead people by the Civil Law.

"The Antiquarian Notices of Syphilis in Scotland" published in 1862 was the outcome of another Herculean effort. A search of the records of antiquity uncarthed no evidence of syphilis in Greek, Roman or Arabian civilisations and it began to prevail in Europe only in the later years of the fifteenth century when it was given such labels as "morbus novus", "aegritudo in audita" and "novus et nostro orbe incognitus morbus". The first epidemic of syphilis broke out in Naples in 1495 and the disease was carried over Europe by the troops of Charles VIII of France. However, the chief object of Simpson's communication was "to show that the new malady was not long in reaching Scotland".

In the Privy Council Records of 1509 was a case of the "punishment of a medical man in whose hands a dignitary of the church had died while under treatment for syphilis"; the man was banished from the town which Simpson felt to be "a proper punishment for an unprofessional charlatan undertaking the cure of syphilis in the sixteenth century" and he goes on to add that it perhaps "would not be an improper proceeding in this—the nineteenth century".

Syphilis soon acquired notorious fame. It paraded under the new names "gore" and "pox" (corresponding with the French "verole") and "grandgore" and "great pox" (corresponding with the French "grand verole"). The word "brenning" meaning burning referred to gonorrhoea. Such was the superstition surrounding syphilis that women sufferers were burned at the stake. The disease was mentioned time and again in the lines of poets since it was now part of the price to be paid for romanticism:

"In his maist triumph and gloir,
For his reward get the Grandgoir."

Simpson was interested to learn how the transmission of the disease had formerly been explained away. He quotes one, Benedict Victorius of Fienga, who "happened to know some honest and religious nuns, who were confined in the strictest manner and yet contracted the venereal disease from the peculiar state of the air, together with that of the putrid humours and the weakness of their habit of body". Others thought it could be propagated by the breath. Cardinal Wolsey was a notable victim of syphilis, and when he was arraigned by the House of Lords in 1529 one of the gravest allegations against him was that, "knowing himself to have the foul and contagious disease of the great pox", he had come before Henry VIII "rowning in (his) ear and blowing upon (his) most noble Grace with his perilous and infective breath". Simpson himself was well aware of how the disease was spread, as indeed were the Aldermen and Council of Aberdeen, who shrewdly "suspected impure sexual intercourse as the mode of communication of the malady".

Simpson wrote about the Pyramids of Egypt and enquired whether the Roman Army were provided with medical officers. On a visit to the British Museum in 1852 a Greek vase caught his eye; it was a container for "lykion" and stimulated him to yet more research. Whatever writings came from his hand bore the stamp of authority; whatever subject came under his scrutiny was made the focus of exhaustive investigation. Sometimes he wrote to reassure people. A series of lectures collected into the book "The Spiritual Interpretation of Nature" was "addressed to those who in their earlier outlook upon Nature felt sure of her inherent spirituality but latterly have found difficulty in bringing this conception into line with some of the results of modern scientific thought"; it was chiefly concerned with the impact of Darwinian theory. A paper on the alleged infecundity of females born co-twins with males (1844) was written to dispel a damaging superstition amongst the Lothian peasants.

The belief to be countered, that females twinned with males were sterile, was derived from the analogy of the free-martin cow, as pointed out by John Hunter in 1779.

To Simpson's way of thinking the real mischief of the superstition was that a girl might be rejected as a wife "for a defect, or taken for an excellence, according to how sterility might be regarded, which she did not possess . . . " His search for the truth took him both to Edinburgh butchers and into the depths of Roman writings where the word "taurae" may have been synonymous with sterile cows. The records of the human offspring of dissimilar twins which he managed to obtain gave an incidence of female sterility of 1 in 10. When this figure was placed beside the sterility rate of 1 in 10 for the villages of Bathgate and Grangemouth, and of 1 in 6½ for the British Peerage the case was proved. On looking through this paper one can only marvel at its thoroughness. Chassar Moir said of it, "As a perfectly constructed scientific paper I can think of nothing to better this publication by Simpson."

Simpson died on May 6th, 1870, at the age of 58 while still at the peak of his reputation. He had been finally conquered by progressive coronary artery disease and an aneurysm of the heart was later discovered. As the news spread the *Medical Times and Gazette* announced, "One of our greatest men has passed from among us; Simpson is dead!", and medical and popular presses both at home and abroad carried copious laudatory obituaries. On May 13th, the day of the funeral, Edinburgh came to a standstill as a demonstration of heartfelt sorrow and deep respect.

Simpson died, but his teachings were carried on by those who had received the benefits of his instruction. Among them was Matthews Duncan, a pupil and former assistant of Simpson's who on November 4th, 1847, had selected chloroform for his chief to try on the basis of inhaling it himself earlier in the day. On Simpson's death Duncan was high on the list of contenders for the Chair of Midwifery and was understandably distressed when he was passed over in favour of Alexander Russell Simpson (a nephew); but Edinburgh's loss was Bart's gain for seven years later Duncan became Physician-Accoucheur and Lecturer in Midwifery to the hospital. He was an acknowledged expert on infertility in women and indeed on all aspects of midwifery and gynaecology.

The enigmatic Lawson Tait had as a student been taken into Simpson's home and regularly assisted him at operations. He performed his first ovariotomy at 23 and would boast a series of 272 with but twelve deaths. Working in Birmingham, he pioneered exploratory laparotomy. He was the first to operate for ruptured tubal pregnancy, was quick to appreciate that removal of small cystic ovaries would cure menorrhagia and described the condition of pyosalpinx. He was amongst the earliest to remove the inflamed appendix, inflamed ovaries, gallstones and hydatid cysts of the liver. Simpson's campaign for hospital reform was taken up by Tait with a vengeance and he castigated many well-respected hospitals for their appalling death rates. The title page of his "Essay on Hospital Mortality" bears the inscription "To the memory of a great master, James Young Simpson, this effort is dedicated by a grateful pupil"

Another former pupil, J. H. Aveling, gained the distinction of founding two well known women's hospitals, the "Jessop Hospital" at Sheffield and the "Chelsea Hospital for Women"; and there were of course many many more who in their various ways disseminated the fame of the Edinburgh midwifery school.

Recently, in 1970, K. F. Russell and F. M. C. Forster prepared a tribute to commemorate the centenary of Simpson's death, and in it they sum up the essential aspects of his greatness, thus: "Looking back, Simpson achieved so much because he had enthusiasm, perseverance and untold energy and the ability to utilise every moment of his time and needed little rest. He explosively changed obstetrics and gynaecology into modern sciences from the sorry state in which he had met them. He founded a new school of thought and his disciples, enthused by him, went to all parts of the world to carry on his teaching. This is why, above all, we should remember Simpson."

Author's Note

Consideration of "acupressure" and Simpson's important work towards hospital reform has been omitted from this presentation; further details, and references, available from author.

This concludes the abridged Wix Prize Essay by N. Stoy. Part I was printed in December 1972 and Part II in January 1973.

The Photograph of the Suction Tractor in Part II is by kind permission of Professor R. J. Kellar.

PLUS CA CHANGE - PLUS C'EST LA MEME CHOSE

by THEODORE T. SCHOFIELD

During the past decade many changes have occurred in hospital routine and life and senior staff in all branches have shown considerable concern at what has been thought to be a lowering of standards. Having, with regret, had to benefit from surgical interference on four occasions since 1962 and one stay under the care of a physician at another hospital, an assessment of this concern can be judged, both as staff and patient.

In 1962 nursing had not had the impact of Salmon and many highly skilled and able women planned their career to as far as Ward Sister and ruled their ward with almost dictatoral power which was rarely questioned, remaining in their posts until retirement. Undoubtedly these wards were exceedingly well run and many surgeons and physicians must owe much of their success to the high nursing skill practised and taught therein. It is debatable whether or not young nurses in training felt able to approach Sisters of this seniority, although the teaching certainly continued to produce nurses of high standard. Yet one remembers the feeling present in the wards when it was Sister's weekend off and there was some unbending in exactitude of routine. The Sisters worked long hours, often of their own choosing, and delegated responsibility only of necessity. The Sisters not only had the majority of nurse training and teaching to do, but also contributed to student and houseman training, the former of which seemed then to spend considerable time on the wards.

As the decade progressed one was aware that the quantity of nurses was declining, although each individual nurse by effort limited the effect of this on patient wellbeing. Salmon altered the whole structure of patient care and the nursing profession. Time will show if this new structure will attract sufficient recruits to a regimented career ladder as were attracted by the erstwhile "calling" of nursing. The student nurse qualifies after three years' training, much of which is off the wards, a further year to obtain her coveted hospital certificate and then, as a Staff Nurse, gains experience until able to apply for the post of Nursing Officer in charge of a ward, but responsible to a higher officer supervising two or more wards. Thus a Nursing Officer with a ward may well be in her early mid-twenties. This was the new situation met in 1972. The ward discipline was still evident to patients' benefit, but was less dictatorial and obviously student nurses found someone, perhaps six or seven years their senior, far more approachable than someone who, from their youthful outlook, was "elderly". The incomparable skill and unstinted kindness were still taught and practised, but the well merited shortening of the professional hours left the application of these very thin on the ground, especially at nights and weekends. The care of twenty-five beds, after a longish list, must have been a testing time for a third year or new belt and a first year nurse, although the night duty Nursing Officer seemed now to make much more frequent rounds. It would appear that the shortening of hours had not been offset by the increase in numbers and a true shortage had been established.

The institution of the training and employment of State Enrolled Nurses may in future offset this shortage as experience of them should show that, whilst not aspiring to such high academic nursing attainment, they discharge the duties entrusted to them with care and keenness.

The shortage of nurse hours worked undoubtedly must be of concern to all, but the amount of strictly non-nursing duties still carried out by nursing staff is perhaps the most striking factor now. The washing of an extremely sick patient is a skilled nursing duty, but the carrying of water to the bed of an immobile, but almost fit patient, is not. Surely the strict application of nursing skills to nursing duties and the delegation of non-nursing duties to untrained staff must be the only way to maintain high standards of patient care.

Some relief of weekend shortages is offset by the "weekend leave" to almost fit patients or to those being treated by a "Five day department". Chatting with them on their return, one realised that little is done to "de-hospitalise" patients before discharge. The security of hospital routine is suddenly gone and the "6.30 a.m. lights on, 6.45 a.m. tea, wash and 8 a.m. breakfast" is replaced by perhaps two hours wakeful waiting. Should not a much greater effort be made to transfer patients to a minimal care or even zero nursing ward for three to four days before discharge, and would this not again save valuable nursing hours? Shortage of beds and wards may exclude this in practice, but could not the moving of beds within a ward provide an area of zero nursing with almost the same result? A relaxation of the "sanctity" of the ward kitchen would be necessary, but this again would relieve further nursing hour wastage. The new hospital staffing structure is here to stay and, if our high standards are to be maintained, many traditional routines and procedures must be reviewed and abolished if no longer of practical use.

Editor's Note:
Mr. Schofield has experience of Bart's both as a member of staff and as a patient.

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

BEETHOVEN SYMPHONIES

How far the symphony has progressed as an art form may be judged by what is today labelled as a symphony. The latest two examples are Shostakovitch's No. 15—a major masterpiece of beauty and style with recognisable melody and tonality, and Henze's No. 6—a piece for double orchestra with such bizarre instruments as amplified guitars, banjos and marimbas—this work has no recognisable tonality. Both contain quotations from other works—the Shostakovitch has Rossini and Wagner incorporated and the Henze has "Stars in the Night", a song of the National Front in Vietnam and also a Theodorakis tune, composed when the latter was in prison. The change in style in 30 years from Sibelius or Elgar is colossal, but in many ways the change in 10 years from 1800-1810 was even more sensational.

Up to 1800 Haydn and Mozart had extended the symphonic form—the figure of the Jupiter or the intricacies or such a monothematic Haydn movement as the first of symphony No. 95 still sound sensational. Beethoven however, using the same size orchestra, introduced a totally new sound concept. The 1st movement of the Eroica with its power and surge must have appeared quite unbelievably radical, not only for its length (as long as most complete Haydn or Mozart symphonies). It has altered sonata form with its premature recapitulation. Gone is beauty for beauty's sake—instead there is a rugged grandeur. The 5th with its joined 3rd and 4th movement, the use of the trombones in the last movement and then, to cap it all, the 2nd movement recapitulated before the last movement coda must have seemed even more sensational (1807). Perhaps the most controversial (and still so, to some) is the 9th. The last movement with choral finale preceded by a sort of introduction which rejects all previous themes used in the work must have sounded unbelievable. All this composed by a man without the sense of hearing!

Records of all the symphonies are plentiful at all price ranges. Again, sets abound, and the standard comments about no one conductor representing the many faceted genius, are true. However, Otto Klemperer's set of all the symphonies with the Philharmonia Orchestra does represent a very fine bargain. We recently conducted a "double blind" guess the conductor spot—Klemperer's speeds are almost always reasonable—the sole exception is No. 7 which is slow and rather wearing: I find his "Eroica" the best of recorded versions and his No. 2, 4, 5, 8, 9, are highly competitive—all this and many overtures in sound that is reasonable and orchestral playing of style and ruggedness, at £9.99 for nine records is treasure indeed—(HMV SLS 788). Other complete cycles by Schmidt-Isserstedt and Bohm with the Vienna Philharmonic and Karajan with the Berlin Philharmonic are ultimately less satisfying (and dearer!). There is a Toscanini cycle that RCA must reissue, even if sonically it is less than fully competitive, mostly emanating from the notorious studio 8-H with the NBC orchestra. An older recording of No. 7 that dates from 1936 is a superb bargain—relentless and wildly exciting (RCA CDM 1046—82p).

In modern sound, my favourite No. 6 at any price is by the Berlin Philharmonic under Andre Cluytens. This is a performance of great beauty and it has just been reissued on cheap label. The playing is radiant, particularly in the last movement, the peace in the country after the storm is so well caught, the mood is so right. It helps having the Berlin Philharmonic in this work who phrase with such elegance and the recording still is beautiful and luminous (CFP 40017—82p).

Other symphonies are less well catered for on bargain records. No. 5 is badly off—the best is probably the ancient recording of the great Erich Kleiber with the Concertgebouw orchestra—coupled with Mozart No. 40 on (Decca ECS 518—99p), but the sound is bad, despite the excellent performance.

The "Choral" is not well catered for either. It is an awkward work to get onto disc—it runs for about 68 minutes and this means, on a two-sided performance, a break in the slow movement or else a three-sided recording. In fact, one recording manages to get the first three movements complete on one side (39 minutes) but this is its only virtue! Of one record performances, Ansermet's and Kleiber's are both quite good as is Cluytens, but quite good is not enough. Better to pay a bit more. I would buy the superb new recording that Carlo Maria Guilini made last year with the LSO—for £3.50 you get a marvellous 9th with a serene slow movement, fine choral singing, excellent soloists in Robert Tear, John Shirley Quirk, Sheila Armstrong and Anna Reynolds and the best EMI sound I've heard yet. You also get an outstanding No. 8 also—a better buy than the new Decca Solti/Chicago version—(HMV SLS 841).

ALLEGRO.

BOOK REVIEWS

ANAESTHESIOLOGY
A Manual of Concept and Management.
Charles W. Quimby.
Butterworth. London. Appleton-Century-Crofts, New York, 1972.

This is a valuable addition to the library of any junior resident in Anaesthetics who is prepared to adapt to American terminology and accept being termed a "neophyte"!

Quimby adopts a logical scientific approach to all aspects of Anaesthesia, beginning with pre-anaesthetic evaluation and ending with late anaesthetic complications. His aim is to encourage the "neophyte" to analyse each patient and be able to decide on the best form of anaesthesia for him. It is his analytical approach to the subject which differentiates the book from other less stimulating anaesthetic text books.

Some of the theoretical aspects of anaesthesia are dealt with. The chapter dealing with the structure of the anaesthetic machine, patient circuits and vaporization of volatile liquids gives an easily read account of the subject, illustrated with clear, explanatory diagrams. Other chapters deal with the uptake and distribution of anaesthetic agents. An entire chapter is devoted to the need for and the use of feedback from patient monitoring so that the anaesthetic can be adjusted according to the patient's needs.

In summary, this is a valuable book but must be read in conjunction with a pharmacology book as Quimby assumes prior knowledge of the basic pharmacology of the agents used.

SUSAN TAYLOR.

HANDBOOK OF HUMAN EMBROLOGY
Haines and Mohiuddin. Fifth Edition. Churchill Livingstone. £1.50.

This book has already stood the test of time and the fifth edition shows no features which should damage its popularity.

It is neat and well-arranged. It could be said that too much has been attempted but on the other hand it is full of interesting descriptive summaries. One omission which will be popular and which is referred to in one of the prefaces is no doubt the omission of dates and measurements. Indeed they can "distract attention from the sequence of changes", but if squarely faced and introduced in a short separate chapter they would surely add the essentials of time and size which are as important as change of form in getting a whole picture.

Much of the definition of terms is done by diagrams, which is good. Without diagrams some of the early text would be quite lost on the student. Nevertheless there is a certain element of "here it is on a plate—now you get on and swallow it quickly"—about some of the text.

Some of the sections are very concise and contain a large amount of very important material—the sort of meat that experience shows must be fed slowly to the student otherwise he gets an indigestion which will quite spoil the rest of his embryological meal. This remark applies particularly to the very early stages of development. In chapters two and three some of the diagrams become difficult to follow—but indeed diagrams of these stages, indicating three-dimensional happenings, are not easy to evolve in any case. Indeed the book contains many unusual diagrams and one is tempted to wonder whether these are more or less use than the "conventional" ones which we know. It is difficult to judge and perhaps the student is the best judge.

Chapter nine is a particularly good summary for students in those medical schools where study of the pig embryo is still undertaken by individuals—an occupation which sounds time-consuming but which can pay handsome dividends. It is so easy to forget that embryology is a difficult three-dimensional subject to many who learn it, and that a little time, patience and concentration at the early stages can help them to enjoy a subject, exciting in its own right, and essential in the understanding of gross anatomy. This book will certainly help in this respect. The student likes it—and for good reasons not least that the authors are enthusiasts (see their preface) and are also aware of their limitations.

M. M. BULL.

ARITHMETIC IN NURSING
Wm. C. Fream, S.R.N., B.T.A. Revised by R. P. Davies, S.R.N., R.N.T. Price 80p.

It is now eight years since this textbook has been revised. The advancement in prescribing and dispensing of the majority of drugs is considerable. This newly revised edition deals admirably with this advancement. The inclusion of chapters dealing with basic Arithmetical problems provides important and necessary grounding for the learner to build upon.

The student or pupil nurse must be fully aware of the correct drug dosage and calculations of the commonly used drugs in order to practice with safety. To this end this book is dedicated and therefore should be a compulsory inclusion to any nursing library and indeed to any student or pupil nurses' reading list.

ANATOMY AND PHYSIOLOGY FOR NURSES
Kathleen Armstrong. Revised by S. M. Jackson. Pp. 374. Price 90p.

The eighth edition to this important series has been superbly revised by Miss Jackson. The inclusion of additional diagrams enhances the relevant text.

The beginning chapter covering Elementary Physics and Chemistry is always a welcome inclusion for the majority of students. The section suggesting sources of further reading should tempt the more able students to pursue areas of special interest. In view of the low price of this book, I am sure it will remain a popular inclusion to any nursing library.

Mr. A. P. SMITH,
Senior Nursing Officer.

BARTS DRAMA - AUTUMN 1972

Bart's Drama has produced some notable "workshop" productions in the last year or so, each of them distinguished by a simple honesty of approach and based on nicely normal events. But if you're going to have an unscripted play, there's no point in chickening out halfway through the production and strangling it with a definite set of words, actions, etc. And this is what emerged most strongly from Martin Gore's "If Wall's Had Ears . . . ". The actors seemed always torn between trying to be themselves and trying to obey the "tyranny" of the script, only Ben Timmis's liveliness escaping the stiffness and unnaturalness which pervaded the whole show. This problem was compounded by the searing banality of some of the exchanges, particularly the so-called discussion about "serious" music; the subsequent departure of Ben, in high dudgeon, was about the most applaudable act of the play. Confronted with such weakness in texture, the players never really had much of a chance to display either acting or non-acting abilities; this was a pity, because there were occasional moments and gestures which suggested better things.

Following on, we had James Saunder's "Next Time I'll Sing to You", a mad actors' frolic set inside a skull. Rob Robertson and Sarah Robertson excelled in a cast which was talented and confident, but the audience seemed fairly irrelevant to the proceedings. Plotless plays of the semi-absurd with their self-examination and lack of explanation are really a rather specialised genre, great to work on but hard work to watch. There were some good laughs, and plenty of outrageous happenings (when did you last see one play contain scenes both of cricket and copulation?) but come the end my main sensation was one of numbness, both in the brain and in my backside. Bart's Drama are good, their record speaks for that, but they do seem occasionally to misfire on their choice of play. This spring they're doing "Hassan", and with their technical ability there's every reason to look forward to an evening of real theatrical enjoyment.

MAGNI NOMINIS UMBRA.

SPORT

(1) SAILING

Three months have elapsed since the Sailing Club was last in print. This time of year tends to be a quiet time so far as our activities are concerned, but there has been considerable interest shown in the club since last October.

We are delighted to have so many freshers interested. Sailing has been restricted to using the Fireflies on the Welsh Harp Reservoir. We have entered regularly into the University League matches, but have only managed to win one match so far.

The Guinness Cup was eventually sailed on January 20th with wonderful conditions prevailing, wind force 3 and rain! We were beaten by St. Thomas' who lost in the final to Guy's. Many thanks to the brave folk who turned up on that rather bleak day.

Our A.G.M. and Dinner were held around early November. Both were well attended. We are pleased to note the interest nurses are expressing at our Club activities. Our annual Hop was also a considerable success.

We have started our maintenance programme on one of our Enterprise dinghies at College Hall and we would be only too grateful of some extra help with a scraper or paint brush—a minimum duty to pave the way for some glorious summer sailing on the East Coast.

Behind the scenes progress is being made on the new barge as a clubhouse for the United Hospitals Sailing Club. Money is still urgently required and any suggestions as to how to raise it would be welcome. The seventy-seven foot barge will have the steel structural alterations completed by April and it is hoped that it will be ready for use in the summer at Burnham.

Please contact me in College Hall if you would like to know about our plans for the Spring and Summer.

RICHARD WELLS.

(2) HOCKEY — CAMBRIDGE TOUR

TOUR PARTY: R. Ashton, (Capt.) P. Donaldson, T. O'Donovan, R. Morgan, C. Hands, J. Tweedie, P. Savage, J. Smallwood, T. Packer, B. Spencer, M. Ashby, C. Reid, R. Barclay, A. Young.

Results:

vs. Caius (3-3), Trinity (1-0), St. Catherine's (2-2), Selwyn (4-1), A Wanderers XI (3-1)

Summary:

Played 5, Won 3, Drawn 2, Lost 0. Goals For 13, Against 7.

Once again, the people of Cambridge were the unlucky hosts to a Hockey Club tour from Bart's. As usual, it was a quiet, sober and sporting occasion, with the emphasis on early nights and peak physical fitness.

The first game against Caius was a little disappointing, the chances to score were there for the taking, and three of them were taken, but some momentary lapses in defence allowed a mediocre attack to score three goals. What should have been a resounding victory turned out to be a rather hard draw.

The Trinity game turned out to be very hard work indeed; "the boys" were showing obvious strain from the previous night's aquatic activities. The game was won by a classy piece of play involving one James Smallwood and someone called Michael Ashby.

Selwyn were well beaten on the Saturday morning. The arrival of Colin Reid was making an obvious difference to the defence, and the most decisive factor of the tour was his resounding success with short corners, scoring four undisputed goals in all. The Selwyn victory was notable for the fact that they were probably the best side we played; to beat them 4-1 was very good indeed. An excellent display by Andy Young at centre-forward helped to swing the game our way; his memorable goal, and an accidental goal by a staggered Tweedie, sunk a hitherto workmanlike Selwyn side without trace.

The Wanderers game in the afternoon was a fine display of hockey by Bart's. Ashton was outstanding at inside-left, and Young and Smallwood proceeded to pound the Wanderers' defence for most of the game. Tweedie intimated that he had "nothing personal" against the Umpire, with whom he appeared to be acquainted, but was very fed-up with the whole thing.

So the tour ended with two memorable victories, in which much good hockey had been played. As a team building exercise, the tour was not very valuable as at least four regular players did not go. As usual, the tendency was for Bart's to allow the opponents too much time and room to do as they wished, and there seemed to be an obvious weakness in mid-field. The Saturday games, however, were a superb effort in which the very high standard of skills which many of the players have was exhibited to the full. Smallwood was described as "looking quite fancy" by an opponent, and added the icing to the cake throughout the tour. The fact that we played five matches in four days, and were unbeaten, speaks for itself.

(3) RUGBY — HOSPITAL CUP REPORT
BARTS vs. KINGS

Bart's won the right to meet the powerful Westminster XV in the semi-finals of the Hospitals Cup, by beating King's 9-7.

The match was very hard-fought but overall was extremely disappointing, the rugby played by both teams being of poor quality and singularly lacking in inspiration. Bart's should have had the match sewn up by half-time after taking the lead when M. Martin kicked an easy penalty. The pack won a steady stream of possession, pushing the King's pack yards back at every scrum and also winning the loose rucks. Against the run of play King's scored the first try, when their wing forward, Walters, who had an outstanding game, kicked a mishandled ball through and scored in the corner. The try was not converted.

Bart's pressure mounted and on the stroke of half-time, the fly-half John Powell side-stepped inside, passed four men, to score a beautiful try near the posts. Martin converted, after missing two other attempts.

The second-half began by following the same pattern as the first, the front five of the Bart's pack generally playing well as a unit, with J. Capper covering well at number 8. It seemed that Bart's must score again but the movements took so long in building up that King's were able to weather the pressure.

In the last quarter of the game Bart's spirits flagged when the King's team raised their game and began to run everything, supporting each other well and for the first time in the match Bart's looked in trouble. The King's captain, Pugh, kicked a penalty goal which began a period of furious King's pressure until the final whistle, with the tiring Bart's being lucky to hang on.

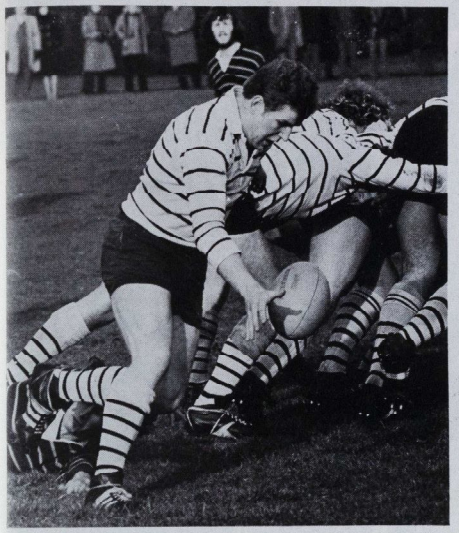
This game should have been won easily, but the questionable Bart's tactics of keeping the ball close to the scrum seemed to bog the whole side down, resulting in a below par performance. When the ball was released to the threequarters, the handling was so bad and the passing so slow, that the King's defence was rarely stretched, and the hard-running Bart's wings, Goddard and Smith, were rarely given the chance to show their speed.

In conclusion, a quote from the captain, Roger Brookstein, probably sums up the match best: "A typical second-round cup game which Bart's tried hard to lose, but were fortunately unsuccessful."

The team:

H. Maurice, J. Goddard, N. Finlay-Shirras, M. Martin, S. Smith, J. Powell, G. Brain, R. M. Brookstein, D. Court, D. F. Badenoch, P. Cooper, A. Wood, D. Elliott, J. Capper, R. Colman.

Photography by E. D. Lacey.



G. Brain kicks from a set scrum.

J. Powell scoring a try.

An attempted tackle by J. B. Goddard.

SAINT BARTHOLOMEW'S HOSPITAL JOURNAL

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Editoral

This month, together with the advent of Mr. Heath's new Eurotax, VAT, comes the announcement by the Chairman of the Students' Union of a proposed new constitution for the Students' Union. These two developments are not entirely unconnected. The Students' Union is registered as a separate organisation, and some of its activities will be subject to VAT. This will have at least one important effect: in future, the Students' Union will have to conduct its financial affairs in a much more professional and business-like manner than in the past. Only recently, any enquiry as to how Union money was being spent produced a reaction more appropriate to some indecent suggestion. Even the minimal requirements of the Constitution concerning publication of reports have not been fulfilled for several years. Hopefully, then, the new Constitution will insist that all the financial dealings of the Students' Union are discussed at a financial meeting once a year and reports of all expenditure published.

The vast majority of Students' Union expenditure is taken up by individual sports and other clubs. These clubs depend entirely on a few individuals who arrange fixtures and meetings and stimulate membership. The amount of money given to each club depends on the combination of the ingenuity of the officers of the club with the ingenuousness of those few who attend the Finance Committee meeting. There is, apparently, enough and more for everyone!

Besides this essentially supervisory function, the Students' Union must operate as an autonomous body to further the interests and welfare of its members. In the past, it has failed to present important issues to the students, and has served simply as an information channel, telling students what has been arranged on their behalf. The announcement about a proposed new curriculum in the Chairman's letter this month exemplifies this in operation. It is not enough to have a few students sitting on a few committees giving opinions based on their own experience or on a recent questionnaire which only a handful of students answered. The Students' Union executive seem to have developed all the machinery for putting views to the medical college without knowing what those views are, or encouraging contributions from the students. As a result, it has become part of the medical college establishment, and any individual student will probably fare at least as well presenting his cause direct to the Dean as he will approaching the Students' Union.

A new Constitution gives an opportunity for the Students' Union executive to revise its position. It must achieve independence of the medical college and responsibly govern its own affairs. It must close the credibility gap between the officers and members so that repetitive letters from the Chairman seeking to justify his existence are no longer necessary. It must stop complaining about apathy among medical students; Bart's students are as committed as any when the right opportunity coincides with the right issue. One's only complaint might be that they voice their ideas and grievances over coffee rather than in a letter to the *Journal*! For a change, let us blame the failure of the Students' Union to present relevant issues to its members so that they feel inclined to turn up to meetings and discuss them. Let us have a much more open style of government—one crowded debate achieves far more than ten committee meetings or sherry-parties. This is a challenge to the Students' Union officers, not an attack on them! They are faced with an opportunity that must not be missed.

THE QUEEN'S ADDRESS AT ST. BARTHOLOMEW'S HOSPITAL 21st MARCH 1973

Photo courtesy of North London News Ltd.

My Lord Mayor, Mr. Treasurer:

I am very pleased to be here today to join in your celebrations of the 850th anniversary of the foundation of the Royal Hospital of St. Bartholomew. Bart's, as it is known throughout the world, has a reputation second to none. The patients can be confident they will receive the best possible treatment, but the Hospital's reputation extends far beyond its walls to wherever there are physicians and surgeons, sisters and nurses, trained here. Your history of service to humanity over eight and a half centuries is a record of which you can be justly proud.

Now you are looking forward to new challenges and I am certain you will surmount them with even greater distinction. When we were all shocked by the explosions in London a fortnight ago, it seemed both appropriate and reassuring to hear that many of the injured were being cared for at Bart's.

It is twelve years since I was last here and this afternoon I am looking forward to seeing some of the developments in the ever widening range of services which you provide.

I congratulate Bart's and all who work here on your notable anniversary and I wish you every success in the future.

On the afternoon of March 21st, Her Majesty the Queen visited Bart's. On a bright Spring day, she drove into a square transformed by extensive preparations; cars had been banned, the North Wing cleaned, the shelters painted, and numerous flowers planted.

Alighting at the James Gibbs entrance to the Great Hall, Her Majesty was met by the Lord Mayor, Lord Mais, the Treasurer and Chairman of the Board of Governors, Mr. R. E. Brook, the Chief Nursing Officer, Miss R. M. Jones, the Chairman of the Medical Council, Mr. D. B. Fraser, and the Clerk to the Governors, Mr. J. W. Gooddy.

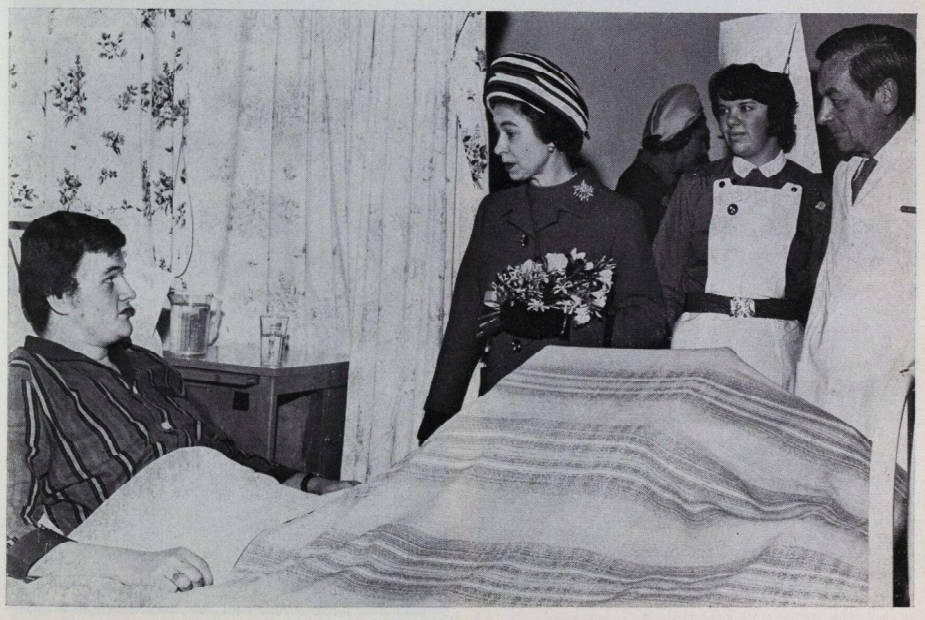
In the Great Hall, Her Majesty was greeted by a large gathering of guests selected from all who work, or have worked, at the Hospital. The Treasurer and Chairman of the Board of Governors made a short address of welcome. Her Majesty's comments on the 850th Anniversary are printed in full on an adjoining page.

Her Majesty unveiled a plaque in the Great Hall inscribed with the following words:

> Her Majesty the Queen visited the Hospital on the occasion of the 850th Anniversary of the Foundation.
>
> 1123 21 March 1973 1973

Her Majesty then left the Great Hall by the main staircase, and passed through a large crowd gathered in the Square, speaking to many, particularly children and others from the wards, on her way. Her Majesty then visited the Orthopaedic wards, James Gibbs and Hogarth, where, by special arrangement, she spoke to some of those injured in the Old Bailey blast. Coming back through the Square, Her Majesty walked around Colston ward, speaking to patients and staff, and then walked across Little Britain to Gloucester Hall where an exhibition of various aspects of the hospital's work was displayed. Her Majesty spent a while talking to those demonstrating at the exhibition, and then left by car from Little Britain.

There can be no question of the success and popularity of this visit from our Sovereign. This was ensured by faultless planning so that all who wished could come close to Her Majesty, by the beautiful weather together with the extensive preparations which made the Square particularly lovely, but principally by Her Majesty's charm and kindness, demonstrated when speaking with many patients and staff of the hospital in what was a very special Bart's occasion.



Her Majesty visits one of the policemen injured in the Old Bailey blast.

Photo courtesy of North London News Ltd.

Her Majesty walks through the Square.

Photo courtesy of North London News Ltd.

Pat Thrower demonstrates audiovisual equipment.

Mr. R. E. Brook escorts Her Majesty round the Exhibition.

Photos courtesy of Dept. of Medical Illustration.

850th ANNIVERSARY - PRESS CONFERENCE

L. to R. Sir George Carroll, Sir James Paterson Ross, Sir Sydney Waterlow, Bart, H.M. Queen Victoria, Mr. James Robinson, Dr. Richard Ellis, and Professor W. G. Spector.

On March 13th, a Press Conference was held in the Great Hall by the 850th Anniversary Committee.

The members of the Press, who were outnumbered by Committee members and Hospital Consultants, included, among others, representatives of the Reader's Digest, Daily Telegraph, Bart's *Journal*, Evening Standard, Reuter's and the B.B.C.

Sir James Paterson Ross opened the conference with an interesting, informative talk about the history of the hospital.

Mr. J. O. Robinson followed with a short talk about the present and future aspects of the hospital.

Professor Spector spoke briefly about the main lines of research at the hospital before inviting various consultants and heads of departments to talk about their own research. This, however, proved to be a mistake because many of the speakers were unable to keep their speeches both brief and comprehensible to non-medical ears.

This resulted in only some of the speakers being called to the platform before this part of the conference was curtailed; unfortunately, not before some of the Press had departed.

Dr. R. Ellis then spoke about the arrangements for the celebration of the anniversary, emphasising that these would be celebrations for the City, and not just for Bart's.

Press sheets giving the text of speeches and details of celebrations were produced, and distributed by a public relations firm.

Sherry was provided before the conference, which was followed by a snack lunch where the Press could meet the speakers.

On the whole, the conference was instructive but far too much time was allowed to the speakers on research at Bart's so that not enough emphasis was attached to the celebrations themselves.

Perhaps the P.R. firm did not appreciate the propensity of clinicians and research workers to talk about their favourite subject when presented with a captive audience of colleagues and Press!

ANNOUNCEMENTS

Deaths

BAKER—On February 3rd, 1973, Edwin Frederick Baker, M.B.B.S. Qualified 1930.

SHERRARD—On January 24th, 1973, Noel Sigismund Sherrard, M.R.C.S.Eng., L.R.C.P. Qualified 1914.

STRANGE—On Februrary 18th, 1973, Edward Howard Strange, M.A., M.R.C.S., L.R.C.P. Qualified 1920.

SMITH—On January 18th, 1973, Dr. N. F. Smith died peacefully in Bart's. He was 82.

Engagement

PALMER—KNIGHT—The engagement is announced between Dr. Bernard V. Palmer and Miss Rosemary Knight.

KING—COOPER—The engagement is announced between Mr. Christopher King and Miss Monica Cooper.

JAKEMAN—LAWRENSON—The engagement is announced between Mr. Paul Jakeman and Miss Nikola Lawrenson.

NICHOLLS—PARRISH—The engagement is announced between Mr. Colin Nicholls and Miss Sue Parrish.

Film Award

The film "William Harvey and the circulation of the blood"—largely made at this Medical College—recently received a gold award from the British Medical Association.

Change of Address

Dr. E. M. Rosser has moved to 25 Rivermill, Grosvenor Road, London SW1 3JN. Tel. 01-828 2146.

Retirement

John Watkins has retired from the Editorship of the *Journal*. The *Journal* staff would like to express their appreciation of his guiding influence over the last few months.

Apologies

In the February *Journal*, we misspelt the name of Miss H. Courtney in the announcement of her marriage.

Also in the February *Journal*, we misspelt the name of the producer of the Theatre Belts show. Our apologies to Miss Mary Bocquet, and to Andante who got it right.

LETTERS

Dear Sir,

Although to the disinterested onlooker, the Students' Union may seem to do very little to justify its existence, I would like to take this opportunity to correct such an impression. Apart from the normal process of representation at council meetings—to which, may I stress, all students are invited—we have undertaken an extensive review of the constitution under which we operate. The Constitution Committee will be proposing some far-reaching changes to an Extraordinary General Meeting during the summer term, and we believe that these changes will carry us through to our amalgamation with OMC and the London.

As regards this joining of the pre-clinical schools, we are in close touch with the Unions at both the other colleges. Meetings have been arranged, and the retiring president of QMC has offered us the use of their facilities. Clubs might be able to make use of their superb gymnasium.

Our other major challenge at the present time is to examine closely the new curriculum which has been prepared by Mr. Fuller, Sub-Dean. We have four student representatives on the curriculum committee, and hope to be able to distribute copies of the proposed changes for general comment.

Finally, I should mention that we seem to be achieving a revival of interest in council meetings, all of which seem to produce some rather emotive debates, particularly, recently on the wine committee and the NUS. We would welcome your views on any subject.

Yours sincerely,
PAUL TAYLOR,
Chairman, Students' Union.

Battle Hospital,
Reading.

Dear Sir,

As a Houseman, my letter to the *Journal* is to focus some attention on a small, but in my view important, gap in the training of Medical Students—The Houseman's care of the dying, in reality.

There has been much idealistic, ethical and moral discussion in the B.M.J. recently about the care of the dying, but basically Housemen, when students, were never instructed on even the basic therapeutic care of the dying. "Keep them happy . . . Brompton . . . Heroin . . . " all mumbled in low tones from the end of the bed, are the introduction and finale to the new Houseman's care of the dying.

One acquires the terminal-care "knack" with time, but occasionally one sees the distressing case die in despair and depression rather than agony.

A few practical ward-round tutorials plus those well attended therapeutic lectures, could relieve the potential suffering of those patients who die in your care while you are acquiring the "knack", or who don't respond to your limited arsenal of terminal drugs.

Yours etc.,
NICK FAIRHURST.

Dear Sir,

I found the articles in the February *Journal* most interesting, in particular Bartholomew Unfair with most of which I had great sympathy; although I think it should be pointed out that the possession of a large amount of factual knowledge is essential to the safe and satisfactory practice of medicine.

I was particularly pleased to see that 100% of students thought that attachment to other hospitals in the second six months was of value—I would agree wholeheartedly with this. At a hospital such as the Prince of Wales where understaffing is a real problem, the addition of one student to the surgical team would markedly raise the standard of patient care. In the process the student could gain a lot of useful experience in patient care, would be able to see operations at close quarters, would see large amounts of good clinical material and would develop a broader outlook on the practice of medicine in this country.

This leads me on to a further suggestion. Perhaps for six months out of every year of their training at Barts the nurses could work as a peripheral London Hospital, thus gaining valuable experience in practical nursing and learning to take responsibility. There is an atrocious lack of staff at, for example, the Prince of Wales such that, despite the high standard of most of the individual nurses, chaotic situations have arisen, even to the extent (when combined with a period when only two porters were available in the whole Hospital) of having to close to all admissions on a Saturday night.

Yet at Barts, particularly in the Q.E.2 block, it is quite common to see several staff nurses on one ward without enough work to keep them occupied. Surely some sort of redistribution would be reasonable.

Yours etc.,
CHARLES J. HINDS.
(H.S. Prince of Wales Hospital,
Tottenham, N.15)

Dear Sir,

I would like to congratulate Allan House and Michael Johnson upon their penetrating and accurate account of student and staff attitudes to teaching (Bartholomew Unfair February, 1973).

Below I have enumerated five points which I believe need looking into and acting upon right now:

(1) A reduction in the number of students per firm. If not by actual reduction in intake, then by increasing use of peripheral hospitals;
(2) Greater efforts to be made in encouraging student participation in patient management;
(3) Staff appointments at Teaching Hospitals to take into account the willingness and where possible the ability, of the intending doctor to teach;
(4) A drastic re-arrangement of the clinical course to avoid such stupidities as having the only elective time available in the final clinical year, when many students, instead of following up an interest or correcting a deficiency, will cram for impending exams;
(5) Greater emphasis being placed on treatment of disease, not as isolated but as it affects the patient within his own particular environment.

Yours etc.,
D. A. ISENBERG.

FROM MR. DONALD FRASER
WAIT FOR IT . . . .

No one ever believes a true story!

Recently, I had occasion to visit a central bank in Milan. While my exchange slip started on its mysterious course in the background, I was invited to take a "comfortable" chair to await my turn at the pay window. The chair was *not* comfortable and the explanation was simple; I was sitting on a gold watch—hunter style—with chain and fob attached.

Having suppressed my first instinct and reported my find, I met an ascending series of officials, culminating in the owner of the watch who had not left the bank. He was a middle-aged oriental—a sunburnt Chinese or perhaps a Thai, with lots of teeth and a pleasant smile and a very deep bow almost to right angles. I could not compete with this latter—too many years of operating with the table at the wrong height and no lateral tilt. The question of reward was waived aside and, with great protestations of mutual regard and a complete failure of communication on both sides, the incident was closed—hardly worthy of the diary I vow to keep and never quite remember.

A few hours later we were tucked into a BEA Trident awaiting take-off for London. This is a magic moment on all flights when minor irritations give way to more fundamental observations on life in general and this one in particular. I fastened my safety belt and looked around for the emergency exit—a wasted exercise anyhow—and whom should I see, two seats away, but my Eastern friend of the morning. I observed "It's a small world" and had I never said it. This was received with a blank look of incomprehension and a little bow modified no doubt by the safety-belt.

"La monde est petite" said I, and a little sigh on my left told me that as usual I had got the genders wrong. How should I know that the French world is masculine—it always seems feminine enough to me! By now I had the smiling attention of all passengers within earshot who also had their grammar problems, but my oriental looked as bland and oriental as ever.

"Il mondo é piccolo" I hurried on and got that right, thanks to Don Camillo, but still no reaction from my friend and a raucous laugh from a nearby holiday-maker.

My audience were all attention now, hanging on my every word, take-off forgotten. The moment of truth had arrived; I was nearing my limits—should I change the endings and hope it might be Spanish, or should I get the correct German from my wife who is ordinarily only too eager to help? She seemed to be troubled by a coughing fit so there was no help there.

"Die welt ist klein" sounds even more stupid than what had gone before, and I had played the fool long enough with communal encouragement.

With shame I have to record that I chickened out and compromised with another restricted little bow. The take-off passed unnoticed and I am told I was quiet almost the whole way back across the channel.

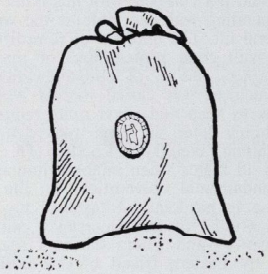
Foreign travel is full of interest and the world is certainly shrinking, but foreign languages should be left to those who understand them.

BART'S NEWS AND VIEWS

850th ANNIVERSARY

In response to the numerous requests from the 850th Anniversary Committee, the *Journal* is pleased to announce the arrangements it has made as regards contributions to the forthcoming celebrations:

1. The recent cleaning of the Hospital has made available many bags of dust, some of which is believed to be well over 700 years old. A limited number of commemorative bags of dirt are available at a cost of £7.50 per 2 lb. bag, each of which is decorated with the Hospital crest.



2. Tickets to meetings of the 850th Anniversary Committee, providing a chance to brush shoulders with the famous and to sample the true atmosphere of Bart's as she has been run for 850 years. At an average of 12 hours per meeting the price of £10 (including refreshments) for a double ticket must be the bargain of the celebrations.
3. The *Journal* is making available a limited number of commemorative beer glasses to mark the part played by Medical Students at Bart's in times past and present. £35 for two.

Illustrations by RUTH.

4. A Grand Competition. We understand that the Committee require a pithy slogan to sum up the whole occasion. The current favourite, "St. Bartholomew's Hospital—healing for 850 years", suggests something more in the line of an unpleasant and poorly treated sore than of a noble tradition justly celebrated. The *Journal* is prepared to offer a Handsome Prize to any who can supply a more suitable (or unsuitable?) slogan: to wit, a free guided tour of the *Journal* office and surrounds. Applications please to Write-a-blurb, *Journal* Office, before the 950th Anniversary.
5. The highlight of the Bartholomew Fair will, no doubt, be the demonstrations of Surgery through the ages. Mr. James Robinson will be CUTTING for STONE, BLEEDING, CUPPING, etc., using the instruments of the time, and wearing the authentic frock-coat and sword of Percival Pott. Six strong volunteers are needed as assistants. Meanwhile at College Hall, visitors may pay £4 per head to see the "Inmates of Bedlam" exhibition.
6. ANDY GEORGEHOLE'S "FLASH".
   A film has been specially made to celebrate the 850th Anniversary and has received glowing praise from few of the country's leading Actors and Critics. It will be shown in a cinema specially constructed on the site of the Hospital (see next issue for 850th Anniversary Stones announcement). The film is a celebration of the Hospital's 850 years, but concentrates on one man who was the greatest, if not the only medical student ever to have worked at Bart's—Jesse Flash. By discovering that the body circulates round the blood, he shattered the theories and philosophies of William Harvey. The film is a collection of scenes of the life of a present-day medical student, showing him asleep at lectures, on ward-rounds, in tutorials, etc. Tickets, costing £20, £30, and 5p obtainable from the *Journal*.

CAR BAR

The programme of cleaning of the Hospital Buildings indicates that the powers that be are concerned about improving the appearance of the Hospital. It has been said before in the *Journal* that the square would be a peaceful and attractive place if only cars were not allowed to be parked there. Perhaps now at last this happy situation could be achieved. Plans are already being made by the Labour group of the G.L.C. for the banning of private cars from Central London. In any event parking space is available on land at Charterhouse which is now used as a car park by N.C.P. The square could then be grassed over or in some other way made a more pleasant place and used for the patients and others in the Hospital.

We note that Professor Lawther has recently been watching the cleaning of the hospital with some interest. If this is a professional concern he is likely to be well pleased, for the workers are well equipped with dust-excluding "space helmets'. Perhaps he should pay more heed to his own peril, lest he contract the dreaded "Spectator's Lung".

"PIGGY BACK" PATELLA

By S. C. CHEN and R. M. KAHANE

Introduction

Anomalies of ossification of the patella can occur; bipartite and even tripartite patellae are common. However, double patellae in the coronal plane are very rare.

Wutschke (1966) in a review of this anomaly reported five cases in the world literature of duplication of the patella, the bone elements being vertically situated.

A search of the English literature for reports of this rare congenital anomaly of double patellae in the coronal plane, has been unsuccessful.

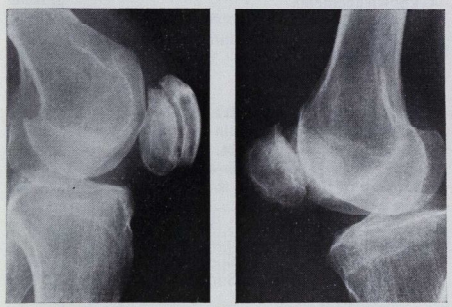


Fig. 1. Lateral views to show double patellae.

Case Report

A 46-year-old male presented with instability of both knees of five years' duration, the right knee being more affected than the left. About 12 months ago he fell from a ladder injuring his right knee. Since this accident the instability in this knee had got worse. He had always noticed large knee caps all his life, but his knees had never locked or given way before. He had no affections of any other joints. There was no previous history of trauma to either knee and no family history of any similar knee trouble.

On examination, the patellae could be made to subluxate laterally, especially on the right, and were larger than normal. There was a full range of movements in both knees, but with marked patello-femoral crepitus. He had bilateral genu valgum of 20°. There was no effusion and no ligamentous instability in either knee.

Lateral and skyline radiographs of his knees showed double patellae in the coronal plane (figures 1 and 2). A diagnosis of bilateral duplication of the patellae with recurrent subluxation and secondary osteoarthrosis was made.

His right knee was operated upon. The insertion of the patellar tendon was lateral to the tibial tubercle. A large patella was situated in front of a smaller one with a joint space between the two (fig. 3). Both patellae were attached superiorly and inferiorly to the quadriceps mechanism. The patellar surface of the femoral condyles showed osteoarthrosic changes.

The duplicated patella was removed and the tibial tubercle with the insertion of the patellar tendon were transplanted distally and medially. The patient was ambulant with his right leg in a plaster cylinder for six weeks followed by mobilisation exercises to his right knee.

He was back at work four months after the operation. At one year he had no symptoms of instability or pain in his right knee, which had a range of movements of 0-140°. His left knee had settled down since the operation on his other knee and does not bother him very much.

Discussion

The patella is preformed in cartilage at about the third month of intra-uterine life. It is cartilaginous at birth. Several bony granules appear and coalesce to form an ossific centre which appears in the third year in girls and in the fourth year in boys. Multipolar ossification is a common radiological finding in young children but

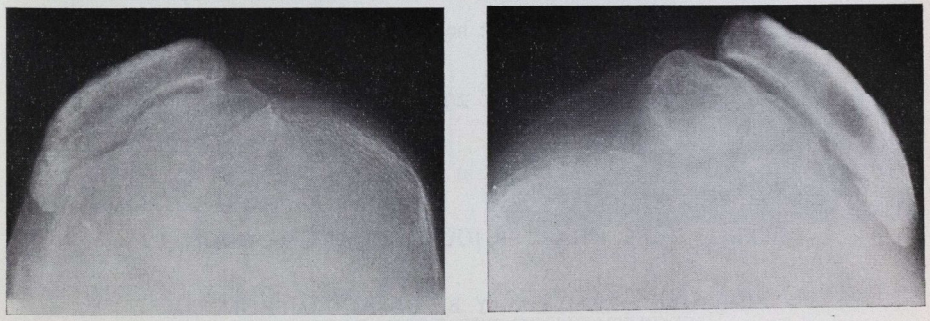


Fig. 2. Skyline views to show double patellae with lateral displacement of the anterior patellae.

in the majority of cases ossification slowly extends to form a single patella at about puberty. However these multiple ossific centres may persist and give rise to anomalies of development.

The main arteries enter at the centre and the inferior pole of the patella and this pattern persists throughout life (Crock 1962). Furthermore, the lateral aspect of the patella has an inadequate blood supply, which may account for anomalies of ossification to occur at the superolateral angle (Crock 1967 and Scapinelli 1967).

Double patellae may also result from traction lesions of the patella either at the superior or the inferior pole (Sinding Larsen Johansson disease) when secondary ossification can give rise to accessory patellae.

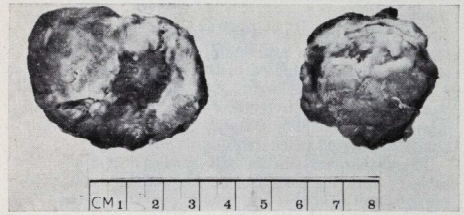


Fig. 3. Double patellae to show the articular surfaces between the two.

The aetiology of the "piggy back" patella (double patella in the coronal plane) is unknown. A bilateral anomaly, as in this case report, indicates a congenital origin. It may be due to ossification proceeding to form two separate patellae, as a result of a shearing force between the two. This could also explain the presence of a joint space between the two.

Unlike the common anomaly of bipartite patella, this rare anomaly appears to be associated with disorders of the knee joint such as recurrent subluxation of the patella and secondary osteoarthrosis.

The term "piggy back" despite its childhood connotations, appeared to be a good description of this anomaly in view of its brevity and clarity of meaning.

Acknowledgements

We would like to thank Mr. D. F. Ellison Nash, F.R.C.S. and Mr. C. W. Manning, F.R.C.S. for permission to publish their case.

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JOURNAL ARCHITECTURAL AWARD

Journal prize for Architectural Achievement In 1973 has been awarded already to the team responsible for the upgrading of the Nurses' Canteen in the basement of the Hospital. In a radical re-analysis of previously sacrosanct concepts of space and time in the field of catering, they have launched a bold experiment in a hitherto little-explored area. Recent research suggests that as much as one-third of available floor space is not in active use, and up to half of the time spent in the canteen is spent in obtaining food and drink. This compares favourably with similar establishments elsewhere, where the vast majority of time and space is occupied by people uselessly sitting, eating, drinking and talking.

This interesting phenomenon is made possible by a revolutionary new space flow technique, the basic principle of which may best be illustrated by a ground-map of the area:

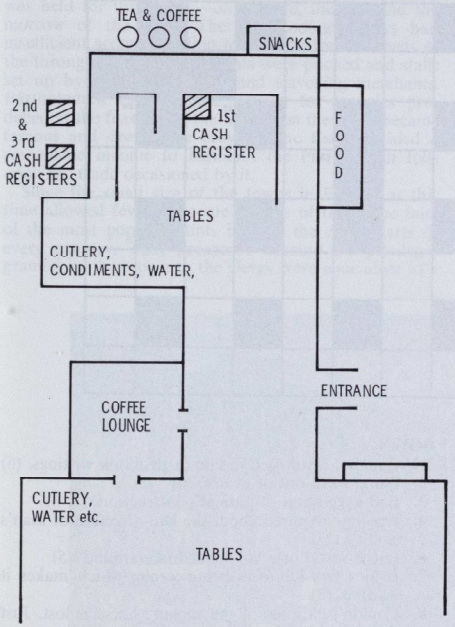
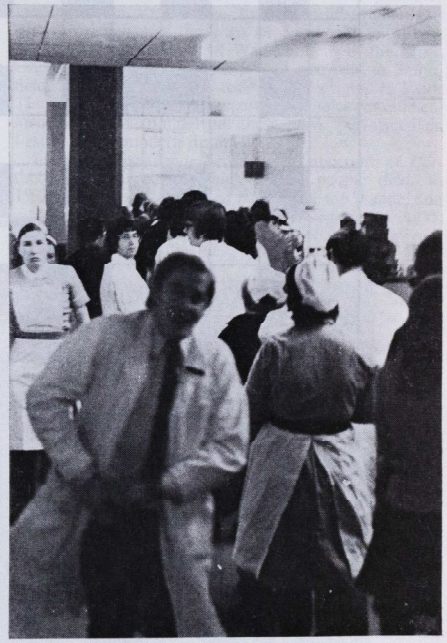


Diagram courtesy of Medical Illustration Dept.

Noteworthy Points

1. The "single stream" principle. No outmoded fast and slow lanes here, no quick dashes for a cup of coffee or sandwich—"push or wait" is the gritty motto of the Seventies.
2. Clever situation of the 1st cash register. No long queues here—it is impossible for more than one person to wait at a time.
3. Clever situation of 2nd and 3rd cash registers. "Alternate flow" principle means that either customers at the third register prevent passage of those who have paid at the second, or that customers paying at the second block access to the third.
4. "Spacial disorientation" principle applied to condiments. Access only available to three or four people holding trays in one hand. Food must then be taken to the table and a return journey made for water and cutlery.
5. Interesting scenic walk to the far end of the Dining Room where the majority of the tables are. Cold food is good food.

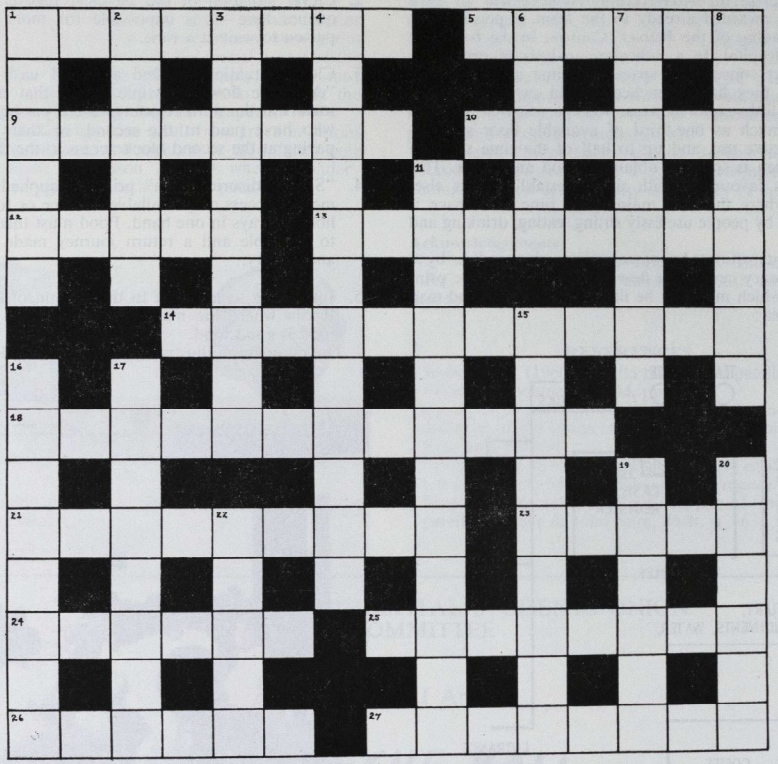
The photograph illustrates the system in full "swing".



Photograph courtesy of Gerard Bulger.

P.S. Gourmets might like to note that although the Dining Room has three relatively separate compartments, none cater for non-smokers. Even British Rail manages a better average than this.

JOURNAL CROSSWORD - No. 1 by DOGSBODY



ACROSS

1. A hundred and fifty in one small state after leaving Charterhouse? (8)
5. Claimed wrongly that I had been left out and became soothed. (6)
9. Determined classical things round instrument. (8)
10. Bores and becomes ill with Doctors all around. (6)
12. Measure, terminate and correct. (5)
13. Burnt, ails badly—do this to make things worse (3, 4, 2)
14. Be utterly wrong. (12)
18. Severe cold might send you there. (2, 3, 7)
21. The little man is all wrong. It is illegitimate. (4, 5)
23. A side number, a larger relating to axes. (5)
24. Make certain the answer has points about the old city. (6)
25. Study of groovy numbers. (8)
26. Mis-stated but tried. (6)
27. Rationalised one found in awkward dares. (8)

Solution on Page 112

DOWN

1. External layer seen in laic or textbook writings. (6)
2. Came forth out of disuse. (6)
3. Bad suggestion of patient's instruction. (3, 6)
4. Apology required about the bad direction of man's study. (12)
6. Large vessel or a volunteer force around. (5)
7. It aint two numbers being wrong which makes it warlike. (8)
8. Couldn't care less if the rocking horse is lost. Just dig one up. (8)
11. Zeis. Out of all proportion. (8, 4)
15. Machinists music on the hills. (9)
16. Harsh crying a short way clear of the Hosp. Dept. (8)
17. Heart-trouble cause is "Rolling" stones. (8)
19. Down is in reject. (6)
20. Took part in sound of fabric. (6)
22. In the end this would be eleven. (5)

BARTHOLOMEW FAIR

By JACKIE HEATH

Now the Fair's a-filling;
O, for a tune to startle
the birds o' the booths here billing
Yearly with old Saint Bartle!
Buy any ballads, new ballads?
Ben Jonson—"Bartholomew Fair"

The first document mentioning the Fair was the Charter of 1133 granted to Rahere by Henry the First, confirming the privileges and possessions of the priory. It stated, "I grant also my firm peace and the fullest privileges to all persons coming to and returning from the Fair of Saint Bartholomew." The first fairs were formed by the gathering of worshippers about sacred places, especially about the walls of abbeys on the feast-days of the Saints enshrined within them. The 24th day of August was the day of Saint Bartholomew, and the fair was held for three days—on the eve, the day and the morrow of the feast. The surrounding district had insufficient accommodation to provide for the needs of the throng assembled, thus tents were pitched and stalls set up by provision dealers and travelling merchants. Bartholomew Fair became renown for miracles produced at the feast—and the institution therefore became famous and drew large crowds. The Fair provided a reasonable income to maintain the Priory from tolls upon the trade occasioned by it.

Since the small size of the towns in Europe at this time allowed few to become centres of trade, the fairs of the most popular saints became the chief marts of every country. They prospered because the privileges granted by the crown to the clergy were equivalent to a concession of free trade, through the midst of a wilderness of taxes. In King John's reign, although livestock, pewter, leather and other articles were traded, cloth ranked first, and Bartholomew Fair became an important cloth fair of England. Fairs continued to be important resorts of trade for many centuries, and stewards of country houses made annual purchases of household stores there. All trade in surrounding shops and markets was forbidden by law for the duration of the fair, and at each there was a special court of prompt justice, called Pie Poudre court, that in later years was held in the Hand & Shears inn.

To add to the attractions of the fair, and to induce the rich to resort to it with full purse, amusements were introduced. The best entertainment in early years, fit for Royalty, was to be found amongst the tents of Bartholomew Fair. An execution during fair-time was a rare entertainment for the public—however, on the Eve of St. Bartholomew in 1305, the traders and pleasure-seekers, friars and jesters, tumblers and walkers-on-stilts hurried across the grass of Smithfield to witness the barbarous execution of Wallace, hero of the Scots. Great tournaments and jousts were also held in Smithfield. Dramatic literature, too, had its origins in Fairs. The Church established a repertoire of tales for enlivenment of sermons, and from these plays, performed on Festival days, modern drama evolved.

In 1348, a pestilence broke out at the time of Bartholomew Fair, from which 50,000 people died. In 1593 the fair was suspended because of the Plague, and in 1603 King James 1st forbade it again. In 1625, Charles 1st announced that to prevent further spread-

BARTHOLOMEW FAIR painting by Charles Green, R.I. circa 1840-98.

ing of the Plague, remembering that there were two fairs of special note, unto which there was usually extraordinary resort *out of all parts of the Kingdom*: one called Bartholomew Fair and the other Stourbridge; all subjects were forbidden to resort to either of the said fairs. In 1665, Plague was rampant and there was no fair, and the following year, although the plague had abated, the holding of Bartholomew Fair was thought unsafe. In September 1666, the Great Fire of London occurred, and at the Fair the year after, Samuel Pepys recorded "Went twice round Bartholomew Fair, which I was glad to see again, after two years missing it by the Plague."

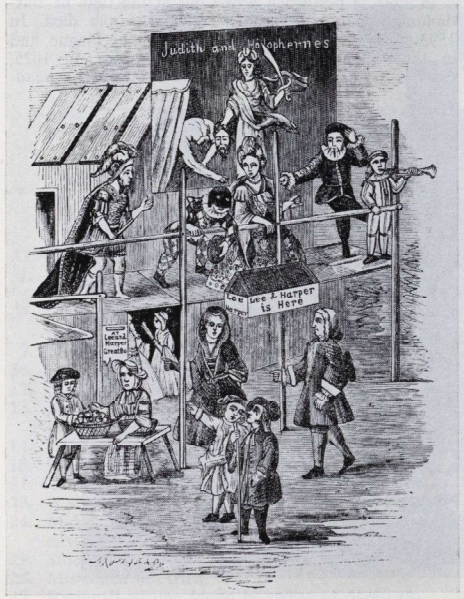
In May 1539, Henry the Eighth ordered the surrender of religious houses, and St. Bartholomew the Great and the tolls of the fair within its enclosure was awarded to Sir Richard Rich. It remained in the possession of his descendants for centuries.

Bartholomew Fair, as a great meeting place of people from all over England, was also used as a political platform. In 1649, the year of Charles 1st's execution, Royalist pamphlets were distributed at the Fair, and there is evidence that such pamphlets had been used before this date. The Fair appeared to hold its own while the playhouses were silenced by the puritans, and in 1660 it was extended to a fortnight's riot of amusement.

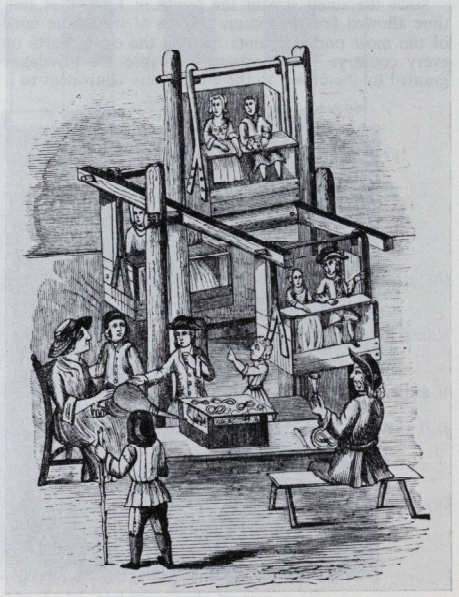
"Bartholomew Fair" by Ben Jonson was first acted in 1614. Many years later, Samuel Pepys chuckled with the multitudes over Fat Ursula the Pigwoman, Adam Overdo, the judge of Pie Powders, Bartholomew Cokes, and Rabbi Zeal-of-the-Land Busy, and remarked: "It is an excellent play. The more I see of it, the more I love the wit of it." Another popular amusement of the Fair was the exhibition of monsters, giants and dwarfs. In 1668, Samuel Pepys was much struck by Jacob Hall's dancing of the ropes at Bartholomew Fair, and recorded "A thing worth seeing, and mightily followed". From 1727 to 1737, Fielding put on plays of high standard in his booth, including Shakespeare and Molière, which even royalty attended. But soon after this time, no dramatists of note appeared, Killigrew and Davenant received patents to build new theatres, and the standards of the Fair sank lower and lower, until the English Stage parted entirely from the story of Bartholomew Fair.

The trade of the Fair became choked by excessive development as a pleasure festival. In 1708, the Council stated that by "erecting booths of extraordinary largeness, not occupied by merchants proper for a fair, but chiefly for stage-plays and musick, lewdness and debauchery have apparently increased", and restricted the Fair again to three days. Every thief in London seemed to regard the fair as an annual performance for his own benefit. In 1776, the Mayor of London refused to allow booths to be erected and in retaliation, a mob broke nearly every window in Smithfield. The Fair ceased to attract fashionable company, and hundreds of prominent citizens of Smithfield protested to the Mayor of its disorder. The Fair consisted now of bawdy theatrical booths, exhibitions of monsters, swings and gambling. During one morning alone in September 1815, 45 cases of felony, misdemeanor and assault committed at the Fair were heard. In 1830, a committee was appointed to investigate under what Charter the Fair was held, and what means could be adopted for the speedy abolition of this scandalous nuisance. The descendants of Rich were persuaded to sell to the Corporation the old Priory rights. In 1839, to prevent the most profligate vices of every kind, the City Solicitor recommended the Fair be shortened to two days, all theatrical representation be excluded, and the rents be doubled each year to discourage stallholders. Soon, only gingerbread sellers were left. In 1854, the last entry of Pie Powders Court book stated "The Mayor not having proclaimed Bartholomew Fair, the Court consequently was not held."

The festival was maintained for seven centuries in England. As knowledge advanced and refinement spread, better enjoyments than the Fair could offer detracted from it. And, as it had long ceased to be a centre of trade, so also it was outgrown by the people as a haunt of pleasure and thus vanished from the midst of London.



Lee and Harper's Booth 1728 by J. F. Setchel.



The Ups and Downs 1728 by J. F. Setchel.

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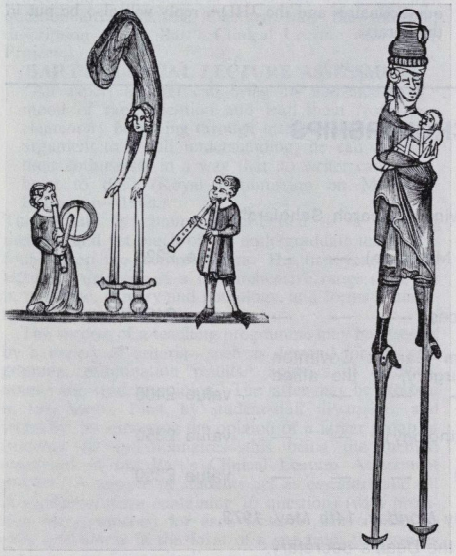

Female Tumbler and Stilt Walker of 13th Century.

Pickpockets at work at Bartholomew Fair 1739.

JOBS AND DOUBLE BEDS

By A. J. SEARLE

As a student, one often gets the impression that married accommodation for housemen is scarce throughout the country, especially so in London, and that the facilities provided at Bart's itself (where over 50 per cent. of the final year may be married) reflect the general availability of such accommodation throughout the whole country. In order to clarify this matter, the *Journal* sent a circular to 55 hospitals, enquiring about the availability of married accommodation for pre-registration housemen. The hospitals selected were all those in the Bart's group, plus hospitals selected throughout England, mainly in small towns, and which were unlikely to be associated with any other medical school. They were chosen from the BMSA Handbook, "Directory of Student Appointments". Hospitals in Wales were not included since they give details of married accommodation in their advertisements for jobs, and also, all the posts in Wales are now linked to a computer scheme, which means that you should have applied last November for jobs in August '73 and February '74!

One month later, 37 replies had been received. This represented, approximately, a 50 per cent. response by the Bart's group and a 75 per cent. response by the others. Ten of these replies were unsatisfactory either because they had no pre-registration jobs, were linked to other medical schools, or had no married accommodation.

Most of the remainder provided some useful information, and showed varying degrees of flexibility and willingness to help. Some put housemen at the top of their priority list for married accommodation, others put them at the bottom.

Not all stipulated the charges for this accommodation, but of those who did, it varied between £10 and £40 per month with most being about £20.

The circular also enquired whether there were any posts available for those students married to others in the same year, and whether these jobs had coinciding duty times and could be rotated. Several hospitals said that this could be arranged. However, it seems that, although both partners would be working in the hospital, they may have to pay for married accommodation, although individually they would be entitled to free accommodation. A letter has been sent to the JHDA enquiring about their policy on this matter, but, unfortunately, a reply has not been received at the time of going to press. It seems likely though, that these married housemen would have to make do with two single rooms, hopefully adjoining, if they wanted to avoid paying for their accommodation. Alternatively, they may be able to pay for married accommodation and also demand the extra free single room to which they are entitled.

The times of commencement of the jobs were also asked for and most hospitals gave these. A few also mentioned SHO jobs coinciding with pre-registration jobs.

Further details about these hospitals can be found in the "Hospital Gazetteer", the most recent edition of which should soon be in the library. The returned questionnaires and the JHDA reply will also be put in the library.

RESEARCH SCHOLARSHIPS

Applications are invited for the following Research Scholarships:

Baly Research Scholarship (Clinical Medicine) — — value £225

Cattlin Research Fellowship (Medicine, Surgery or the allied sciences) — — — value £450

James & Henry Cooper and William Garlick Coventon Research Scholarship (Medicine, Surgery, or the allied sciences) — — — — — — — value £400

Lawrence Research Scholarship (Pathology) — — value £350

Luther Holden Scholarship (Surgery) — — — value £350

Applications should reach the Dean by *Monday, 14th May, 1973.*

Further details may be obtained from the Dean's Secretary.

TEACHING ENTHUSIASM

By COLIN LEWIS
Vice-chairman, Students' Union Teaching Committee

The essential aim of the Students' Union Teaching Committee is to express to the academic staff and college authorities the opinion of students about the numerous aspects of teaching in the Medical College. There are two main ways through which student opinion may be obtained: One is through the spontaneous interest shown by students in their teaching, resulting in direct communication back to the teaching committee on all topics of medical education. Unfortunately, very few students do volunteer their views to the teaching committee about the medical teaching that they receive. The second way is more successful and examines specific areas of teaching by means of a questionnaire survey of student opinion. However, the percentage of the issued questionnaires returned is embarrassingly small and very disheartening to the team who have put much work into designing the forms and who then chase up people to exhort them to fill in the forms. The information gained from the survey can be very valuable and greatly appreciated when presented to the relevant teaching department. The results of the 1st year questionnaire were published in February (Bart's *Journal*). Soon the data evaluated from the Obstetric course survey, and medical/surgical firm survey will be available for inspection by staff and students. A rather more specialised survey was undertaken into the 1st year clinical lectures (October to December 1972). Initially, 30 people were eager to help in this project and each student in the sample was issued with questionnaires (fig. 1), together with the following description of the Bart's Clinical Lecture Assessment Project:

BART'S CLINICAL LECTURE ASSESSMENT

"An expert lecturer can bring his audience to a mood of rapt attention and lead them from an elementary beginning through increasingly intricate argument to a full understanding; he can arouse their enthusiasm in a way that no writer can ever hope to do." (Royal Commission on Medical Education—1968.)

The lecture is commonly criticised as a teaching method, and yet much of the undergraduate teaching is founded on the lecture system. The first year clinical lecture course covers a comprehensive range of topics in medicine, surgery and pathology, and forms a fundamental part of the course.

The success of a teaching programme may be assessed by a variety of criteria—such as demand for the programme, examination results,[1] analysis of students' notes,[2] and student opinion.[3] The latter may be assessed in two ways: First, by student-staff discussion, and secondly, by surveying the opinion of a larger group of students via questionnaires—this being the method employed in the Bart's Clinical Lecture Assessment project: A sample of students act as assessors and fill in a questionnaire containing 10 questions (with provision for comments) for each lecturer. The answer to each question is in the form of a spectrum that ranges between two "opposites", e.g., good to poor. The five possibilities within the spectrum means that a score is assigned to each answer, i.e. 1 (minimum) to 5 (maximum), thus simplifying data handling. Finally the completed questionnaires for each lecturer are computer-analysed and a confidential summary produced which can then be presented to the lecturer.

1. Did the lecturer make the subject relevant to you for your medical career ?
2. Was the lecture presented in a sequential / orderly manner ?
3. Did the lecturer clearly explain all his points ?
4. Did the lecturer respond to the audience ?
5. Did the lecturer suggest any articles / papers / books for further reading ?
6. Lecturer's acting ability ?
7. Lecturer's sense of humour ?
8. Speed of lecture delivery.
9. Visual presentation – slides, film, blackboard, overhead projector.

Fig. 1. Part of the Questionnaire.

The main aim of the project is to analyse the features of a lecture that make it "good" or "bad" by means of observed criteria.[4] This analysis forms valuable feedback to the lecturer of student opinion.

The questionnaire method can be criticised in that the sample of students tends to be biased towards a keen set; because the assessors are volunteers and obviously students who do not attend lectures are excluded from the project. The number of students taking part number between 25-30 and this has been shown

to be an adequate sample. The number of question criteria (10) has been kept to a minimum in order to produce an attractive form that is easily completed. The reliability of the questionnaire method of lecture assessment has been proven by a recent survey.[5,6]

Only 15 students consistently filled in the questionnaires from the original 30-strong eager sample. It is a disappointingly small sample for any statistical analysis—so this has not been attempted. Some of the students who dropped out of the original sample said that they had stopped attending lectures regularly because lectures were presented very poorly. Individual summaries for each lecturer have been prepared and returned to each of the lecturers assessed.

There are two important committees both of which require and act upon student opinion. One is the student/staff committee which meets to discuss all matters concerning medical education at Bart's at present—i.e., liaison between student and teacher. The other is the curriculum committee which is a newly-formed body to consider Mr. Fuller's new medical curriculum. Details of this new curriculum will be circulated presently together with questionnaires inviting comments about our present medical course and what changes students would like to see. Such a newly-organised clinical curriculum will solve many of the grievances mentioned in "Bartholomew Unfair" (Bart's *Journal*, February). This article adopted a very critical approach to teaching at Bart's, and I was disappointed that the authors did not suggest some more constructive comments. However, the authors did hint at a very important constructive METHOD of looking at medical education—medical OBJECTIVES. This concept merits special consideration and is discussed further in the following article. A new curriculum viewed through the medical "Objectivescope" provides an exciting basis for a first-class medical course at Bart's. It is up to the college authorities, teaching staff, and others to design the curriculum BUT taking into consideration the recommendations of student opinion. I hope that this student opinion will be critical, constructive and even complimentary towards future teaching at Bart's and that students will be very forthcoming and enthusiastic so that we can dispel the image of "Apathetic Students".

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2 Hartley, J. and Cameron, A. (1967). Some observations on the efficiency of lecturing. Educ. Review **20** (i), pp. 30-37.

3 Gauvain, S. (1968). The use of student opinion in the quality control of teaching. Brit. J. Med. Educ. **2,** pp. 55-62.

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5 Cooper B. and Foy, J. M. (1967). Evaluating the effectiveness of lectures. Univ. Quat. **21** (2), pp. 182-185.

6 Foy, J. M. (1969). A note on lecture evaluation by students. Univ. Quat. Summer, p. 345.

Clinical Teaching Committee:

Roger Peppiatt (Chairman), Primrose Watkins (Secretary), Gerard Bulger, Doug Russell, Peter Richards, Colin Lewis.

Pre-clinical Teaching Committee:

Rory Shaw, J. Cooper, R. Humphrey.

Solution of Crossword No. 1

Across	Down
1. *clinical*	1. *cortex*
5. *calmed*	2. *issued*
9. *resolute*	3. *ill advice*
10. *drills*	4. *anthropology*
12. *emend*	6. *aorta*
13. *rub salt in*	7. *militant*
14. *mispronounce*	8. *disinter*
18. *to the plumber*	11. *abnormal size*
21. *isn't legal*	15. *operators*
23. *axial*	16. *strident*
24. *ensure*	17. *stenosis*
25. *virology*	19. *disown*
26. *tasted*	20. *played*
27. *reasoned*	22. *large*

A Systematic Approach to Doctor Training

By GERARD BULGER

Members of the Teaching Committee and others attended the BMSA conference on medical education in Nottingham last December. The principles of education have developed into a science of their own, and these can be applied to improve and assess medical education at all stages. This article is a synopsis of what we learnt about "objectives" and how it may apply to Bart's.

An *objective* in the educationalist's jargon states what a student should be able to do as a consequence of learning. Any educational programme can be defined as a series of *objectives*. Here are some examples of *objectives*:

The student

is able to carry out all medical phases of diagnosis and management without consultation in 90 per cent. of cases. Consultation for technical procedures may be necessary.

Notice that the *objective* is assessable. Although that example was a very generalised *objective*, one can have a whole range of *objectives* stemming from that one, each becoming more specific. For example: Examination of the heart. Auscultation;

The student can

(a) Position both patient and himself adequately for cardiac auscultation.

(b) Define proper use of the stethoscope bell and diaphragm.

(c) Define purpose and areas and method of cardiac auscultation.

As the *objectives* become more specific they become easier to define and assess, for example:

The student can:

Define the surface markings of the aortic and pulmonary valves in the normal subject.

The most specific *objective* is called a *specific learned outcome.*

These objectives in themselves point to the method of learning that should be used to achieve the objectives. Objectives are formulated in order to ensure that:

1. the goals of learning and teaching are unambiguous.

This means that every member of staff could see in precise terms what is to be achieved, moreover, staff in other departments, students and the outside community could see this, and suggest modifications if necessary.

2. Achievement of the goals can be assessed.

Methods of assessment are another subject, but suffice it to say that our present attitudes and examination system assess the wrong objective, viz.:

"That the student is able to pass M.B. B.S. after no more than four attempts"

How relevant that would be to being a doctor in the community is questionable, whereas assessing the first example of an objective given in this article is more obviously relevant.

3. Reasons for falure to achieve the objectives can be identified and corrected, e.g. gaps in instruction, incorrect method of teaching, etc.

At the moment there is no telling why one failed an exam, and there is no telling how one can modify one's predicament.

Objectives can only do all these wonderful things if they are drawn up properly. It is not the job of doctors to *phrase* these objectives or to assess them but those trained to do this, i.e. educationalists. For example doctors and teaching staff here are amateurs at setting multiple choice question exams—one needs an education expert to do this. However the *content* of objectives can be defined by doctors and other parties.

Traditionally the curriculum has been generated by academics and faculty members appointed because of special qualifications in a particular field, committed to passing on their knowledge onto their students. This system, and the lack of co-ordination of the courses is under attack; from pre-clinical students who see everything as irrelevant and practitioners who complain little attention is paid to practical and attitudinal goals; and from an increasingly aware public who find doctors unresponsive to the health needs of the whole community. In the past we have suggested many ways to change this, but we have been getting nowhere as the ideas have tended to contradict themselves. There have been no coherent plans from staff or students. The old way of curriculum-making has no way of justifying its content, except by subjective opinions, which can be manipulated at will. *Objectives* form a system that encourages clarity, specificity, assessability and reduces the element of personal bias and maximises precision.

How are the overall objectives of a course developed? There are a number of ways.

Critical incidence technique, where a number of public people list the things they think a doctor should do, which are then formed into objectives.

Job Analysis, a time and motion study of what the doctor actually does.

Morbidity and mortality statistics used to highlight the educational priorities in terms of health problems. McMaster Medical Faculty in Canada have defined their whole course by starting at the top, i.e. what the doctor should do in the community. Although idealistic, it is not necessary to do this. We can start by using objectives for parts of our present course.

Once one has the objectives they can be organised under three headings:

1. Cognitive (knowledge)
2. Psychomotor (professional skills)
3. Affective (attitudes and values)

These headings are called *domains.* Each domain has special methods of teaching and learning to be applied, for example psychomotor (skill objectives) are best learnt by demonstration, reinforced by the learner repeating the skills (this on a 1:1 teacher:learner basis) Affective (attitudinal objectives) are not achieved by didactic teaching, but in small discussion groups. The cognitive (knowledge objectives) are achieved by conventional methods, i.e. lectures, audio visual and using textbooks.

Much work has gone on since 1956 organising these *domains.* They are ordered in "Tables of the Taxonomy of Objectives". Part of Bloom's table for the Cognitive domain appeared in February's *Journal*, in the "Bartholomew Unfair" article. Other tables have been drawn

up for the Affective (Krathwohl) and psychomotor (Simpson) domains.

Once a set of objectives have been derived, assembled, and organised into a programme outline, consistently bearing in mind the overall objectives, the final form must take into account:

1. Terminal behaviour towards which the education is aimed.
2. The level of competence to be achieved by the student.
3. The circumstances in which 2 must be demonstrated.

We are interested in applying objectives in medical education at Bart's. Ideally the whole of the course should be defined in terms of objectives, but we could start in the middle. The module scheme being drawn up for the clinical course is particularly suited to being made into an objective plan. Each module would have a series of clearly defined objectives.

At present we have bad communications at Bart's in our teaching, and this will get worse. The firms have large numbers of students and the time spent on each firm is less than it used to be. Most of the time in future years will be spent in Hackney and beyond. Even now staff find new students on the firm, and have no idea from where they came. There is no way they can know the knowledge and skills the student has achieved at that particular time. They also have no idea, along with the student, what should be achieved at the end of the firm. The teaching staff should know the *objectives* the student has achieved before entering a module. They can then sensibly approach the task of achieving their objectives for their particular module. Any method can be employed to achieve the objectives; group discussions, ward-rounds or what-you-will, providing the objectives are achieved in the end.

We have no doubt that to use objectives would be hard work, and demand more of the teaching staff, even if used on a small scale at first. Even drawing up objectives would take up a lot of effort and money. Are there other less demanding ways of improving the course? We don't think there are. Medical objectives are difficult to understand at first because of the jargon used. Only a brief introduction has been possible here. It is important to realise that it should take a body of college authorities, teachers, GPs, students and the consumer, to act as a source of objectives. Educationalists are needed to draw up a programme in its final form, they would also be needed to continuously assess the achievement of the objectives by correct method of examinations, and finally monitor the value of the objectives. Such a body should be incorporated in a department of medical education.

If any member of staff is interested in objectives or has any comments to make, please contact the teaching committee. We would like to be able to draw up objectives for parts of the course, and hold seminars on medical objectives.

The purpose of teaching is to produce a behavioural change in the learner; once a detailed statement of the changes to occur in the learner (i.e. objectives) has been made, it is possible to consider the best method to achieve those objectives.

The leader so far in our "Furthest sign from Bart's" competition is Tom Morgan with this sign at Frazer Canyon, British Columbia.

ST. BARTHOLOMEW'S HOSPITAL
PRE-REGISTRATION HOUSE APPOINTMENTS
JULY, 1973

APPLICATIONS ARE INVITED FOR the following appointments:—

1 post:	House Phyeician to Dr. Hayward
1 post:	House Physician to Dr. Black
1 post:	House Physician to Dr. Oswald
1 post:	House Physician to Dr. Gibb
1 post:	House Physician to Professor Scowen
1 post:	House Surgeon to Mr. Tuckwell
1 post:	House Surgeon to Mr. Nash
1 post:	House Surgeon to Mr. Robinson
1 post:	House Surgeon to Mr. Todd
1 post:	House Surgeon to Professor Taylor
1 post:	House Surgeon to the E.N.T. Department
1 post:	House Physician to the Department of Child Health
2 posts:	House Surgeon to the Department of Orthopaedics

Regional Board Hospitals

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

Application forms, which must be returned by the *24th April, 1973*, are available from the rack outside the Medical College Library, or by post from the Sub-Dean's Office.

A. P. FULLER, F.R.C.S.,
Sub-Dean of the Medical College

BART'S DRAMA

HASSAN by JAMES ELROY FLECKER

"For lust of knowing what should not be known
We take the Golden Road to Samarkand."

"Hassan" is the story of a simple confectioner of Baghdad. It was written by James Elroy Flecker around the turn of the century and is the tragic and moving story of how Hassan, through no fault of his own, is befriended by the cruel and tyrannical Caliph of Baghdad. In his new position in the court of the Caliph, he finds himself unwilling witness to the sad story of two young lovers. The vindictive Caliph gives the lovers the choice between love and life. They choose love and after 24 hours are tortured to death. After this, Hassan is so disillusioned with himself and life that he leaves Baghdad to make the pilgrimage to Samarkand.

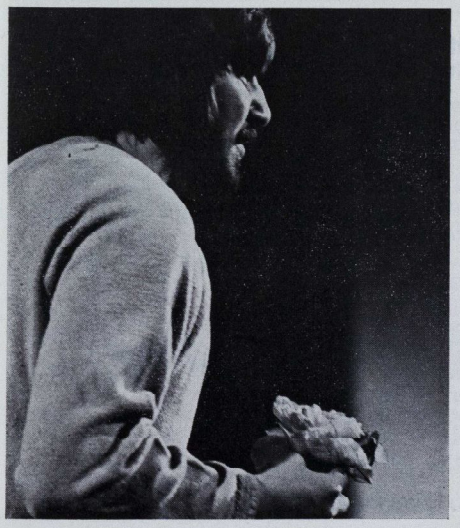
"Hassan" marked Rob Robertson's debut as a director at Bart's, and a very ambitious debut it was. If there were weak points in the production, it was only because a cast of 24 is bound to have some less experienced members. In the first act, I felt Rob's direction was a bit heavy handed, changing the interpretation between comedy and pathos too often to let the audience settle. In acts two and three, however, the play really moved into top gear.

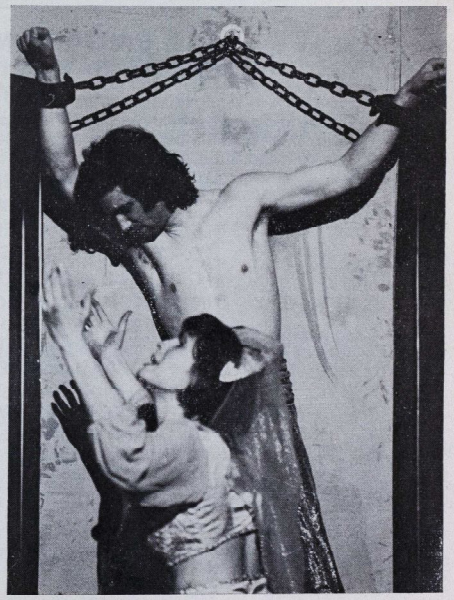
The character of Hassan was wonderfully brought to life by Doug Russell. Any actor who can spend the whole second half of a play crying without boring the audience to death must be talented. Doug has a very powerful presence on stage when necessary, but he also has the commendable ability not to overshadow the other actors.

Bart's Drama now has strength in more depth than ever before, and I felt particularly fine performances came from Martin Gore as the Caliph, and from Al Dickson and Ruth Dunlop as the lovers. There was also some nicely judged comedy from Rob Robertson and Jon Ramsay.

It is very pleasing to see Bart's Drama at last getting the size of audience that it deserves. The presence of some new faces in the cast is a healthy sign for the future. I, for one, am looking forward to the next production.

ALLARGANDO





Photographs by Charles Wellingham.

BARTS MUSIC

THE BARBICAN ORCHESTRA CONCERT IN THE GREAT HALL

The Great Hall provided again a splendid venue for a concert. It lends a resonant atmosphere which is, in itself, flattering for the musicians to play in. Balance occasionally becomes difficult—the horns of an orchestra have to play softly whilst the viola line needs more weight. Such difficulties were rapidly overcome by the Barbican Orchestra under their musicianly conductor David Thompson when they entertained us on February 15th.

The programme selected was a marvellous blend of Mozart and Schubert with Respighi; Faure and Ravel also represented. Mozart's wind sinfonia concertante K 297 b was the opening work. If its authenticity is in doubt, surely only Mozart could have written the beautiful adagio slow movement which sounded like an extended cantilena—very close to Act 4 "Figaro" in style. The soloists and orchestra produced the rapt intensity demanded here, and plenty of punch and virtuosity in the outer movements. All the soloists were highly competent and if one hears that Peter Wiggins (oboe) has joined one of London's big five orchestras, I for one would not be surprised.

The two Pavanes which followed showed Mr. Thompson's great musical qualities—he is prepared to allow music to breath, to its advantage. The nostalgic melancholy of the flute solo in the Faure and the string tone of the Ravel not only conveyed the excellence of the band but the total musical commitment.

Respighi's "Birds", based on 16th century themes was hugely enjoyed by the moderately well-filled hall, particularly the clucking hen and the cuckoo. The Mahlerian horn, woodwind and high violin line, too, of the Nightingale were haunting.

Schubert's 3rd symphony ended the concert. Mr. Thompson clearly sees this work as something more than an early work of light weight ideas and charm. The first movement was truly maestoso—much more truly "Tragic" than that which Schubert called Tragic (his fourth). In the last movement the cumulative powerful effect (almost "Great" C Major like) was very exciting.

This was a splendid evening—one hopes this orchestra will grace Bart's with its playing again. If it does, it will be a date to put in the diary long in advance!

ALLEGRO

ST. BARTHOLOMEW'S HOSPITAL
POST-REGISTRATION HOUSE APPOINTMENTS
JULY, 1973

Applications are invited for the appointments set out below. Application forms, which must be returned by *Monday, 16th April, 1973,* are available from the Sub-Dean's Office.

H.P. TO THE DEPARTMENT OF CHILD HEALTH
H.S. TO THE E.N.T. DEPARTMENT
H.S. (2) TO THE EYE DEPARTMENT
H.O. (2) IN OBSTETRICS
H.O. (2) IN GYNAECOLOGY
H.S. (2) TO THE THORACIC DEPARTMENT
H.S. (2) TO THE NEUROSURGICAL DEPARTMENT
H.P. TO THE SKIN DEPARTMENT AND SPECIAL TREATMENT CENTRE
H.P. TO THE DEPARTMENT OF NEUROLOGY AND PSYCHOLOGICAL MEDICINE
H.S. TO THE DEPARTMENT OF UROLOGY
H.P. TO THE ACCIDENT AND EMERGENCY DEPARTMENT
H.S. TO THE ACCIDENT AND EMERGENCY DEPARTMENT

Posts are tenable for six months from July 1st, 1973.

A. P. FULLER, F.R.C.S.,
Sub-Dean of the Medical College

BOOK REVIEW

RICHARD ASHER TALKING SENSE
Pitman Medical. London. £1.50p.

Every so often one is fortunate enough to come across a book of such enormous distinction that it simply cannot be put down. Only very rarely does it have anything to do with medicine, and even more infrequently is it marvellously funny too. These qualities have all been miraculously welded into one work, and Richard Asher Talking Sense will, I am sure, become a classic and a bestseller.

It is a book of magic, a distillation of the finest and most flamboyant writing of the kind which made Richard Asher famous. It is inimitable in its style and flawless in its common sense. There are so many jewels among the pages that any reader—and especially those with a passing interest in medicine—will find something to his taste. At the start of the book there is an extensive discussion of clinical sense, which displays his masterly skill at what the Americans call "physical diagnosis"; and even a short word about the value of taste in clinical medicine:

"I remember about 10 years ago seeing a baby with ascites of such milky whiteness, that some of the wondering doctors thought it was milk which had leaked from some breach in the alimentary tract. Others alleged that it was chylous ascites secondary to blocking of the thoracic duct. Dr. John Humphrey, our Biochemist at the time, was called in to settle the problem. He looked thoughtfully at the specimen of the fluid for a few seconds, and then he gravely took a generous sip. Without a moment's hesitation he shook his head and said: 'That is not milk.' "

What stupendous breadth this physician had! Dr. Doolittle, Humpty Dumpty, Sherlock Holmes and Rumpelstiltskin all feature here; but then so do Sir James McKenzie, William Harvey, Crawshay-Williams, and Michael Balint. The sheer fluency of the writing is dazzling, and never more so than when he is having a go at something. In this instance, it is the tenth-rate medical news reports in the national press:

"Teresa Teardrop, a little crippled girl with pleading eyes, has lain paralysed for seven long years in a picturesque cottage at Little Sobbing-on-the-Sleeve. But now she is going to have the chance of her life. She is off to London to see the great Harley Street Specialist, Sir Bernard Bogus. For months, all the villagers at Sobbing-on-the-Sleeve have been putting their pennies together, and little Teresa is trying to sell her pet kitten to raise money, but at last the necessary two hundred guineas have been found, and a brave little figure, clasping her dolly was whisked off to London this morning with her blue eyes full of happiness."

But Asher was not only an iconoclast, a scathing critic of other people's work. Most doctors know already that he rediscovered myxoedema madness from the literature, and described beautifully several cases cured by thyroid extract. Fewer are aware that he coined the term "Munchansen's syndrome" and that he wrote on "The Dangers of Going to Bed" in 1947, long before early ambulation was fashionable. All three of these magnificent papers are included here; and all, I need hardly add, are written in beautiful English which anyone can understand. In fact, he frequently rails long and hard against the jargon-users, the mistreaters of language, and those who confuse profundity of thought with the use of impressive-sounding, esoteric (but usually inappropriate) words:

"My charlady once said to me, of someone she heard on her television: 'Oh he's a real scholar, he is. He talks so clever you can't understand a single word he says.' "

If you've read this far, you've wasted three minutes that could have been spent reading Asher first-hand. Don't waste a moment more! Rush out and buy!

P.S.: Dear Sub-Dean. Do you still circulate a short booklist for new students? This ought to be at the top, in the section marked "compulsory".

JEFFREY TOBIAS

RECENT PAPERS BY BART'S ALUMNI

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

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

BART'S SPORT

CROSS-COUNTRY

Wednesday, November 29th, 1972, was the occasion of a major Bart's disaster. The event was the St. Mary's Hospital Porritt Cup race—that 5½-mile frolic around the perimeter of Hyde Park and Kensington Gardens—and a victory for Bart's in both 1970 and 1971. With no disrespect to anyone Bart's were, of course, the hot favourites, although it was rumoured that St. Mary's Hospital, Paddington (W.2) also thought themselves in with a chance. Blast-off was delayed by dramatic late arrivals of representatives of both these highly organised squads, and the eventual appearance of Bart's ace Tim Hunt—still encased in plaster—finally heralded the start.

There is little that one can say about a race around Hyde Park . . . it looks much the same as at walking pace, except that it goes by a bit faster.

Steven Mann made a particularly brief tour of the park's duty spots to finish 6th: Bruce Campbell tottered in 7th, and Bob Miller followed in 9th place. Tim Hunt, Paul Taylor and Graham O'Byrne completed the scorers in fine form.

Unfortunately the outcome was a victory for Mary's, and a beaming Lord Porritt, recently retired Governor General of New Zealand for the occasion, presented the trophy to his old hospital.

BART'S PLACINGS

Place	Name	Time	
6th	S. Mann	29mins.	23secs.
7th	B. Campbell	29	45
9th	R. Miller	30	32
14th	T. Hunt	32	51
20th	P. Taylor	34	04
26th	G. O'Byrne	38	51

The first U.L. Leagues match of 1973 was held at the University of Surrey, Guildford, on January 24th. The meeting caught a glimpse of Spring fashion, as M. Page premiered his embarrassingly smooth skin-tight black track suit with sophisticated double white stripe. A team from St. Mary's Hospital paraded their new low-cut blue vests with floral design, but unfortunately these did not seem to enhance their performance during the race.

The course was little altered from last year an unpleasant three laps of Surrey plough and swamps—but the inimitable Bart's squad struggled to an impressive eighth place in the University. This was Graham Howell's first race for Bart's, and he deserves congratulations, with the rest of the team (minus the author, who was mysteriously absent), for helping to maintain our position in the League.

Each year David Wainstead is allowed a paragraph to himself.

BART'S PLACINGS

Place	Name	Time	
18th	S. Mann	35mins.	30secs.
28th	R. Miller	36	57
48th	D. Wainstead	39	24
54th	T. Hunt	40	39
64th	M. Page	41	37
75th	G. Howell	44	13

Bart's finished 8th in Division I; a West London hospital finished 9th.

The next Leagues race, on February 14th, was a two-lap affair in picturesque Richmond Park—about five miles in all. This attracted an eight-man Bart's team, which in the event was led home by the amazing Steve Mann (14th). Bob Miller—the incredible clockwork athlete—began his sprint towards the finish during the first lap, and was stopped as he crossed the line in 35th place. Bruce Campbell wheezed to a halt 41st, and the dynamic duo of Tim Hunt and Mike Page occupied 67th and 68th positions. Martyn Wall, in his first appearance with the team, followed in 75th place, and Graham Howell gracefully brought up the rear—94th. Bartsman number eight was forced to withdraw with an asthmatic attack, but fortunately did not require medical attention.

Our next exclusive report will include a frank and ruthless account of the Kent Hughes Inter-Hospitals Championships. I understand that St. Mary's Hospital will also be fielding a team.

BRUCE CAMPBELL

CRICKET CLUB AGM

The Cricket Club AGM was held in the Hospital Abernethian Room on February 22nd: at short notice. Mr. Vartan kindly agreed to take the chair.

About 20 members were present. Many views were expressed about the reasons for the poor displays of last season. However, most people agreed that all that was required for an improvement in the situation was an increased efficiency in organisation and a greater sense of responsibility from all members.

The following officers were elected:
President: Professor Lawther
Captain: A. Davies
Vice-Captain: J. Capper
Social Secretary and Pre-Clinical Rep.: T. Dudgeon
The following were re-elected:
Treasurer: E. Rowlands
Secretary: A. Munro

P. Cooper, A. Davies, M. Martin and A. Munro were recommended for Club Colours.

Practice-matches and nets will be arranged for the end of April and all who wish to play this season (students, medical and lay staff) are urged to attend. The Secretary would also be very pleased to hear from anybody who would like to score or umpire.

RUGBY - BARTS vs. WESTMINSTER Lost 31-4

Bart's received their biggest defeat in the Hospitals Cup for many years at the hands of the powerful Westminster team; and nobody watching the game could say their victory was undeserved, scoring seven tries to Bart's one.

Westminster obviously came into the semi-final with a plan to run the ball from everywhere, and to bring their powerful three-quarters into play wherever possible. Bart's did nothing to disrupt this plan, by missing easy kicks to touch from penalties and by kicking hard won possession into the grateful hands of Rees, the Westminster captain and full-back.

The lead was gained early in the game by Westminster when Rutter dropped a goal from the Bart's twenty-five. They immediately began to play attractive rugby, inspired by K. Hughes and R. Phillips, their London Welsh three-quarters. The first try came after 18 minutes when Rees came into the line and scored in the corner. The try, like the other six Westminster were to score, was not converted.

Soon afterwards their left-wing scored another, after a break by Hughes, and the score at half-time was 11-0. Martin, the Bart's fly-half, had missed four penalties from within his normal kicking range, but Bart's otherwise had shown no sign of crossing the Westminster line in the half.

Any hopes of Bart's revival were dashed in the second-half, when Westminster scored again after another break by Hughes. They added four more good tries during the second-half, all their tries being shared by Rees and the wingers. The Bart's tackling was not all it could have been in the second-half, but the credit must go to the Westminster three-quarters for their bold attacking play, especially Phillips, who had to contend with wretched service from his brother at scrum-half, and Hughes, who showed time and time again what an international centre can do to a side at this standard of rugby.

Between the Westminster tries Bart's won a rare ruck in the Westminster "25", and after a half-break on the blind side by Martin, Findlay-Shirras scored a consolation try. Findlay-Shirras had earlier made a fine break, and generally played well for Bart's in the centre, and M. Porter did well at scrum-half, usually being under severe pressure.

In retrospect Bart's only chance of winning this game lay in mastering the Westminster pack and harassing their scrum-half into mistakes, but the Bart's pack never really achieved any sort of dominance in the loose or line-outs. D. Court, the Bart's hooker, held his own in the tight scrums, no mean achievement against an International reserve hooker, and was one of the few to show some fire in the loose. D. Elliot also showed up well in the back row, but generally the team disappointed.

However, it must be remembered that only four players had played Hospital Cup rugby before, and with some promising young players being available for the next few years, the future of Bart's rugby is not as bleak as it sometimes appeared against Westminster.

TEAM

H. Maurice, J. Goddard, N. Findlay-Shirras, R. Adley, S. Smith, M. Martin, M. Porter, D. Badenoch, D. Court, R. Brookstein (Capt.), A. Wood, P. Cooper, D. Elliot, R. Coleman, J. Capper.

M. PORTER (Bart's) passes from a set scrum.

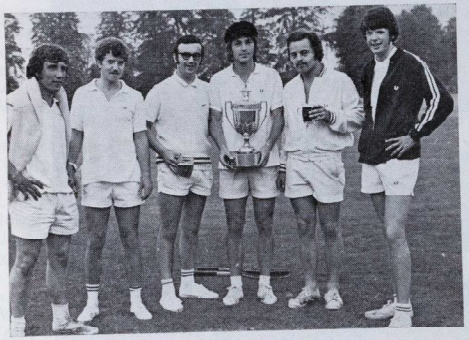
Photo courtesy of E. D. LACEY.

S. Smith (Bart's) is unable to stop D. Lincoln scoring the second Westminster try.

K. Ashbridge, attended by J. M. Goddard (Bart's), about to score the third Westminster try.

Photos courtesy of E. D. LACEY.

TENNIS



1973 MEN'S TENNIS CLUB REPORT FOR 1972
Bart's 1st VI after winning the U.H. Cup. From L. to R.: J. WELLINGHAM, H. SIMPSON, D. STEWART, N. PERRY, J. SMALLWOOD, P. MORTIMER.

The promise shown by the Bart's tennis team in 1971 came to full fruition in 1972, a year which saw Bart's have their best season in the long history of the club. They retained the Inter-Hospitals Cup for the third consecutive season, thus creating a club record, and added to it the Inter-Hospitals League Championship and University of London Inter-Collegiate Cup for the first time.

In Nick Perry, the team not only had a very keen and enthusiastic captain, but an extremely good player. In 1972 in addition to playing for Bart's, Nick represented the University and also reached the semi-final stage of the British Universities Championship. Despite his heavy tennis commitments, Nick played every cup and league match for the hospital, winning 25 out of his 26 matches, the only loss being in a doubles against Mary's 1st pair, which contained J. P. R. Williams. No other team member has played more of a part than Nick in the success of the hospital's tennis over the past three years, and it was fitting that during his year as captain, the team should have had such success.

Despite the pressures of second M.B., Peter Mortimer and Jim Smallwood added great strength to the team, particularly during the later stages of all three cup competitions when it was needed most. Peter, having played at senior county level for Devon, and Jim, a past junior Wimbledon player, should continue to add depth to the team for the next few seasons.

David Stewart had a very successful season playing No. 2 string to Perry in most of the league and cup matches. David was the only player apart from Perry to play in all league and cup matches.

Particular mention should be given to Adrian Dixon, Chris Higgins and Antony Hambly, who completed their last season with Bart's tennis. As qualified doctors we wish them every success in their future careers.

No other team, I am sure, could have called upon the reliability, expertise or experience of such a third pair as Dixon and Hambly. One could be assured that although their opponents' tennis may have been superior, Dixon and Hambly's verbal versatility would see them through.

Chris Higgins and John Wellingham provided another valuable pair. Despite losing Chris, we still have John for another year. He played many matches for the team in 1972, but none will be remembered more than his tenacious singles victory in the final rubber against Mary's. This victory provided the necessary points for Bart's to win the league. Other players who represented the team were: J. Howell, A. Colver, S. Grainger, R. Bulley, C. Wellingham and H. Simpson.

Staff Match

On July 2nd the annual match v. the staff was held at Chislehurst. The staff were represented by Drs. Kelsey Fry, Galton, M. Setchell, N. Houghton, C. Garrard and Messrs. Dowie, Lettin, McNab Jones, and Kenefick. As usual the result was never fully resolved but the assembled gathering retired to Dr. and Mrs. Kelsey Fry's home for a splendid buffet supper, for which the club thanks them.

AGM and Dinner

On December 1st the AGM was held in the Abernethian Room, followed by a dinner in the Great Hall. Mr. Dowie, the President of the Club, presented each of the 1st team squad with engraved tankards to commemorate the year's achievements. Also present at the dinner were Vice-Presidents, Mr. Lettin, Dr. Galton and past-President Mr. Donald Fraser.

Appointments for 1973
Captain: P. S. Mortimer
Secretary: D. Stewart
Vice-Captain: J. Howell
Social Secretary: A. Colver

Colours were awarded to
D. Stewart
J. Howell

Results of 1972 U.H. League Championship
Winners: Bart's
Runners-up: Mary's
3rd: Tommies
4th: Westminster
5th: Guy's
6th: London

P. S. MORTIMER

SAINT BARTHOLOMEW'S HOSPITAL JOURNAL
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Editoral

Barts—in case you hadn't noticed—is 850 years old. During those 850 years it has experienced the extremes of fame and obscurity, its doctors have treated the richest and the poorest in the land, and the ideas propagated there have varied between revolutionary and ultra-reactionary. It is well to remember that the history of no institution consists of a continuous blaze of glory, and it allows the more rational appraisal of the role of the hospital in society present and future.

Yet the ultimate tradition of Barts is not one of contrasts but of similarity—of a continuous thread running through the various episodes of the hospital's life and linking them all in some mysterious fashion. Governments, nations and whole civilisations come and go, but Barts goes on for ever. To what extent is this true? Does Barts (or what it stands for) represent something lasting and important, or is the great Barts tradition merely an attempt to make an unpalatable present more acceptable by linking it with a romanticised past and future?

I think not—and inability to define this common factor does not weaken that conviction. Barts may have had an attraction to people through the ages for reasons that are noble, base or pedestrian, but the attraction is undeniably always there.

However, society has changed in a drastic and irreversible way and one is left with the feeling—implicit in the present celebrations—that the next few years will see the end of a long era as far as Barts is concerned. One can only hope that all that has gone before will not be completely forgotten in the brave new world to come.